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Planned Happenstance: Constructing Unexpected Career Opportunities

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Chance plays an important role in everyone's career, but career counseling is still perceived as a process designed to eliminate chance from career decision making. Traditional career counseling interventions are no longer sufficient to prepare clients to respond to career uncertainties. Work world shifts challenge career counselors to adopt a counseling intervention that views unplanned events as both inevitable and desirable. Counselors need to teach clients to engage in exploratory activities to increase the probability that the clients will discover unexpected career opportunities. Unplanned events can become opportunities for learning.

Traditionally, career counselors act as if chance plays no role in their clients' career planning. We intend to explore how chance events inevitably play a major role in everyone's career and how events attributed to chance are often indirect outcomes of effective behavior. Career counselors can teach their clients to act in ways that generate a higher frequency of beneficial chance events on which clients can capitalize.

The popular Tom Cruise movie *Jerry McGuire* (Crowe, 1997) is based on the life of a high-powered professional sports agent, Leigh Steinberg. In a recent interview, Steinberg explained that he got his start through "pure, random chance" (Snider, 1997). But did he? Tracing a sequence of events in Steinberg's life provides key points to be considered.

During the early 1970s, Steinberg was a student at the University of California at Berkeley working his way through law school as a dormitory counselor and serving as student body president. Steinberg planned to pursue either a job opportunity with the County District Attorney's Office or opportunities in the field of environmental law. As luck would have it, the freshman football team moved into his dormitory. He befriended several of the student athletes including one named Steve Bartkowski, who went on to become an outstanding professional football player. (Note that Steinberg had managed to get admitted to law school, that someone had detected qualities in him sufficient to appoint him as a dormitory counselor, that Steinberg had persuaded a majority of university students to elect him as their student body president, and that he had become good friends with a star athlete. Were all these events the result of pure random chance?)

During his final year at the university, Bartkowski was selected as the first draft pick of the Atlanta Falcons. Bartkowski asked Steinberg to represent him in contract negotiations with the Falcons, and "the rest is history" because Steinberg has gone on to represent many professional athletes and other celebrities during the last 20 years. (Was Steinberg the only person capable of representing Bartkowski? Obviously Bartkowski must have observed qualities in Steinberg that gave him confidence that he would be well represented. Did his subsequent clients choose him through pure random chance? It is very likely that other clients must have observed the results of his performance while representing Bartkowski.)

It certainly did not hurt Steinberg's cause that he began his career by representing a National Football League first round draft choice. His decision to accept Bartkowski's invitation was a risky move. He had no actual experience in the highly competitive, pressurized, and sometimes cut-throat arena of professional sports. Steinberg could have said "no," but instead he took the risk and said "yes."

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The only element of luck in this story is that the freshman football team happened to be assigned to Steinberg's dormitory (although, admittedly, how that decision was made is not known). What would have happened had the football team been assigned to another dormitory? What is known is that Steinberg and Bartkowski both capitalized on that lucky pairing, much to their mutual benefit.

THE ROLE OF CHANCE IN CAREER COUNSELING

This story of Leigh Steinberg illustrates several important issues for career counselors. Chance plays an important role in everyone's career. No one can predict the future with any accuracy. On any given day no one knows for sure what people will be met, who will call, or what letters or e-mail messages will arrive. If one day cannot be predicted, what is the likelihood that future plans spanning 2, 5, or even 20 years can be realized with any accuracy? Most people agree that "chance," "luck," or "happenstance" has played an important part in their careers (Betsworth & Hansen, 1996). In fact, it is hard to believe that anyone would seriously claim that unpredictable events had no influence on their career direction. Yet career counselors rarely discuss unexpected or chance events with their clients.

A few authors of career development literature have recognized, to a certain degree, that chance events are present in career exploration (Bandura, 1982; Betsworth & Hansen, 1996; Cabral & Salomone, 1990; Hart, Rayner, & Christensen, 1971; Miller, 1983, 1995; Scott & Hatalla, 1990). However, some believe that including chance events in a career counseling model is a complex and formidable undertaking.

For example, the authors of two separate articles have claimed that whereas happenstance is a component of career development, it is problematic to include happenstance in a career counseling model. Cabral and Salomone (1990) wrote, "While it would be difficult to develop a model that incorporates chance into the counseling process, it is nonetheless essential that the counselor help clients to recognize its effects and develop coping behaviors that anticipate unforeseen events" (p. 14); and Scott and Hatalla (1990) stated, "The thought of including chance factors such as unexpected personal events into the theory and practice of career counseling is disconcerting because it is, by its very definition, unpredictable and untidy" (p. 28).

It is interesting that Scott and Hatalla (1990) conducted research on chance and contingency factors identified most strongly by women. The authors defined *chance factors* as those elements contributing to a vocational choice that have no predictable relationship to it, for example economic situations, unexpected personal events, and unexpected information. The major chance factor reported was "unexpected personal event," and the authors recommended further research on this factor.

Miller (1983) advocated a quite different point of view, questioning whether rational career planning is even possible or desirable, and stated that counselors would benefit by viewing happenstance as a normal aspect of career choice. Cabral and Salomone (1990) called for a model of career decision making that integrates some combination of planfulness and happenstance.

Rational planning alone would serve its purpose if careers were to follow a simple, straightforward, and logical path. Unfortunately, due to major technological advances, the world of work today is not what it used to be. In virtually every employment sector, job descriptions are changing, some occupations are becoming obsolete, and unforeseen occupations are being created (e.g., web page designer). Although one of the main goals of career counseling has been to help clients to identify the name of a future occupation, it will be increasingly difficult for career counselors to continue to be effective, given the traditional model.

Planning has remained a strong component in career exploration. Frank Parsons, credited as the father of career counseling, developed his theory of career development during a time when people were moving from a largely agricultural society to the beginning of the industrial age (G. A. Watts, 1994). People left the farm and moved to newly developing cities to seek work. Parsons developed the first effort to assess workers' values, skills, and interests (Jones, 1994). The emphasis in his assessment questionnaire was on matching the client to appropriate jobs. Chance events were not included in the questionnaire developed by Parsons.

Probably because of Parson's emphasis on "true reasoning" (Jones, 1994) as the basis of matching, career counseling is still perceived as a process that is intended to eliminate chance from career decision making. Many career counselors are reluctant to admit that their own current occupations were not totally the result of rational planning. The traditional trait-and-factor approach of matching individual interests, skills, and values with specific occupations is seen as a way to reduce the role of chance, luck, or happenstance. In fact, career counselors prefer clients who seem to be heading in a definite direction or seem on the right track as the counselor has helped them to define it. The purpose of interest inventories and many other available tools is to help clients to identify a successful career direction. Clients who reject this push toward certainty are often viewed as "difficult" or "problem" clients—certainly as "indecisive." Some career counselors even believe that these indecisive clients should be referred to counselors who focus on so-called personal issues.

PLANNED HAPPENSTANCE THEORY

Planned happenstance theory may be considered as an amendment to the learning theory of career counseling (Krumboltz, 1996), which was an expansion of the social learning theory of career decision making (Krumboltz, 1979). The basic propositions remain the same. Humans are born with differing characteristics and predispositions at a given time and place to parents not of their own choosing. They grow up in an environment where innumerable unpredictable events occur that provide opportunities for learning of both a positive and negative nature. Individuals can also generate events

on their own and can capitalize on all kinds of events and resources to maximize their learning. The counselor's job is to facilitate the learning of skills, interests, beliefs, values, work habits and personal qualities that enable each client to create a satisfying life in a constantly changing work environment.

Planned happenstance theory is a conceptual framework extending career counseling to include the creating and transforming of unplanned events into opportunities for learning. The goal of a planned happenstance intervention is to assist clients to generate, recognize, and incorporate chance events into their career development. The words "planned happenstance" have been intentionally united as an oxymoron. Clients must plan to generate and be receptive to chance opportunities. A strong component of planned happenstance is facilitating the client's actions of generating and anticipating possible opportunities. Planned happenstance theory should not be confused with magical thinking or reliance on fate. Clients should not merely meander through experiences initiated by others while passively awaiting a "knock on the door." They need to learn to take action to generate and find opportunities.

REFRAMING INDECISION AS OPEN-MINDEDNESS

The term *open-mindedness* displaces *indecision* in planned happenstance theory. Blustein (1997) suggested that counselors help clients learn to tolerate ambiguity and to develop an exploratory attitude. He defined exploratory attitude as "an open and nonrigid way of relating to the world such that one is able to approach the vast number of new situations and changes that individuals face in a manner that encourages growth and further self-definition" (p. 270).

Clients should not leave everything to chance. There is a crucial difference between someone who passively relies on luck to solve problems and someone who is actively searching while remaining open to new and unexpected opportunities. The career counselor can play a crucial role in helping clients to create positive chance events. As a result, clients may not end up where they requested, but they may very well end up where they want to be.

The advantages of open-mindedness. Most of us credit small children with possessing great curiosity. We take joy in watching children explore new objects through turning, touching, and smelling. Curiosity introduces the world to the child through exploration of sights, sounds, and textures. However, what if each time a child reached for an object, a parent asked, "What is your goal?" Much wonderment, joy, and knowledge could be denied to the child. Somehow, when a child explores, adults are able to stand back with protective interest and trust that the experience will bring the child more deeply into the world.

Yet, when people experience a career dilemma and seek the assistance of a career counselor, in many cases, the career counselor moves quickly to fix the puzzlement with a solution, a definitive answer—administering a battery of tests so that the client's anxiety about lacking an occupational goal can be alleviated. Too often, career counselors have not been trained to be comfortable with a client who remains undecided for very long. In fact, some researchers in career decision making suggest that counselors go beyond merely acknowledging client uncertainty and advocate distinctions between categories such as "undecided" and "severely indecisive" (Fuqua & Hartman, 1983; Hartman, Fuqua, & Blum, 1985; Hornak & Gillingham, 1980). The implication is that any form of uncertainty is to be diagnosed and treated.

An alternative to a "quick fix" may be more appropriate in many cases. Imagine a counselor stating as a client goal, "Let's work at your becoming more comfortable with your undecidedness." When friends ask the client, "So what are you going to do?" the client would then respond, "I'm learning to keep an open mind about future possibilities." Do we have an appropriate cultural response to that? Generally, no. When we ask, "What are you going to do?" our American culture frequently causes us to expect a definitive response, for example, "I am going to study engineering," "I am going to work for IBM." The specificity of the answer seems to be a well-established cultural expectation, even if the answer has no basis in reality.

Typically, in our American culture, a decisive person is thought to be one in charge—one who knows the way. An undecided person is thought to be "wishy-washy" and easily swayed. However, Krumboltz (1992) argued that indecision about making definite long-range plans is actually more sensible than making firm commitments when the future is so uncertain. In our world at present, more prestige accrues to the person who gives a definitive answer—no matter how poorly investigated that answer. The trouble occurs when the people who feel pressured to state a definitive occupation then have to implement the decision—ready or not.

An open-minded person is in the middle of what was and what will be. Being undecided means that all the data are not in. The person has a chance to develop the skill of asking questions just to know, not necessarily to do anything about the answer. The person has an opportunity to be curious, to be guided by "what would happen if" questions and to explore options, not to be bound to a plan that may be obsolete before it is formulated. The story of Laura is a case in point.

The case of Laura. Laura has been a social worker for many years. She had entered social work full of idealism and the desire to help other people. A chance requirement of her job, which she had not anticipated, was that she had to write up case notes on her clients. She entered career counseling hoping to leave the field of social work and find a new occupation. She described vivid tales of human suffering, neglected babies, and drug-addicted parents. Home visitations were trips into human misery replete with unclean living conditions, populated by people who felt trapped by poverty and lack of hope. It was becoming more difficult for Laura to maintain enthusiasm for her work, despite her idealistic aspirations.

Her respite from the sights and sounds of her encounters came at the end of her work day when she would close her

office door, sit in front of her computer, and in detailed narratives recount what she had seen, heard, and recommended. This solitary activity of writing reports, originally an unexpected and onerous chore, became the thread connecting her to a new career interest. Although the subject matter of her reports was depressing, she discovered that the act of writing itself could be insightful and invigorating.

Laura wanted to pursue her writing interest and requested that the counselor tell her the name of a suitable occupation. Her career counselor responded that job titles could eventually be found, but while the vision of her interest was forming, job titles might foreclose possibilities. Instead, they looked at the purpose for Laura's writing, the stories she wanted to tell and to whom. The counselor helped her identify an initial topic, some possible publication outlets, and some authors and editors to interview. One editor suggested that Laura submit a query letter on her topic. Her proposal was accepted, and she wrote her first article that was soon published. Other publications responded favorably to her letters, and she continues to be published regularly to this date. Her exploration into writing introduced her to people who she never dreamed were available to her and who enabled her to capitalize on her curiosity, sensitivity, reason, and creativity to translate stories of human misery into inspiring challenges for social action.

Although Laura presently remains employed as a social worker, something monumental has shifted in her attitude about her clients and her life. The chance happenstance of report writing deepened her sensitivity to her clients and renewed her commitment to ease their struggles through advocacy and action. She sees their lives not as cases to be closed but as stories to be told.

Generating, Recognizing, and Encouraging Beneficial Chance Events

Unplanned events are not only inevitable, they are desirable. Gelatt (1989) proposed that being uncertain about goals and wants leads to new discoveries. Counselors need to teach clients to engage in exploratory activities that increase the probability that they will be exposed to unexpected opportunities. Counselors need to teach clients to approach new opportunities with an open mind, to ask questions, and to experiment.

Betsworth and Hansen (1996) found that two thirds of the 237 participants in their study believed that their careers were significantly influenced by chance events. The authors identified 11 categories of serendipitous events that participants reported as significant to their career development. "Professional or personal connections," "unexpected advancement," and "right place/right time" were cited most frequently. Clients often overlooked the steps they took to get to know significant people, or the actions they performed that led to a promotion or placed them in the right place at the right time.

The case of Ted Robinson. "It was just a fluke," said San Francisco Giants' broadcaster Ted Robinson during an interview with Gary Radnich (1996) on San Francisco radio station KNBR when he described how he started his career in broadcasting. He attained his initial job in the major leagues by calling the Oakland Athletics (A's) office and was surprised to find that team owner, Charlie Finley, was on the other end of the line. "The next thing I knew I had a job interview lined up." Before these chance events turned "lucky" for Robinson, he had worked as a college sports broadcaster during his student years and provided broadcasting for a minor league hockey team. In his second season, the hockey team went out of business, and Robinson seriously considered giving up on his dream to become a major league announcer. His father encouraged him to call the Oakland A's because Charlie Finley had a reputation for hiring inexperienced people at low salaries. A chance event then occurred; Finley answered the phone. Robinson was able to talk Finley into giving him an audition and eventually an opportunity to broadcast a few innings a week. As Robinson continued to develop as a broadcaster, he went on to become a full-time major league broadcaster. It was more than luck that got him started. He had acquired prior experience as a sports broadcaster. He sought advice about a team owner who might be open to new talent, and he took the initiative to make the telephone call. He did not know who would answer the phone, but he placed the call and seized the opportunity to sell his talents.

Planned happenstance theory includes two concepts: (a) Exploration generates chance opportunities for increasing quality of life, and (b) skills enable people to seize opportunities. Blustein (1997), in his work on career exploration, concluded that people explore as a way to express their natural curiosity and that the benefits of career exploration, can cross over into other life domains. Austin (1978) perceived that responses to chance opportunities vary according to one's preparedness and receptivity to possibilities. Salomone and Slaney (1981) proposed that chance factors may indeed create vocational options; however, these authors cautioned that for career possibilities to be realized, people must take action.

Planned happenstance theory proposes that career counselors can assist clients to develop five skills to recognize, create, and use chance as career opportunities. These five skills and the accompanying definitions are as follows:

1. Curiosity: exploring new learning opportunities
2. Persistence: exerting effort despite setbacks
3. Flexibility: changing attitudes and circumstances
4. Optimism: viewing new opportunities as possible and attainable
5. RiskTaking: taking action in the face of uncertain outcomes

Bandura (1982) recommended teaching entry skills as a way of influencing or controlling chance to one's advantage. Entry skills can be as diverse as interpersonal communications, networking, and social support building (as cited in Cabral & Salomone, 1990, p. 15). Planned happenstance can also be facilitated in other ways.

Using assessment instruments to generate chance events. Interest inventories provide an efficient exposure to job titles and offer clients a link to the world of work. The degree to which a counselor engages a client in dialogue and discussion is often determined by the counselor's style and knowledge of and comfort with a particular assessment instrument. More often than not, interpretation sessions focus more on the counselor telling than on the client discussing.

The planned happenstance model for interest test interpretation is constructed from questions that invite discussion. For example, in traditional Parsonian test interpretation, emphasis is placed on identifying career fields similar to the client's interests. The planned happenstance session would focus on dissimilar areas also. Interests are learned and can continue to be learned. Clients need to consider the idea of developing new interests, not merely matching occupations to prior interests (Krumboltz & Jackson, 1993). The counselor might ask such questions as "What happened to discourage your interest in these areas?" "Did someone significant discourage your interest ?" "What would have to change for you to become interested in these fields?" "How do you think people who work in these fields developed their interests?" and "If you wanted to develop an interest in one of these areas, how would you go about it?"

Counselor interpretations of assessment results can easily discourage dialogue and restrict exploration. Engaging a client in discussing both prior and potential interests can reveal vital values and liberate client exploration.

Eliciting encouragement. We are not born knowing how to encourage ourselves to investigate new interest areas; we learn the skill of self-encouragement from someone who has encouraged us to take action on our own behalf. Before we can be encouraged, however, we must provide the person with a glimpse into our curiosity. In a study to investigate significant factors that enabled people to integrate previously unrecognized talents or personality traits into their lives, Young and Rodgers (1997) found the role of *witness* as significant. A witness in their study was a person who observed a talent in others and encouraged them to develop the talent or interest. This encouragement was sometimes a brief encounter, yet the exchange left the participants willing to take risks.

Scott Adams (1997), the creator of the popular cartoon *Dilbert*, attributes his persistence and risk taking to encouragement. He shared this wonderful example with his readers over the Internet:

> In January of 1986 I was flipping through the channels on TV and saw the closing credits for a PBS show called "Funny Business," a show about cartooning. I had always wanted to be a cartoonist but never knew how to go about it. I wrote to the host of the show, cartoonist Jack Cassady, and asked his advice on entering the profession. A few weeks later I got an encouraging handwritten letter from Jack, answering all of my specific questions about materials and process. He went on to warn me about the likelihood of being rejected at first, advising me not to get discouraged if that happened. He said the cartoon samples I sent him were good and worthy of publication.
>
> I got very excited, finally understanding how the whole process worked. I submitted my best cartoons to *Playboy* and *New Yorker*. The magazines quickly rejected me with a cold little photocopied form letter. Discouraged, I put my art supplies in the closet and forgot about cartooning.
>
> In June of 1987—out of the blue—I got a second letter from Jack Cassady. This was surprising since I hadn't even thanked him for the original advice. Here's what the letter said:
>
> Dear Scott:
>
> I was reviewing my "Funny Business . . ." mail file when I again ran across your letter and copies of your cartoons. I remember answering your letter.
>
> The reason I'm dropping you this note is to again encourage you to submit your ideas to various publications. I hope you have already done so and are on the road to making a few bucks and having some fun, too.
>
> Sometimes encouragement in the funny business of graphic humor is hard to come by. That's why I am encouraging you to hang in there and keep drawing.
>
> I wish you lots of luck, sales and good drawing.
>
> Sincerely,
> Jack

The cartoon strip *Dilbert* emerged as a result of this encouragement. Adams dragged out the prints he had abandoned and reengaged his creativity. Today, *Dilbert* appears in books, calendars, and many other art forms.

The encouragement Adams received did not really come "out of the blue." He initiated the encouragement by bringing his interest to the attention of Cassady. He was not blocked by the belief, "Cassady is a big name; he would never take time to respond to my questions." Instead, he took the risk of writing to Cassady, thus generating an encouraging response that helped to launch Adams into becoming a much sought after cartoonist. Adams was persistent and optimistic even though he had been rejected. He took a risk and submitted his work again even though he had no guarantee that his cartoon strip would be accepted.

Learning as the Purpose of Career Counseling

Instead of matchmakers, career counselors should conceive of themselves as educators—facilitators of the learning process (Krumboltz, 1996). "I want you to find me the ideal job," clients appeal. Clients often expect counselors to match them up with ideal jobs, and counselors often play into the client's unrealistic expectations by failing to challenge the assumption that a career counselor can actually meet this request. Instead of "playing along," perhaps it would be better for counselors to say, "If I had the ideal job for you in my pocket, I'd take it out and hand it to you right now. But that's not the way the system works. You want to build a satisfying life for yourself. I'd like to help you learn how to do it." Instead of striving to help clients identify their one "ideal job," career counselors may be of far more value to clients by teaching them how to enhance the quality of their lives.

Counselors must equip clients with new attitudes and skills to embrace the twenty-first century. Savickas (1997) called this new attitude "adaptability" and defines it as "the readi-

ness to cope with the predictable tasks of preparing for and participating in the work role and with the unpredictable adjustments prompted by changes in work and working conditions" (p. 254). Offering an additional perspective to the goal of traditional career counseling, Savickas underscored that career counselors must help clients to develop into the person they want to be rather than to encourage the client to adhere to a "linear continuum of developmental tasks" (p. 254).

Reconceptualizing informational interviews. Informational interviews have traditionally been assigned to clients by career counselors to facilitate information gathering. The formula for conducting an informational interview is to find someone involved in work of interest to the client, to ask prepared questions, and to evaluate the information for suitability to one's own career plan.

Informational interviews can also be used to generate unexpected events. Suppose the client shows up for an informational interview, but the interviewee says, "I don't have much time to talk with you now—I have so much work to do." The conventionally polite response would be to withdraw and offer to reschedule the appointment later. The happenstance-generated response would be to say, "Wonderful! I'll help you. You don't have to pay me anything. Show me something I can do to take some of the load off you." Teaching clients to respond in this manner gives them a way to demonstrate enthusiasm, a willingness to work hard, and an opportunity to get better acquainted with someone already working in a field of interest. Even if the offer is declined, the spirit behind the offer is likely to make a favorable impression.

The planning part of the informational interview is identifying the field of interest, finding a person to interview, and preparing pertinent questions. The happenstance part of the informational interview can occur at any time before, during, or after the interview. For example, while waiting for the interview to begin, the client can begin a conversation with someone else in the waiting room. Through the unplanned conversation, the client may discover information about a job opening or an academic program of interest.

The career counselor can apply the planned happenstance model by preparing the client for unanticipated events. Cognitive restructuring is a counseling technique for helping clients interpret events in alternative ways. Clients can be taught to reframe unplanned interruptions as opportunities for learning, not as annoyances to be endured. The counselor and client can practice on past events, cognitively restructure current events, and anticipate ways of reframing possible unplanned future events.

Making the most of educational opportunities. In the arena of educational planning and career exploration, emphasis has traditionally been placed on decisiveness. Entering college students are often asked, "What is your major?" The expectation is that the student should be decisive even before the educational process begins. Baumgardner (1982) cautioned students against making a commitment to a currently marketable major early in college because job market demands change so rapidly, the major may become obsolete by graduation.

Planned happenstance is a useful career counseling intervention in that it replaces "What is your major?" with a question such as "What questions would you like your education to answer?" A student might respond, "How can I explore my curiosity about graphic design to build a web site?" Specific questions like these will motivate and self-direct the student to helpful classes and programs.

Career counselors can help students formulate questions that express their values, interests, skills and curiosity; unexpected events can happen in classes to cast light on salient questions. By enrolling in classes that are relevant to the student's questions, the student is more likely to learn from the chance events that occur there (Bandura, 1982).

The career counselor may also discuss ways to integrate unexpected events into the student's experiences. For example, if the student reports to the counselor a new and exciting idea introduced by a guest speaker in a class, the counselor and student may discuss how that idea relates to the student's major questions. Career counselors can be very helpful in encouraging clients to record chance events and to identify the steps they took to respond to presented opportunities.

People who have adopted the planned happenstance model are willing to change plans, take risks, work hard to overcome obstacles, and be actively engaged in pursuing their interests. They may see initially that unplanned events play a role in their careers, but most are modestly unaware that their own actions contributed to the unplanned events from which they benefited.

Overcoming obstacles. Counseling by itself is of little value unless it leads to constructive action. It is easy to talk about good intentions, but actually implementing them is far more difficult. Counselor efforts need to concentrate on enabling clients to take the necessary actions. Actions are often inhibited by the clients' beliefs. The Career Beliefs Inventory (Krumboltz, 1991) provides one tool for assessing blocking beliefs and initiating discussions of ways to examine them. For example, Scale 3 (Acceptance of Uncertainty) provides an opportunity for clients who are feeling pressured to make a quick decision to think through the sources of that pressure and the advantages of being undecided. Scale 20 (Persisting While Uncertain) helps clients think about the value of doing excellent work now, even if they are not sure how that work is related to an unknown future.

Obstacles are sometimes inherent in the way clients express their goals. Counselors can help their clients reframe goals in such ways that progress toward them is possible. The following are some examples:

- Stated Goal: I want to change jobs; I am going to start sending out résumés.
  Reframe: I am getting more and more dissatisfied with my job. What are the steps I can take to begin to look at other options?

- Stated Goal: I want to go back to college; I am going to start applying to schools now.
  Reframe: I have wanted to complete my college education for a long time. What are the steps I can take to investigate the subjects I'm interested in and the colleges offering those subjects?

- Stated Goal: I want to find what I am really interested in; I'm going to take a lot of tests to find my interests.
  Reframe: I know that interests are acquired and developed throughout my life. What steps can I take to investigate my interests as possible career interests? How can I remain open to acquiring and developing new interests?

The expectation that careers should follow a planned and logical path seems to be deeply ingrained in the American public despite innumerable case studies to the contrary. Many prominent people attribute their successes to luck, although they seem genuinely surprised that luck could play a role.

COUNSELOR ACTIONS TO IMPLEMENT PLANNED HAPPENSTANCE

Pasteur's adage "chance favors only the prepared mind" (as cited in Bandura, 1982, p. 750) challenges us to prepare for unexpected events. Yet, how does one prepare for unexpected events in career exploration?

A. G. Watts (1996), in an eloquent narrative of the changing role of career counseling, had the following to say about the role of chance and career development:

> Careers are now forged, not foretold. They are based on a long series of iterative decisions made throughout our lives. Career counseling needs to be available at all these decision points. Without it, there is a risk that decisions are reactive rather than proactive and focused on survival rather than on development. People need to be encouraged to set trajectories for themselves, but to revise them constantly in response to the changing context and the new possibilities offered. The core concepts need to be oxymorons: Gelatt (1989) suggested "positive uncertainty"; I offer "planful serendipity." Lifelong access to career counseling can help to deliver such concepts. (p. 46)

Applying Planned Happenstance to Career Counseling

Counseling procedures under a planned happenstance model would differ in several important respects from traditional career counseling. The goal is to prepare clients for a counseling process in which unplanned events are a normal and necessary component. Explain the following:

- Anxiety about planning the future is normal and can be overcome.
- Plotting a career path is a life-long learning process that requires you to make innumerable decisions in response to unexpected events.
- Our goal is to facilitate that learning process by discussing how your curiosity is excited, how you can take advantage of unplanned events, and how you can create future beneficial unplanned events.

Counselors would include the following steps.

Step 1: Normalize planned happenstance in the client's history. In traditional career counseling, the first session begins with establishing rapport with the client and asking about the client's background or history. In the planned happenstance model, history taking would have an additional purpose: to make clients aware of how their own actions can contribute to constructing unplanned career opportunities. Clients would be asked to identify examples of happenstance in their lives, and most important, they would be asked specifically to identify actions that they had taken to enable, contribute to, generate, and benefit from happenstance events. Many people feel guilty that their careers benefited from chance—as if they really did not deserve what they achieved. The purpose of this first step is to help clients become aware that unplanned events affect everyone and that actions taken before or after the event can have a profound impact. The following questions could be asked by a career counselor:

1. How have unplanned events influenced your career?
2. How did you enable each event to influence you?
3. How do you feel about unplanned events in your future?

Step 2: Assist clients to transform curiosity into opportunities for learning and exploration. When unexpected events do occur, clients must learn to see them as opportunities to be explored. Each telephone call is a chance to forge a new relationship and exchange valuable information. Clients often have the false expectation that career counselors can identify the one perfect career for them. In the planned happenstance model, career counselors will reframe such requests by helping clients to identify opportunities for learning and exploration. The counselor might say something like the following: "If I had a way to identify the perfect occupation for you, believe me, I'd do it right now. Instead let's start a learning process that will expand your options and teach you how to take advantage of events you could never have anticipated." The career counselor would ask the following types of questions:

1. How is your curiosity excited?
2. How have chance events contributed to your curiosity?
3. How have you acted to heighten your curiosity?
4. How could you explore the career implications of your curiosity?

Step 3: Teach clients to produce desirable chance events. Stovall and Teddlie (1993) developed a student guide designed to lead young students into self-evaluation and analysis of career opportunities open to them in the twenty-first century. A section in the guide titled "Chance or Luck" acknowledges that many people benefit from chance. However, the authors proposed that students should not leave their future passively to chance but must take concrete steps to become open to chance. The authors advised that students

constantly learn new things and that they actively look for chance opportunities in everyday activities.

Career counselors will need to stress to their clients that not only will unplanned events inevitably occur, clients can also initiate constructive action to generate more desirable chance events. Visiting sites of interest, taking classes directly or remotely connected to an interest, sending letters and e-mail messages, networking, conducting informational interviews, and surfing the net are a few of the possible actions clients can learn in order to generate unexpected but beneficial information. Possible counselor discussion questions include the following:

1. Tell me a chance event you wish would happen to you?
2. How can you act now to increase the likelihood of that desirable event?
3. How would your life change if you acted?
4. How would your life change if you did nothing?

Step 4: Teach clients to overcome blocks to action. Counselors need to help their clients actually engage in constructive actions, not merely discuss them as abstractions. Some clients may be resistant to constructing unexpected opportunities because they lack the skills of curiosity, persistence, flexibility, optimism, and risk taking. Moreover, clients may possess deeply held beliefs that block their willingness to take action, to experience their curiosity, and to take advantage of unexpected opportunities for learning and exploring. Problematic career beliefs are commonly related to seeing problems as being overwhelming, having fears about the reactions of others, and being unwilling to change course or learn new skills. The career counselor could ask questions like these:

1. How have you been blocked from doing what you want to do?
2. How could you find out how permanent that block is?
3. How have other people overcome blocks like that?
4. How would you begin overcoming that block?

Dealing With Client Questions About Planned Happenstance

The Appendix includes questions that anticipate what a client might ask. We suggest possible counselor answers from a planned happenstance point of view.

Suggestions for Further Research

The influence of chance events has received relatively little attention in career development. Almost all research efforts have focused on measurement, matching, prediction, and reducing indecision. The planned happenstance theory opens up four important areas for researchers to advance our knowledge and improve counseling practice.

Identifying demographic links. To what extent do people attribute their current and past occupations to chance events? How do these attributions differ by demographic categories? From one point of view, it could be said that unplanned events affect 100% of career choices. No one chooses his or her own parents, place and date of birth, and first language or initial educational experiences, yet these events inevitably affect subsequent career paths. At the same time, people do plan and implement actions that affect their careers.

Prior research indicates that the majority of those studied attribute major responsibility to unplanned events, for example, 57% of workers, with a higher percentage among unskilled workers and a lower percentage among professionals (Hart et al., 1971); 72% of college graduates (Baumgardner, 1975); and 100% of prominent female counseling psychologists (Williams et al., 1998). Much depends on the way the sample group is recruited and the exact way in which the questions are worded. It would be valuable to know whether attributions to chance differ, for example, by occupation, gender, ethnicity, socioeconomic status, nationality, religion, sexual orientation, marital status, or age.

Developing needed skills. The following five skills have been hypothesized as aiding people to benefit from chance events: curiosity, persistence, flexibility, optimism, and risk taking. These five skills were also identified by Williams et al. (1997) along with other characteristics such as a low tolerance for boredom and being unconventional, hard working, motivated, self-confident, alert, and stable. What skills can be confirmed as distinguishing those who generate and profit from chance events from those who do not? How can counselors teach their clients to develop the skills that are most beneficial?

Relating outcomes to different types of chance events. Chance events are not all positive. Some are negative, for example accidents, illnesses, and rejections. Some people react to negative events with discouragement and inaction. Others are challenged to exert even greater effort. Williams et al. (1997) identified outcomes not only in career direction but also in altered self-concept. Some were revitalized by certain types of chance events. What kinds of chance events have what kinds of outcomes on which types of individuals?

Improving counseling interventions. Planned happenstance theory proposes a four-step intervention model. To what extent does the counselor's normalizing of chance events contribute to reduction in client anxiety and an increase in motivation to engage in career exploration? How well does a counselor's engaging client curiosity promote new learning activities? What are the most effective ways for counselors to inspire clients to generate their own chance events? How can clients be helped to identify and overcome both internal and external blocks to action?

CONCLUSION

Career counseling has been laboring under an over-simplified theory that has distorted the ways in which career choices are actually made, has led some counselors to feel that their task is boring, and has left clients mystified about essential steps in advancing their careers. The basic three-step theory of matching the name of an occupation to cur-

rent client characteristics may have sufficed in 1895 (the year Parson's offered vocational counseling; Belkin, 1980) but is insufficient for the twenty-first century.

Everyone's career is affected by events that could not have been predicted. Rather than ignoring or decrying the influence of chance events, the planned happenstance theory advocates that clients and counselors acknowledge the pervasive role of unplanned events, take advantage of these events, and actively take action to create these events.

The planned happenstance theory offers some radically different advice for career counselors as follows:

1. Acknowledge that it is normal, inevitable, and desirable for unplanned events to influence careers.
2. Think of indecision not as a problem to be remedied, but as a state of planful open-mindedness that will enable clients to capitalize on unforeseen future events.
3. Teach clients to take advantage of unplanned events as opportunities to try new activities, develop new interests, challenge old beliefs, and continue lifelong learning.
4. Teach clients to initiate actions to increase the likelihood of beneficial unplanned events in the future.
5. Follow through with clients to provide continuing support for their learning throughout their careers.

Career counseling is not a simple three-step process that is completed when the client names an occupational aspiration. Career counseling is an exceedingly complex and fascinating process that involves both personal and work-related issues, knowledge and wisdom about the realities and possibilities of life, and a profound care for the welfare of humankind.

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APPENDIX

Client Questions About Planned Happenstance

1. Isn't it amazing how chance events have affected my life? Can you think of anyone in the world who has not been affected by chance events? Everyone has. You had no choice of your parents. You did not decide which language you would learn first. Your choices of schools and friends

were enabled by the happenstance of your geographical proximity to them.

2. *If chance events play such a big role in everyone's life, do we have any power to control our own destiny?* You actually do have a great deal of power to affect the course of your own life. You are making decisions every minute about words you speak, clothes you wear, places you go, sights you see and sounds you hear. You can make big decisions, too, such as what part of the world to live in, what kind of work you want to do, what religious organization (if any) you wish to join, or with whom to form a relationship or to marry. Much depends on how you state your goals, how you set your priorities, and how carefully you examine your own beliefs.

3. *Would you agree that there are constraints on my power to decide?* There are obviously constraints for everyone. The world is not set up to grant your every wish. However, it is important to examine carefully the constraints you think exist.

4. *What kinds of constraints are there?* It is helpful to think of constraints falling into four major categories: (a) physical limitations, (b) permission of others, (c) costs, and (d) your own beliefs.

a. *How do physical limitations constrain my decisions?* Much depends on how you state your goals. If you were to say, "I want to fly by flapping my arms," you would soon discover the physical impossibility of your wish. However, if you were to say, "I want to fly like a bird" and then learned hang gliding, you might achieve a portion of your wish.

b.i. *Why should the permission of others be required for what I want to do?* Only sometimes is permission required, and it is important for you to distinguish when permission is needed and when it is not. Permission is required when an action depends on the active participation of another person or persons. Permission is not required when you merely hope others will approve of what you want to do.

b.ii. *What happens if the active participation of another person is not required, and still permission is not given?* You want your parents to approve your choice of an occupation. You want your friends to approve your new clothes. You want your boss to think you are smart. Although such admiration and approval might be nice, it is not required. You can seek any kind of employment you wish, whether your parents approve or not. You can wear whatever you like, whether your friends approve or not. You do your job the best you can, and the boss can think whatever she likes. You do not need to run your life to win the approval of other people.

c. *How do costs constrain my choices?* Costs can be measured in terms of money or time. Some people do have more money than others. A vacation in Europe will cost money. If you do not have it, or cannot borrow it, you will not go. Even if you do have it, you may well decide that you would rather use your money for some other purpose. Your choices depend on your own priorities. If you want something badly enough, you economize in other areas. *Time is different.* Everyone has the same amount of time—24 hours each day. The question is how to allocate those hours. Some people say, "I don't have enough time to do that." A more accurate statement would be, "I choose to spend my time doing other things that I consider to be more important."

d. *How could I possibly be constrained by my own beliefs?* It is hard to recognize your own beliefs and assumptions. They seem so self-evident that you would almost never question them. You may believe, for example, "Whatever I do, I must not fail." A belief like this inhibits you from taking risks with which you might either fail or succeed. Fear of failure would constrain you to take the easiest path, even though you might ultimately be happier and more successful doing something quite different. An alternative belief would be, "Whether I succeed or fail, I'll still learn something valuable, so I'll give it a try."

5. *What should I do with the rest of my life?* Maybe this question is a bit too broad to start off your career exploration. Perhaps you might want to begin with "I would like to investigate the things that keep me curious and the type of work settings and people with whom I am compatible. I would like to try out some relevant work experience to see how I like it." You do not need to plan your whole life now. Take it one step at a time and evaluate your options as you proceed.

6. *What if I make a plan and something happens to interrupt it?* All plans have that possibility. Look at surprises not as interruptions or disappointments, but as new opportunities.

Toward a New Paradigm for Multicultural Counseling

Fred J. Hanna
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Wisdom is introduced as a fundamental quality of the effective multicultural counselor. Wisdom is defined, discussed, and differentiated from intelligence. The authors propose that to be an effective multicultural counselor requires more than textbook knowledge. Wisdom, as a transcultural concept, is considered in relation to culture, context, dialectical thinking, awareness, metacognition, deep interpersonal insight, and advanced empathy. Implications for counselor education and professional practice are discussed. Wisdom is an ancient subject that may provide a "new" paradigm with the potential to bring the field to a higher plateau of effectiveness in practice and training.

A great deal has been written detailing the knowledge necessary to be effective in a multicultural setting (e.g., Pedersen, Draguns, Lonner, & Trimble, 1996; Ponterotto, Casas, Suzuki, & Alexander, 1995; Sue & Sue, 1990). Over the years, research has increasingly demonstrated that the personal characteristics of a counselor have a greater influence on outcome than the approach or theory that a counselor uses (Goldfried, Greenberg, & Marmar, 1990; Lambert, 1992; Whiston & Sexton, 1993). As a consequence, some researchers have found their attention focusing on understanding the qualities of the effective counselor, rather than on the efficacy of a particular theory or approach. This shift may be especially significant regarding the concept of wisdom as it relates to multicultural counseling.

Hanna and Ottens (1995) pointed out that the human qualities included under the heading of wisdom are also remarkably descriptive of the effective, as opposed to less effective, counselor. They suggested that wisdom accounted for the difference between counselors who are highly effective and counselors who are ineffective or merely adequate. This suggestion was based on the work of many researchers in the areas of intelligence and human development (e.g., Arlin, 1990; Baltes & Smith, 1990; Kramer, 1990; Orwoll & Perimutter, 1990; Pascual-Leone, 1990; Sternberg, 1986, 1990). Our aim is to suggest that the *concept of wisdom also provides a comprehensive view of what constitutes the effective multicultural counselor*. We propose that effective cross-cultural counseling professionals consider going beyond the traditionally identified knowledge base, in both theory and practice, to incorporate the concept of wisdom in the development of their own skills.

Sue, Ivey, and Pedersen (1996), in presenting a new theory of multicultural counseling, proposed that current theories and practices of multicultural counseling are inadequate. Sue and Sue (1990) were even more forceful in their criticism of traditional counseling theory and practice, claiming that it has done serious harm. We propose that the concept of wisdom addresses many of these criticisms and that it may be a missing element in the understanding of the effective multicultural counselor. Thus, the central theme of this article is that the effective multicultural counselor is a "wise" multicultural counselor, as defined and described in this article.

In this article, we define and describe wisdom and examine contemporary research on wisdom. We also explore the distinction between wisdom and intelligence. Dialectical thinking as well as metacognition, as two of the characteristics of wisdom, are also discussed to make wisdom more easily understood within a multicultural counseling context. We also discuss the growing criticisms of training in the field of counseling and explore how focusing on wisdom may provide new avenues for improvement of this vital area. The primary purpose of this article is to explore how wisdom can be used as a guide to understanding the counseling process and the nature of the effective multicultural counselor.

DEFINITION OF WISDOM

Although the concept of wisdom is an ancient, transcultural concept, it was not until the 1980s that it received the serious attention of Western behavioral science. As the paradigms of logical positivism and radical behaviorism have gone into decline, the concept of wisdom has begun to be examined by researchers in the areas of human development and intelligence (D. V. Robinson, 1990). In the following paragraphs, the reader is asked to consider the character-

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istics of wisdom as outlined by researchers in the context of multicultural counseling. Although age is a characteristic automatically associated with wisdom in some cultures, the evidence indicates that it is not necessarily a factor in determining the actual degree of wisdom possessed by a particular person. For example, in Hindu, Taoist, and Buddhist cultures, a person's degree of wisdom is a result of spiritual attainment and insight. Even though age is respected and even revered in these cultures, spiritual development is viewed as the key to wisdom. Similarly in Western developmental psychology, younger people can attain higher stages of development (Loevinger, 1976), and young people can also display higher degrees of wisdom, than adults. In Erikson's (1964) classic developmental scheme, there is no assurance that older people will attain wisdom. Likewise, a wise person need not be well-known or highly regarded, and may even seek to avoid fame or notoriety. We also wish to state at the outset that certain aspects of wisdom, notably the developmental and dialectical, have been addressed by several researchers such as Ivey (1986, 1991) and Blocher (1983) but they have not embraced or encompassed the entire concept.

Wisdom can be defined as a particular set of cognitive and affective traits that are directly related to the possession and development of life skills and understanding necessary for living a life of well-being, fulfillment, effective coping, and insight into the nature of self, others, environment, and interpersonal interactions. Baltes and Smith (1990) defined wisdom as "expert knowledge" in the "fundamental pragmatics of life" (p. 95) and involving "exceptional insight into human development and life matters" as well as "exceptionally good judgment" in the contexts of "life planning, life review, and life management" (p. 97). Sternberg (1990), a researcher in the areas of both intelligence and wisdom, noted that wisdom is made up of a variety of characteristics that include listening skills, concern for others, maturity, deep psychological understanding of others, a high capacity for self-knowledge and self-awareness, empathy, the ability to take an overview of problems, the ability to acknowledge and learn from mistakes, and the ability to reframe meanings.

Sternberg (1990) also identified intuitive understanding as a wisdom characteristic. It is interesting to consider that these attributes are often highly valued in many cultures, easily transcend cultural boundaries, and have nearly universal applicability. Arlin (1990) reported that wisdom applies to problem solving as the ability to correctly identify and properly frame a problem for solution—so that a solution does not cause more problems. She described this as "problem finding." Kramer (1990) noted that wisdom has to do with the ability to be aware of and identify emotions and feelings. Pascual-Leone (1990) and Kramer (1990) noted that empathy is a major characteristic of wisdom and the wise person. This definition and list of characteristics immediately and obviously link wisdom with traits of the effective counselor (Hanna & Ottens, 1995). A complete listing of wisdom characteristic is displayed in Table 1.

WISDOM AS DISTINCT FROM INTELLIGENCE

Researchers in developmental psychology have differentiated wisdom from intelligence. An exploration of this distinction is helpful for attaining a more detailed understanding of wisdom. The point of such a comparison is to show that wisdom may be a much more vital aspect of effective counseling than is intelligence. One of Sternberg's (1986, 1990) distinctions is that wisdom is concerned with the limits, assumptions, and knowledge of knowledge, whereas intelligence is concerned with the analysis, recall, classification, and use of knowledge. Wisdom is concerned with depth of understanding, whereas intelligence is concerned with extent and breadth of understanding. Another difference pointed out by Sternberg (1990) is that wisdom is "*comfortable with ambiguity*" (p. 155). In contrast, intelligence has little patience with ambiguity and "*sees ambiguity as something to be resolved, preferably sooner rather than later*" (Sternberg, 1990, p. 155). Tolerance of ambiguity is a mark of higher stages of development. Wisdom is also concerned with resolution of ambiguity but by allowing clarity to emerge from ambiguity without reduction or oversimplification (see Hanna, Giordano, & Bemak, 1996).

For example, there are hundreds of theories of counseling, yet research has not found that any one of them is clearly superior. The field is currently allowing clarity to emerge by recognizing the importance of the recognition of common factors, or the integration of theories (Hanna, 1994; Norcross & Goldfried, 1992). The emerging clarity also dictates that attention be placed on the perspective and needs—including culture and developmental stages—of the client, rather than molding the client to fit the needs and assumptions of the theory itself.

In a more practical example, one of the benefits of membership in the African American culture is the remarkable ability, in many cases, to penetrate to the essence of situations and communications (Asante, 1987). When the dominant group conveys messages of equality, many people look beyond appearances, perceiving incongruency between statements and promises of equality but little or no visible support for change in communities. African Americans often accurately perceive that the actual "message" about equality is propaganda and determine that racial discrimination in the form of jobs or living conditions is not likely to change, thus continuing a long history of false promises and lip service to the contrary.

Another aspect of wisdom is its tendency toward deautomatizing habitual thought routines and behaviors, similar to what is done in cognitive and behavioral therapies. Sternberg (1990) observed that the "wise person *resists automatization of thought but seeks to understand it in others,*" whereas "*the intelligent person welcomes automatization*" (Sternberg, 1990, p. 153). Wisdom seeks to evaluate and understand habitual or scripted human behavior and the rationale for this type of conduct. Intelligence, on the other hand, values and seeks to increase the number of automatized thought routines to become more timely and ef-

TABLE 1

A List of Major Affective, Awareness, and Cognitive Characteristics ofWisdom Based on the Literature

Wisdom Characteristic	Description
Affective and Awareness	
Empathy	A strong sense of the feelings and outlooks of others; understanding others from their subjective point of view and from a perspective that is not self-centered
Concern	Compassion for others; caring for the welfare of living beings and the environment
Recognition of affect	Recognizes the interdependence of cognition and affect; awareness of emotions and feeling states
Deautomatization	Resists tendencies toward habitual, automatic behavior and thinking patterns; emphasis on awareness of actions and responsible choice
Sagacity	Listening skills, deep insight, and awareness of human beings and relationships; possesed of self-knowledge, and is capable of self-transcendence; learns from mistakes
Cognitive	
Dialectical reasoning	Recognition of context, interdependence of phenomena, situations, and the interplay of opposing views; considers all sides of an issue; oriented toward beneficial change
Efficient coping skills	Ability to cope with a wide range of people and life situations in an optimum fashion; the ability to find fulfillment and meaning in life
Tolerance of ambiguity	Recognition of ambiguity as intrinsic to the nature of human beings and their interactions with others and world; able to perceive, integrate, and appreciate shades of gray
Perspicacity	Ability to "see through" situations; not easily fooled or deceived; ability to intuitively understand and accurately interpret the environment; looks beyond appearances
Problem finding and solving	Ability to identify and properly frame a problem, so that the solution is efficient and does not lead to more problems; ability to reframe problems and situations
Metacognition	Concerned with the limits and presuppositions of knowledge; awareness of awareness; knowing about knowing; thinking about thinking; intuitive knowing

Note. From "The Role of Wisdom in Psychotherapy," by F. J. Hanna and A. J. Ottens, 1995, *Journal of Psychotherapy Integration, 5,* p. 199. Copyright 1995 by Plenum Publishing Corporation. Adapted with permission.

ficient in task-setting and goal attainment. Thinking characterized by intelligence can be brilliant but narrow or flawlessly logical and quite blind to other viewpoints. Skinner may have been an example of an extremely intelligent person who was contextually limited by dogmatism (Mahoney, 1989). Hanna and Ottens (1995) pointed out that it is possible to be simultaneously dogmatic and intelligent but not dogmatic and wise (also see Hanna et al., 1996). Along these same lines, a highly intelligent antisocial person is virtually always woefully lacking in wisdom.

A comparison of characteristics of wisdom and intelligence can be found in Table 2. Although clearly differentiated for the sake of illustration, it should be understood that wisdom and intelligence overlap in many respects. Nevertheless, in view of the distinction between the two, it is clear that the characteristics of wisdom are more essential for effective counseling than many of the characteristics listed under intelligence. Ideally, of course, the two complement each other and should not be thought of as being in opposition. Although it seems strange at first glance, many of the characteristics of intelligence may, when not guided by wisdom, actually be "detrimental" to the counseling process. For example, research has shown that dogmatic counselors tend to be ineffective (Sexton & Whiston, 1991; also see Hanna et al., 1996). It is wisdom, not intelligence, that discourages the kind of dogmatism inherent in homophobia, racism, and sexism. Similarly, although intelligence seeks to automatize thoughts and behaviors, wisdom seeks to deautomatize them so that they can be restructured or changed for the better. Thus, problematic habitual thinking patterns, such as the automatic thoughts mentioned by Beck (1976) or the negative self-talk mentioned by Meichenbaum (1977), are routinely deautomatized through the counseling process that contains within it virtually all of the characteristics of wisdom. Wisdom is clearly more relevant to the counseling process than characteristics of intelligence, especially with its attention and emphasis on awareness and on both affect and feelings. Intelligence seems to be unconcerned with feelings, whereas wisdom sees the integration of thinking and feeling as optimum (Arlin, 1990). We believe this is particularly meaningful when approached from a cultural perspective.

WISDOM AND CULTURE

The conception of wisdom presented here is by no means unique to Euro-American culture. Many cultures have valued wisdom and promoted wisdom over intelligence, sometimes for thousands of years. In these cases, the same qualities found in this discussion are valued among certain religious leaders. One example is in Buddhist cultures, which place an extremely high emphasis on wisdom. Many Buddhist texts such as the *Prajnaparamita Sutra* and the *Dhammapada* are exemplary studies, specifically devoted to the development of wisdom and dialectical thinking. The definition of wisdom in this article can easily be found in principles of other schools of Buddhism, such as Theravada, Madhyamika, and Yogacara. Although a spiritual component

TABLE 2

A List of Contrasts Between Wisdom and Intelligence Regarding Various Aspects of Life

Category	Contrasts and Complements: Wisdom Modality	Contrasts and Complements: Intelligence Modality
Knowledge	Concerned with the recognition of limits, presuppositions, and origins of knowledge.	Concerned with the recall, classification, analysis, and application of knowledge.
Understanding	Concerned with depth of understanding.	Concerned with extent and breadth of understanding.
Learning	Seeks deautomatization of habitual thought routines toward awareness and insight.	Encourages automatization of thought processes toward efficiency and speed.
Reasoning	Dialectical, fluid, intuitive, integrative, and experiential; transcends context.	Logical, analytical, mathematical; largely limited by context.
Problems	Focuses on accurate framing and identification of problem in relation to other contexts.	Focuses on solutions, task setting, and goal acheivement; tends to stay within context.
People	Seeks empowerment and liberation through empathy and compassion.	Prediction and control of behavior; seeks adjustment and adaptation.
Affect	Sees affect as necessary and intrinsic to integrated thought.	Sees affect and emotions as extraneous and tangential.
Relationships	Relationships seen in context of connection, care, and empathy.	Sees relationships as a means of meeting mutual needs.
Environment	Views environment in terms of interdependence, harmony, and as part of a global whole.	Effectively uses the environment as a source of supply for further survival.
Ambiguity	Accommodates ambiguity; appreciates shades of gray; sees ambiguity as part of solutions.	Resists ambiguity; tends toward an either/or stance; seeks simple, clean solutions.

Note. The two modalities are presented as complementary, ideally operating in unison, and not in opposition to each other (Hanna & Ottens, 1995; Sternberg, 1990).

is clearly present in the description of wisdom in this article, this aspect is emphasized in cultures and countries such as Sri Lanka, India, Burma, Thailand, China, and Japan. In addition, in Tibetan Buddhist culture, the leader is traditionally considered to be a spiritual being who is chosen while still a child by visionary monks to undergo rigorous training in preparation for spiritual leadership. This leader, the Dalai Lama, is revered for his wisdom regarding both human beings and the nature of life and the world. In fact, his name literally means "the teacher whose wisdom is as great as the ocean" (Fischer-Schreiber, Ehrhard, & Diener, 1991, p. 51).

Wisdom as discussed in this article is also implicit in African American culture. For example, the seven principles or *Nguzo Saba* system (Robinson & Howard-Hamilton, 1994) is replete with wisdom in that it is empathic, dialectical, empowering, liberating, compassionate, and stresses awareness, perspicacity, sagacity, and deautomatization (see Table 1). These seven principles emphasize creativity, healthy resistance, collective work, self-determination, unity, and responsibility. In addition, the value placed by African Americans on the ability to penetrate to the essence of a problem (Asante, 1987) or situation is a quality of wisdom inherent in the *Nguzo Saba*.

Wisdom is also inherent and highly valued in Native American cultures in which wise leaders assume not only the guidance for the tribe but also the spiritual growth and development of tribe members (Lame Deer & Erdoes, 1992). Other examples of spiritually based cultures that consider wisdom to be at the heart of helping would include Hinduism, in which teachers such as Ramana Maharshi and Shankaracharya taught self-knowledge and self-transcendence. In accord with our definition, African ministers such as Desmond Tutu, and African Americans such as Malcolm X and Martin Luther King, provided leadership through wisdom replete with rich interpersonal insights and deep understanding.

Teachers may also be in the role of traditional healers who are, as Hiegel (1992) noted, greatly respected and trusted within their cultures. Healers and shamans from new and ancient cultures around the world are based in wisdom traditions of healing and helping (Eliade, 1964; Harner, 1990). Much of the wisdom in these traditions is held in the form of stories or narratives, a form gaining more attention in Western psychology and psychotherapy (Howard, 1991; Zimmerman & Dickerson, 1996). Of course, just because a person is a designated teacher, counselor, or spiritual leader is no guarantee that the person is actually possessed of wisdom.

Wisdom, like intelligence, is associated with problem-solving ability (Arlin, 1990; Sternberg, 1990). However, wisdom is more concerned with finding solutions that do not cause more problems. For example, the production of technological marvels in this society solves many problems but also causes additional problems in the form of pollution and damage to the environment. Wisdom would be amenable to technological advances while simultaneously considering the needs of the environment. This is inherent in the Baltes and Smith (1990) characterization of wisdom as expertise in understanding and living life. Empathy, a particularly important aspect of counseling, was pointed to by Pascual-Leone (1990) and Kramer (1990) as a major characteristic of wisdom. In addition,

the currently popular notion of "emotional intelligence" (Goleman, 1995) can be viewed as a subset of wisdom characteristics, which fit handily into the greater framework and definition of wisdom in the more global sense.

WISDOM, CULTURE, AND DIALECTICAL THINKING

Sternberg (1990), Kramer (1990), and Arlin (1990) pointed to dialectical thinking as an important characteristic of wisdom. Dialectical reasoning recognizes and uses the interplay of opposing views in human thought processes (Tolman, 1983) such as opposing cultural viewpoints. At the same time there is an avoidance of needless intellectual abstractions by staying close to actual human experience (Hanna, 1994; Hanna et al., 1996). Dialectical thought is also characterized by cutting to the essence of a problem without oversimplifying it, as we saw in the case of many African Americans. Powerful examples of dialectical thinking in different cultures can be found in the classic text *Tao Te Ching* (Chang-yuan, 1975) from ancient China, or in the Indian philosopher Nagarjuna's (200/1970) brilliantly insightful classic in dialectical philosophy, the *Mulamadhyamikacarika*.

Kramer (1990) noted that dialectical thinking is able to recognize multiple levels of meanings in communications. Basseches (1980, 1984; see also Kegan, 1982) pointed out that dialectical thought is a characteristic of higher stages of development. Orwoll and Perlmutter (1990) stated that when "empathy, understanding, and caring" combine with dialectical thinking, people are capable of "penetrating interpersonal insight and discernment" (p. 164). It is precisely this penetrating interpersonal insight—referred to by Sternberg (1990) as perspicacity—that is typified in African American culture. The writings and speeches of Frederick Douglass, Malcolm X, and Martin Luther King abound with insights that are moving in their depth of understanding and staggering in their implications. Fostering and cultivating such dialectical insight in multicultural counselors goes well beyond simple skills training or memorizing the traits and customs of various cultures. For example, a Cambodian client who dialogues with a deceased ancestor for advice and solace may be perceived as delusional or psychotic by traditional Western mental health standards. However, a deeper inspection reveals that the Cambodian client is performing an action that is remarkably similar to the much more recent but familiar empty chair technique in Gestalt therapy. An effective, dialectically oriented multicultural counselor can effortlessly bridge such seemingly disparate activities and creatively combine them with therapeutic benefit.

Dialectical reasoning recognizes the importance of context. As a part of wisdom, dialectical thinking has the capability of recognizing, surveying, and moving beyond contextual limitations. Specifically, this means that dialectical thinking can move comfortably from culture to culture without becoming ensnared, enmeshed, or repulsed. This makes dialectical thinking more accommodating to the use of metaphor and reframing by being able to transfer knowledge from one context to the other. In counseling, dialectical thought contemplates and uses the many theories of counseling/therapy in the contexts of individual, family, and group approaches as appropriate to a client's given situation and needs. A counselor is thinking dialectically when he or she takes the interplay and interdependence of these various modalities into account (Hanna, 1994; Hanna et al., 1996).

Hofstede (1980, 1986, 1992) first portrayed constructs that have important implications for counseling and are conducive to understanding complex cultural differences. He introduced individualism versus collectivism as a way of examining one's social and cultural proclivity; power and equality by virtue of social status and income; and avoidance versus nonavoidance of the unpredictability and chaos of human existence that is reflected by the importance one places on rituals, rules, and traditions as opposed to flexibility and spontaneity. These dimensions are good examples of cross-cultural perspectives from a dialectical standpoint. In effect, dialectical thinking has the capacity to see through the limits of a narrow mindset or a "one-note interpretive framework" (Chandler & Holliday, 1990, p. 139).

A simple example of a dialectical thought process would be seeing beyond ethnocentrism to delineate the limits and assumptions of a cultural mindset—especially one's own. Individuals such as Frederick Douglass and Mahatma Ghandi were eminently capable of pointing out the assumptions and limits of majority cultures as well as the limits within their own cultures. This involves the transcendence of self as well as that of culture. Dialectical thinking is fluid, flexible, and encompassing of many viewpoints. It can find harmony in contradiction, and clarity in complexity without the need for reductionism (Rychlak, 1976, 1988). It is the antithesis of rigid, dogmatic, stereotypical, and doctrinal thinking styles.

In some cases, a member of an oppressed minority culture must deal with the dominant culture in such a way as to necessarily incorporate dialectical thinking as a foundation or strategy for liberation of the minority group. Some examples are the thinking of Mahatma Ghandi and Martin Luther King, both of whom were constantly seeking to understand their dominant cultures while charting a path to freedom from oppression within that context. In contrast, members of the dominant culture may not be as inspired to shift to dialectical thinking due to the complacency that often comes with being in the majority and the mindset that prevails (Miller, 1986). More specifically related to counseling is Ivey's (1995) recent introduction of psychotherapy as a means of liberation within the framework of multicultural counseling. Along these same lines, wisdom also implies empowerment in the sense of emancipation, liberation, and the enhancement of existential freedom. Chandler and Holliday (1990) suggested, through their study of Habermas, that wisdom is emancipatory in that it is an attempt to "free oneself from both the arbitrary forces of nature and the social structures that limit self-understanding" (p. 122). This includes liberating oneself from the confines of one's own culture, moving toward the identification with all of humanity that Adler (1956) called social interest or community feeling.

The experience of Malcolm X during his visit to Mecca is an example of this process.

WISDOM, AWARENESS, AND METACOGNITION

Awareness is a major component of wisdom as well as the counseling process (Kottler, 1991). This is related to wisdom's metacognitive stance (Sternberg, 1990). Metacognition is commonly defined as thinking about thinking (Pesut, 1990) or knowing about knowing. Pesut associated metacognition with "the skill or ability to 'be aware of being aware'" (p. 109). Flavell (1979) defined it as the active monitoring, regulating, and coordination of memory, attention, thinking, learning, and language. Flavell also associated it with the executive processes that decide, monitor, and attend to self-regulation, self-instruction, and the integration of experience (also see Meichenbaum & Asarnow, 1979).

Thus, any talk of consciousness raising, or gaining awareness through counseling, has to do with metacognitive wisdom functions, as does self-monitoring in behavioral therapy. From this perspective, it is not surprising that Hanna and Ritchie (1995), and Hanna, Giordano, Dupuy, and Puhakka, (1995) found that metacognitive processes may play a crucial role in therapeutic change. Slife and Weaver (1992) found that deficits in a person's metacognitive skills may play a role in depression. Some cultures may implicitly operate on a more metacognitive level of consciousness than others. For example, the wisdom traditions of the Hindu culture of India or the Buddhist cultures of Asia encourage awareness routinely as part of the emphasis on spiritual development found in various meditative practices. Miller (1986) has pointed out that minority cultures tend to develop a keen awareness and perception of the majority culture so that they can cope with being deprived of the benefit of power and status enjoyed by the dominant culture. She noted that this keen awareness is rare in members of the dominant culture, but that it is a necessity for survival for those who are deprived of power or status. Another aspect of this awareness is the ability to see through deceptions and half-truths, so commonly encountered by counselors in, for example, substance abuse counseling. This is associated with the wisdom characteristic of perspicacity.

CULTURE AS CONTEXT

Because every culture exists within a context (Scharfstein, 1989), the ability to traverse and move fluidly between and among contexts is a function of wisdom. Each culture, as a context, contains within itself an entire set of internally consistent meanings. These meanings are in keeping with the fundamental assumptions or worldviews of the culture itself and relate to how we construct meaning in the world. This way of experiencing the world incorporates values, opinions, attitudes, and concepts, and influences behavior, cognitive processes, and how meaning is constructed (Sue & Sue, 1990) for both the individual and members of the culture as a whole.

Counseling across cultures requires the professional to understand different meanings of systems and contexts. It may be far easier to counsel people from one's own cultural background in which meanings are more readily understood and the subtleties of the cultural context need not be articulated or delineated. The greater challenge for the multicultural counselor is to work within other cultures and thus, within multiple contexts. This involves a continuous dialectical process of surveying, contemplating, weighing, matching, shifting, sifting, and reframing meanings within and outside of those cultural contexts—for both client and counselor (Hanna & Ottens, 1995). Perhaps more than in any other kind of counseling, effective multicultural counseling routinely demands this dialectical approach.

An example may be a Hispanic counselor from a suburban area working with an Asian client from an urban area. This would require not only awareness and sensitivity to cultural stereotypes and differences but also wisdom to bridge the gap between the two worlds of the client and counselor and to establish a viable therapeutic relationship. For an effective multicultural counselor, this approach may seem to be simple common sense. Our point is that when this is done effectively, wisdom is operating to deepen the relationship and provide transitions in the form of cultural metaphors and therapeutic analogies that effectively enhance the working alliance. There may be inherent biases regarding urban and rural clientele from Hispanic and Asian populations. In this or any cross-cultural exchange, counselors must examine the sociopolitical and economic influences of the dominant culture on the client, understand and accurately interpret the range of verbal and nonverbal cues, factor in stereotypical assumptions of the client, and simultaneously examine their own biases.

If the Asian client stated a belief that "You [the counselor] can't understand what I've been through," an adequate response may involve empathic paraphrasing, reflection, or probing questions about what happened. If, on the other hand, the Hispanic counselor shifted and sifted contexts to validate common ground, the response may be, "You are right. I may not completely understand what you have been through, but I do understand pain, and I can sense it in you regardless of how it happened. I am interested to know about that pain and hurt, if you are willing to talk about it." This response transcends the cultural context and finds commonality with the Asian client. The approach is dialectical in that it accommodates the client's message of differences while simultaneously finding a point of similarity in shared human experience and an interest in establishing a meaningful relationship.

Context has a profound influence on virtually all thought processes. Bateson (1979) pointed out that "Without context, words and actions have no meaning at all. This is true not only of human communication in words but also of all communication whatsoever, of all mental processes, of all mind" (Bateson, 1979, p. 15). Scharfstein (1989) also pointed out the importance of recognizing context as an intrinsic aspect of thought. Feminists such as Daly (1973, 1978) and Miller (1986) used contexts in revealing subtle meaning and

language structures that exert great influence on sexist patriarchal attitudes and behavior. In contrast, thinking characterized by intelligence tends to ignore or minimize the importance of multiple contexts.

WISDOM AND MULTICULTURAL COUNSELING

Historically, traditional cultures have identified and respected certain members of society as wise. The level of respect for these individuals is attributed to their compassion, empathy, and deep understanding of worldly or spiritual realms, as well as human beings and themselves. Even a casual inspection of the qualities identified in Table 1 leads to the conclusion that these are virtually the same qualities found in the effective counselor and therapist (Hanna & Ottens, 1995). Thus, it is possible that mental health professionals can enhance their effectiveness by understanding and developing their own wisdom.

In Western cultures, mental health professionals, particularly psychiatrists, have traditionally been regarded as having special knowledge about the mind and healing. This is usually due to their degree and education. Frank and Frank (1991) pointed out that the curative powers attributed to the psychotherapist are bound by such culturally specific beliefs and symbols. They also noted that the more unified the societal worldview, the easier it is to assume the role of healer. Thus, in this culture, the attribution of wisdom is rightfully or wrongfully placed on the counselor, and the efficacy of counseling is significantly influenced by the cultural context and consistency. In other words, the culture believes that counselors or healers have wisdom. Unfortunately, just because wisdom is attributed does not guarantee that the counselor or healer is actually wise. Nevertheless, wisdom may be the factor that makes the difference between effective helping and merely going through the motions.

Wisdom's emphasis on depth, fluidity, and richness of understanding is vital in multicultural settings. Integrating rich and diverse experiences may assist a person to recognize both the universal core of humanity in each individual and the unique cultural heritage and attributes of that person. Through extensive research, Carkhuff (1969a, 1969b) and his associates (Carkhuff & Berenson, 1977; Truax & Carkhuff, 1967) isolated core conditions of the effective counselor that included empathy, genuineness, positive regard, and concreteness. We are suggesting that the necessity for wisdom for the multicultural counselor *includes* and *transcends* these parameters. It is an ability involving advanced empathy—communicating understanding to a client at levels well beyond the usual reflections and paraphrases (Ottens, Shank, & Long, 1995). This is a crucial aspect of wisdom (Kramer, 1990; Pascual-Leone, 1990; Sternberg, 1990) as well as an essential foundation for effective multicultural counseling. Likewise, the developmental aspect of Ivey's (1986, 1991) approach is helpful in cultivating wisdom. The additional and equally important trait is having the wisdom to understand what one sees in another human being, complete with all the inherent conflicts, paradoxes, and contradictions in the client as well as within oneself.

The ability to establish and maintain empathy, genuineness, positive regard, and concreteness is the vital first step in the therapeutic relationship. Traversing cultural boundaries in understanding the client as a human being, both within and beyond his or her culture, requires getting past fundamental skills to reach the underlying contextual foundation and framework for "seeing" and internalizing the cultural complexity of other individuals. In other words, the wise counselor would be a person with an extraordinary degree of empathy, sensitivity, and awareness, who harbors exceptional interpersonal and relational skills, and deep insight into human nature. Perhaps wisdom is the essence of the *master counselor*.

To have wisdom as a counselor is not simply possessing skills or knowledge. There are many professional counselors who have excellent skills and are "textbook smart" and well-grounded theoretically. There are many mental health professionals who have intellectually studied other cultural groups and may engage in professional work and socialize across cultures. Even so, if such individuals have not taken the time to reflect, question, internalize, and integrate these experiences in ways that transcend traditional training and knowledge, they may still be lacking the wisdom necessary to be highly effective. It may be that to acquire wisdom, individuals must go beyond the defined parameters traditionally offered as cross-cultural, so that they may acquire deeper, richer understanding. This is every bit a matter of character and development as it is skill.

EDUCATION, TRAINING, AND MEASUREMENT OF WISDOM

Western education has largely ignored the development of wisdom, due to a bias that places a premium and emphasis on intelligence in the way of mathematics, the hard sciences, and technology (Robinson, 1990). Much could be said about the consequences of this attitude and the negative effects that it has had on the environment and interpersonal relations. Nevertheless, if the characteristics of wisdom are indeed remarkably similar to the characteristics of the effective counselor, then exploring and developing training methods based on wisdom may be a worthy task. Such training methods hold the promise of providing a comprehensive view of what constitutes effective counseling. This may require a shift in how we look at counselor training.

Such a shift may be vitally important. Graduate training has not generally been successful at producing counselors and therapists who are more effective than paraprofessionals who have relatively little training. In fact, current training methods and approaches have been the object of considerable criticism over the past decade for what seems to be inadequate results (Christensen & Jacobson, 1994; Dawes, 1994; Humphreys, 1996; Peterson, 1995). A well-conducted, highly scrutinized meta-analysis by Hattie, Sharpley, and Rogers (1984) indicated that professionals are no more effective than paraprofessionals, despite the level of education and years of experience of the professionals. Berman and Norton (1985) concluded that professional training

does not seem to make a therapist more effective despite supervision, course work, and curriculum. Dumont (1991) pointed out that experience can actually lead to a person's becoming less effective, just as Hattie et al. suggested. Stein and Lambert (1995), in an effort to challenge these findings, found that years of graduate level training produced therapists who were only slightly more effective than paraprofessionals. They remarked that there was an absence of compelling evidence to support current methods of training. Why is this, and what is the relationship to multicultural counseling?

The difference may be due to neglecting the development of wisdom. Counselors and other mental health professionals have no monopoly on it. We suspect that, because wisdom is not directly addressed by education, it may be randomly distributed throughout the population (Hanna & Ottens, 1995). Thus, many people lacking in wisdom can still apply for admission to counseling programs and be accepted and graduated. Despite their training and high grades—due in part to intelligence level—they may never become highly effective counselors. In the admission of students to counseling programs, wisdom is neither addressed nor detected by the Graduate Record Examination (GRE), which has been criticized for its lack of utility as well as its gender bias (Sternberg & Williams, 1997). Along these same lines, Loevinger and Wessler's (1970) studies of the development of helping professionals indicated that professional helpers were no higher in terms of their developmental stage than the rest of the population. Because the higher stages of Loevinger's developmental scheme also seem to have direct parallels to the characteristics of wisdom (Kramer, 1990), it is not unreasonable to suppose that both are randomly distributed.

The point is that, hypothetically, if training programs were capable of developing wisdom in students, those programs would also be turning out more effective counselors. In other words, a highly effective multicultural counselor is virtually the same as a wise multicultural counselor. It is possible that an emphasis and focus on wisdom may be able to alleviate the problems pointed out by those studies of paraprofessionals and professionals that are critical of current training methods. But how does one measure wisdom? Kramer (1990) suggested that the characteristics of a person at Loevinger's higher stages of development are also characteristics of wisdom. Kramer also pointed out that ego development—also called "character development" (Loevinger, 1985)—is a necessary condition for the development of wisdom. Loevinger's stages do indeed take into account the broad range of wisdom characteristics as discussed here.

Thus, the Washington University Sentence Completion Test of Ego Development (Loevinger, 1976, 1985; Loevinger & Wessler, 1970; Loevinger, Wessler, & Redmore, 1970) might be especially useful in detecting wisdom as part of training or supervision. This approach has been suggested before (Swenson, 1980) but was not widely adopted. Carlozzi, Gaa, and Liberman (1983) found this instrument to be useful in measuring the presence of empathy. Given Kramer's (1990) suggestion that wisdom characteristics parallel Loevinger's more advanced stages, this instrument may be valuable in measuring wisdom overall. This may well be a fruitful avenue for further study.

Discovering training techniques that can help to establish and engender wisdom is still in its infancy. This task is not unlike discovering ways to help a counselor, or anyone, advance along developmental stages. However, teaching *dialectical thinking* (Hanna et al., 1996; Hanna & Ottens, 1995) would certainly be conducive to cultivating wisdom. Similarly, using *awareness techniques* adapted from Gestalt therapy, such as contact, excitement, therapeutic frustration, centering exercises, and polarity, could be helpful in promoting wisdom in counselor trainees. Existential–phenomenological techniques for the *exploration of being* and the *transcendence of self* may aid in developing sagacity (see Hanna, 1993a, 1993b). Experiential learning approaches might also be more extensively used. Use of techniques from the Sufi tradition of Islam, such as *surrender* and *paradox* may also be of help. Similarly, metacognitive skills such as those acquired through Buddhist *vipassana*—insight meditation based on mindful awareness—can be helpful in bringing about greater awareness and potential for developmental psychotherapeutic change (Hanna et al., 1995). The point here is that the use of the GRE and purely academic or scholarly assignments may not be at all helpful in training effective practitioners, multicultural or otherwise (Sternberg & Williams, 1997).

CONCLUSION: TOWARD A NEW PLATEAU OF EFFECTIVENESS

Through the centuries and across many cultures there have been countless journeys to find wisdom. One common feature of these quests is the ability to incorporate new insights and experiences into different ways of understanding and thinking. In the field of multicultural counseling, this is a continuous monitoring and integrating of contrasting worldviews, meaning systems, customs, traditions, perceptions, and biases against a greater background of shared fundamental human qualities. In summation, the wise multicultural counselor is highly empathic and compassionate, does not automatize skills or approaches, is deeply insightful, is not easily fooled or deceived, has extensive self-knowledge and self-awareness, learns from mistakes, can readily reframe cultural contexts, knows a wide range of coping strategies, can cut to the essence of situations and conditions, properly frames problems, sees the interdependence and connections among people and things, is extremely tolerant and accepting, and is adept at self-transcendence. Of course, intelligence remains a highly valued construct but must be seen in terms of its utility in a therapeutic context. This same list of qualities can also be seen as desirable outcomes for clients to achieve as well (Hanna & Ottens, 1995).

Courses in multiculturalism as well as traditional curricula in the counseling field are limited with respect to attaining wisdom and remain largely mired in a training

modality based on intelligence. An unfortunate result is students who are able to espouse the appropriate rhetoric and present politically correct language. To move beyond this, to acquire more than mere information, training programs designed to emphasize and enhance wisdom may be able to take the field to a new level of effectiveness. Inherent in this process is the necessity for counselor educators and researchers to examine the depth and magnitude of their own automatized thought routines, assumptions, and subtle prejudices—yet another characteristic of wisdom.

In this article, we have attempted to look beyond traditional or conventional thinking toward elucidating those personal qualities that are at the heart of the effective multicultural counselor. Research is needed to explore the area of wisdom and counselor effectiveness. The irony is that just because a person researches or writes about wisdom does not mean that he or she can lay any special claim to it. Although wisdom is eminently worthy of pursuit, it probably can never be fully attained. Like many things in this field, it is a matter of process and degree.

The concept of wisdom contains the essence of personal growth and development. On reflection, the omission of wisdom in the counseling literature actually makes it seem conspicuous by its absence. Perhaps, through encouraging metacognitive skills, advanced empathy, dialectical thinking, perspicacity, and sagacity in practice, training, and research, we can learn to foster and cultivate master counselors—counselors with wisdom—and reach a new plateau of effectiveness. Paradoxically, as ancient as wisdom itself may be as a concept, it may serve as a "new" paradigm for research to determine the characteristics, skills, and qualities of the highly effective multicultural counselor.

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Identifying the Career Decision-Making Needs of Nontraditional College Students

Darrell Anthony Luzzo

As the number of nontraditional college students (defined as students over the age of 25) continues to increase on college campuses nationwide, there is a clear need to address the career development needs of this growing population. This article critically reviews the results of recent research evaluating the relationship between the age of college students and various aspects of their career development. On the basis of this review, several implications for career counselors who work with nontraditional college students are discussed, and ideas for future research in this domain are presented.

Estimates indicate that between one third and one half of today's college students are over the age of 25 (Griff, 1987; Hirschorn, 1988; Rathus & Fichner-Rathus, 1997). In fact, it is expected that more than 20 million nontraditional students will be enrolled in college-level studies by the turn of the century (Haviland & Mahaffy, 1985). As career counselors have repeatedly observed, the process of choosing an academic major and engaging in career decision-making tasks and activities are of central concern to nontraditional college students (Brock & Davis, 1987; Mounty, 1991). Indeed, there is little doubt that adult motivation for returning to college is based primarily on career enhancement needs (Ashar & Skenes, 1993).

Because the majority of college and university career development and career counseling programs have traditionally focused on the needs of students roughly between the ages of 18 and 22, there is a growing need to respond to the expanding population of nontraditional college students by developing age-appropriate career development programs (Ginter & Brown, 1996; Griff, 1987; Mounty, 1991). The first step to establishing effective treatment strategies requires an increased understanding of some of the career decision-making differences that exist between traditional and nontraditional college students.

Miller and Winston (1990) argued that *nontraditional students* (defined as students over the age of 25) experience substantially different developmental needs than traditional students. In terms of developmental needs that are specifically linked to vocational issues, Super (1984) theorized that nontraditional college students are likely to possess fewer career-related needs than traditional students. Super believed that most older college students are engaged in *recycling*, the process of reexperiencing earlier stages of career development. Because nontraditional students are expected to use their accumulated knowledge from previous career decision-making experiences, it is likely that they will be much more effective and efficient in repeating earlier stages of career development (Healy & Reilly, 1989).

However, it is important to note that some researchers have reported career decision-making similarities between traditional and nontraditional college students. The age of college students apparently has very little influence on their knowledge of career decision-making principles (Healy, Mitchell, & Mourton, 1987; Luzzo, 1993a), knowledge of preferred occupation (Greenhaus, Hawkins, & Brenner, 1983), and level of career indecision (Slaney, 1986; Zagora & Cramer, 1994). On the other hand, significant differences between traditional and nontraditional students have been revealed for various other indices of career development. A focus on some of these differences may be particularly useful in developing appropriate career counseling interventions for nontraditional student populations.

ATTITUDES TOWARD THE CAREER DECISION-MAKING PROCESS

Several investigations conducted over the past 10 to 15 years have provided evidence for Super's (1984) notion that the age of college students is associated with their career decision-making needs and presenting problems. Much of this research has focused on age-related differences associated with Crites's (1971) model of career maturity. According to Crites, an individual's attitudes and emotional reactions toward making career decisions are important properties in career maturity. In support of Crites's claim, numerous investigations have revealed that age is positively correlated with college students' attitudes toward career decision making (Blustein, 1988; Guthrie & Herman, 1982; Healy, O'Shea, & Crook, 1985; Luzzo, 1993b). Older students tend to exhibit attitudes toward the career decision-making process that demonstrate a lack of anxiety and fear, whereas younger students are more likely to exhibit attitudes indicative of insecurity and general concern about making career decisions.

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Research by Healy and his colleagues (Healy, 1991; Healy et al., 1987; Healy & Mourton, 1987; Healy et al., 1985; Healy & Reilly, 1989) has been especially useful in this domain and has helped career counselors gain a clearer understanding of the role that age plays in the career development of college students. Consider Healy et al.'s (1985) study of the relation of career attitudes to age and career progress during college. Participants completed the Attitude Scale of the Career Maturity Inventory (CMI; Crites, 1978) and a demographic form that asked for information regarding age, grade point average (GPA), and occupational status. Results revealed a positive correlation between age and career decision-making attitudes ($r = .48$, $p < .01$). A path analysis also showed a direct link between age and occupational level as well as linkages between age, career attitudes, and GPA. As expected, the results suggested that career attitudes mature with age and that their maturation enhances employability and fosters academic achievement.

Similarly, in an investigation of the relationship between career choice crystallization and career maturity, Blustein (1988) asked participants to complete measures of career indecision, career commitment, and career maturity. Consistent with earlier findings (Healy et al., 1985), Blustein discovered a significant relationship between age and career maturity, with age accounting for nearly 5% of the variance in career maturity scores. A more recent study (Luzzo, 1993b) also provided evidence that age may be an influential factor in determining college students' attitudes toward career decision making. Participants completed measures of career decision-making self-efficacy (Taylor & Betz, 1983), career maturity (Crites, 1978), and a demographic questionnaire. Results revealed that the age of participants was positively correlated with attitudes toward career decision making ($r = .31$, $p < .001$), with age accounting for over 9% of the variance in students' career decision-making attitudes. As found in prior studies, nontraditional students were more likely than their younger, traditional classmates to exhibit attitudes reflective of people who are adequately prepared, at least emotionally, to effectively engage in career decision-making activities.

ADDITIONAL CAREER DECISION-MAKING VARIABLES OF INTEREST

In addition to the differences between traditional and nontraditional college students in their attitudes toward career decision making, there is evidence to suggest that traditional and nontraditional students differ in other important aspects of career development, including career commitment, vocational identity, career decision-making self-efficacy, and perceived career counseling needs (Colarelli & Bishop, 1990; Greenhaus et al., 1983; Haviland & Mahaffy, 1985; Luzzo, 1993a; Peterson, 1993).

In a study of 341 students working toward their master's of business administration (MBA) degree, participants completed two career commitment measures as well as measures of locus of control, role conflict, and role ambiguity (Colarelli & Bishop, 1990). Results indicated a significant, positive relationship ($r = .25$, $p < .01$) between age of participants and career commitment. Older, nontraditional students were more committed than traditional students to their identified career choice. Results of the study also suggested the importance of considering important personal (gender, ethnicity) and psychological characteristics (e.g., locus of control, multiple role conflict) along with age when working with college students in career counseling contexts.

Haviland and Mahaffy (1985) also conducted an investigation to evaluate differences in the career development of traditional and nontraditional college students. Participants in their study—all of whom were nontraditional students—completed the My Vocational Situation (MVS) inventory (Holland, Daiger, & Power, 1980), a short diagnostic tool that identifies three problem areas associated with career decision making: lack of vocational identity, lack of vocational information or training, and perceived barriers to occupational goals. Participants' scores were compared with the scores of traditional college students represented in the MVS manual. Nontraditional students reported the perception of more barriers to reaching a chosen occupational goal and a greater need for occupational information than did traditional students in the normative sample. Haviland and Mahaffy concluded that nontraditional students would probably benefit from discussing perceived barriers in career decision making and receiving ample occupational information associated with the careers they are considering pursuing.

Two relatively recent investigations (Luzzo, 1993a; Peterson, 1993) examined the relationship between the age of college students and their career decision-making self-efficacy. Career decision-making self-efficacy, based on Bandura's (1977) self-efficacy theory, refers to an individual's confidence in her or his ability to engage in career decision-making tasks (Taylor & Betz, 1983). College students' level of career decision-making self-efficacy has been found to be significantly correlated with several other measures of career development and maturity, including career exploration behavior (Blustein, 1989), career indecision (Taylor & Betz, 1983; Robbins, 1985), and career locus of control (Luzzo, 1995). Results of the Luzzo (1993a) and Peterson (1993) studies revealed a significant relationship between age and career decision-making self-efficacy among college students, indicating that nontraditional students are somewhat more likely than traditional students to possess confidence in their ability to engage in the career decision-making process.

Probably the most comprehensive analysis of the career decision-making differences between traditional and nontraditional college students was conducted several years ago by Healy and Reilly (1989). Nearly 3,000 students attending various community colleges were surveyed about career counseling needs and services. Participants rated their needs in seven career areas: knowing more about interests and abilities, understanding how to decide on career goals, becoming more certain of career plans, exploring careers related to interests and abilities, selecting courses relevant to career goals, developing job finding skills, and obtaining a

job. Each career area was assessed by asking participants to rate their need in that particular area, indicating whether it was a *major* need, a *minor* need, or *no need at all*. Findings revealed several significant differences between the two groups of students. As expected, nontraditional students were likely to rate most of the career needs as minor or nonexistent, whereas traditional aged students were likely to rate the same career needs as major. Results generally indicated a decline in perceived career decision-making needs with age.

At the same time, however, Healy and Reilly (1989) discovered that many of the career decision-making tasks that were "thought to pose minimal concern if repeated during the adult years [were] instead reported as major needs by 25% to 35% of the adults over 30 years of age" (p. 544). For instance, over 35% of students over the age of 40 indicated a need to explore jobs related to their career interests and abilities. Data also showed that a majority of nontraditional students (like their traditional student counterparts) reported at least minor needs in each career area. "The lowest needs for the older cohorts were in deciding upon career goals, becoming more certain of plans, and in obtaining jobs, while their highest needs were in exploring jobs related to talents and interests and in selecting courses related to goals" (Healy & Reilly, 1989, p. 544). On the basis of these findings, Healy and Reilly concluded that many nontraditional students apparently adopt an exploratory posture toward the ever-changing opportunity structure. As such, they continue to seek and anticipate academic and work experiences that will provide them with the opportunity to develop and discover their career potential.

PRACTICAL CAREER COUNSELING IMPLICATIONS

Several recommendations for the effective career counseling of nontraditional student populations can be inferred from existing literature on the topic. One of the clearest messages that emerges from a review of the literature is that, despite some significant differences in career development between traditional and nontraditional students, nontraditional students are not so advanced in their career development that they need *substantially* less guidance in career planning and decision making (Healy et al., 1987; Healy & Reilly, 1989; Luzzo, 1993a). Furthermore, based on the research reviewed in this article, it would be inappropriate to assume that nontraditional college students possess *completely* different career decision-making needs than their younger classmates. For example, "All students, both from traditional and nontraditional perspectives, expect that college will enhance their career plans and goals in today's competitive marketplace" (Mounty, 1991, p. 43).

In essence, career counselors should recognize the widespread need for career exploration and academic assistance (e.g., course selection) among college students of all ages (Healy & Reilly, 1989; Luzzo, 1993a). The results of Healy and Reilly's investigation suggest that many nontraditional students who are attending college and contemplating career changes may need guidance in learning and employment opportunities in new fields just as traditional students often require. By coordinating services with other campus agencies, counselors can help establish a network of resources that can be used by students of all ages for obtaining valuable experiences in career exploration and planning. Similarly, by establishing ongoing liaison relationships with their college or university's vocational and academic departments, career counselors can keep abreast of the content of courses and can help ensure that timely information is available to students of all ages and academic levels. Finally, although the career decision-making needs of traditional and nontraditional students are not vastly different, differences exist that warrant consideration.

Counselors also need to realize that although the age of a nontraditional college student may be directly related to her or his readiness to engage in career decision-making tasks, certain psychological characteristics can also have a meaningful influence in career development (Blustein, 1988; Colarelli & Bishop, 1990; Ginter & Brown, 1996). When working with nontraditional students, career counselors are advised to consider the role of various psychological factors (e.g., career locus of control, perceptions of occupational barriers, multiple role conflict) in career decision making. Integrating a discussion of these types of psychological characteristics into the career counseling process can help counselors avoid stereotyping nontraditional students' career development needs solely on the basis of age.

As the number of nontraditional students continues to rise on college campuses nationwide, it will be increasingly important for counselors to determine whether traditional methods of career counseling are appropriate for nontraditional student populations. As Healy and Reilly (1989) found, although nontraditional students are as likely as traditional students to enter the career counseling process with a perceived need to explore job options associated with their career choice and to obtain assistance in academic planning and course selection, nontraditional students tend to exhibit somewhat more defined career-related needs and a greater awareness of the career decision-making process in general. Experimental research is needed to determine whether traditional career counseling interventions are as effective for older college students as they are for younger students for whom they were originally developed.

Support for the notion that traditional methods of career counseling may not be as effective when applied to older students stems from previous research on the development of nontraditional students within higher education contexts. Numerous researchers and student affairs professionals have recognized several characteristics that differentiate most traditional and nontraditional students (e.g., Ashar & Skenes, 1993; Chartrand, 1992; Chickering & Havighurst, 1981; Miller & Winston, 1990). Among these differences is the realization that nontraditional students usually have work, family, and community responsibilities outside of the college or university environment. Such students are often less concerned with establishing an identity or engaging in university-sponsored social activities. Nontraditional students,

unlike many traditional students, usually work full-time and focus on occupational and family goals as salient factors in their lives. As Ashar and Skenes summarized, "As their participation in the college's social life is limited . . . their participation in other communities (family and work) is much more extended" (p. 92). Furthermore, there is evidence that nontraditional students possess more of an instrumental educational orientation rather than the expressive orientation exhibited by younger students (Chickering & Havighurst, 1981). As a result, nontraditional students' motivation for returning to school is more likely to be based on career enhancement needs, suggesting that a strong career culture might be more important to academic retention and persistence than intellectual and social integration.

Because of these and related differences in the lives of traditional and nontraditional students, Chartrand (1992) argued that widely accepted models of student development (e.g., Pascarella, 1980; Tinto, 1975), which usually focus on developmental factors that are relevant to late adolescence, may not apply equally well to an understanding of nontraditional student development. Miller and Winston (1990) echoed this concern as follows:

> This older adult group . . . reflects a population that is experiencing considerably different developmental needs and tasks than those of students of traditional college age. Because these nontraditional students are at different developmental levels, it is important that psychosocial assessment strategies and instrumentation be geared to the special characteristics and life patterns of these different age cohorts. (p. 109)

On the basis of these arguments, it seems likely that expanding career counseling services to address issues relevant to the nontraditional student population will increase the degree to which nontraditional students seek career counseling services (Mounty, 1991). Consequently, numerous resourceful and creative career intervention strategies that might be particularly useful when working with nontraditional students have been suggested (Brock & Davis, 1987; Healy & Reilly, 1989; Mounty, 1991). For example, based on the fact that many nontraditional students work during daytime hours, it seems likely that expanding career service center hours to include evenings and weekends will allow adult and part-time students to access services after their workday has ended. Similarly, offering evening and weekend orientation sessions will allow nontraditional students the same opportunity as traditional students to become oriented to the numerous adjustments and changes that take place when reentering school.

Counseling workshops and seminars for nontraditional students should include well-established methods for addressing some of the specific career-related concerns identified by participants in previous investigations (Haviland & Mahaffy, 1985; Healy & Reilly, 1989; Luzzo, 1993a). The results of Healy and Reilly's analysis can be especially useful in this regard. Although nontraditional students tend to view selecting a career goal, becoming certain of those plans, and searching for jobs as less important activities than traditional students view them, nontraditional students do place a strong emphasis on the need to explore jobs related to their talents and interests. They also perceive a significant need to learn about the process of selecting appropriate courses to prepare for specific careers. Such topics should be the focus of workshops and seminars specifically targeted to meet the needs of nontraditional students.

Results of Haviland and Mahaffy's (1985) research suggest that one of the most influential factors in nontraditional students' career development is the perception of career-related barriers. As such, counselors should consider integrating a discussion of perceived barriers into the career counseling process and should assist clients in developing strategies for addressing and overcoming career-related barriers. Albert and Luzzo (1997) recently proposed several strategies that might be used in this regard, including encouraging clients to keep a journal of barriers encountered in the past, wherein clients can explain how these barriers were confronted and handled. Clients could then be encouraged to list additional ways in which specific barriers could have been managed or prevented. Counselors also can help bolster nontraditional students' confidence in their ability to successfully encounter career-related barriers by discussing barrier perceptions from an attributional perspective, helping clients evaluate the degree to which they have control over the career decision-making process. Such techniques could be used in hopes that nontraditional students would begin to gain an increased sense of control over and responsibility for those barriers which they might actually be able to overcome with increased effort or training.

A CRITICAL REVIEW OF EXISTING LITERATURE AND IDEAS FOR FUTURE INQUIRY

Despite the helpful information about career decision-making similarities and differences between traditional and nontraditional college students that previous research has provided, there is an ongoing need to improve our understanding of nontraditional students' career development. To that end, high-quality, empirical investigations are sorely needed. An effective method for developing such research strategies should begin with a critical review of previously published investigations in this domain.

Probably the most obvious weakness associated with the research conducted thus far is that it has been entirely correlational in nature. Although correlational studies are valuable in their own right, they do not provide information about causal relationships between variables. Researchers should strongly consider conducting experimental investigations to increase our knowledge of the similarities and differences in the career development of traditional and nontraditional college students. Experimental methods that use attribute–treatment interaction (ATI) designs might prove especially helpful in determining whether certain interventions are more appropriate for traditional or nontraditional student populations (Fretz, 1981).

Future research should also attempt to address many of the unanswered questions regarding the ways in which traditional and nontraditional college students engage in the career decision-making process (Healy & Reilly, 1989). Do younger and older students explore careers through the same or different means? Do they ask the same or different questions about possible careers and courses that will assist them in preparing for careers? Are traditional and nontraditional students equally concerned about economic issues? Do they exhibit a comparable degree of understanding of the world of work and current employment trends? Answers to these questions will help counselors who are searching for the most effective career counseling interventions for traditional and nontraditional college students. Qualitative research may be especially useful in this regard, allowing in-depth accounts of how nontraditional students experience the career decision-making process.

It will also be important in future research to evaluate the role that age plays in the career development of nontraditional students relative to other important psychological and contextual factors, such as an individual's sense of personal agency toward career decision making, role ambiguity, sexual orientation, cultural identity, and socioeconomic status (Blustein, 1988; Colarelli & Bishop, 1990; Healy & Reilly, 1989). Career counselors and vocational psychologists have argued that the influence of contextual factors in career exploration and planning has been traditionally ignored in career development research (Blustein & Phillips, 1988; Morrow, Gore, & Campbell, 1996; Parham & Austin, 1994). It will become increasingly important to integrate such variables into future investigations. Similarly, researchers would benefit from an examination of other variables that have emerged in the student development literature as especially relevant to older student populations (Ashar & Skenes, 1993; Chartrand, 1992; Miller & Winston, 1990). The multiple role strain of competing work, family, and community responsibilities, an instrumental educational orientation, and lack of social integration to college and university life—identified as particularly influential factors in nontraditional student development—need to be evaluated in the context of the career decision-making process.

Finally, an overall weakness with existing research in the career area is that the participants in most investigations represent the traditional college student population. Except for a few notable exceptions (e.g., Haviland & Mahaffy, 1985; Healy & Reilly, 1989), the majority of participants in previous studies of college students' career development have been less than 25 years of age. Even investigations specifically designed to evaluate differences between traditional and nontraditional students have suffered from relatively few participants representing the nontraditional student population. An in-depth analysis of the career decision-making needs and concerns of nontraditional college students requires additional data to be gathered from a much larger proportion of students over the age of 25. Because of the changing landscape of the college population, career researchers must make a concerted effort to achieve greater representation in their studies.

There is no question that the number of nontraditional students attending college will continue to increase as the twenty-first century approaches (Ashar & Skenes, 1993; Hirschorn, 1988). With this expanding population of older students comes the challenge of building on existing programs and services to more effectively address their career decision-making needs (Griff, 1987). Research focusing on the career development of nontraditional students will play an important role in meeting that challenge and will be a critical factor in the development of effective career counseling services for college students of all ages.

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Situating Psychological Well-Being: Exploring the Cultural Roots of Its Theory and Research

John Chambers Christopher

Psychological well-being is a seminal concept in counseling and yet it is seldom discussed, researched, or critiqued; this article examines the cultural values and assumptions underlying its theory and research. Contemporary understandings of psychological and subjective well-being are placed in cultural and historical context to illuminate their Euro-American cultural roots. Approaches to psychological well-being are shown to presuppose ontological and liberal individualism as notions of the self and as normative prescriptions for the good or ideal person. It is argued that culture-free theories or measures of well-being are unattainable; all understandings of psychological well-being are based on moral visions.

> It is not possible to live as a human being without having an idea of what it is to be human. (Heelas & Lock, 1981, p. 3)

> At work in a theory of social science is a vision of life, and it is only when this vision is made manifest and analyzed that the merits and demerits of the theory can be fully recognized. (Fay, 1987, p. 1)

Throughout human history, normative understandings of well-being have defined particular human characteristics and qualities as desirable and worthy of pursuit or emulation (Brinton, 1959/1987; MacIntyre, 1984; Taylor, 1989). Such normative understandings are epitomized by traditional philosophies and religions that often stress the cultivation of certain virtues (Coan, 1977; Diener, 1984). In contemporary Western society, these norms are largely provided by notions of psychological well-being. Psychological well-being is among the most central notions in counseling. It plays a crucial role in theories of personality and development in both pure and applied forms; it provides a baseline from which we assess psychopathology; it serves as a guide for clinical work by helping the counselor determine the direction clients might move to alleviate distress and find fulfillment, purpose, and meaning; and it informs goals and objectives for counseling-related interventions. Moreover, an understanding of psychological well-being may be a transcendental requirement for human existence, what Geertz (1973) terms a "pervasive orientational necessity" (p. 363). In other words, human beings always and necessarily live on the basis of some understanding of what is a better, more desirable, or worthier way of being in the world (Christopher, 1996; Christopher & Fowers, 1996, 1998; Coan, 1977; Taylor, 1988, 1989).

Yet, as a topic itself, psychological well-being receives relatively little attention. This stands in stark contrast to the sheer quantity of published material devoted to psychopathology. Compared with psychological well-being, topics related to psychopathology dominate journals. Indeed, although numerous journals are dedicated solely to increasing our understanding of psychopathology (e.g., *Journal of Abnormal Psychology*, *Journal of Abnormal Child Psychology*, *Journal of Affective Disorders*), there are no journals specific to psychological well-being. Interest in psychological well-being and positive mental health seems to have peaked between the late 1950s and 1970s. Since this time, interest seems to have waned, especially in the type of theorizing done by Jahoda (1958), Maslow (1968, 1971), and Shostrom (1973), with the possible exception of the somewhat marginalized field of transpersonal psychology (Boorstein, 1980; Walsh & Shapiro, 1983; Wilber, 1977, 1995). Contemporary research conducted on psychological well-being usually involves discerning the variables that enhance or diminish well-being with a specific population through the use of some preexistent measure of well-being. Well-being itself is defined in these studies as the outcome on a particular measure or set of measures. Consequently, focus is on the variables that affect well-being, whereas the nature of well-being itself is secondary to these studies.

These observations suggest a curious discrepancy: Although notions of psychological well-being lie at the core of counseling, very little time is spent theorizing or researching about this. We have differentiated, scrutinized, and articulated those aspects of social reality and human behavior that we term *psychopathology*, but we have failed to invest

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the same amount of time and energy differentiating, scrutinizing, and articulating aspects of well-being. Such a discrepancy suggests that we are not as explicit or clear about our understanding of psychological well-being as we are about what we see as problematic about human behavior. Under these conditions, we may be simply drawing on our "common sense" understandings of well-being in a largely unrecognized and uncritical manner. This can be problematic in a number of ways. If, as Geertz (1983) argued, common sense is itself a cultural system, then our understandings of psychological well-being may be much more informed by our own culture then we have tended to consider. To use the language of a previous article (Christopher, 1996), Western concepts of psychological well-being may be deeply shaped by our culture's individualistic moral visions. Moreover, by failing to account for the assumptions and influences underlying the field of psychological well-being, we may fall prey to what Bernstein (1978) termed *disguised ideology*. In fitting with the positions of multiculturalists such as Pedersen (1991) and Sue and Sue (1990), it is crucial for us to understand the cultural values and assumptions that underlie the field of counseling.

This article explores those values and assumptions that underlie two reigning approaches to psychological well-being. I attempt to show not only that the theories and research on psychological well-being are substantively shaped by Western individualistic moral visions of the good or ideal person but also that the general neglect of psychological well-being, as an area of inquiry, is related to our cultural values and assumptions. Contemporary theory and research on psychological well-being will be situated in a cross-cultural and historical context that demonstrates their heritage in Western cultural history (cf. Coan, 1977; Marcus & Fischer, 1986; M. B. Smith, 1985; see also Author's Note). This aim is meaningful for at least three reasons. First, our common sense, culturally informed notions of psychological well-being are likely to be at odds with clients whose ethnic backgrounds are different from ours. Second, as counseling and counseling-related interventions are increasingly applied in non-Western parts of the world, it is necessary to have some critical awareness of what is actually being exported. Third, gaining some awareness of the cultural roots of our understanding of psychological well-being is a first step toward critically assessing our own presuppositions (and perhaps revising our own theories).

At this point, it is essential to briefly define what I mean by individualism, for as Foucault (1984/1986) warned, individualism "is so frequently invoked" that "entirely different realities are lumped together" (p. 42). Although individualistic outlooks can be found outside Western culture (i.e., Elvin, 1985; Munro, 1985; Nakamura, 1964), in this discussion I am limiting *individualism* to a specific moral vision that emerged in Western history beginning with Renaissance humanism. As a moral vision, individualism combines ontological claims about the nature of the self with normative prescriptions about the good or ideal person.

Individualism relies on an atomistic understanding of the person as being metaphysically discrete and separate from other persons. Geertz (1983) provided a classic statement of this position:

> The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment and action organized into a distinctive whole and set contrastively against other such wholes and against its social and natural background. (p. 59)

The individual is seen as the primary reality—the supposed "man" in the state of nature (gender bias intentional)—whereas society is a derivative, second-order level of reality that is simply a collection of individuals (Dumont, 1986; Sullivan, 1986). Society becomes the arena where relatively autonomous and self-contained people, who already contain their own objectives, needs, desires, interests, potentialities, and rights, express and act on these inner attributes (Dumont, 1980; Lukes, 1973). Such an individual should be "self-defining" (Taylor, 1985a, 1985b), able to step back from his or her life and rationally determine the best manner of pursuing self-chosen goals and interests (Sandel, 1982). The self is seen as prior to these goals or interests, and "what matters above all, and what is most essential to our personhood, are not the ends we choose but our capacity to choose them" (Sandel, 1984, p. 86). Sullivan demonstrated the centrality of individualism to American sociopolitical structures through his analysis of liberal individualism. As embodied in the Declaration of Independence and the Constitution, liberal individualism rests on the belief that government should provide and enforce rules of fair conduct so that people can pursue life as they see fit (see also Sandel, 1982, 1984).

Different versions of individualism have been identified. One powerful strategy adopted by Taylor (1975) and Bellah, Madsen, Sullivan, Swidler, and Tipton (1985) is to demonstrate the roots of these different versions of individualism in particular historical epochs. Thus, utilitarian individualism (Bellah et al., 1985) can be linked back to the European Enlightenment and its emphasis on the instrumental pursuit of rational goals. Expressive individualism can be traced to the romantic movement with its emphasis on self-cultivation and artistic expression of the wellsprings of nature that lie within. However much these individualistic conceptions seem like common sense to those in the West, they are "rather peculiar . . . within the context of the world cultures" according to researchers like Geertz (1983, p. 59) and Shweder and Bourne (1984).

We now consider how individualism in its different guises underlies and informs the two main approaches to studying psychological well-being: subjective well-being and Ryff's (1989) psychological well-being. Before this consideration, three caveats need to be elucidated.

First, although terms such as *individualism*, *collectivism*, *Western*, and *non-Western* are helpful for preliminary analyses, they are overgeneralizations that obscure much diversity. Anglo, Italian, and Jewish ethnic groups in the United States might all be considered Western, yet there are significant differences among them. Second, Spiro (1993) warned us not to assume that cultural accounts of the self (like individualism) are necessarily the same thing as the person's

"mental representations of their self" or even "with their very self itself" (p. 117). In consequence, I treat both individualism and also the many non-Western alternatives increasingly termed *collectivism* (Hui & Triandis, 1986; Kim, Triandis, Kâgitçibasi, Choi, & Yoon, 1994; Triandis, 1989) as indigenous conceptions of the person or self and not as actual accounts of the person or self. Third, the very notion of psychological well-being is itself a Western concept. The division of well-being into a psychological dimension and a presumably physical dimension is a direct byproduct of our philosophical, particularly Cartesian, heritage. It seems to be a division that is unique to Western culture. As Lock (1982) emphasized, "there is no mind/body dichotomy in East Asia medicine and no concept of mental health as distinct from physical health, either historically or at the present time" (p. 220).

SUBJECTIVE WELL-BEING

The predominant approach to studying well-being has been termed *subjective well-being*. Subjective well-being consists of two general components: (a) judgments about life satisfaction and (b) affective balance or the extent to which the level of positive affect outweighs the level of negative affect in someone's life (Andrews & Withey, 1976; A. Campbell, Converse, & Rodgers, 1976; Diener, 1984). *Life satisfaction* is based on an individual's subjective cognitive appraisals. This approach "relies on the standards of the respondent to determine what is the good life" (Diener, 1984, p. 543). Diener (citing Shin & Johnson, 1978) claimed they captured the essence of this orientation when they described it as "a global assessment of a person's quality of life according to his own chosen criteria" (p. 543). Research on *affective balance* uses a notion of well-being that corresponds to the popular usage of the term *happiness*. Happiness is an affectively oriented evaluation of well-being that entails a "preponderance of positive affect over negative affect" (Diener, 1984. p. 543). Simply stated, from this perspective we are doing well (we are happy), when we experience (i.e., individual's appraisal) more positive than negative feelings in our life.

It is not surprising that researchers have relied on this approach; on the surface it seems to preserve the scientific neutrality valued by mainstream social science (Bernstein, 1978; Richardson & Christopher, 1993; Taylor, 1985a, 1985b). Although such an approach to well-being seems to avoid the imposition of particular cultural values and norms, on closer examination it is clear that this approach is directly linked to certain Western individualistic assumptions and values—or moral visions.

Subjective well-being places the onus of well-being on the individual. It is the individual alone who determines the standards and criteria by which to evaluate her or his life. Researchers in this tradition defer to the individual both the responsibility for evaluation and for the selection of norms by which the evaluation is made.

The attempt to evaluate well-being subjectively, without relying on normative standards, is consistent with the political liberalism and liberal individualism central to Western societies. For liberal political theorists such as Dworkin, "a liberal society is one that as a society adopts no particular substantive view about the ends of life. The society is, rather, united around a strong procedural commitment to treat people with equal respect" (Taylor, 1992, p. 56). The field of subjective well-being seems to manifest this same outlook in its theories and research. As an approach to psychological well-being, subjective well-being refrains from making strong claims about the good life and good person. As embedded in the machinery and ideology of our liberal individualistic form of government, the good life is freedom to choose—the freedom to purse happiness as defined by the individual and as guaranteed by the Declaration of Independence (Sandel, 1984; Sullivan, 1986). Subjective well-being gives the individual this right. It advances a subjective approach that remains both democratic and egalitarian by minimizing the role of the expert with his or her criteria. Thus, the subjective well-being researcher has adopted the prevailing attitude of the liberal individualistic society: "A liberal society must remain neutral on the good life, and restrict itself to ensuring that however they see things, citizens deal fairly with each other and the state deals equally with all" (Taylor, 1992, p. 57).

Individualism emerged, in part, as a socially constructed moral vision that provided ideological resources during the Renaissance, Reformation, and Enlightenment for rejecting what came to be seen as the hierarchical, patriarchal, and authoritarian excesses of the Middle Ages (Lukes, 1973; Taylor, 1989; Ullmann, 1966). This newly created view of the self, identified by MacPherson (1962) as *possessive individualism*, casts the individual as the possessor or owner of his or her own being. This represented a radical transformation of our sense of self—what Berlin (as cited in Bernstein, 1978) called "a great liberating idea"—and it enabled activists during the Enlightenment to demand the freedom to restructure society, politics, and religion, and even the principles of scientific and rational thought.

Before individualism, the masses were not believed to possess the intelligence, discipline, or courage to choose their own destinies or rule their own lives. The *munt*, for instance, was a medieval social institution that codified a patriarchal view of relationships. The *munt* emphasized obedience to hierarchy because those higher on the hierarchy in essence knew what was best for their underlings. Hence, the kingdom was understood as very much in the trust of the king, just as a father was the guardian of his child, and a husband the guardian of his wife (Ullmann, 1966). By constructing the person as the owner of himself [gender bias intentional] the Enlightenment wrested control of the self away from the church and king and in doing so undermined the existing sociopolitical and religious systems. This coincided with the creation of new "positive" epistemologies (i.e., empiricism) that in principle empowered the average citizen by locating the source of knowledge in the information received through a person's senses rather than in the Bible and the classics, which only a small elite could read or had access to (Ullmann, 1966).

From this heritage we have developed an emancipatory and antiauthoritarian outlook (Baumeister, 1986; Johnson, 1985; Richardson, 1989; Taylor, 1975). As we have progressively expanded our sense of what we want freedom from (Bellah et al., 1985; Berlin, 1969; Taylor, 1989), each generation has found new sources of arbitrary authority. Americans have inherited a suspicion of anyone telling us how to live, telling us what the good life is, or in this case defining for us what psychological well-being is. The antipsychiatry movement (Laing, 1967; Szasz, 1961) in the 1960s exemplifies this suspicion; however, even mainstream theorists such as Rogers (1961) and Ellis (1962, 1997) have been concerned with liberating the individual from social expectations. The field of subjective well-being thus fits squarely in the middle of our individualistic culture, for the use of any norms or standards to assess psychological well-being runs the risk of being seen as dogmatic, ethnocentric, or relative. As we shall see, this subjective and relativistic thrust stands in contrast with non-Western cultures (and our own earlier heritage) in which there were clear standards of conduct that were frequently derived from the order of the cosmos itself (Brinton, 1987; Lovin & Reynolds, 1985; MacIntyre, 1984; Taylor, 1975, 1985a, 1985b).

Satisfaction With Life

A closer inspection of the two components of subjective well-being reveals even more the influence of Western cultural values and assumptions. Satisfaction with life measures such as the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) presuppose that the high scoring person is one whose life is satisfactory or fulfilling. In some ways this is not problematic for Americans who are taught to stress their uniqueness and to engage in a process of self-promotion. Indeed, this imperative permeates our lives so thoroughly that average Americans assume they are above average in many domains (Markus & Kitayama, 1991), and it is the clinically depressed who are most likely to see themselves "realistically" (Alloy & Abramson, 1979). In many non-Western societies such as Taiwan and Japan, the kinds of self-assertions that Americans consider normal and a sign of health are considered immature and an invitation to bad luck (Bond, 1986; Hu, 1944; Markus & Kitayama, 1991). Generally, in collectivist cultures one should be modest and avoid drawing attention to oneself. For instance, in Japan there is a common aphorism that warns "the nail that sticks out gets pounded down" (Markus & Kitayama, 1991). Similarly, Chinese are far less inclined than Americans to say they are experiencing a state of well-being, even if they believe they are (Hu, 1944). These tendencies identified among Asians to be what we could call "self-effacing" and "self-abnegating" (Bond, 1986) do not mean that one actually feels weak or necessarily treats oneself negatively. What frequently happens in collectivist cultures is a sort of reciprocity, in which one is self-effacing but family and friends compensate by providing praise or a more "objective" evaluation of the person (Christopher, 1992). Thus, in the United States we are taught to "toot our own horn," whereas in Taiwan one should let a friend, neighbor, or family member do the tooting.

Historically, in most cultures the person's subjective impression of himself or herself has been devalued, discouraged, or considered of minor importance. Individuals were usually valued for the social roles they played, not because they had natural rights and inherent dignity (King & Bond, 1985; Munro, 1985; Sullivan, 1986; Ullmann, 1966). For instance, in the Middle Ages the individual commonly was seen as important only to the extent that she or he was an instrument or "vehicle through which God acted" (Ullmann, 1966, p. 45; see also Baumeister, 1986). This downplaying of individuality was revealed in art forms such as painting and sculpture and in narrative forms such as myths and fables (MacIntyre, 1984; Morris, 1987; Ullmann, 1966). Through history and across cultures the individual's own desires, goals, or wishes have been frequently subordinated to those of the larger collective. This is true whether the group is the larger family or kin group or the nation, as evidenced in the totalitarian states of the twentieth century.

Although self-expression, self-promotion, and the pursuit of self-chosen satisfactions can be seen as virtues from the perspective of Western psychology and its moral vision of individualism, they are seen as signs of selfishness and immaturity in many collectivist cultures (King & Bond, 1985; Markus & Kitayama, 1991). Consequently, a psychological measure that implicitly draws on the "self-serving bias" or "tendency to false uniqueness" that accompanies Western individualism is of questionable value for use in cultures that exhibit a "modesty bias" or "other-enhancement bias" (Bond, Leung, & Wan, 1982; Heine & Lehman, 1995).

Affective Balance

This modesty bias also seems to influence the other dimension of subjective well-being, affective balance. I (i.e., Christopher, 1992; Christopher, Lightsey, & Christopher, 1999) found that on the Positive Affect Negative Affect Scale (PANAS; Watson, Clark, & Tellegen, 1988) American undergraduate students were more likely to endorse positive affect items (interested, excited, strong, enthusiastic, proud, alert, inspired, and determined) to describe themselves, whereas Taiwanese undergraduate students were more likely to endorse negative affect items (upset, irritable, ashamed, nervous, jittery, and afraid). Similarly, Diener, Suh, Smith, and Shao (1995) found that students in Korea and China were more accepting of experiences of negative affect than were American students. Before assuming that these differences are because Americans actually have more well-being, it is important to consider two other factors potentially influencing research findings. First, as previously discussed, measures of affective balance are likely to be subject to response bias. We can expect that many non-Western people would not engage in the type of self-enhancement bias typical of Americans. As Heine and Lehman (1995) suggested, "individuals in interdependent cultures come closer to realizing their cultural ideals by self-effacing thereby removing their distinguishing and potentially alienating features and allowing them to maximize their sense of belongingness"

(p. 605). In contrast, many Americans may self-promote and stress their positive attributes because as "independent and autonomous beings" they need to be self-contained and to find psychological resources within to maintain a sense of worth. Many non-Western people, drawing on a more interdependent sense of self, find support and acknowledgment from others and thereby can afford to see themselves as average or below average and in doing so strengthen the bonds of affiliation with others.

Differences in affective balance across countries can also be understood by looking at the presuppositions underlying the notion of affective balance. Affective balance assumes that well-being is partially based on the predominance of positive affect over negative affect in one's life (Bradburn, 1969). This assumption—that the emotional state is important to, if not determinate of, well-being—ties in with an individualistic moral vision that sees happiness as the yardstick of the good life. For Westerners, as Taylor (1985b) observed, "the good life is defined in terms of emotional satisfaction" (p. 262). For the purpose of contrast, let us consider traditional Chinese society in which the good life was measured not by happiness but by filial piety and the ability to live in harmony with others (King & Bond, 1985; Munro, 1969). In China a person's status or worth as a human being was based on the extent to which he or she is a dutiful son or daughter and fulfills family obligations (Mei, 1968); it was not based on a subjective emotional state. Therefore, it is quite possible that a Chinese person might have either never really considered whether they were satisfied or considered themselves to be satisfied even though they had, from our perspective, sacrificed what we might consider their own happiness. Or put another way, personal happiness has not traditionally been considered the highest good for the Chinese. (See Jahoda, 1958, and Ryff, 1989, for other problems resulting from equating happiness with mental health.) This interpretation draws support from a recent research finding that "how a collectivist feels about himself or herself is less relevant to his or her life satisfaction than is his or her view of whether he or she behaves properly in the organized social order" (Diener & Diener, 1995, p. 662).

As an approach to assessing well-being, affective balance is further complicated by its apparent dependence on Western emotions and its failure to include indigenous emotions of non-Western cultures. Western emotion terms have been found to have a two-dimensional scaling solution (Russell, 1980); they can be mapped along the first dimension of pleasant/good versus unpleasant/bad and the second dimension of active/high energy versus inactive/low energy. This same two-dimensional pattern of results is found in those non-Western societies that have been examined. However, collectivist cultures such as Japan also exhibit a third dimension not found in the United States (Markus & Kitayama, 1991). This dimension pits self-centered or ego-centered emotions against other-centered emotions. It is important to note that these other-centered or social emotions are frequently neither positive nor negative. Some examples of other-centered emotions in Japan include *amae*, the hopeful anticipation of another's indulgence (Doi, 1971/1973); *fureai*, the feeling of connection to other; and *tanomi*, the feeling of relying on someone (Markus & Kitayama, 1991). In the Micronesian islands of Palau, *ta rengrir* refers to getting along or being of one mind (K. D. Smith & Tkel-Sbal, 1995), and in Ifaluk, *fago* refers to a mixture of sadness, love, compassion, and longing that is not entirely pleasant or unpleasant (Lutz, 1988). The Baining of Papua New Guinea have a term, *awumbuk*, that denotes a sort of social hangover. It is described as follows:

> A lassitude that people feel after the departure of visitors, friends, or relatives who have resided with them. . . . When the social group disbands, these connections are severed. The extended persona is destroyed and individuals must reconstitute their boundaries. . . . The departure induces a loss of social vitality and leaves the home party feeling relatively weakened and diminished, experienced as an additional weight or burden. (Fagans, 1985, pp. 380–381)

These examples have several implications related to our topic. First, they indicate different ways of construing the self. In individualistic cultures, most of emotional life focuses on the individual. This is consistent with our construction of ourselves as beings with interiority and depth (Dreyfus & Rabinow, 1983; Taylor, 1989). Emotions are generally regarded as private and personal, things that come from within. The individual in the West is thought of as "having" emotions in a manner consistent with MacPherson's (1962) analysis of possessive individualism. In many collectivist cultures, on the other hand, much of emotional life focuses on other people. Emotions are more interpersonal or intersubjective. People in collectivist cultures are more likely to use external cues (such as the social setting) to interpret their emotional experience, rather than looking within as Westerners do. To overstate the case, instead of "having" emotions as in the West, people participate in emotions as with group moods. This emphasis on social emotions is consistent with a more interdependent sense of self in which, as with the Baining, "the social actor is not a rigidly defined and delimited entity" for "the boundaries of the individual and the definition of the person are neither permanent nor immutable, but alter and adapt in specific contexts" (Fagans, 1985, pp. 380–381).

The identification of social emotions in non-Western cultures does not necessarily mean that Americans do not experience these emotional reactions. However, it does indicate that for Americans such social feelings are largely undifferentiated. This lack of differentiation implies that these feelings may not be as important to Americans—they have not been accorded enough value to have been labeled, given a specific word. This general neglect of interpersonal emotions is consistent with our individualistic moral vision in which the interpersonal dimensions of reality and of the self are downplayed in favor of a view of the self as independent and autonomous. Indeed, as with the notion of codependency, we often consider people who strongly experience social emotions as pathological.

The existence of these social emotions raises a number of issues for a measure such as the PANAS. First, what does it

mean that emotions with a social referent are not included in the measure? What happens to scores on the PANAS for those from collectivist cultures when their three dimensional emotional experiences are compressed into the two dimensions of the West? Second, if a large part of non-Western people's emotional life is based on interpersonal emotions, then how appropriate is it to evaluate an individual's well-being based on his or her emotional balance. For instance, if individuals from Ifaluk took the measure and were experiencing *fago*, they might (response bias aside) indicate that they are experiencing sadness, a negative emotion from the perspective of the PANAS. However, *fago* is both negative and positive, and the ability to feel *fago* is seen as a sign of maturity by the Ifaluk (Lutz, 1985).

Given these considerations it is not surprising that Diener and Diener (1995) found that the average life satisfaction of a country is highly correlated with its degree of individualism. These results support the hypothesis that, despite intentions to be value-neutral, subjective well-being is actually normative; its very design presupposes values and assumptions that are central to Western culture. We now consider a second approach to well-being.

RYFF'S PSYCHOLOGICAL WELL-BEING

Ryff (1989) critiqued research on subjective well-being for what she saw as its impoverished theoretical basis. She acknowledged that current approaches to subjective well-being have been extensively evaluated, and that psychometrically solid measures have been constructed. What she took issue with is not particular measures and indexes per se, but rather she holds the view that subjective well-being research was a result of historical accident and was "not designed to define the basic structure of psychological well-being" (1989, p. 1070). Acting on the basis of her critique, Ryff (1989) developed an alternative approach to well-being that she refers to as psychological well-being. Synthesizing ideas from the personality theories of Malsow, Jung, Rogers, Allport, Erikson, Buhler, Neurgartens, and Jahoda, she constructed a measure of well-being around six subscales: Autonomy, Environmental Mastery, Positive Relations With Others, Purpose in Life, Personal Growth, and Self-Acceptance. The strength of Ryff's measure of psychological well-being is also ironically its Achilles' heal; to the extent that she integrates Western personality theorists, she also includes the cultural values and assumptions underlying their work. A hermeneutic analysis that draws on history and anthropology helps to situate Ryff's criteria of psychological well-being and raises questions about their universality.

Autonomy

Ryff equates autonomy with attributes such as self-determination, independence, internal locus of control, individuation, and internal regulation of behavior. Underlying these attributes is the belief that one's thoughts and actions are one's own and should not be determined by agencies or causes outside one's control. This belief, although common in Western psychology, is also one of the main ideals and defining values of individualism (Lukes, 1973). It is related to the Western concepts of liberty and freedom, and, as Kant (1965/1781) theorized, it is our capacity for autonomy that brings us our dignity as human beings.

Autonomy is a value that emerged in Western culture for historical reasons. As the following examples illustrate, it is not at all clear how relevant or appropriate autonomy is for non-Western cultures, or for women and ethnic minorities. For instance, Shweder and Bourne (1984) empirically compared whether the concept of the person varies in India and the United States and concluded that "the concept of an autonomous, bounded, abstract individual existing free of society yet living in society is uncharacteristic of Indian social thought" (p. 190; see also Roland, 1988). From the Japanese perspective, we are less than fully human when we are stripped away from our social connections (Nakamura, 1964). According to Rosenberger (1992), "The very word for self in Japanese, *jibun*, implies that self is not an essentiality apart from the social realm. *Jibun* literally means "self part"—a part of the larger whole that consists of groups and relationships" (p. 4). Lebra maintained that the Japanese individual is "in some sense a 'fraction' only becoming whole when fitting into or occupying one's proper place in a social unit" (as cited in Markus & Kitayama, 1991, p. 246). Similarly, Read (1955) found in his fieldwork in New Guinea that the Gahuku-Gama refuse to "separate the individual from the social context" or grant a person "intrinsic moral value apart from that which attaches to him as the occupant of a particular social status" (p. 257). In many parts of the world conformity is not seen as the moral weakness that it is for Americans. Indeed, in many cultures conformity is a sign of maturity and strength (Markus & Kitayama, 1991). For example, a Japanese "person can be diverted from a belief or principle, but such diversion from principle is accepted favorably by others because it shows that he or she has warm empathy" (Azuma, 1984, p. 970). And as Gergen (1973) noted, "if our values were otherwise, social conformity would be viewed as prosolidarity behavior" (p. 312). Thus, the importance of autonomy and its opposite, conformity, varies depending on whether the self is construed in independent or interdependent terms.

Significantly, the meaning of an attribute like autonomy can also vary across cultures. Munro (1985) offered a penetrating analysis of how such stereotypically Western values as uniqueness, privacy, autonomy, and dignity were present in ancient Chinese culture but held a different meaning than they do for contemporary Americans (see also, Elvin, 1985; Nakamura, 1964). Bodde described how "Confucian 'individualism' means the fullest development by the individual of his creative potentialities—not, however, merely for the sake of self-expression but because he can thus fulfill that particular role which is his within the social nexus" (p. 66, as cited in King & Bond, 1985, p. 36). Taiwanese students value self-reliance even more than Americans but apparently because this is a prerequisite to being able to help

others (Christopher, 1992). Similarly, for the Northern Cheyenne "individuality supports a tribal purpose, a tribal identity" because "individuals are like the poles of a tipi—each has his own attitude and appearance but all look to the same center [heart] and support the same cover" (Strauss, 1982, p. 125). Although values and assumptions may be shared across cultures or time, they may be accorded different significance or ranked differently within that culture's hierarchy of values and assumptions. Thus, although autonomy and respect are values found in both Chinese and American cultural history, the Chinese are more likely to place more weight on respect, whereas contemporary Americans give priority to autonomy. Thus, both the meaning and weighting of autonomy can vary depending on local contexts. These points apply to Ryff's other subscales as well.

Environmental Mastery

Ryff (1989) defined environmental mastery as the ability to "choose or create environments suitable to his or her psychic conditions" (p. 1071). This criterion is also a central part of individualism. Environmental mastery presupposes a particular view of the world as, to use Weber's (1946) term, *disenchanted*—without deeper purpose or *telos*. The mature individual from the Enlightenment onward is one who can rationally face this disenchanted world and calculate the most effective means of accomplishing self-chosen goals. The ability to manipulate, control or master the environment both confirms and proves this vision of the world as disenchanted (Taylor, 1975). Clearly, however, this disenchanted world is at odds with the views of many non-Western cultures in which the world is embued with deeper meaning and purpose (Pedersen, 1979). In cultures that see the world as part of a larger cosmos or natural order, harmony with and adaptation to one's environment are promoted. In Bali, for instance, surrendering to the will of the gods is seen as the appropriate response to hardships and life in general.

Although Americans are encouraged to pursue self-chosen goals by exerting efforts to control or master their environment, many non-Western cultures advocate adapting to the social order. Such differences show up in cross-cultural research on the psychology of control. Weisz, Rothbaum, and Blackburn (1984) identified two types of control that people use. *Primary control* entails influencing existing realities, through personal agency, dominance, and even aggression. In contrast, *secondary control* is based on individuals attempting to align themselves with existing realities by exerting control over the psychological impact of events and leaving the environment largely unchanged. Weisz et al. found that Americans rely predominantly on primary control, whereas Japanese rely more on secondary control. This is reflected in one of Japan's indigenous psychotherapies, Morita therapy, in which the client is encouraged to "[a]ccept things as they are" (Lebra, 1992, p. 116; Reynolds, 1976, 1980). Such findings raise questions about the appropriateness of using environmental mastery as a universal criterion of psychological well-being.

Positive Relations With Others

Ryff (1989) defined positive relations with others as warm, trusting interpersonal relations and strong feelings of empathy and affection. At first glance this subscale/criterion seems most sympathetic to or compatible with collectivism. However, there is a significant difference between having relations with others and being psychologically constituted by one's location in a social network. In other words, what is the self that is in relations to others? Is it the individualistic self who has relationships to get certain psychological needs, such as intimacy, met? Or is it the self experienced as metaphysically connected to others such that identity already incorporates others, and the self is no longer "skin-encapsulated" or a "dimensionless point of subjectivity." It may be the case that the Western understanding of the individual, even one with a strong "support network," seems from the perspective of some non-Western cultures such as the Orissa in India as "alien, a bizarre idea cutting the self off from the interdependent whole, dooming it to a life of isolation and loneliness" (Shweder & Bourne, 1984, p. 194).

Purpose in Life

Ryff (1989) suggested that having "a clear comprehension of life's purpose, a sense of directedness, and intentionality" are important parts of the "feeling that there is purpose and meaning to life" (p. 1071). This concern for purpose in life seems tightly linked to individualism with its stress on human freedom. Traditionally, in Western history and in most collectivist cultures, people lived in worlds of "fate" (Berger, 1979)—purpose and meaning were seen as embedded in the very structure of the cosmos. Although questions of purpose and meaning have certainly surfaced around the world throughout history, particularly in times of cultural transition, it is unlikely they have ever been as widespread as they are in the contemporary West. Indeed, Frankl (1967) viewed our contemporary preoccupation with purpose and meaning as "our collective neurosis" (p. 117). In contrast to the premodern world (Taylor, 1975) or much of the non-Western world, modernity relies on both an objectified, materialistic view of the world that lacks any inherent meaning, design, or purpose and a view of the person as fundamentally separate, unique, and alone. It becomes the responsibility of the individual to define meaning in their life—to choose their own "world view" (Berger, 1979).

On situating purpose in life in a historical context, it seems clear that we must ask questions about the nature of the self that is to obtain purpose. For example, is purpose attained by radically free modern individuals stepping back from life, from their commitments, and choosing whatever suits them? Or is purpose bound up with one's locus in a larger order of some sort that defines what is meaningful and worthy of pursuit? What does it mean to use purpose in life as a criterion of psychological well-being if the self in question is the latter? Moreover, does the type of meaning that is derived make a difference? In other words, does the sense of purpose of a Balinese Hindu, a French existentialist, and an Ameri-

can neo-Nazi all confer the same psychological benefits? Is it really possible to decontextualize purpose such that the type of purpose has no bearing on well-being?

Personal Growth

Ryff (1989) defined *personal growth* as the continuing ability to "develop one's potential, to grow and expand as a person" (p. 1071). This notion of self-growth has clear roots in both our Enlightenment and Romantic heritages. For example, Taylor (1988, 1989) pointed out how during the Enlightenment the notion was prevalent that self could be remade. For instance, Locke

> develops a view of the subject and his formation in which in principle everything is, as it were, up for grabs, susceptible in principle of being shaped in the direction desired. The mind is a tabula rasa. . . . The ideal stance of the rational subject is thus not to identify with any of the tendencies he finds in himself, which can only be the deposits of tradition and authority, but to be ready to break and remake these habitual responses according to his own goals, as far as this is possible. (Taylor, 1988, pp. 308–309)

Similar sentiments are also found in the Romantic tradition as in the idea that a person should cultivate the "inner voice of nature" (Taylor, 1975). For the Romantics, the self is seen as containing an inner force that must struggle to express itself against external obstacles. Importantly, and perhaps uniquely in human history, this is the source of the ingrained American tendency to view commitments "from marriage and work to political and religious involvement—as enhancements of the sense of individual well-being rather than as moral imperatives" (Bellah et al., 1985, p. 47).

In discussing personal growth Ryff never addresses certain key questions. For instance, growth in what direction? Is personal growth an asset in and of itself? Or are we implicitly requiring that such personal growth be along certain dimensions, in certain domains, and with respect to certain values? Are we able, for instance, to applaud the personal growth of a member of the Ku Klux Klan who is advancing in the ranks and becoming a strong spokesperson and leader?

Self-Acceptance

Ryff (1989) maintained that "holding positive attitudes toward oneself emerges as a central characteristic of positive psychological functioning" (p. 1071). Yet Ryff did not specify what the nature of this self is. What if one lives in a culture, such as Java (Geertz, 1973), that does not think of "selves" as a primary reality? What would it mean to have self-acceptance in a society that does not value "selves"?

Moreover, it is not clear whether the self should always be accepted. Are there not times when actions or behaviors are so morally reprehensible that we cannot accept the self and instead demand that the self be radically transformed? Common speech suggests that we now think of self-esteem as almost a natural right people are entitled to instead of something earned. In addition, self-acceptance also seems to imply that the self is self-alienated. What is the part of the self that is evaluating and deciding if it will accept the totality? Is this not the self-defining subject that Taylor (1975) identified as peculiarly Western?

It may also be that the contemporary Western preoccupation with self-acceptance and self-esteem are partially dependent on "ontological individualism" (Bellah et al., 1985). In other words, these concerns may be predicated on a notion of the self as metaphysically separated from other human beings, society, nature, and the cosmos. Such an independent self becomes the sole locus of concerns about acceptability or worth. Johnson (1985) spoke to this issue when he wrote, "The positive heightened significance given to self-determination and self-actualization is accompanied by a personal sense of heightened responsibility and an inflated propensity for guilt, self-recrimination, and self-doubt" (p. 120; see also Draguns, 1989; Rosaldo, 1984). If the self is construed interdependently as in collectivist cultures, then worth and acceptability become partially issues diffused throughout the ingroup, and the locus of evaluation is not as narrowly focused on the individual. This is not to say that self-acceptance is not a concern in collectivist societies or that self-acceptance is not an aspect of psychological well-being. Rather, it is to recognize that because of our moral vision self-acceptance may be more of a concern or issue for Westerners, and we may as a result give it a more prominent position in the hierarchy of psychological virtues.

Summary

Having considered some of the ways in which Ryff's (1989) subscales are consistent with or even build upon Western individualism, I would like to note several additional points that seem to bear on her measure as a whole. First, most of the normative criteria in the subscales are decontextualized and procedural. For instance, purpose in life is discussed without reference to the type of purpose, self-acceptance without reference to the moral status of the individual that should be accepted, and personal growth without reference to the direction of the individual's growth. Other subscales, such as Environmental Mastery and Autonomy, are clearly concerned with the means of living, but they are silent about the ends. In this sense Ryff's quasi-neutrality emphasizes a set of values that are normative respecting the means of living (e.g., promoting efficient means–ends relations) but sets aside all questions of the direction or end. Presumably, these questions should be left to the individual. By focusing on the inner psychological world and on the means of satisfying subjectively defined goals and purposes, this approach fits right in the middle of the liberal individualist tradition (Sullivan, 1986). My intent is by no means to prove that Ryff's criteria lack any merit or are "all bad" or even that she has no awareness of these issues (see Ryff, 1985, 1989). Rather, it is to show how the very virtues that constitute psychological well-being from within the Western psychological tradition are predicated on individualistic presuppositions.

CONCLUSION

The main point I wish to emphasize from this discussion is that our understandings of psychological well-being, including both theories and measures, are clusterings of cultural assumptions and values. Theories and measures of psychological well-being may be best thought of as different "takes" on the good or ideal person. Understandings of psychological well-being necessarily rely upon moral visions that are culturally embedded and frequently culture specific. If we forget this point and believe that we are discovering universal and ahistorical psychological truths rather than reinterpreting and extending our society's or community's moral visions, then we run the high risk of casting non-Western people, ethnic minorities, and women as inherently less psychologically healthy. In addition, we blind ourselves to the indigenous virtues, such as *fago* among the Ifaluk, that other people cultivate and promote and from which we might learn something about coping with the new dilemmas and challenges we and our clients encounter. Moreover, in those situations in which we have values or practices that might come to seen as desirable or useful by those from another culture, we are likely to communicate them in an unsubtle or heavy-handed manner if we decontextualize them and obscure the historical roots that they can never fully escape.

By placing contemporary understandings of well-being in cross-cultural and historical contexts, this critique disclosed two main ways in which individualism influences the cross-cultural application of theories and measures of well-being. First, our contemporary individualistic moral vision may be greatly "Other" to certain cultures or time periods. This total otherness is perhaps most apparent from anthropological research with groups like the Baining in Papua New Guinea. Such groups live with very different understandings of personhood and of normality and abnormality. The distance separating our moral vision from theirs is staggering, suggesting that our understandings of well-being may contain little of relevance for them.

Second, even though certain elements of moral visions may be shared across cultures, these elements are often interpreted and weighted differently in different contexts. In Taylor's (1985b, p. 247) language, there is a real "diversity of goods" in every society. These "goods" are weighted differently both across cultures and by different individuals and groups in a particular society (see also R. L. Campbell & Christopher, 1996). Thus, although theories and measures of well-being developed in the West might reflect values and assumptions that have a counterpart in non-Western cultures, non-Western cultures might arrange and prioritize these elements in a very different manner. Despite initial similarity, these values and assumptions can only be fully understood within the larger interpretive framework that includes a culture's notion of the self and the good or fulfilled life. As a result, different components of our understanding of psychological well-being (like autonomy or happiness) cannot simply be transported to another culture without risk of serious misrepresentation and misunderstanding.

IMPLICATIONS FOR PRACTICE

I would like to suggest four specific implications for the practice of counseling.

1. The "goods" promoted as psychological well-being (i.e., autonomy, environmental mastery, positive relations with others, purpose in life, personal growth, self-acceptance, happiness, and the freedom to live life as one sees fit) overlap to a significant degree with the goods that shape our treatment goals and motivate our choice of interventions in counseling. When we examine and critique approaches to psychological well-being, we are at the same time illuminating many of the core concepts and "goods" underlying the practice of counseling and putting ourselves in a position to effectively reconsider any blind spots or shortcomings they may contain. I would stress that this process is perfectly congruent with what often goes on in counseling itself—identifying and rethinking assumptions and values that guide a client's (and sometimes our own) life and living. If we fail to identify and recognize these "goods" in relevant situations, we both shortchange the counseling process and help to uncritically perpetuate a cultural status quo that may be deficient or unjust (Braginsky, 1992; Cushman, 1996; Prilleltensky, 1994).

2. The idea of developing entirely culture-free measures, theories or interventions is seriously misguided. Any notion of psychological well-being will always be, in part, a conception of the good or ideal person formulated from a particular vantage point. It is important to be alert to the need to articulate assumptions and values that are called into question or need to be clarified in the light of events. However, to describe this critical reflection as a matter of achieving some kind of detached objectivity and neutrality only impedes awareness of our own cultural "embeddedness" and can have deleterious effects in practice. For instance, a counselor on the International Counseling Network (ICN) listserv remarked, "Our role is not to interject our values on others. Shouldn't we be more concerned with the client we are serving? How can we help them make decisions within the value system they find meaningful?" Such sentiments appeal to many of us, partly because they probably reflect a desire to respect clients and avoid authoritarianism. However, they are subject to two serious shortcomings. First, from a hermeneutic perspective of the sort I have adopted in this article (Fowers & Richardson, 1996; Richardson & Christopher, 1993; Richardson & Woolfolk, 1994), the idea of a "hands off" approach is impossible when we have genuine or vital interaction with others, including clients. Trying to avoid confronting these issues is itself another way of dealing with them that exerts influence, for better or worse, just like any other stance or intervention. Thus, although the counselor from the listserv intends to be value-neutral, he or she actually relies on certain Western liberal values and assumptions (the same values and assumptions found earlier to underlie subjective well-being). Second, the comments from the listserv imply a severe relativism in the face

of which counselors may lose their own effective voice or powers of persuasion in confronting attitudes or behaviors that are pathological or morally insensitive (cf. Christopher, 1996; Doherty, 1995).

3. Third, there is no good reason to view our inescapable cultural embeddedness as a "bad" thing, as a shortcoming or harmful limitation. Rather, it is a precondition for us to know anything at all or participate meaningfully in human life and its struggles (Gadamer, 1975). In the hermeneutic view, what is healthy, worthwhile, right, or good, has to be worked out in an ongoing "dialogue" between one society and another, among individuals within a given culture, or between counselor and client. As counselors, we need to develop what Gadamer called "effective historical consciousness," so that we can cultivate awareness of how the theory, research, and practice of counseling as well as our individual thoughts, feelings, and behaviors, are shaped by our cultural traditions. What is "bad" is acting as if we are not culturally embedded.

We can gain partial clarity about our own embeddedness in culture—our own historicity—by drawing on historical and cultural studies (Cushman, 1996; Marcus & Fischer, 1986; M. B. Smith, 1985). By understanding and learning from the indigenous conceptions of well-being of previous historical periods and of non-Western people, we can gain further insight into the assumptions and norms underlying our own concepts of psychological well-being. In addition, we can better safeguard against uncritically and inappropriately applying our understanding of well-being to those from differing cultural backgrounds. This will be especially important as the practice of counseling is increasingly used in non-Western societies and with the diverse ethnic groups in the United States.

4. There are no clear-cut answers or formulas for determining the nature of well-being, either in general or for specific clients. Instead, what is needed is an ongoing interpretive process and continuing dialogue. This process will always be somewhat "messy." We cannot simply apply stereotypic notions about different cultures to our clients. We cannot follow "cookbook" approaches to multicultural counseling that tell us to be directive with Asian Americans and not to expect eye contact with Native Americans. Instead we must approach each case, each client, afresh. We must interpretively come to understand their moral visions—the sense of self and good that underlies their lives and informs their actions. We have a responsibility to discuss these issues (Sue & Sue, 1990) and enter into critical conversation about them with our clients, our colleagues, and the general public. Such a dialogue will be about not only the means of counseling but also the ends we seek. At best, this dialogue will take the shape of a collaborative process (as stressed by many feminist counselors), one that takes seriously the moral visions of both the client and the counselor. In this way our reflections about psychological well-being can contribute to and even become one form of public philosophy (Bellah et al., 1985; Sullivan, 1986). We all benefit from such openness and scrutiny.

Author's Note. Because of the length of this article frequent overgeneralizations are made regarding non-Western people. The intent of this article is to use non-Western cultures to highlight our own cultural values and assumptions. Non-individualistic outlooks can be lumped together under the same rubric only through the crudest type of typology and analysis. Thus, it is essential to keep in mind that a term such as *collectivism* or *communalism* obscures much diversity.

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Helping Clients Move Toward Constructive Change: A Three-Phase Integrated Counseling Model

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This article presents a 3-phase integrated counseling model that draws from object relations and attachment theory for assessment and uses cognitive behavioral techniques to promote constructive client change. A case vignette is presented to illustrate implementation of the model.

Successful counseling facilitates constructive client change that occurs within a learning process (Egan, 1994). This learning process assists clients in developing insight, exploring and validating affective and cognitive processes, and promoting behavioral modification in response to insight, affect, and cognitions related to the person's difficulties. Although changes in the mental health system and managed care have resulted in decreased resources for many clients, therapy that is meaningful with distinct, time-limited phases is now more indicated than ever. This treatment approach combines the conceptual understanding and relationship building offered by more traditional psychoanalytic therapies with the efficiency and demonstrated efficacy of cognitive behavioral techniques. The client is assisted in developing increased insight, awareness, and self-acceptance. However, treatment does not terminate with these important concepts typically deemed necessary for psychological growth (Ginter & Bonney, 1993; Levenson, 1995). The client learns to engage in and apply active cognitive refutation, accurate self-monitoring, and behavioral strategies as evidence of constructive change.

This article outlines a psychotherapeutic treatment model that includes three phases: (a) an assessment and relationship-building phase aimed at developing insight; (b) an experiential and cognitive restructuring phase aimed at linking insight to feelings and current thoughts and behaviors; and (c) a behavioral phase aimed at promoting qualitative, growth-promoting change. Object relations theory and attachment theory are the conceptual bases for the assessment and relationship-building (first) phase. The second phase involves the use of both experiential and cognitive techniques. Behavioral techniques with goal setting and homework assignments are used in the third and final phase of treatment. A case illustration based on the profile of "Goody Two-Shoes" reported by Spitzer, Gibbon, Skodol, Williams, and First (1994, p. 221) is used to further illustrate each component of this process.

The professional literature reveals increasing efforts to blend current psychoanalytic theories with more practical treatment strategies such as cognitive behavioral techniques (see Frank, 1990; Levenson, 1995; Lockwood, 1992; Westen, 1991). This hybrid approach offers the enriched understanding provided by object relations theory (Fairbairn, 1954; Kernberg, 1972; Klein, 1975; Mahler, 1963; Winnicott, 1965) and attachment theory (Bowlby, 1969) in conjunction with the practical and concrete strategies offered by a cognitive behavioral treatment format. This model addresses typical criticisms that object relations interventions are esoteric and "non-ending," as well as the view of some counselors that cognitive behavioral treatment approaches minimize the etiology of difficulties and the affective experience of the client. An object relations/attachment theory conceptualization of the client and the counseling process coupled with cognitive behavioral techniques addresses both the structure and the content of the client's thinking and behavior. This approach also investigates, supports, and refutes the negative thinking and interpretation of events that may cause and maintain interpersonal difficulties and emotional distress. Therapeutic client change results from the internalization of increasingly mature and adaptive levels of self and other representations and patterns of interpersonal functioning (Blatt & Maroudas, 1992). The application of this model should assist the client in working toward building a more effective and essentially positive sense of self and self-efficacy through relationship building with the counselor, achieving client self-understanding based on exploration of the client's worldview, discovering new ways of constructing meaning of experience, and behaving in a more adaptive manner.

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CASE VIGNETTE: MARYANN

Maryann, an attractive, 35-year-old single woman, originally from San Diego and employed as a magazine editor, lives alone in a deteriorating Boston neighborhood. She was referred for psychotherapy by her female primary care physician. Her physician suggested she needed to work on problems in her relationships with men. Maryann resisted following through on the referral for a year, saying, "I don't like getting help, I like giving it."

Information from the intake session with Maryann revealed that, as the eldest of four children, Maryann often had to grudgingly care for her young siblings. Both of her parents were alcoholics and extremely religious. Their heavy drinking left many of the caretaking responsibilities in the family to Maryann. Maryann became a "Goody Two-Shoes," while her younger brothers were permitted to "act up." In church and school she did well and won many awards until, in her teens, she rebelled and left home. Her parents predicted she would "go to hell." She remains estranged from her family.

Maryann went through a period of "sexual liberation" during which she had about 50 lovers, often in one-night stands, which she rarely enjoyed because she "didn't love those guys."

As a young adult, she was always involved in some worthy cause for the underprivileged, the poor, or the politically disadvantaged.

Maryann presented on interview as intelligent and articulate. She immediately clarified that she did not want a male counselor because she was mistrustful of men who, in her experience, wanted only to exploit women. However, with the exception of her family physician, she had no close female friends.

Maryann described a history of choosing "ne'er-do-wells" whom she characterized as her "outlaw loves." Often, her partners had problems with drinking or drug abuse. She felt that her partners were like little children who needed "mothering." When they treated her badly by cheating on her, she felt resentful and embittered, but always helped them when they needed money or assistance. As a result, she felt "more like Mother Theresa than a girlfriend."

A number of "nice" men who had monogamous intentions and were without emotional or substance abuse problems frequently attempted to date her, but she had avoided them because they all seemed "boring." In her other relationships, Maryann always gives help but never asks for it, even when in real need. Most of her friends and former boyfriends have been drug addicts, former addicts, or alcoholics. She herself has never abused drugs or alcohol. She often visits these people in jail and offers to help them, but when they are released, they hardly ever visit her. (See Spitzer et al., 1994, pp. 221–223 for additional information pertaining to the case vignette.)

DESCRIPTION OF MODEL

Phase 1—Assessment

Object relations theory and attachment theory. It is generally accepted that the social interactions of early life predict later emotional and cognitive development (Ainsworth, 1989; Bowlby, 1969). Studies evaluating early attachment patterns with caregivers show that similar patterned attachment responses are evident in adult relationships (Flaherty & Richman, 1986; Kotler, 1989; Winefield, Goldney, Tiggemann, & Winefield, 1990). Available and responsive caregivers provide an environment that allows an individual to become self-reliant and secure in relating with others (Ainsworth, 1989; Sable, 1992). This environment is referred to in object relations theory as the *holding environment* (Winnicott, 1965). When caregivers are unavailable, unresponsive, and ineffective at providing an adequate and nurturing environment, dysfunctional mental representations (i.e., mental images of self and the relationship of self to others) can occur and result in future problems in interpersonal functioning and adult development.

Children quickly learn how to interact with their caregivers with a minimum of anxiety. These patterns of interacting become the patterns used in subsequent relationships (Summers, 1994).

> According to the object relations paradigm, children prefer painful attachments to isolation in order to avoid the anxiety of annihilation. This seminal principle is the object relations explanation for the observation that children and adults form intense, resilient bonds with harmful figures. (Summers, 1994, p. 351)

Familiarity, no matter how pathological, is experienced as safe and accounts for the tendency to repeat dysfunctional relationship patterns in adulthood (Ginter & Bonney, 1993).

Given the importance of the quality of early attachment and an appropriate nurturing environment, object relations theorists have proposed various coping mechanisms individuals use to defend against the reality of inadequate caregivers and holding environments. Specific defense mechanisms used by Maryann and further explained in this article are introjection, splitting, projection, and projective identification. Adult attachment patterns are also briefly discussed and applied to Maryann's case.

Introjection. Introjection is the process of formulating internal working models derived from experience and interactions with significant others such as caretakers (Diamond & Blatt, 1994). If the child is continuously rejected when seeking comfort from a caretaker, the internal working model is composed of representations of a rejecting caretaker interacting with an unworthy self. If the caretaker is nurturing, working models consist of representations of a loving caretaker interacting with a worthy self. Internal working models are based on introjections encompassing aspects of both the self and the other in the dyadic attachment relationship (Diamond & Blatt, 1994). According to object relations theory, the child introjects the negative aspects of the caregiver to preserve the impression of the goodness of the parents (Della Selva, 1992). The child separates and internalizes the negative aspects of the caregiver, thus preserving control and hope for the child; that is, if the child changes, is different, or somehow becomes good, the parents will "love" him or her (Della Selva, 1992).

Maryann did not have a secure environment during childhood. Because of her parent's unavailability due to their alcoholism, Maryann assumed the role of caregiver for her younger siblings. Maryann may have introjected the neglectful aspects of her parents rather than dealing with the anxiety of facing that the lack of security and comfort from her parents was a result of their inadequacies and inability to meet her needs. Her achievements in church and at school and her care of her siblings, despite her parents' neglectful behavior may have been an attempt to win approval from her parents. Maryann's mental representations may have suggested that if she was a good enough caregiver for the family or made good enough grades, her parents might love her properly; she may have assumed that perhaps there was something inherently bad about her that elicited this lack of care from her parents.

Splitting. Splitting involves viewing the world in an extreme negative or positive fashion (Hamilton, 1989). This primitive defense occurs when the child removes unpleasant qualities of the caregiver and stores them as negative or distressful categories or representations. This minimizes the child's anxiety because he or she relies on the caregiver for survival. In splitting, the child relates only to the positive qualities of the caregiver. Positive or pleasing images are stored as separate categories or representations. The child then identifies with either the positive or negative images as he or she develops a sense of self. As the individual matures, he or she becomes unable to view himself or herself or others in a "whole" fashion (known in object relations theory as *whole object relatedness*), which requires accepting both negative and positive qualities within one person (Klein, 1975). This pattern of dealing with relationships will repeat itself in adulthood. People are related to as either all good or all bad; likewise, the self is viewed in this extreme manner.

Maryann's early style of relating to her parents was indeed repeated in her adult life. The men in her life were all needy and unable to reciprocate caring. Her splitting defense was evident in her inability to relate to "nicer men" who "seemed boring" and in her contention that "I don't like getting help, I like giving it."

Projection and projective identification. The ego attempts to control an imbalance of internal positive and negative representations through projection (Summers, 1994). Through this process, the person projects onto others aspects of themselves that are either negative or positive, but conflicting (Sussal, 1992). Furthermore, through projective identification, the individual behaves in a manner that elicits from another person the affects and self-images that are projected (Ginter & Bonney, 1993). Adler and Rhine (1992) suggested that the projector gets rid of unwanted aspects of the self while identifying with and maintaining a relationship with the other person to control the projection. Through identification, it is possible that an individual may see a part of herself or himself in another person and then may feel the need to "join that aspect of herself [or himself] in the other" (Hamilton, 1989, p. 1554).

Maryann retained the caring aspects of her internal relational images. This is apparent in her tendencies to "mother" her lovers and to immerse herself in worthy causes. She projected the neglectful aspects of her internal relational images onto men who readily took on the role of "user" and recipient of her giving. Maryann could control the split by caring for these men. She could also identify with her projections by watching these men receive the unconditional love that she needed as a child.

Adult attachment patterns. Sperling and Berman (1994) maintained that adult attachment is the tendency of an individual to establish relationships with specific people who provide the potential for physical and psychological security. Bowlby (as cited in Sable, 1992) described four adult patterns of insecure attachment: anxious attachment, insistent self-reliance, insistent caregiving, and emotional detachment. Any of these patterns may result in vulnerability to interpersonal problems.

It seems apparent that Maryann's relationships were imbedded in her pattern of insistent caregiving. *Insistent caregiving* is defined as the behavior of people who establish affectional relationships in which they devote themselves to caring for others. The person engages in close relationships but always as a caretaker. The childhood experience may have been one with a caregiver who was unable to nurture the child but instead welcomed or demanded care (Sable, 1992). Studies (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987) have demonstrated that an early history of poor attachment with significant others predisposes individuals to difficult adult love relationships (also see Sperling & Berman, 1994). In short, what was necessary for the child's survival in early interactions with parents clearly affects personality development and may result in vulnerability to disappointing adult relationships.

The interpersonal paradigm maintains that sexuality is a powerful vehicle for expressing relational patterns because of the social meaning it conveys. It can become a medium for connecting with others. The search for reassurance through sexuality may result in compulsive promiscuity (Summers, 1994). This promiscuity was evident in Maryann's history of "sexual liberation." Maryann's sexual promiscuity, which occurred soon after she left home, also seemed to be a part of her individuation. Bowlby (1988) described the importance of establishing a secure base from which to effectively achieve individuation. Unfortunately, Maryann's family did not remain a secure base from which she could receive confirmation and support. This lack of support may have contributed to her choices of troublesome relationships. It is notable that Maryann reportedly experienced little sexual pleasure, further illustrating her chronic difficulty in participating in balanced, equally gratifying adult relationships.

Assessment goals. It is crucial that the counselor empathetically hear the client's story and establish a phenomenological understanding of the client's experience (Ginter & Bonney, 1993). Throughout the assessment process, the counselor builds rapport with the client. The counselor creates a

holding environment to provide a safe and secure place within which the client can process painful memories. With the assistance of the counselor, the client can explore his or her "internal working model" or way of making sense of his or her life and how early experiences helped to shape life patterns and themes.

A genogram is a useful assessment tool (see McGoldrick & Gerson, 1985). The counselor and client can graphically display the family configuration, including the various types of relationships between the family members and other significant individuals. Important events and transitional periods can also be depicted. This depiction can assist both the counselor and client in discerning and evaluating life patterns.

Although the achievement of insight is a major goal within this model, it is insufficient in achieving constructive client change. Ginter and Bonney (1993) maintained that "insight is regarded as a major source of change but only when accompanied by affect and followed by some form of action within and outside of therapy sessions" (p. 154). Furthermore, Ellis described the powerful influence of cognitive processes on client change (Ellis & Dryden, 1987). Therefore, an additional focus of counseling must include exploration of client feelings regarding past and present circumstances and thought patterns influencing the client's interpretational system.

Phase 2—Linking Insight With the Present: Experiential and Cognitive Techniques

The purpose of the second phase of this model is to create an understanding of how early relational patterns contribute to present difficulties. Bowlby (1988) described the five main roles of the therapist as follows: providing a secure base, encouraging exploration of relationships with significant others, examining the therapist/client relationship, fostering consideration of how working models may be the by-product of early experiences with caregivers, and assisting the client in recognizing that these working models may or may not be currently effective. Possibilities for new choices must be evaluated, representing the potential for change in problematic areas of the client's life. This understanding is incomplete, however, without including the affective component of the client's experience. Insight can facilitate a focus on affect within the counseling process.

Insight empowers the client to adaptively manage his or her affects, thoughts, and behaviors. This results in decreased anxiety because the client is learning to control his or her inner world. There is less fear about unknown processes within. The client comes to better self-understanding and uses the counselor as a supportive, *growth-producing object* (Pine, 1992). The counselor supports the client by establishing a "good object relationship" that is internalized by the client and, in turn, fosters a more positive sense of self (Buckley, 1994). With this support from the counselor, the client is able to face painful memories, feelings, and thoughts. Processing previously repressed and dissociated memories and feelings in counseling can lead to changes in perceptions of self and others (Della Selva, 1992). Clarification and confrontation are useful techniques in assisting clients with changing perceptions.

Through clarification, the counselor assists the client in sorting through personal history, affirms responses to descriptions of situations, encourages recall of memories and feelings in which there is reluctance, and facilitates reinterpretation of misconstrued events (Sable, 1992). Hamilton (1988) defined *confrontation* as making an observation to a client about himself or herself. As these observations are interpreted by the client and the counselor, the client either assimilates or rejects the interpretation. Interpretation becomes psychoeducational because the client learns to connect early patterns of relating to caregivers with present patterns of relating to others. The client examines inner representations and how they emerged as a result of past object relationships. This new understanding can then be integrated as the client begins to form new representations and to alter his or her worldview in a therapeutic manner. This is more direct and time effective than the usual psychoanalytic emphasis on working through transference as the means to change internal representations (Rothbard & Shaver, 1994).

Kohut (1959) and others (Buckley, 1994) noted the crucial importance of the empathic-introspective qualities of the counselor. Therefore, it is important to establish the therapeutic relationship before beginning interpretation. This development of the relationship through empathic understanding enables the growth of the client's sense of self and promotes stronger ego functions (Buckley, 1994).

Through cognitive restructuring, the client is introduced to new ways of thinking about life and interpreting situations. New perspectives coupled with more adaptive choices and worldviews are examined. "The client's life situation is cognitively restructured in ways that permit her [or him] to *move actively* [italics added] to improve it" (Blocher, 1980, p. 6). This restructuring promotes personal responsibility and a sense of self-efficacy within the client to foster growth. The client, in this phase, learns and uses such techniques as situational analysis, cognitive refutation, and goal attainment scaling. The client learns to calm himself or herself and think in a more adaptive and self-enhancing manner.

Throughout the process, the counselor must consistently demonstrate that he or she is a secure base from which the client can ventilate, explore, and risk. Notably, object relations counselors do not become surrogate mothers or physically hold their clients to make up for past emotional injuries. Primarily, the counselor uses an understanding of development to provide the therapeutic environment that allows the client to use insight to facilitate growth (Hamilton, 1988). Furthermore, the client learns to self-nurture through the separation and individuation process experienced in counseling. A healthy process of separation and individuation, which may not have been experienced by the client during past crucial junctures of development, can be modeled through the counselor–client relationship. Phase 2 counseling goals for Maryann are as follows:

1. Achieves insight concerning her relationship with her parents and understands how her internal images of this relationship influenced her choices of partners and relational patterns.
2. Affectively experiences and actively grieves the lack of parenting she received as a child and her current estrangement from her family.
3. Establishes a cognitive understanding of her life pattern and its influence on her continued lack of life satisfaction. Learns to cognitively challenge and refute maladaptive assumptions and expectancies.

Phase 3—Promoting Change: A Behavioral Approach

Resolving, affirming, and acknowledging feelings in conjunction with efforts toward cognitive restructuring are integral components of this model. However, meaningful and adaptive client growth is not fully demonstrated until the client makes behavioral changes. During the final phase of counseling, the client attempts new behaviors based on insight, understanding, and cognitive restructuring achieved in Phases 1 and 2. According to Egan (1994), "one of the goals of counseling is to help clients become more effective agents in life; to help them become doers rather than mere reactors, preventors rather than fixers, initiators rather than followers" (p. 75). Counseling is not complete unless the client takes action. The client must do more than achieve insight. The client must be willing to risk and make changes (Corey, 1991).

Phase 3 counseling goals for Maryann are as follows:

1. Accepts dates with one or more of the "nicer men with monogamous intentions." Dating would involve allowing these men to do nice things for her while Maryann focuses on how it feels to be cared for by someone else. The dating process will also enable Maryann to make a comparison between these "nice men" and the partners she usually chooses. This comparison may further the development of whole object relations whereby Maryann relates to both the negative and positive aspects within each person, rather than only one or the other extreme, thereby demonstrating her ability to develop and maintain healthier and more reciprocal intimate relationships.
2. If Maryann is willing, initiates contact with her family via visit or a phone call. This interaction with her family will enable Maryann to have the opportunity to begin relating to her parents on a more realistic level. On the basis of her achieved insight, she can work toward accepting them for who they are, without her splitting defense or having them out of her life altogether. If her parents are not responsive, works through this rejection based on the insight and understanding already achieved while continuing to foster the containment process in therapy.
3. Joins a support group. This involvement should offer reinforcement and support for healthy adult relationships that are mutually supportive. It should also assist in increasing social engagement and decreasing isolation. The support group should provide a holding environment for Maryann as she works toward changing the way she relates to others. The group will be particularly helpful if Maryann's family is not responsive to her reconciliation attempt.

ASSESSMENT OF INTERVENTION EFFECTIVENESS

The effectiveness of this intervention can be assessed at each phase. The assessment phase is completed and successful once rapport and trust are established between counselor and client, history has been clarified, and the counselor has a complete conceptualization of the client.

Phase 2 is assessed by the evaluation of client insight and understanding through the object relations and attachment paradigms. The extent to which the client accesses painful feelings from past experiences and losses and then relates them to current feelings determines the success of the experiential component of this treatment phase. Cognitive restructuring involves new, adaptive ways of thinking and coping. This restructuring is evident in the manner in which the client verbalizes perceptions and insights about past and future choices.

Phase 3 is evaluated by observation and self-report. Successful completion of this phase requires that the client engage in goal-directed activities and active coping efforts. The counselor relies on client report of experiences and perceptions. The client and counselor should decide to terminate the therapy based on a perceived qualitative change in the client's relationships and lifestyle.

It should be noted that working through the three phases of this model is not necessarily accomplished in a linear fashion. Depending on the client's ego strength, cognitive developmental level, ability to engage in introspection, and readiness to move toward constructive change, components of the model such as maintaining the holding environment, fostering the client–therapist relationship, confrontation, interpretation, and providing a secure base from which the client can explore change may need to be revisited frequently throughout the counseling process.

CRITIQUE

Because a component of this counseling model involves a psychoanalytic approach, Phase 1 and a portion of Phase 2 (assessment and facilitating insight) may take longer than is allowable by some managed care policies. Furthermore, in the recent past, object relations theory had been criticized for neglecting organic contributions to psychopathology (Hamilton, 1989). Environmental–human interaction may also be neglected by object relations theory because of its intrapsychic focus (Blocher, 1980). However, in developing this three-phase treatment approach, we allowed for greater flexibility than is found in a more traditional object relations therapy approach. In our model, a psychoanalytic approach is used primarily as an assessment tool to understand the origin of the client's difficulties (which may be determined to be organic, leading to an appropriate referral). The cognitive and environmental contributions to human growth and development are addressed in Phases 2 and 3,

which include the cognitive and behavioral components of the model. If the treatment goals of each phase are well defined, it is possible for a counselor and client to work through all three phases in a reasonable amount of time. According to Koss and Shiang (as cited in Levenson, 1995), a total of 25 sessions has been taken as the upper limit of brief dynamic therapy. Although managed care has imposed limits ranging from 6 to 20 sessions (Levenson, 1995), research has found that there is a dramatic drop in client attendance between the second and eighth sessions (MacKenzie, 1991). Given these constraints (managed care and client imposed), using an integrated model must emphasize making the most of each session, with duration of the treatment providing a secondary focus (Levenson, 1995). Although treatment length in this integrated model will be variable depending on client characteristics such as ego strength and cognitive developmental level, establishing clear goals for each phase will provide an efficient framework within which to structure the counseling intervention.

There is increasing support in the literature that blending psychodynamic theory with cognitive behavioral theory can result in observable, constructive client change. Approaches that integrate psychodynamic and cognitive behavioral therapy have demonstrated success in treating clients with personality disorders (Beard, Marlowe, & Ryle, 1990; Ryle, 1996; Westen, 1991), and clients with panic symptoms (Reisner, 1990), agoraphobia (Friedman, 1985), anxiety (Hamilton, Sacks, & Hamilton, 1994), and substance abuse issues (Scott, 1983). We believe this treatment approach would not be indicated for individuals with thought disorders because of its emphasis on introspection and cognitive restructuring; however, it would clearly be applicable to general counseling populations, given the demonstrated success of similar integrated models with more difficult client populations.

CONCLUSION

In summary, this three-phase counseling model facilitates client growth, learning, and constructive change. It incorporates an object relations/attachment theory interpretive approach with cognitive-behavioral techniques such as homework, assertiveness training, and situational analysis. This model offers a reparative relationship with the counselor, coupled with the teaching of more adaptive thinking patterns and coping skills. The counseling environment offers a forum in which the client can attempt new, healthier behaviors within a context that is both supportive and challenging. This treatment model assists the client in acquiring self-understanding and awareness of problematic issues and relational patterns. The final step toward constructive change—action—becomes the client's responsibility, and through the aforementioned steps, the client is empowered to assume this responsibility.

Clearly, achievable treatment goals are established in each counseling phase. Goals are measurable by client self-report and counselor observation. The counselor provides a supportive, nurturing environment to promote self-examination, insight, and the linking of current maladaptive patterns with previous history, in conjunction with affective exploration and experience. Cognitive restructuring and behavioral changes finally demonstrate and reinforce a stable, cohesive, and adaptive adult identity.

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Spiritual Wellness for Clients With HIV/AIDS: Review of Counseling Issues

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The epidemic of HIV/AIDS has resulted in an increasing population of individuals in need of counseling services: persons living with AIDS, as well as family, friends, and caregivers. The relationship between HIV/AIDS clients' counseling and spiritual issues is demonstrated by a review of salient literature. Three broad themes are used: terminal illness issues such as post-death existence and existential meaning of life, religious disenfranchisement from society or families of origin, and multicultural spiritual and religious issues. Practical recommendations for counselors and research implications are included.

The epidemic of HIV/AIDS has resulted in an increasing population of individuals in need of counseling services. Given the complexity of this disease, and its ramifications on many levels, the counseling of persons living with AIDS (PLWAs), as well as their family, friends, or caregivers, may well include the need to address spiritual concerns. The purpose of this article is to demonstrate how HIV/AIDS counseling issues are integrally connected to spiritual issues, as clients struggle to integrate themselves and their beliefs vis-à-vis the disease, their families of origin, and cultural and religious influences. Although a number of authors have partially discussed spiritual ramifications with this population (Burke & Miller, 1996; Carson, Soeken, Shanty, & Terry, 1990; Hall, 1994; Helminiak, 1995; Kain, 1996; Lamendola & Newman, 1994; Nelson & Jarratt, 1987; Saynor, 1988; Warner-Robbins & Christiana, 1989), this article provides a comprehensive and current overview of HIV/AIDS spiritual wellness issues for the counseling professional. Practical counseling recommendations and research implications are provided as well.

For the purposes of this review, a clear distinction is made between "religion" and "spirituality," as the following definition indicates: "[S]pirituality can occur in or out of the context of organized religion, and not all aspects of religion are assumed to be spiritual" (Chandler, Holden, & Kolander, 1992, p. 170). Legere (1984) stated, "Spirituality is not a religion. Spirituality has to do with experience, religion has to do with the conceptualization of that experience. Spirituality focuses on what happens in the heart; religion tries to codify and capture that experience in a system" (p. 376). Our use of spirituality as a concept also includes clients' existential concerns about life and death, as well as a questioning of life's purpose and meaning (Milton, 1994; Saynor, 1988). This article explores three broad themes related to spirituality that may arise in counseling sessions with HIV/AIDS clients: (a) terminal illness issues such as post-death existence and meaning of life, (b) religious disenfranchisement from society and families of origin due to the stigma of HIV/AIDS, and (c) cross-cultural spiritual and religious issues.

THEME 1: TERMINAL ILLNESS AND SPIRITUALITY

Recent advances in medication are changing the status of HIV/AIDS from that of a terminal illness to a chronic illness (Beaudin & Chambre, 1996; Centers for Disease Control, 1997c). Yet, as with cancer, the spectre and stigma of living with this disease, regardless of its official status, can have long-ranging psychological effects. Questions of life and death and their connection to spirituality are significant presenting issues for those dealing with such illnesses and may be particularly poignant for clients in the latter stages of HIV/AIDS. For instance, in a qualitative research study of nine men living with HIV/AIDS, Lamendola and Newman (1994) stated, "The expanding consciousness associated with coming to grips with HIV/AIDS [could] be seen in the chang-

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ing quality of these men's lives [and] . . . included . . . a deepening of their spirituality. They were facing the profound issues of living and dying in a meaningful way" (p. 19). Warner-Robbins and Christiana (1989) noted, "It is not uncommon for PWAs [*sic*] to be drawn even closer to their spiritual beliefs. Having to face the finality of this disease will frequently encourage a person to address issues never before confronted in his or her life" (p. 46). In "Hope and Spiritual Well-Being: Essentials for Living With AIDS," Carson et al. (1990) reported "the terminally ill . . . exhibited the greatest spiritual perspective" (p. 30). In addition, spirituality seems to have a positive relationship with PLWAs' ability to cope and live a reasonably peaceful and fulfilling life. In a report that focused on the well-being of people diagnosed with HIV/AIDS, researchers found spirituality to be a major theme in the lives of those who were able to face an HIV/AIDS diagnosis with equanimity (Kendall et al., 1989). One client discussed his positive attitude toward death, which was a result of his belief in a higher power: "Someday I will be free—flying high among the birds . . . I will be free from this pain and suffering and leave this body behind me" (Kendall et al., 1989, p. 161).

Yalom (1980) identified three issues that become particularly relevant for the general population of terminally ill clients: fear of death, the need for hope, and creation of life meaning. First, it is logical to assume that fear of death becomes magnified when one is faced with the prospect of death from an illness such as HIV/AIDS, particularly in the disease's final stages. Murphy (1986) stated: "In their weakened and vulnerable condition, the inner spirits of persons with AIDS are easily attacked and eroded. There are doubts and fears we all have about our relationships to others and to God. These are often magnified for the dying person" (p. 39). Other authors support the view that through confrontation of death, terminally ill clients find comfort in spirituality (Elkins, 1995; Ingersoll, 1994; Smith, 1993).

Second, according to Yalom (1980), terminally ill clients often express the need to process the issue of hope and its changing status, given their impending death. For many of these clients, an integral connection exists between examination of hope and spiritual issues. Research documents that clients living with HIV/AIDS are no exception; spirituality often becomes a resource for dealing with an otherwise hopeless situation (Carson et al., 1990; Hall, 1994; Lamendola & Newman, 1994; Nelson & Jarratt, 1987; Sherr, 1996). Allowing for instillation of a new kind of hope through the PLWA's faith may thus become an essential aspect of counseling: "Spirituality can be an oasis for both the person with HIV/AIDS and his or her counselor. . . . [H]ope and caring can provide a person with HIV/AIDS a sense of power" (Burke & Miller, 1996, p. 190). Respondents in the study by Kendall et al. (1989) identified positive thinking as a means of coping with AIDS, emphasizing the role spiritual beliefs played in the development of hope. According to the authors, "[T]he way they seemed to regain their psychological balance was to enter a type of spiritual or existential journey toward a further understanding of themselves with their disease" (Kendall et al., 1989, p. 163). Spirituality provided the path that led to hope, not necessarily in finding a cure for the disease, but in obtaining the means of living a positive life, given the PLWA's present circumstances.

A third issue faced by clients with HIV/AIDS who are actively grappling with illness involves creation of life meaning. In Yalom's (1980) research, terminally ill cancer patients found life meaning by facing the inevitability of their own death. Narrowing the issue to PLWAs, Burke and Miller (1996) noted that "turning to the spiritual dimension may be an attempt to find some meaning and an effective coping style" (p. 188); Nelson and Jarratt's (1987) research on PLWAs showed that "the search for meaning often involves a new or renewed interest in the spiritual self and/or concern for others" (p. 487). Not only is the need for spirituality integrally connected to this search for meaning, many PLWAs also paradoxically come to see the disease in a positive way, as providing meaning to their lives by its presence in their bodies. For instance, in Kendall et al.'s study (1989), the authors found that AIDS and its resultant inner search provided a number of respondents "with a different, and more significant, life meaning" (p. 164). Kain (1996) also noted, "Often a remarkable growth can occur when clients [with HIV/AIDS] face the limited nature of their lives. Facing death creates a crisis of the spirit; what can result is often . . . miraculous" (p. 108).

In working with the HIV/AIDS population, one of the authors (Holt) encountered this phenomenon as well. A PLWA who had been an intravenous drug user for 20 years was finally able to remain drug-free after receiving the HIV/AIDS diagnosis. As a result of his HIV status, he went on to become a professional community liaison with HIV/AIDS drug researchers and a well-known political activist for PLWAs. He commented, "Ironically, this disease has given me my life's purpose and at the same time, is taking my life away."

THEME 2: RELIGIOUS BASED DISENFRANCHISEMENT

An issue for clients with HIV/AIDS revolves around societal judgment and religious disenfranchisement. This may be an extremely important and problematic area of spiritual exploration for the client. For instance, Graydon (1988) stated the following:

> As the patient struggles to maintain meaning and hope in his life, traditional sources of support are viewed with distrust and uncertainty. This may be especially true of faith and religion. Past experience, or public pronouncements of condemnation, rejection, and divine punishment from organized religious bodies may reinforce feelings of distrust and exaggerate a sense of spiritual alienation. (p. 68)

Murphy (1986) reported the spiritual anguish of one young man with AIDS, "'How can God love me? I am one of His mistakes'" (p. 39). Given the stigma attached to the disease, the spiritual issues that arise for those diagnosed with HIV/AIDS may be particularly intense and shame-producing. The manner in which religious disenfranchisement and societal judgment are experienced may differ for specific sub-

groups of the HIV/AIDS population, as the following discussion indicates.

Populations Most at Risk of Stigmatization

Lifestyles and sexual mores of the gay, lesbian, bisexual, and transgender (GLBT) population are often the subject of intense judgment by religious institutions. In one research study of rural community attitudes toward PLWAs, a participant said, "We all know it [the GLBT lifestyle] is a sin. When they came out to demand their rights in government, God stepped in with AIDS. That's how I feel about it" (Preston, Koch, & Young, 1991, p. 121). Housel (1995) wrote, "[O]ne of the most powerful forces perpetuating homophobia . . . is the overriding sex phobia that pervades this country and that has been institutionalized in Judeo-Christian religious dogma" (pp. 118–119). Yet this societal attitude has not precluded GLBT-PLWAs from embracing spirituality and, in many circumstances, being involved in an organized religion. GLBT individuals are now openly included in many traditional spiritual institutions. Such groups as Dignity (Catholic), Integrity (Episcopalian), Wing Span (Lutheran), the Universal Fellowship of Metropolitan Community Churches and the World Congress of Gay and Lesbian Jewish Organizations have been created specifically for GLBT fellowship (Housel, 1995). However, despite efforts to find spiritual and psychological integration, the social stigma surrounding HIV/AIDS and a GLBT lifestyle can result in deep pain and turmoil for some GLBT-PLWAs, and may thus be a topic of concern in counseling.

Nontraditional GLBT individuals have sought spiritual connection through yoga, meditation, new age healing, community activism, and Twelve Step groups. For those who have chosen a nonreligious lifestyle, examining spiritual issues in counseling may still be very important. In addressing the needs of nonreligious GLBT-PLWAs, Helminiak (1995) argued: "Living with HIV disease provokes life's big questions: How can my life be worth living? . . . Why me? Why this? . . . These *are* [italics added] spiritual matters because they concern human meaning and purpose; they touch on the ultimates of life" (p. 301). Helping clients sort through such issues may very well be an important part of counseling work.

GLBT-PLWAs are not the only targets of religious persecution. Intravenous drug users, who are statistically and historically the second largest subgroup with HIV/AIDS (Centers for Disease Control, 1997a), are often judged harshly as well. The connection between HIV/AIDS and "immoral" behavior in general has engendered a fury from the religious right, with HIV/AIDS being referred to as "God's punishment" (Carson et al., 1990; Dworkin & Pincu, 1993; Graydon, 1988; Hall, 1994; Kayal, 1985; Murphy, 1986; Nelson & Jarratt, 1987; Saynor, 1988; Warner-Robbins & Christiana, 1989). Otten (1990) noted, "Because AIDS is . . . associated with homosexuality, promiscuity, and intravenous (IV) drug abuse, . . . issues of sin, alienation, judgment and longed-for forgiveness, understanding, and acceptance [are experienced by PLWAs]" (p. 137). Although intravenous drug users share the stigma of HIV/AIDS, personal reactions may be somewhat different from those of GLBT-PLWAs. If the intravenous drug user is heterosexual, being aware of the public perception of HIV/AIDS as a "gay disease" may cause anxiety or homophobic feelings. In addition, drug using is seldom talked about and carries a stigma similar to that of being homosexual. Therefore, the intravenous drug user may also need to work out issues surrounding societal and familial judgment. The intravenous drug-using PLWA may also experience shame and guilt about his or her behavior due in part to religious beliefs, which may then become relevant in the counseling setting.

Families

In addition to societal judgment, the PLWA faces potential condemnation on a more intimate level. Familial judgment may be one of the greatest personal tragedies for PLWAs, as well as for their loved ones. In a study of 18 PLWAs, researchers found just one respondent who cited the family as a source of support (Richmond & Ross, 1994). Stewart noted in a 1994 study of PLWAs' familial attitudes, "Sadly the stigma and ostracism expressed in over three fourths of the families mirror the stigma and ostracism in society" (p. 334). Many families are confronted with multiple shocks in the case of a child who had never shared his or her sexual orientation with the parents: "Some people find out their son is gay, that they have a lover, that they have AIDS, and that they're going to die all at one time" (Longman, 1994, p. 89). The impact of multiple effects can often prevent even the most well-intentioned family from being able to adequately assess the situation, and provide support. George (1989) stated that, as a result, such families "may find it easier to talk of their feelings about their son's sexuality with a counsellor [*sic*] than with the PWA [person with AIDS] himself" (p. 86). For heterosexual PLWAs, similar familial issues may arise due to the family's suspicions about how the PLWA became HIV-positive, that is, through drug use or sexual promiscuity. Often, if the family is willing to enter into counseling, resolution on emotional and spiritual levels becomes possible and can be essential in helping the PLWA come to terms with his or her illness and facilitating healthy relationhips for family members. In addition, whether or not counseling directly addresses spirituality, for the PLWA to resolve family issues can be immensely powerful in a spiritual sense: "Familial reconciliation [is] a metaphor for spiritual reconciliation" (Landau-Stanton, Clements, & Tartaglia, 1993, p. 274).

Although many families are unable to provide the most minimal levels of support, some families attempt to put aside their prejudices to offer much needed help to the PLWA. One study reported that "more and more persons with AIDS are returning to their families of origin for support and care as their disease progresses" (Preston et al., 1991, p. 110). But such a living situation can put stress on both the PLWA and the family. Often, the PLWA's autonomy and independence

are quashed and the differing sets of values can create conflict: "[P]arents may need help in coping with the PWA's frustration and other strong emotions which can be evoked by such a [living] situation" (George, 1989, p. 86). In addition, such a situation can result in a disturbing lack of regard for the lifestyle choices of the PLWA:

> As a result of their concern, parents hinted, coerced, openly requested, or even mildly harassed their sons by asking them to, "Please put things right with the Lord." . . . For a number of the sons who were growing increasingly weak and vulnerable, giving in to the psychological and moral demands of parents was easier than trying to maintain an independent stance. (Sohier, 1993, p. 481)

Finally, a clashing of spiritual values can often result in the family's unwillingness to allow the PLWA's community to be present at the funeral, resulting in an even more complicated grief process for those who have been disenfranchised (Housel, 1995; Longman, 1994; Richmond & Ross, 1994; Worden, 1991a). Clearly the need exists for counselors to act as a sounding board in spiritual issues surrounding the family of origin, particularly for those specializing in family or systems counseling approaches.

Women

Data on women living with HIV/AIDS indicate alarming trends. A special issue published by the Centers for Disease Control and Prevention (1997b) devoted to women, reported that the percentage of women with HIV/AIDS has nearly tripled since the disease's beginnings, rising from approximately 7% in 1985 to 20% in 1996. In approximately the same period, the statistics on male PLWAs dropped from 92% to 85% (Centers for Disease Control and Prevention, 1996; U.S. Bureau of the Census, 1996). In addition, HIV/AIDS is now the third leading cause of death in the United States for women 25 to 44 years old, and the leading cause of death among African American women in the same age group (Centers for Disease Control and Prevention, 1997b; Solomon, Moore, Gleghorn, Astemborski, & Vlahov, 1996). Female clients who are HIV-positive may be confronted with a number of unique circumstances concerning spirituality in the therapeutic setting. First and foremost, as noted earlier, HIV/AIDS is associated with what some consider "immoral behavior" (Dworkin & Pincu, 1993). Therefore, female clients may be dealing with shame, particularly concerning sexual issues. It is notable that "[t]he current AIDS epidemic in Europe and North America has . . . focused attention on prostitutes, despite the dearth of evidence on their role as vectors of disease" (Carr, 1995, p. 201). The public continues to regard women with HIV/AIDS as an anomaly, one that can be explained as the result of sexually promiscuous behavior. Yet, besides intravenous drug use, the most common means of HIV transmission for women takes place in the context of a monogamous relationship (Campbell, 1995; Carr, 1995; Cohan & Atwood, 1994; Shevitz, Pagano, Chiasson, Mueller, & Thomas, 1996; Smeltzer & Whipple, 1991; Solomon et al., 1996; Walker, 1991). Walker commented, "Perhaps the most misleading to women has been the AIDS education theme that in monogamy lies safety, since so many of the non-drug-using women who have contracted HIV sexually are the long-term (heterosexual) partners or wives of HIV-positive men" (p. 54). The Centers for Disease Control and Prevention (1997c) reported, "The largest proportionate increases in prevalence occurred [in 1996] among men and women who acquired AIDS through heterosexual contact (28% and 23% respectively), the only risk/exposure category that experienced increases in AIDS-OI [opportunistic infection] incidence" (p. 865). Yet society may still consider HIV-positive women to be promiscuous. This "blame the victim" mentality can result in dire consequences for women with HIV/AIDS, because anxiety and denial about this disease may prevent them from obtaining medical help (Cohan & Atwood, 1994). The deeper issues preventing women from getting help—shame and guilt—could be argued to have their roots in religion; women are supposed to remain "pure and untouched." Perhaps because of this religious message, women with sexually transmitted diseases such as HIV/AIDS may be judged far more harshly than men. Therefore, counselors need to be aware of the underlying issue of "immorality" when working with female PLWAs. Such clients may need to work through stereotypical religious judgment in favor of a deeper, more accepting spiritual grounding.

Youth

Youth are one of the fastest growing, and most troubling, populations with HIV/AIDS (Dworkin & Pincu, 1993). For instance, between 1988 and 1994, one source indicated that "[c]ases of adolescent AIDS increased by 330%" (Forsberg, King, Delaronde, Geary, & The Haemophilia Behavioral Evaluative Intervention Project Committee, 1996, p. 629). Given this alarming trend, it is important to consider youth's unique counseling needs. Although the diagnosis of a life-threatening disease is devastating for individuals of any age, for youth it may be especially overwhelming. To learn that one's life may be drastically shortened at a time when independence and autonomy are just beginning to be asserted can create tremendous depression, anger, anxiety, and hopelessness. Some evidence indicates that spiritual concerns increase with age (Worthington, 1989); a diagnosis of HIV/AIDS may force youth to deal with spiritual issues prematurely. Many young PLWAs experience denial of the disease (Dworkin & Pincu, 1993; Feldman, 1989). Thus, spiritual issues may be ignored completely as a part of this denial process. Regarding counseling, PLWA youth may not have the emotional skills and maturity to adequately cope with their diagnosis. One source noted, "It is important to allow the teenager to discuss his or her feelings openly and without criticism" ("Module Four," 1993, p. 53S). No sources were found concerning spiritual aspects of counseling terminally ill youth, despite the fact that evidence suggests spirituality is a primary consideration when youth think

about death and its implications (Morin & Welsh, 1996). Morin and Welsh found this may be especially true for African American youth (see next section).

In counseling youth living with HIV/AIDS, feelings of guilt and blame may arise, often related to religious beliefs about having "sinned" by having premarital sex, same-gender sex, or both ("Module Four," 1993). It is also possible for young people to experience a sense of being "punished" by God (Stricherz & Cunningham, 1981–1982). Therefore, an important part of counseling may include helping the younger HIV/AIDS client develop a healthier self-concept, including working through religious beliefs about sexual behavior. In addition, adolescents may not yet be able to adequately conceptualize death and its implications. One source stated, "Adolescents, many of whom lack the capacity for abstract thought, have fixed infantile ideas of what death is. Any discussion of death should be preceded by a thorough exploration of the youth's preconceived notions about dying" ("Module Four," 1993, p. 58S). Youth may also experience spiritual isolation and confusion over spiritual issues, if they do not have a spiritual or religious community to turn to for support. Thus, spirituality may be an important topic in counseling as the young PLWA attempts to make sense of this disease, perhaps a shortened life span, and the subsequent impact on his or her life in terms of meaning and purpose.

THEME 3: MULTICULTURAL SPIRITUAL AND RELIGIOUS ISSUES

Multicultural spiritual beliefs and practices are extremely important to consider, given the high percentage of ethnic minorities affected by HIV/AIDS. In the United States, African Americans and Hispanics currently constitute approximately 75% of all women and 48% of all men with HIV/AIDS (Centers for Disease Control, 1996); "AIDS rates for Black and Hispanic women are 17 and six times higher than for whites" (Centers for Disease Control and Prevention, 1997b, p. 2). In many minority cultures, the connection to family and community is very important; religious communities are often an integral means of support and solidarity for the individual. Therefore, spiritual issues are likely to arise in counseling. In the book *AIDS, Health, and Mental Health: A Primary Sourcebook*, Landau-Stanton et al. (1993) stated, "Appreciating the role of religion in the life of African-Americans begins with the recognition that the church has been historically the only institution 'owned' by the African-American community. . . . The church has been a key component of this group's extended family concept" (p. 281).

Multicultural issues for PLWAs are inextricably connected with those of women. As stated earlier, female PLWAs may be labeled as prostitutes or immoral, and this seems to be particularly true in African American and Hispanic cultures (Weeks, Schensul, Williams, Singer, & Grier, 1995). Although such stigmatization is unfortunate for all women, it has been noted that women of color are more likely to rely on their spiritual community in times of trouble (Landau-Stanton et al., 1993). Unfortunately, individual or group judgment from religious sources may result in the PLWA's estrangement from their spiritual community, and a double stigmatization can be experienced by such PLWAs.

Ironically, religious mores can also prevent women of color from practicing behaviors that would help prevent HIV infection. Weeks et al. (1995) pointed out that the Catholic Church's stated position forbids the use of condoms during intercourse. Therefore, unprotected sex practices are inadvertently "reinforced by the teachings of the Catholic church [*sic*], the predominant religion of Latinos" (p. 254). Cohan and Atwood (1994) supported this finding with the observation that "culturally defined gender roles and rules that prohibit the use of birth control, may impinge on [Hispanic women's] ability to negotiate safer sexual practices with their partners" (pp. 8–9). Thus, women of color may become more vulnerable to HIV/AIDS as a result of religious beliefs. Their religious communities, meant to be havens of comfort and succor, may deny them real and symbolic refuge in the midst of their troubles. The role of the counselor may include providing comfort and support for such clients, and, in some cases, alternative spiritual resources may need to be explored.

COUNSELING IMPLICATIONS AND RECOMMENDATIONS

There are a number of excellent resources covering general counseling strategies for PLWAs and their families, friends, loved ones, and caregivers (Dworkin & Pincu, 1993; George, 1989; J. Green & McCreaner, 1996; Landau-Stanton et al., 1993; Tallmer et al., 1990; Winiarski, 1991). However, we have limited this article to a discussion of spiritual issues that may arise in counseling the HIV/AIDS population. Several suggestions follow regarding spiritual wellness issues and HIV/AIDS clients.

Countertransference Issues

It is incumbent upon the counselor to work through and address countertransference issues regarding HIV/AIDS clients and spirituality to prevent the work from being impeded. One issue that may arise for counselors concerns personal anxiety about death and dying and the related spiritual implications (Dworkin & Pincu, 1993; Hover-Kramer, 1988; Otten, 1990; Sherr, 1996; Smith, 1993). This can be revealed as an avoidance of the topic in sessions, or conversely, an over-focusing on death as an attempt to relieve inner anxiety (Sherr, 1996). Counselor anxiety about death and dying can also result in denial of client feelings. Winiarski (1991) stated: "One counselor, upon seeing a very sick patient, immediately began saying, 'Don't worry. Everything will be all right.' . . . This does nothing to alleviate the client's worries, which may be firmly based in his or her situation" (p. 52). If the counselor feels unqualified to help the client process such questions, that should be made clear as gently as possible, and a referral provided. Burke and Miller (1996) concurred, commenting on the effect of counselor-based fear: "The [counselor's] fear and denial associated with HIV/AIDS and death-related concerns may limit the effectiveness of counseling" (p. 186).

A related issue concerns possible impatience with, and judgment toward, clients in denial about death. J. Green and Sherr (1989) reported, "It is interesting to note that it sometimes seems to be the professionals who find 'denial' more distressing than the patient" (p. 209). One of the authors (Holt) has dealt with this issue, in working with HIV/AIDS clients. In trying to achieve the highest actualization for the client, both spiritually and emotionally, there may be a tendency to try to push beyond where the client is ready to go. Indeed, HIV/AIDS clients are no exception to the counselor's general clientele: in many cases, clients may not extend themselves beyond surface concerns and palliative support, and the counselor needs to be accepting of this. In addition, just because the PLWA does not wish to process spiritual or death and dying concerns in counseling does not preclude the development of a rich and deeply rewarding counseling experience, and may not indicate denial. In some instances, a client's denial may be obvious to the counselor. However, this avoidance of the topic of death may serve a very useful function, at least initially:

> [D]enial often acts as a mechanism to allow the person to absorb the information and prepare emotionally to face what lies ahead. . . . It may be necessary to allow the client to slowly come to terms with feelings such as fear and anger and neither rush insight nor push immediate recognition of the entire situation. (Dworkin & Pincu, 1993, p. 276)

Another countertransference issue involves judgment about clients' sexual mores, lifestyle choices, or drug-using habits. Dworkin and Pincu (1993) stated, "[G]iven that the hardest hit population so far has been gay men . . . [t]he therapist must explore his or her own attitudes toward gay and lesbian life-styles" (p. 275). Counselors' homophobic feelings, or value judgments concerning promiscuity or drug use, will almost certainly be communicated implicitly to the client and could result in significant damage (Burke & Miller, 1996; Dworkin & Pincu, 1993). Beginning the process of rebuilding the client's self-esteem is essential, as Dworkin and Pincu noted, "It is particularly important for the HIV-infected person to internalize a positive self-concept and shed the stigmas that are associated with the illness" (p. 277). If counselors have such strong negative beliefs about the lifestyle choices of PLWAs that it impedes their counseling, it is imperative to refrain from working with such clients. Counseling needs to be a "safe haven" for all clients; negative personal judgments impede the counseling process. If a counselor believes the PLWA's lifestyle is "immoral," then to work with this population is unethical.

Differing religious beliefs between counselor and client constitute a fourth countertransference issue. Smith (1993) commented, "[T]he counselor must exercise restraint so as not to impose his or her own theology on the patient, and the counselor must strive to totally accept the patient's belief system, whatever that belief system might be" (p. 72). Spirituality is highly personal and often results in strong feelings and intense opinions. For example, a hypothetical situation might involve a born-again PLWA who believes that God is punishing them for this disease and that their redemption requires repentance of their sins. Although a counselor may view this as unhealthy or harmful, to reject such a belief could result in alienation, especially if the counselor also attempts to impose their own spiritual values. "Not only does a counselor not give a theology to a client, but just the opposite is to be the case: The counselor is to receive the theology of the client in a non judgmental attitude of acceptance" (Smith, 1993, p. 72).

Spiritual Assessment

Winiarski (1991) recommended making a thorough assessment of clients who are HIV-positive. An important part of this assessment should include exploring the client's spiritual (and religious) history. This will clarify possible sources of client anxiety and distress. In addition, such an assessment will help to identify other spiritual sources of support in the PLWA's community and can facilitate building a network of support for the client (Landau-Stanton et al., 1993; Perelli, 1991). This spiritual assessment could be done during the initial intake session or take place in another session during the beginning stages of counseling. Possible questions to ask might include the following: "What are your spiritual beliefs?" "Do you belong to a particular religious institution?" "What role does spirituality play in your life?" "What effect has a diagnosis of HIV/AIDS had on your spiritual outlook?" "Are there any individuals whom you turn to for spiritual guidance?" "What are your family of origin's religious beliefs?" "Are there any issues in the realm of spirituality and religion that you would like resolved?"

Certainly the counselor should remain aware of the degree of relevance this topic has for each client individually and proceed accordingly. For some clients, spirituality is not an immediate concern and one or two questions will suffice; however, spiritual issues may arise in later sessions. For other clients, having the freedom to discuss spiritual and religious doubts or fears may require several sessions and become a main focus of counseling work. In such cases, discussing spiritual conflicts, long-held guilt feelings, and negative belief systems may be a cathartic and deeply healing experience (Landau-Stanton et al., 1993).

Counselor Acceptance

A supportive atmosphere created in counseling is a microcosm that can have far-reaching effects on the PLWA's life. "[T]he therapist represents mother and father, neighborhood and society—the embodiment of a community that validates and appreciates the individual. It is the therapist's accepting stance that permits the new connection" (Winiarski, 1991, p. 56). In fact, Helminiak (1995) suggested that in the case of nonreligious PLWAs, the counselor may actually serve the role of spiritual advisor: "[I]ndividual psychotherapy may sometimes be the contemporary version of traditional 'spiritual direction' or consultation with the religious leader, the holy man or woman, the guru" (p. 316). In addition, Hedge (1996) stated the following:

> With the realisation [*sic*] that life may be curtailed by an AIDS-related death, it is not uncommon to find an increased interest in mortality and spiritual issues even in those who have previously ignored religion. Counsellors [*sic*] are often chosen as suitable people with whom to air these topics as they are not professionally aligned to any particular belief system. (p. 77)

An openness to, and acceptance of, spiritual concerns on the part of HIV/AIDS clients will therefore be an important consideration for counselors.

Sense of Purpose

Given that research indicates hope to be an important tool in the lives of PLWAs, the counselor's work may include encouraging the PLWA to develop a sense of purpose or the instillation of hope. As George (1989) stated, "It is important to empathise [*sic*] with feelings of hopelessness whilst giving reassurance about how things can change. . . . The aim is to maximise [*sic*] the quality of life in a realistic way" (p. 77). Spirituality may be an integral component of the PLWA's life purpose in the face of HIV/AIDS, and therapeutic skills such as empathy, emotional support, and active listening can assist this process. Clients will differ, however, in their definition and working through of issues surrounding life purpose and hope. This may involve coming to a deeper peacefulness or acceptance about untimely death. However, such a state of acceptance does not preclude other goals, such as assisting the client in retaining a "fighting spirit," a healthy self-esteem, and an appropriate degree of assertiveness in pursuing life-affirming goals. Remaining hopeful about life should not be taken negatively or seen as a form of denial, particularly given the recent advancements in HIV/AIDS treatment (Beaudin & Chambre, 1996; Centers for Disease Control and Prevention, 1997c). Learning to live with such an illness is a complex process, and, ideally, all the various feelings and emotions of the PLWA will be accepted and honored. "Perhaps what clients, and therapists, actually experience are complicated admixtures of acceptance and hope" (Winiarski, 1991, p. 56).

Multiple Losses

Each person affected by HIV/AIDS, including PLWAs, their families, friends, loved ones, and caregivers, will most likely experience multiple losses. First, the debilitating nature of the disease results in a series of physical losses as the immune system of the PLWA becomes increasingly weakened. Numbness of extremities, headaches, dementia, night fevers, constant aches throughout the body, and detrimental changes in appearance such as hair loss are just some of the physical problems that may gradually limit the PLWA's life (Worden, 1991b). Second, many emotional losses will be experienced, such as those associated with career expectations and the prior anticipation of a normal life span. Also, individuals intimately connected to the PLWA must face the possibility of impending death as well as the metaphorical death of any hopes and future expectations in their relationship to the PLWA. For instance, Nord (1996) commented, "[W]hen parents lose a [child] to AIDS they are not only losing a [child] but also their future expectations related to the [child]'s life and the expectation that their child will outlive them" (p. 390).

Given society's tendency to downplay and disenfranchise the relationships of GLBT-PLWAs, it is also important to note that, for many such PLWAs, the parents and biological family have ceased to be a significant part of their life and the GLBT community created by the PLWA is far more important to acknowledge in counseling. In addition, the lovers of GLBT-PLWAs deserve every consideration accorded to a heterosexual spouse and, if the PLWA wishes, should be included in as much of the decision-making processes surrounding counseling as possible.

Perhaps the most important way multiple losses are experienced for PLWAs and their extended communities concerns the multitude of deaths. There are two communities that have been affected more profoundly than any others: the GLBT community and the inner-city poor (Ward, 1993). In such communities, death from HIV/AIDS has become a commonplace occurrence for its members (Bidgood, 1992; Nord, 1996). Multiple loss survivors understandably often believe they will never completely finish the grieving process (Nord, 1996). Bereavement overload is thus a common occurrence: "The compounding impact of surviving multiple AIDS-related deaths complicates the resolution of grief because there is insufficient time between deaths to work through the grief process before another death occurs" (Nord, 1996, p. 393). The impact of this on counseling sessions is very important; that is, a variable period of numbness accompanied by lack of emotional affect is entirely appropriate, given the possibility of multiple and disenfranchised grief issues. In fact, expectations that such clients will be able to adequately resolve their grief issues may be unrealistic (Kübler-Ross, 1969; Nord, 1996; Worden, 1991a). In addition, clients should be encouraged to recognize that grieving the death of a loved one is a very important way of honoring their memory; however, a balance needs to be struck between obsessing over the lost one(s) and maintaining a healthy memory. Ritual, spiritual or otherwise, may play an important role in assisting the grieving process.

Entire families are often living with the disease. In some cases, one or both parents are infected, and the infection has been transmitted to the children. Enormous feelings of loss and guilt are experienced as the family attempts to cope (Captain & Selder, 1990; Sherr et al., 1993). In such circumstances, family counseling may be an avenue of healing and processing, including work in the spiritual domain. Using spiritual resources in the community, such as a chaplain or spiritual counselor, may also be helpful (Landau-Stanton et al., 1993). In general, for clients or families dealing with multiple HIV/AIDS losses, a questioning of faith or bitterness toward a higher power may be a major part of counseling. Therefore, it will be important to create an atmosphere of trust and acceptance in which such feelings are honored and, if not resolved, at least understood and validated.

Disenfranchised Grief

Closely related to the concept of bereavement overload, disenfranchised grief involves a lack of validation for the griever(s) of the PLWA. This phenomenon is most common for GLBT-PLWAs and their GLBT lovers and friends (Corr, Nabe, & Corr, 1994; Housel, 1995; Worden, 1991b). One of the most concrete examples of denying the PLWA's alternative lifestyle and community concerns funeral arrangements in which the family may refuse to allow friends of the PLWA to be a part of the funeral due to prejudice or denial about the PLWA's lifestyle. This unwillingness to acknowledge GLBT community members may stem from religious beliefs in the "sinfulness" of such a lifestyle and thus is directly related to spiritual and religious issues in the counseling process.

Disenfranchised grief can also play a role in inheritance matters. A gay male friend of one of the authors (Holt), who was the primary caregiver for a gay male PLWA in his last years of life, repeatedly called the PLWA's family for help while the PLWA's health and spirit slowly deteriorated. The family, devoutly Christian, refused to visit or extend themselves, having apparently disowned the PLWA many years ago due to his gay lifestyle. Yet after his death, the family contested the will, which was to have left all his possessions to GLBT friends. The primary caregiver was understandably very angry and upset, especially given the family's "Christian" values. This lack of compassion and validation further exacerbates the grief that is already being experienced. Many counselors would agree that the expression and processing of emotions is a very important element of counseling. Given the fact that the loved ones of GLBT-PLWAs may not have many outlets through which to express their feelings, the counselor can play an important role by acknowledging the relationship to the deceased and by providing "permission" for the grieving process.

Listening to Clients' Needs

Serving as a listener and sounding board will of course be one of the counselor's main roles when working with clients with HIV/AIDS who are struggling with spiritual issues. This should be distinguished from proselytizing or offering personal opinions or advice: "The specific spiritual needs of PWAs can be identified only by PWAs themselves" (Warner-Robbins & Christiana, 1989, p. 44). However, it is certainly appropriate to bring up the issue of spirituality and ascertain the client's interest in examining his or her own beliefs. As Hover-Kramer (1988) stated, "[C]aregivers ponder what to say to patients about life after death. In the past they have perhaps been too vague about their beliefs for fear of challenging others' religious convictions. Yet, people in the final stages of life are spiritually hungry" (p. 9). Kain (1996) noted, "[W]e may find that spirituality plays a much bigger role in clients' lives than even they recognize" (p. 108).

However, caution is necessary. Spiritual concerns may not be an important area to explore for many clients with HIV/AIDS. For a variety of reasons, PLWAs may not be interested in the spiritual realm, having never embraced any kind of religion or having turned their back on spirituality as a source of support. On the other hand, PLWAs may be secure and comfortable with their spiritual path and have no desire to explore this in counseling. In addition, clients struggling with survival issues such as extreme physical or mental debility may not have the energy to engage in reasoning processes that extend beyond practical matters (Maslow, 1968; Winiarski, 1991), and counseling will be focused on more immediate needs. However, in many cases, spirituality may provide a grounding of support and sustenance for HIV/AIDS clients at all stages of the disease, particularly those near death. "A . . . spiritual need is to die appropriately. This means dying in a way consistent with one's self-identity. There is no one, right way to die. Not everyone has to 'accept' death. . . . [E]ach person will define an appropriate death differently" (Doka, 1989, p. 132). To provide PLWAs with nonjudgmental acceptance and permission to live and die as they wish can be considered a spiritual process in and of itself.

Stages of HIV/AIDS

Counselors will want to keep in mind the spiritual needs of clients in differing stages of the disease. New medications have increased the life expectancy of some PLWAs to the point that HIV/AIDS is now being called a "chronic illness" (Beaudin & Chambre, 1996; Centers for Disease Control and Prevention, 1997c). Given the lengthening life of PLWAs, those in the early stages of the disease may not be interested in or willing to consider terminal illness issues. On the other hand, at least two sources indicated death and dying issues may come to the forefront in the earlier stages of this disease: "People with AIDS often find it easier to discuss death and dying fairly early on in their illness, while they are relatively well, when they can realistically address these as issues for future concern" (Hedge, 1996, p. 77). Housel (1995) concurred: "The very diagnosis of AIDS demands an often rapid spiritual readjustment and alteration in the person's way of being in the world" (p. 123).

Systems Approach

A systems approach to counseling for PLWAs can be very useful in that as many resources in the client's community system as possible are used (Landau-Stanton et al., 1993; Perelli, 1991). This applies to the client's spiritual community as well. For those affiliated with a particular religious tradition, counselors may encourage the client to find a chaplain or clergy member to consult as a spiritual resource. This individual might be consulted by the PLWA on a regular basis. In addition, the clergy member could attend some counseling sessions. If the client is not affiliated with a spiritual community, other sources of support can be provided. Landau-Stanton et al. (1993) elaborated on various spiritual choices: "[A] religious figure's symbolic intervention of confession, forgiveness and penance might be appropriate. For clients who do not draw upon religious resources . . . referral could be made to a 12-step fellowship program. Al-

ternatively, referral for family counseling might incorporate the principles of repentance and reparation" (p. 269).

AIDS and Euthanasia

Green (1995) found that PLWAs were far more likely to seek assisted suicide than the general population. In his study, approximately 33% of all respondents (all PLWAs) considered euthanasia as a possible means of terminating their life. Given the fact that a third of those living with AIDS may consider euthanasia a viable option, it is very important for the counselor to determine the legal, moral, and spiritual issues and ramifications for themselves as well as their clients. In addition, for those PLWAs who are seriously considering such an option, their loved ones are usually made aware of such a plan and may even be asked to assist in the act. As such, family and other loved ones may have counseling needs as well.

Considerations for PLWA Caretakers

HIV/AIDS counseling issues involve more than the PLWA alone. For each PLWA, there are several individuals affected by the disease, including caregivers, significant others, friends, and family members (Nord, 1996). Such clients bring their own sets of unique problems to counseling, including grief about the potential death of someone they love and care about and guilt about being HIV-negative despite possibly engaging in similar risky behavior. In addition, just as the PLWA may struggle with deeply spiritual questions, these loved ones also struggle with similar issues (George, 1989; Rice, 1990). This group may also experience anguish, anger, and helplessness about the pain and suffering they see their loved ones going through, particularly PLWAs dealing with the final stages of the disease. Thus, it is possible that spiritual and religious issues will arise as families, friends, and caregivers attempt to reconcile the reality of HIV/AIDS with their underpinning beliefs.

RESEARCH IMPLICATIONS

The issue of spirituality can play a central role in the lives of many PLWAs and may enter into the counseling relationship. For counselors to become better prepared to help this population, more research is needed in a number of areas. First, the spiritual needs of specific populations in the HIV/AIDS community are important to examine. Youth, for instance, seem to have a unique developmental perspective concerning spirituality, and yet this topic has not been a primary focus of research for young terminally ill clients in general and for HIV-positive adolescents and young adults in particular. Also, although a number of articles have examined spirituality and GLBT-PLWAs, the significance of spirituality as a resource for ethnic minority PLWAs deserves increased attention.

In addition, given the disease's new status as a chronic illness, the counseling concerns of PLWAs may indeed be shifting, and certainly spiritual issues can be expected to be affected by such a shift. Research to examine the long-term emotional effects of an HIV/AIDS diagnosis, specifically its impact on clients' personal and spiritual development as well as counseling needs, would be helpful.

Finally, the need exists for more counselor training regarding inclusion of spiritual issues in general and in counseling PLWAs in particular. Burke and Miller (1996) concurred on the latter, stating, "Counseling skills that are adequate for work with other populations may be too fragile and too shallow to endure the intensity and depth of focus often found in therapy with people with HIV/AIDS" (p. 189). Therefore, training sessions to delineate the needs of such clients and to address common countertransference issues are warranted. (See Britton, Cimini, & Rak, 1999, for an example of a training model.)

CONCLUSION

Working with PLWAs can be a complex experience, and spiritual aspects are only one facet of an extremely intense process. Counselors are encouraged to continue to explore resources in dealing with this population. The rewards can be immense because the HIV/AIDS client begins to trust and value a counseling process that is inclusive of spiritual needs. Investing in this process can also be reflected in the counselor, whose personal and professional acumen is deepened and enriched as a result of being available to the spiritual concerns of the PLWA. As Kain (1996) noted, "At times we may be surprised to find that when we provide clients with the room to pursue spiritual matters, accelerated psychological growth often occurs. This makes sense, for in many ways and in many cultures, there is no distinction between psychological and spiritual growth" (p. 117).

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Techniques for Teaching HIV Counseling: An Intensive Experiential Model

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This article provides a thorough guide to experiential as well as didactic methods that have been used in teaching an HIV course at two separate graduate counselor education programs. This model is based on sound pedagogy, experimental techniques, and effective debriefing methods to enhance the skills of counselors in working more effectively with clients affected by HIV/AIDS. Pertinent themes that have emerged in the classes are discussed.

There is a growing demand for trained mental health practitioners to treat people challenged with or affected by HIV disease (Hoffman, 1991; Knapp & VandeCreek, 1990; Odets, 1995). This is evidenced by the rapid rise in HIV transmission and the multitudes of psychosocial stressors associated with the disease that dramatically affect mental health delivery systems. Although no cure seems to be imminent, people with HIV/AIDS are living substantially longer, contributing to changing mental health issues. With the advent of protease inhibitors, HIV/AIDS is no longer considered to be essentially a terminal disease, but instead is increasingly conceptualized as a chronic illness. It is estimated that most counselors will at some point be confronted with clients whose concerns relate to HIV disease (Hoffman, 1991).

The complexity and multifaceted mental health issues facing people in the HIV spectrum have been discussed at length in the literature (Hoffman, 1991; Kain, 1996; Kalichman, 1995; Kelly & St. Lawrence, 1988). The American Counseling Association has underscored the importance of preparing counselors to deal with this issue in their position statement on AIDS (i.e., American Association for Counseling and Development, 1989). Moreover, specific training of mental health practitioners in dealing with HIV disease has been proposed (Croteau, Nero, & Prosser, 1993; Hoffman, 1991; Robiner, Parker, Ohnsorg, & Strike, 1993; Werth, 1993; Werth & Carney, 1994). However, it is noteworthy that much of the published literature is specifically aimed at training psychologists (i.e., most articles appear in journals devoted solely to the field of psychology), although it has been our experience that licensed professional counselors and other mental health workers provide the bulk of these services.

Researchers have found that mental health professionals who have had specific training in HIV disease report feeling more willing and able to treat people experiencing the full range of the disease (Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; St. Lawrence, Kelly, Owen, Hogan, & Wilson, 1990). Yet, even with the volume of extant literature there still seems to be a paucity of training pertaining to this content area in academic environments (Campos, Brasfield, & Kelly, 1989; Hoffman, 1991; Hunt, 1996; Pingitore & Morrison, 1993). Several surveys have investigated the amount of graduate training mental health practitioners receive related to treating people with HIV. Campos et al. examined American Psychology Association (APA) approved programs in counseling and clinical psychology and found that only 19% had a course on HIV/AIDS. Diaz and Kelly (1991) surveyed social work programs and found that only 14% offered a course on counseling those with HIV. Counselor education programs also seem to be in need of more training. Hunt (1996) surveyed 64 counselor education graduate programs and found that about one half of these programs offered no training in even basic information about HIV/AIDS. Only approximately 25% of the programs offered a course on HIV/AIDS or at least designated a large section of a course that focused on HIV/AIDS issues.

Clearly, the recommendations in the literature (Hoffman, 1991), as well as those of the American Counseling Association, have not yet been implemented nationally, while the

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need for such services continues to expand. Although several excellent training models have been suggested in the literature (Britton, Rak, & Cimini, in press; Croteau et al., 1993; Hoffman, 1991; Robiner et al., 1993; Werth, 1993; Werth & Carney, 1994), graduate programs in counseling seem to be remiss in putting the curriculum into action. This article provides a more thorough guide to the experiential and didactic methods involved in teaching a graduate course on counseling people with HIV/AIDS. Over the past 5 years, this approach to teaching the class has been successfully implemented at two graduate counselor education programs.

We hope that offering a more detailed guide in the method of teaching this course as well as a discussion of common themes that emerged will encourage more counselor education programs to offer this critically needed training. (We also hope this article will encourage others to begin to empirically investigate such training approaches—a much needed next step.) We are aware that an entire course on HIV disease may not be realistic for some graduate programs. Our intent is that the information in this article might be generalizable to inclusion in related courses in counseling programs or for briefer presentations. We do recommend that the information from this class would be best assimilated after a student has had at least an introductory course in counseling along with two or three core counseling courses, so they are familiar with language and pedagogy in the field.

COURSE FOR TEACHING HIV COUNSELING

The topics covered in this course follow from the recommendations of Robiner et al. (1993), Werth and Carney (1994) and Hoffman (1991). These topics include the following: medical overview; community resources; ethical, legal, and professional issues; assessment and diagnosis; counseling diverse populations; counselor attitudes about AIDS; individual, family, and group interventions for clients; death and dying; and countertransference issues. Because detail and justification are provided regarding the recommended course content by Hoffman and Werth and Carney, readers are referred to these sources for further specifics. Instead, we focus on the ways that we introduced and integrated the curriculum in our training. We first describe the experiential activities and methods we used, and second we discuss the common themes that emerged in the classes.

Opening Experiential Component

We begin the course by asking that each graduate student reflect and share what brings her or him to the course. This exercise allows the students to begin to process their individual issues and their professional and personal goals. Frequently, it gives them an opportunity to share any personal or professional interaction they have had with HIV/AIDS. On one occasion, a student shared his own HIV positive status. On several other occasions, students shared that family members had HIV disease. We have found this to be an important way to begin, because it allows for the group process to emerge and for students to be more honest and open about the multitude of feelings they may experience.

Overview of HIV/AIDS

A basic introduction to the disease (referred to as "AIDS 101") is presented early in the course. A local physician who specializes in working with people with AIDS shares with the students an overview of the medical facts of HIV disease. A secondary gain from this section of the course is the exposure of many of the student's fears and hidden beliefs they hold regarding AIDS. For example, despite existing available information, several students were concerned about transmission from contact with tears or hugging clients.

We have also been aware that many students in our urban area universities have verbalized mistrust of the medical establishment. This may be particularly true for people of color who report mistrust in doctors and medical information (Penn, Kar, Kramer, Skinner, & Zambrana, 1995). We felt that students' fears and anxieties are best addressed in person by a physician and others who have had direct contact with this disease. An example of the level of mistrust in some students is exemplified in one pregnant student's unwillingness to be present when people with HIV were scheduled to attend class. Other students possibly displace their fears by sharing their spouse's or friend's fears of their possible contact with people with HIV in our classroom. The physician and professors spend considerable time addressing and allaying these fears.

Greek Chorus: A Demonstration of Multi-Stressors

This powerful exercise is helpful in introducing the psychosocial factors of this disease. We first present a case of someone who recently tested positive for HIV. We have the students identify issues and stressors that perhaps the client will be faced with (e.g., stigma, loss, financial strain, fear, guilt, hopelessness, suicide, isolation, chemical dependency). As the student identifies an issue, we write it out on a poster and have them stand in a semicircle holding their respective poster. For each identified issue, the student is instructed to think of a short sentence using an "I" statement, exemplifying the respective psychosocial issues, such as "Am I going to die?" "What about my baby?" or "I want a drink." The instructor then role-plays a counseling session with a client. As the issues emerge during the role play, the chorus shouts out their sentence. After several minutes the chorus is instructed to just shout out the sentence while others do the same. The result is a powerful representation of the chaos and complexity of the counseling process especially in the early phases of treatment. This exercise allows students to get in touch with their own sense of vulnerability and helplessness in facing the chaos that may emerge in this work. We spend considerable time processing this exercise.

Exercise Focused on Multiple Losses

This experiential exercise demonstrates that HIV is a disease of adjustment and explores the concept of the "roller-coaster" effect of HIV/AIDS as it affects both client and counselor. The students are asked to complete a list of their five favorite material possessions, their five favorite activities, and their five favorite living people. They are told a disaster strikes, and they are asked to remove any two items from their list. (The students are asked to cross these items off of their lists.) Then they are told to remove three more, then two, until enough items are crossed off so that the students are faced with the elimination of people from their lists.

During the exercise and afterward in the processing, students often react with anger, nervous giggles, and refusal to participate. The process discussion heightens their awareness that each loss caused by HIV must be grieved and adjusted to and then is often followed by another loss, and thus the cycle goes on. Coping mechanisms, anticipatory fear, and suicidal ideation to "make the pain stop" are also explored.

Panel of People Affected by HIV/AIDS

Approximately one third of the way into the course, we invite a panel of people affected by HIV/AIDS to speak to the class. Almost every city or area has an HIV speaker bureau through their local AIDS service agency. Our panel includes people with full-blown AIDS, people who are asymptomatic and HIV positive, long-term survivors, parents or siblings of people with HIV/AIDS, parents who have lost children to HIV/AIDS, women with HIV/AIDS, and partners of people in the spectrum. We ask the panel to tell their respective stories and to discuss what they would want and would not want from a counselor. After the formal presentation, students are free to ask questions, with the stipulation that panel members may choose not to respond.

The panel awakens the class to the harsh realities of HIV/AIDS in a real and experiential way that lecture and other class strategies fail to do. Students frequently comment that this is the first time they have ever formally met a person with HIV/AIDS, and now the disease has a face. We believe this contact is essential, and students frequently verbalize that this is the most salient part of the class.

Overview of Ethical Issues and HIV Disease

Perhaps this is one of the more dynamic and anxiety producing sections of the class. We strategically discuss these issues about halfway into the course because the students have been with each other long enough to become comfortable and honest (i.e., cohesiveness has developed). The complexity and nuances of the ethical issues, as they relate to HIV disease, makes this a complicated part of the course. We review the literature on confidentiality, duty to warn, competency, and rational suicide (e.g., Erickson, 1990; Harding, Gray, & Neal, 1993; Kain, 1996; Rogers & Britton, 1994; Werth, 1992). However, due to the relative newness of these issues and the lack of agreement between professionals, case law, state interpretations, and professional organizations (Allers & Katrin, 1988; Werth, 1993), we are left giving students a somewhat vaporous message. The conflict between the duty to protect a client's confidentiality and the duty to protect society particularly raises emotional issues for students (Cohen, 1995). For some students, these questions interact with a subtle but real homophobia or prejudice. As instructors, we have found it generally important to stay neutral in presenting the material, which allows the biases and ambiguity to surface. Using case discussions to assist in application of the material is helpful. We stress the importance of supervision and consultation in dealing with ethical dilemmas.

Family Sculpting

Family dynamics are described along the continua of approach/avoidance and enmeshment/disengagement. We include psychosocial issues involving disclosure, chemical use, same-sex partners, support and caregiving, and the family grieving process relative to a parent, partner, or child being lost to or ill with HIV/AIDS. We then use the techniques of family sculpting developed by Peggy Papp (see Papp, Silverstein, & Carter, 1975) to demonstrate the complexity of these relationships. A case is introduced that represents the dynamics that frequently occur in families of origin. Students volunteer for the family roles and are given three adjectives that describe each member. They are then placed by the instructor in the room depicting distance or closeness between family members and power (demonstrated by members being "high or low" in physical relationship to one another). In addition, the disease of HIV can be represented in the sculpture by placement of a student.

The class processes the initial picture that will elicit the basic dynamics of the family. The role players are then given a stereotyped movement or motion (i.e., the mother hugging the son with HIV, then the son pushing her away, etc.). They perform these activities three times in slow motion without words. At the end of the sculpture, the class and role players process their feelings. Some students are able to predict what might happen next with this family or suggest appropriate interventions based on the sculpture.

Multicultural Exercise

This section focuses on an introduction to the multitude of multicultural issues that interface with AIDS (e.g., women, ethnic minorities, drug abusers, religious communities). Following the recommendations of Croteau et al. (1993), we challenge students to become aware of prejudicial beliefs about HIV. We also stress that professionals must familiarize themselves with possible group specific HIV-related misconceptions and notions. We discuss the reality of multiple discrimination or stigmatization when people are a member of more than one oppressed group. Particularly, we stress the importance of recognizing that we are all guests in other cultures and the importance of honoring and respecting these differences.

Our activity is used to heighten awareness of multicultural difference as it interacts with individuality. Students are asked to rank the importance of their following cultural identities: religion, appearance, ethnic heritage, gender, gender orientation, socioeconomic status, occupation, age, residence, and societal role. Graduate students often express surprise at the variation of the rankings that exists among them. The exercise assists students in recognizing the uniqueness and complexity of the concept of culture.

Exercise in Practicing Safer Sex

The instructor uses a variety of comic condom products available at specialty stores to discuss safer sex techniques and practice. Emphasis is on the difficulty of changing one's sexual practices. We then suggest that all sexually active members of the class are asked to use a condom or alter some other aspect of their lovemaking as a homework assignment. The next class, students often comment on how difficult it is to change sexual practices.

Because a portion of our students work in educational settings, we express our hope that they communicate to their students that they care about their sexuality and that they want them to be responsible and happy in their sexual choices. This message, of course, includes the possibility and desirability of youth abstinence. We also remind graduate students that the counseling relationship is the one sanctioned place where it is appropriate to talk about what one does sexually. It is an opportunity for counselors to discuss preventive behavior in a specific and planful manner.

Attention to Language

We use an experiential exercise to introduce the topic of language. It involves clustering the class in groups and giving each group a large poster board. At the top of the poster board, we have written the following words: penis, breast, intercourse, vagina, and death. We ask the groups to write down all of the euphemistic terms that are used to refer to this word. We then ask the groups to read the terms out loud to the entire class. Although we have fun with this exercise (and there is always laughter to some degree), it allows graduate students to practice verbalizing sexual language they otherwise may not approach in working with clients. We also examine the idea that these euphemisms develop due to fear and discomfort. For instance there are few euphemisms for "knee" or "heterosexual."

Moreover, the sensitivity of semantics is stressed throughout the class. We model for them appropriate use of terms and confront students when we hear inappropriate language such as "AIDS victim," "high-risk groups," or "AIDS test." The language is ever changing, and students express fear of using the "wrong" language. We normalize this and try to encourage students to stay on top of the literature in this area.

Individual Counseling Simulation

This lab section gives students the opportunity to practice interventions in a role-play setting. Each triad of students is given a scenario. Students role-play and then discuss reactions with one student observing. Through the exercise, students experience some counseling dilemmas with clients who are HIV positive and discuss their questions about techniques, fears, dilemmas, and confusions. The large group discussion synthesizes the experience and questions the appropriateness of various techniques with clients who are HIV positive.

Exercise Processing Death and Dying

This section involves imagery in which students are asked to bring up a memory of a loss in their own lives. Students are asked to relax, close their eyes, and imagine a room. They then invite someone that they have lost into the room; they are asked to tell this person something and then to hear the response. Some students are overwhelmed by this process, but most are grateful for the opportunity of once again connecting to someone who they have loved. Some use the opportunity to take care of "unfinished business." Most become aware that those we lose are still with us in our hearts and minds, and this is a comforting factor for those who work with the dying. What we stress is that working with people who are dealing with issues about death and dying will frequently trigger our own issues about death. The more aware we are of our own fears and anxieties, the more likely we can appropriately pay attention to these and then be more available to our clients. Other issues examined are rituals for grieving as well as the stages of grief (Kübler-Ross, 1969) and their varying presentation in our clients. The importance of allowing the clients to discuss their issues based on their own timing and not the counselor's is emphasized.

Group Counseling Demonstration

This section is underscored because group counseling is frequently the treatment of choice for people with HIV/AIDS (see Livingston, 1995). The material is presented didactically, then modeled for the class by eight volunteers who participate in a group. Other class members observe the instructors leading the volunteer group. Through this experience, students are given the opportunity of experiencing or observing the group process. We have found this to be a much more effective procedure than simply talking about the process.

Group Simulations

Toward the end of the class, we invite the members of our HIV/AIDS panel back to participate as group members. Students are grouped with several other students and several panel members. The students are asked to take turns leading the group with the panel members and other students acting as clients while an instructor observes. It has been important that we stress to graduate students that we are not grading them on their group counseling skills. Instead, we want them to have the experience of the intervention and

the group process. We then return to the class to discuss this exercise.

Closing of the Class

After each class period, and at the final closing, we ask the students to express one thing that they would like to take from the class and one thing they would like to leave. We include the panel in the final closing. It is a powerful experience and allows students to debrief from the intensity of the class meetings.

COMMON THEMES

Over the 4 years of teaching the course, we have noticed some common themes that emerged from the class (themes that can be expected to occur).

Various Levels of Homophobia Are Present

Homophobia was expressed in all of our classes in both direct and subtle ways. Comments such as the "innocent victim of HIV" when discussing hemophiliacs or children were prevalent. Because homophobia is inherent in many students, we found the guidelines from Wright and Thompson (1990) a very helpful source. We challenge and confront our students on their use of language, for example, using the term *high-risk behaviors* versus *high-risk groups*. We also challenge them to try new ways of thinking. The HIV/AIDS panel is a beneficial tool in helping students confront their biases and fears. As the course progresses, it is refreshing to see the process of some students owning their prejudices. Others resist letting go of their homophobic attitude, and sadly their prejudice comes through clearly in their writing assignments. (In some cases this type of resistance may require further exploration with the student outside the class setting.)

Fear About HIV Transmission Occurs

On several occasions, students discussed their fear of getting AIDS through casual contact. We found that the underlying anxiety needed to be acknowledged and examined in a nonthreatening manner. In our course format, this fear was frequently expressed during the closing exercises. This allowed for some students to hear and identify with the fear and for others to confront and challenge it. As in all forms of group process, the confrontation is always more effective coming from the members, themselves, instead of the leaders or instructors.

Anger Frequently Develops

As the course progresses and students are exposed to the many injustices that occur in relationship to the stigma attached to HIV/AIDS, a growing awareness of the profound violations in peoples' lives frequently becomes apparent. Again, the panel contributes to this in that the injustices now have a face attached. As instructors, we support and affirm the anger but try to model how one contains the anger to be effective in developing a therapeutic environment.

Feelings of Being Tired and Overwhelmed Occur

This fatigue seems to peak about halfway through the course. As instructors, we allow this and encourage students to talk about it. We suggest that to do this work, one needs to be able to manage the feeling of being overwhelmed, because indeed the work may be overwhelming. We discuss these issues in the context of counselor self-care and knowing one's limits.

A Sense of Incompetence and Ineptitude in Treating People With HIV/AIDS Can Develop

Questions develop such as "How can I, with my limited experience, expect to help someone dealing with so much?" We encourage graduate students to talk about their vulnerabilities, and we share some of our own. We discuss the importance of being present with people versus the fantasy of helping or rescuing. Letting go of the "fix it" mentality provides some relief for students enrolled in the course who struggle with issues about skill level.

A Strong Emotional Component Arises

This may be connected to the intensive nature of the course, but it also is tied to the fact that the issues related to HIV/AIDS have to do with life/death, sexuality, and morals (i.e., issues that can touch us deeply). As a result, graduate students need to discuss their experiences in the course. We find that we need to monitor the emotional level of the class and to maintain a teaching atmosphere. We remain available to students after class, and on some occasions refer students to counseling. However, we always need to pay attention to our own emotions as we teach the course. It is helpful to use a team teaching model, so that we can provide support and relief for one another.

Issues of Spirituality and Religion Occur

Although we encourage discussion of spiritual issues and their relationship to this work, we remind students that it is important to separate their own spiritual paradigms from those their clients might maintain. Students need to find a way of managing their religious orientation with the realities of doing this work. We recommend referring to an article appearing in this issue of the *Journal of Counseling & Development* for an overview of spiritual issues related to HIV/AIDS clients (Holt, Houg, & Romano, 1999).

Increased Commitment Toward Action Is Evident

Toward the end of the course, many students can be expected to express a commitment to working with people with HIV/AIDS, and some students will begin to act on this commitment even before the course is completed. This is

evidenced by student efforts to find volunteer experiences and internships in the HIV/AIDS service community, gratifying for those of us who have felt like pioneers in the early days of this work.

CLOSING REMARKS

Because counselors will probably encounter clients with HIV/AIDS, it is crucial that counselor education programs prepare counselors to address the issues of these clients. This article provides counselor educators (and trainers) several methods to assist in training counselors to work with people affected by HIV/AIDS. We believe the model, based on our experiences, is replete with sound pedagogy, meaningful experimental techniques, and effective debriefing experiences to enhance the learning opportunities of counselors in training. It is hoped that the information in this article can be generalized to numerous applications.

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Patterns of Expectations About Counseling: Relations to the Five-Factor Model of Personality

Michael Schaub
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The authors sought to identify groups of students who differed in their patterns of expectations about counseling, and then to relate those groups to personality, as organized in the 5-factor model (FFM). Results of cluster analysis of 150 female and 96 male students' responses to the Expectations About Counseling–Brief form (EAC-B; H. E. A. Tinsley, 1982) questionnaire revealed 5 distinct clusters. Results of discriminant analysis identified 2 FFM personality functions (A Neuroticism and Closedness and Optimism) that meaningfully discriminated among the 5 clusters. A brief interpretation is offered of each cluster that integrates information based on EAC-B factor scores and the significant personality functions.

Counseling researchers have long theorized that clients' expectations about the nature of the counseling process exert an important influence on their readiness for therapeutic change as well as their actual experience in counseling (Apfelbaum, 1958; Bordin, 1955; H. E. A. Tinsley & Harris, 1976). Recent research has provided preliminary empirical verification of these theoretical links: Researchers have found clients' expectations about counseling to be related to their stage of counseling readiness (Satterfield, Buelow, Lyddon, & Johnson, 1995), their perceptions of the working alliance with their counselor (Al-Darmaki & Kivlighan, 1993; Tokar, Hardin, Adams, & Brandel, 1996), and their level of involvement in an initial counseling interview (H. E. A. Tinsley, Tokar, & Helwig, 1994). Given the important influence of clients' expectations about counseling on their actual counseling experience, research examining how different person and situational factors may be related to individual differences in expectations about counseling is warranted.

To date, most of the published research on expectations about counseling has focused on surface traits of the respondents, including sex (e.g., Hardin & Yanico, 1983; Sipps & Janeczek, 1986; Subich, 1983), race (e.g., Hanlon, 1992; Kunkel, 1990), and client versus nonclient status (Hardin & Subich, 1985), or on counseling-related situational/contextual factors, such as amount of fee charged for counseling services (Subich & Hardin, 1985) and problem type (Hardin & Yanico, 1983). Taken collectively, results of these studies have revealed few consistent differences in respondents' expectations about counseling as a function of demographic variables or situational/contextual factors. These null findings suggest that it may be more fruitful for researchers to investigate the potential influence of more core, internal-individual-differences variables on people's expectations about counseling. Craig and Hennessy (1989) called for

> a more comprehensive, theory-driven exploration of expectations . . . one that is based on the assumption that aspects of client personality structure suggest aspects of expectations rather than on the premise that various descriptive, context, or process variables, which singularly are related to differences on measures of specific expectations, can be identified. (pp. 401–402)

These and other authors (e.g., H. E. A. Tinsley, 1992) also have suggested that future investigations of the complex relations that likely exist between expectations about counseling and theoretically relevant constructs should use multivariate statistical procedures (e.g., cluster analysis) that do not assume a linear relation.

To date, only a handful of studies have explored the potential influence of students' and clients' core personal dispositions on their expectations about counseling. For example, Leong, Leong, and Hoffman (1987) found that expectations about the counselor's acceptance, nurturance, attractiveness, and expertise differentiated among rational,

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intuitive, and dependent decision makers. D. J. Tinsley, Hinson, Holt, and Tinsley (1990) found relations between students' expectations about counseling and their level of psychosocial development, with greater levels of psychosocial development generally associated with more positive expectations about counseling. Other researchers have found that counseling expectancies are related to students' conceptual system development (Craig & Hennessy, 1989), femininity, (M. E. Johnson & Knackstedt, 1993; Sipps & Janeczek, 1986), and resemblance to both Social and Realistic Holland (1992) vocational personality types (Herzog & Subich, 1995). Taken collectively, these data suggest that important relations exist between people's core personal attributes and their expectations about counseling.

However, hampering the potential utility of most of these studies are two major limitations, one methodological (i.e., the data-analytic strategies used) and one theoretical (i.e., failure to relate expectations about counseling to a comprehensive model of personality). The former, to which we alluded in previous passages, concerns the reliance by previous researchers on data-analytic procedures that are univariate (e.g., analysis of variance [ANOVA]) or that assume linear relations (e.g., regression). Indeed, H. E. A. Tinsley (1992) and his colleagues (H. E. A. Tinsley, Bowman, & Barich, 1993; H. E. A. Tinsley et al., 1994; H. E. A. Tinsley, Workman, & Kass, 1980) suggested repeatedly that expectations about counseling very likely have complex curvilinear, rather than linear, relations with many relevant personality and counseling-related variables.

One technique that may prove useful for exploring the possibility of such complex curvilinear relations is cluster analysis. Cluster analysis is a statistical procedure for combining complex sets of data into homogeneous groups in a way that minimizes within-group variance (Borgen & Barnett, 1987). Cluster analysis has been used in counseling research to identify complex groupings of variables, including career indecision (e.g., Larson, Heppner, Ham, & Dugan, 1988; Lucas & Epperson, 1990; Savickas & Jarjoura, 1991; Wanberg & Muchinsky, 1992), "things unsaid" during group counseling (Wheeler & Kivlighan, 1995), helpful and nonhelpful events in counseling (Elliott, 1985), clients' attachment to their counselors (Mallinckrodt, Gantt, & Coble, 1995), clients' presenting problems in counseling (Heppner et al., 1994), and leisure activities (H. E. A. Tinsley & Eldredge, 1995).

In addition to the obvious benefit of reducing complex multivariate data sets into more meaningful sets of subgroups, cluster typologies of persons have provided counseling researchers and practitioners with useful frameworks for organizing and integrating previous research findings, for hypothesizing future correlates of the types, and ultimately for understanding how different types of people might behave in and benefit most from counseling. For example, Lucas (1993) had intake counselors classify students seeking career counseling services into one of five types based on Lucas and Epperson's (1990) typology of career undecided students and found that the types differed meaningfully in number of problems presented at intake by the student, number of problems perceived by intake counselors, and number of counseling sessions. In summary, the application of cluster analysis to the investigation of relevant counseling-related variables (in particular, the identification of meaningful typologies of persons) holds promise for both counseling researchers and practitioners. Thus, in response to scholars' (e.g., H. E. A. Tinsley, 1992) calls to move beyond univariate, linear analyses of circumscribed expectations-personality relations, the primary purposes of this research were (a) to develop a typology of students based on their patterns of expectations about counseling, and (b) to examine the distinctions between the types in terms of core personality dimensions.

The second major limitation of extant research relating expectations about counseling and personality concerns previous investigators' failure to incorporate a comprehensive account of personality features. Decision-making style, level of psychosocial development, stage of conceptual system development, and feminine gender traits, although potentially useful individual-differences constructs for understanding expectations-personality relations, do not offer the researcher a comprehensive, unifying individual-differences model to fully understand the complexity of a sociocognitive variable such as expectations (see Craig & Hennessy, 1989). Failure to include a comprehensive personality system certainly could obscure or suppress important expectations-personality relations.

One model of personality that seems promising for the proposed investigation is the five-factor model (FFM) of personality (Digman, 1990; Goldberg, 1990; McCrae & Costa, 1987). The FFM represents a taxonomic scheme for describing at a global level the basic dimensions of normal personality: neuroticism (calm–anxious; secure–insecure), extraversion (reclusive–sociable; cautious–adventurous), openness to experience (conventional–original; closed–open), agreeableness (irritable–good-natured; uncooperative–helpful), and conscientiousness (undependable–responsible; low–high achievement striving). These five major trait dimensions have been postulated to encompass individual differences in enduring motivational, attitudinal, emotional, and interpersonal styles. The Big Five, as they are commonly referred to, have been recovered repeatedly in factor analyses of peer ratings of trait descriptors (e.g., McCrae & Costa, 1987; Norman, 1963; Tupes & Christal, 1961/1992), and in similar ratings of self (e.g., Goldberg, 1990, 1993; McCrae & Costa, 1987). The comprehensiveness of the five-factor model is demonstrated further by research suggesting that other personality schemes may be interpreted and organized in terms of the Big Five (see Costa & McCrae, 1992a, for a review). Thus, the five-factor model seems to be an unusually robust and comprehensive representation of personality structure, which makes it an ideal framework for evaluating potential expectations-personality links.

In addition, expectations about counseling present a theoretically relevant application for the five-factor model. McCrae and Costa (1996) recently advanced a theory of personality development/processes that clearly implicates

basic dispositions, the most important of which are the Big-Five personality dimensions, as important causal influences on a number of sociocognitive variables, including beliefs, attitudes, perceptions, and preferences. Therefore, it is reasonable to posit similar links between these same basic tendencies (i.e., personality) and expectations (viz., about counseling), which have been postulated as primary sociocognitive mechanisms that figure prominently in directing behavior (see Bandura, 1986; Rotter, 1966).

A final reason to study expectations about counseling in relation to the FFM is based on theoretical (e.g., Costa, 1991; Costa & McCrae, 1992b; McCrae, 1991; McCrae & Costa, 1991) and empirical (e.g., Miller, 1991) writings delineating important clinical uses of the FFM. These authors have suggested that counselors supplement traditional, clinically oriented assessment instruments with assessments of the FFM to obtain a more comprehensive understanding of their clients' personality styles. Personality, as organized by the FFM, also has been postulated to interact with counselors' treatment mode to influence clients' experience in counseling (McCrae, 1991; Miller, 1991), and empirical data reported by Miller suggest that counseling prognosis may be predicted from clients' Big-Five personality profiles. In Miller's study, clients' scores for neuroticism correlated inversely and scores for extraversion and conscientiousness correlated positively with counseling outcome. These findings suggest that clients who enter counseling with tendencies to be more outgoing or willing to self-disclose (higher extraversion) and those who are more willing to take personal responsibility to work hard in and between sessions (higher conscientiousness) may benefit more from counseling.

Given the theoretical and empirical associations of expectations about counseling and the FFM to both counseling process (Bordin, 1955; Costa & McCrae, 1992b; Highlen & Hill, 1984; Miller, 1991; H. E. A. Tinsley et al., 1994; Tokar et al., 1996) and outcome (e.g., Costa & McCrae, 1992b; Duckro, Beal, & George, 1979; Heilbrun, 1961, 1974; Miller, 1991; Pope, Seigman, Blass, & Cheek, 1972; H. E. A. Tinsley et al., 1993), it is reasonable to hypothesize substantive relations between expectations about counseling and personality domains. H. E. A. Tinsley et al.'s (1994) and Tokar et al.'s data are particularly relevant to the present study. Results of these studies indicated that clients who had higher expectations for personal commitment (i.e., for assuming personal responsibility and working hard in counseling) were more involved in the counseling process (H. E. A. Tinsley et al., 1994) and perceived the working alliance with their counselor to be stronger (Tokar et al., 1996) than clients with lower expectations for personal commitment. These results are consistent with Miller's finding that high-conscientiousness clients fared better in counseling. Thus, although the current study is exploratory, we hypothesized that conscientiousness would differentiate types characterized by high versus low expectations for personal commitment.

To summarize, despite the theoretical and empirical links between expectations about counseling and circumscribed features of personality, empirical demonstration of the relations between counseling expectations and the FFM has not been forthcoming; this study represents an initial investigation of their relation. In response to previous scholars' (e.g., H. E. A. Tinsley, 1992) recommendations, we first used cluster analysis to derive a multivariate typology of students based on their patterns of expectations about counseling; we then compared the types with one another on the Big-Five personality dimensions. By relating these sets of constructs, we hoped to (a) extend previous efforts to identify psychologically relevant individual-difference correlates of students' expectations about counseling, (b) further evaluate the FFM's comprehensiveness by testing its capacity to encompass individual differences in students' expectations about counseling, and (c) offer counseling practitioners a potentially useful taxonomy for anticipating how subgroups of clients who differ in their patterns of counseling expectations may envision, approach, and behave in counseling.

METHOD

Participants and Procedure

Two hundred forty-six students (150 women and 96 men) enrolled in undergraduate courses at a large midwestern university participated in this research. Mean age of the participants was 22.3 years (SD = 5.7). Regarding racial/ethnic identification, 79% self-classified as White/Caucasian, 13% as African American/Black, 4% as Asian American, 3% as Bi/Multiracial, and 1% indicated other ethnicities or left the item blank. In terms of year in college, 41% were in their 1st year, 31% in their 2nd, 15% in their 3rd, 10% in their 4th, and 4% beyond their 4th year (due to rounding, percentages do not total 100%). Participants were informed of all procedures and consented to participate. After completing the instruments described as follows, they received written educational debriefing materials. They also received course credit or extra credit for their participation.

Instruments

Expectations About Counseling–Brief Form (EAC-B). H. E. A. Tinsley et al. (1980) developed the Expectations About Counseling (EAC) measure to assess students' expectations about counseling. The brief form of the measure (EAC-B; H. E. A. Tinsley, 1982) yields scores correlating > .83 with scores from the original EAC. Participants respond to 66 items reflecting different expectations about counseling using a 7-point Likert-type scale (1 = *not true*; 7 = *definitely true*). The 17 EAC-B subscales measure expectancies in four areas: client attitudes and behaviors (Motivation, Openness, and Responsibility), counselor attitudes and behaviors (Acceptance, Confrontation, Directiveness, Empathy, Genuineness, Nurturance, and Self-Disclosure), counselor characteristics (Attractiveness, Expertise, Tolerance, and Trustworthiness), and counseling process and outcome (Concreteness, Immediacy, and Outcome). H. E. A. Tinsley (1982) reported internal consistency reliabilities for the scales rang-

ing from .69 to .82 (*Mdn* = .77). Internal consistency estimates for the current sample ranged from .68 to .83 (*Mdn* = .78). H. E. A. Tinsley reported 2-month test–retest reliabilities that ranged from .47 to .87, with a median stability estimate of .71. An analysis of the cognitions stimulated by the items on the EAC-B (H. E. A. Tinsley & Westcot, 1990) provided support for the instrument's construct validity. In addition, research has demonstrated similar levels and patterns of EAC-B scores for students and actual clients (Hardin & Subich, 1985; R. D. Johnson, 1990; Subich & Coursol, 1985), and for applicants for counseling services with and without prior counseling experience (R. D. Johnson, 1990). Thus, use of the EAC-B with nonclient student samples, regardless of prior counseling experience, is warranted.

Several studies of the EAC-B have yielded three factors that account for the relations among the subscales (e.g., Hayes & Tinsley, 1989; Kunkel, Hector, Coronado, & Vales, 1989; D. J. Tinsley, Holt, Hinson, & Tinsley, 1991). The Personal Commitment factor (composed of the Motivation, Openness, Responsibility, Attractiveness, Concreteness, Immediacy, and Outcome scales) measures students' expectations to assume responsibility and to work hard during counseling. The Facilitative Conditions factor (composed of the Acceptance, Confrontation, Genuineness, Nurturance, Self-Disclosure, Tolerance, and Trustworthiness scales) measures students' expectations that the interview conditions (e.g., genuineness) identified by Rogers (1957) and others as theoretically necessary for progress in counseling will be present. The Counselor Expertise factor (composed of the Directiveness, Empathy, and Expertise scales) measures expectations that the counselor will be a skilled clinician who will be able to help the client.

NEO Five-Factor Inventory (Form S). The NEO Five-Factor Inventory (Form S, NEO-FFI-S; Costa & McCrae, 1989, 1992a) was developed to assess the five major dimensions of normal personality: neuroticism (N), extraversion (E), openness (O), agreeableness (A), and conscientiousness (C). Participants respond to 60 items on a 5-point Likert-type scale ranging from *strongly disagree* (0) to *strongly agree* (4). The NEO-FFI-S was developed as a short version of the NEO Personality Inventory (NEO-PI; Costa & McCrae, 1985) by selecting the 12 items from the longer inventory with the highest positive or negative factor loadings on each of the five corresponding factors. Cronbach's alpha reliability estimates of .86, .77, .73, .68, and .81 were reported for the N, E, O, A, and C scales, respectively, for a sample of 1,539 adults (Costa & McCrae, 1992a). For the current sample, alphas were .86, .78, .73, .72, and .83 for the N, E, O, A, and C scales, respectively. Construct validity of the NEO-FFI-S is indicated by correlations with self-report adjective factors of the five-factor model (see Costa & McCrae, 1992a).

Demographic questionnaire. The demographic questionnaire developed for this study asked participants to indicate their age, sex, race/ethnic background, current educational level, income, prior experience with counseling, father's and mother's education, and father's and mother's current occupation.

RESULTS

Gender differences have been reported consistently for the EAC-B (e.g., H. E. A. Tinsley, 1992) and for the NEO-FFI-S (e.g., Costa & McCrae, 1992a). Therefore, 2 one-way MANOVAs with gender as the independent variable were performed to determine if participants' scores on the research instruments varied by gender. Results of the first MANOVA, with the 17 EAC-B subscales as dependent variables, revealed gender differences for the subscales: Wilks's Lambda = .74, $F(17, 228) = 4.81$, $p < .001$. Likewise, results of the second MANOVA, in which NEO-FFI-S scores served as dependent variables, revealed gender differences for the set of personality variables: Wilks's Lambda = .85, $F(5, 240) = 8.67$, $p < .001$. To account for the observed gender differences, scores on the EAC-B and NEO-FFI-S subscales were standardized (i.e., converted to *T* scores) separately for women and men before subsequent analyses.

Next, to identify subgroups of students based on their patterns of counseling expectations, participants' standardized scores on the 17 EAC-B subscales were cluster analyzed using Ward's (1963) minimum variance method. Borgen and Barnett (1987) recommended this procedure for forming similar groups of people across a set of variables. As the groups are combined to produce successively fewer and larger clusters, the error index (based on the proportion of within-group variance) will increase. Typically there will be a sharp increase or "jump" in the error index when relatively heterogeneous groups are combined at a given step. Such a jump in within-group heterogeneity informs the researcher that the two groups should remain distinct clusters and that only cluster solutions obtained before that step should be considered. An unusually large increase (i.e., approximately 16%) in within-group error occurred when the EAC-B scores were merged from the three-cluster solution to the two-cluster solution (see Table 1). This suggested that relatively heterogeneous groups had been combined at that stage and that a Three-cluster solution would be inappropriate for this sample (Borgen & Barnett, 1987). Because the first atypically large

TABLE 1

Increases in the Error Index for Cluster Solutions From Ten Clusters to One Cluster

Number	Error Index	% Increase in Error
10	192008.47	3.0
9	198162.59	3.2
8	205152.83	3.5
7	212226.44	3.5
6	219394.77	3.4
5	231797.03	5.7
4	247816.41	6.9
3	265629.81	7.2
2	309125.53	16.4
1	414800.06	34.2

jump in error (i.e., from approximately 3% to approximately 6%) occurred when combining the six-cluster solution to a five-cluster solution, we examined the mean scores for the 17 EAC-B subscales for the three-, four-, five- and six-cluster solutions to determine if any meaningful information was gained by retaining the additional fourth, fifth, and sixth clusters. Comparison of the EAC-B subscale profiles for the three-, four-, five-, and six-cluster solutions revealed that one cluster from the three-cluster solution was composed of a combination of two clusters from the four-cluster solution, and that these two clusters differed in both magnitude and level of EAC-B subscale scores. Similarly, the two clusters in the five-cluster solution that combined to form one larger cluster in the four-cluster differed in both magnitude and level. Because meaningful information was lost when the four-cluster solution was combined to form the three-cluster solution and when the five-cluster solution was combined to form the four-cluster solution, the three- and four-cluster solutions were deemed unacceptable. EAC-B subscale scores for two clusters from the six-cluster solution, which were combined to form a larger cluster in the five-cluster solution, differed only in terms of level. Borgen and Barnett cautioned investigators to the bias of Ward's method to "produce clusters that are heavily influenced by level differences" (p. 465). Based on these results, we concluded that little meaningful information was lost when the six-cluster solution was combined to form the five groups. Thus, the five-cluster solution was retained and used in subsequent analyses.

Although the 17 EAC-B subscale scores were used as input data to form the clusters, we decided to interpret the clusters based on cluster group means for the three EAC-B factors (recovered by D. J. Tinsley et al., 1991, among others) for several reasons. First, results of a one-way MANOVA with cluster membership as the independent variable and the three EAC-B factor scores as dependent variables confirmed that the clustering procedure created groups that differed substantively on the EAC-B factors: Wilks's Lambda = .11, $F(12, 633) = 70.31$, $p < .001$. The means and standard deviations for the clusters on the three EAC-B factor scores convey the essential differences among the five clusters (see Table 2 and Figure 1). Second, interpreting the clusters in terms of factor scores allowed for a more parsimonious description of the patterns of expectations for the students within each cluster. It would have been unwieldy to interpret the clusters based on combinations of high and low scores for all 17 EAC-B subscales. Third, describing the clusters based on factor scores is justified because previous research (e.g., Satterfield et al., 1995; H. E. A. Tinsley et al., 1993; H. E. A. Tinsley et al., 1994; Tokar et al., 1996) has both posited and revealed empirically important relations between aspects of counseling and EAC-B factor scores. One could argue that, because we interpreted the clusters based on factor scores instead of subscale scores, perhaps we should have derived the cluster typology based on factor scores as well; however, to do so likely would have limited the potential utility of the cluster analysis procedure. A major advantage of cluster analysis is its ability to form homogeneous groups based on large, complex data sets (Borgen & Barnett, 1987). Thus, by forming clusters based on the entire set of 17 EAC-B subscale scores and then interpreting them based on the three EAC-B factor scores, we were better able to exploit the advantages of both our data-analytic strategy and previous researchers' (e.g., Hayes & Tinsley, 1989; Kunkel et al., 1989) efforts to identify the major dimensions underlying the EAC-B.

Next, to investigate whether students' patterns of expectations about counseling differed in terms of the FFM, we performed a one-way MANOVA with cluster membership as the independent variable and standardized scores on the NEO-FFI-S as the dependent variables. Results indicated that the clusters differed on the FFM dimensions: Wilks's Lambda = .72, $F(20, 787) = 4.16$, $p < .001$. Means, standard deviations, and results of the univariate ANOVAs for the NEO-FFI-S variables by cluster are presented in Table 3. To discern the sources of cluster group differences, a direct discriminant analysis was performed with scores for the five NEO-FFI-S subscales as the predictors and EAC-B cluster group membership as the categorical criterion. Researchers

TABLE 2

Means and Standard Deviations of Five Clusters on the Expectations About Counseling–Brief Form Factors

	Cluster 1 (n = 46)		Cluster 2 (n = 72)		Cluster 3 (n = 57)		Cluster 4 (n = 37)		Cluster 5 (n = 34)		Univariate ANOVAs	
EAC-B Factor	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F* ratio	*p* value
Personal Commitment	58.79	4.08	51.71	5.71	54.99	5.95	42.44	6.21	34.36	8.45	107.04	< .001
Facilitative Conditions	54.55	4.92	46.18	4.48	60.68	4.17	50.28	5.82	33.74	8.17	152.55	< .001
Counselor Expertise	49.21	5.87	45.04	6.94	61.02	5.90	54.37	7.16	38.34	6.94	81.79	< .001

Note. EAC-B = Expectations About Counseling–Brief Form; ANOVA = analysis of variance. Scores on all measures have been converted to *T* scores. All means in the same row are significantly different at $p < .05$ in the Tukey honestly significant difference comparison.

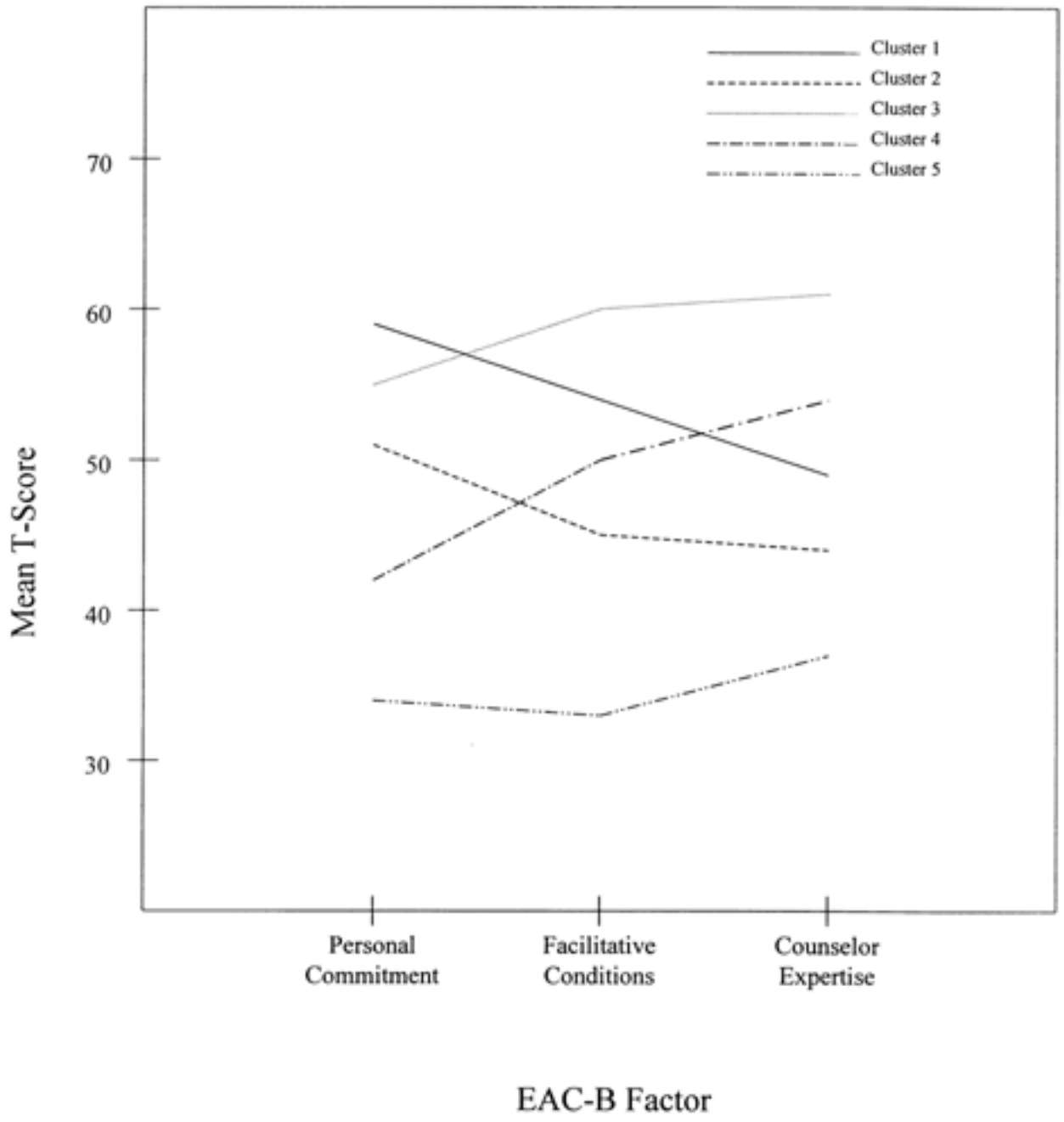

FIGURE 1

Profiles of the Five Clusters on theThree EAC-B Factor Scores

Note. EAC-B = Expectations About Counseling–Brief Form.

have recommended conducting a discriminant analysis rather than separate univariate *F* tests as a follow-up to a significant MANOVA (see Betz, 1987) because it (a) controls for experiment-wise error, and (b) provides information on the dimensionality of group differences due to the simultaneous examination of the predictor variables. Results revealed two significant discriminant functions: Function 1, Wilks's Lambda = .72, $\chi^2(20) = 80.04$, $p < .001$; Function 2, Wilks's Lambda = .85, $\chi^2(12) = 39.62$, $p < .001$. The proportion of variance in the two significant functions associated with cluster group differences was 30%.

Taken collectively, salient (i.e., $\geq |.35|$) loadings for Function 1 indicated a Neuroticism and Closedness dimension (composed of neuroticism and low openness), whereas Func-

TABLE 3

Means and Standard Deviations of Five Clusters on the NEO-FFI-S Big Five Variables

	Cluster 1 (*n* = 46)		Cluster 2 (*n* = 72)		Cluster 3 (*n* = 57)		Cluster 4 (*n* = 37)		Cluster 5 (*n* = 34)		Univariate ANOVAs	
NEO-FFI-S Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F* ratio	*p* value
Neuroticism	46.89_{a}	9.82	47.91_{a}	11.05	53.71_{b}	9.94	52.40	7.93	49.81	7.44	4.69	.001
Extraversion	52.16_{a}	10.65	50.61_{ac}	9.37	53.57_{a}	9.12	46.07_{bc}	10.39	44.09_{b}	7.37	7.58	< .001
Openness	54.35_{a}	11.96	51.97_{ad}	8.86	48.15_{bd}	10.32	45.76_{b}	8.10	47.66_{bd}	7.53	5.97	< .001
Agreeableness	52.27	9.24	51.13	9.94	49.57	9.43	48.64	13.02	46.74	7.20	1.96	*ns*
Conscientiousness	51.24	11.42	50.34	10.15	51.17	9.50	48.75	9.41	47.00	8.64	1.31	*ns*

Note. See Table 2 *Note*. NEO-FFI-S = NEO Five-Factor Inventory (Form S). Scores on all measures have been converted to *T* scores. Means in the same row with different subscripts are significantly different at $p < .05$ in the Tukey honestly significant difference comparison.

tion 2 indicated an Optimism dimension (defined strongly by extraversion and, to a lesser extent, by openness and conscientiousness) that differentiated the five cluster groups (see Table 4). Figure 2 graphically displays the centroid (i.e., multivariate mean) plots of the five clusters on the two significant discriminant functions. The first function, Neuroticism and Closedness, maximally differentiated Cluster-1 students (high expectations for personal commitment in counseling and moderately high expectations for facilitative conditions) from Cluster-3 students (high expectations for counselor expertise and facilitative conditions in counseling, and moderately high expectations for personal commitment in counseling). Function 2, Optimism, maximally differentiated Cluster-3 students (generally high expectations about counseling) from Cluster-5 students (very low expectations about counseling).

TABLE 4

Correlations Between NEO-FFI-S Variables and the Significant Discriminant Functions and Group Centroids on the Significant Discriminant Functions

Predictor Variable	Function 1	Function 2
	Correlation	
NEO-FFI-S scale		
Neuroticism	**.65**	.01
Extraversion	.00	**.85**
Openness	**–.63**	**.38**
Agreeableness	–.25	.31
Conscientiousness	–.03	**.35**
Canonical *R*	.39	.38
	Group centroids	
Cluster		
1 (*n* = 46)	–.52	.28
2 (*n* = 72)	–.31	.06
3 (*n* = 57)	.58	.44
4 (*n* = 37)	.39	–.46
5 (*n* = 34)	–.03	–.75

Note. See Table 3 *Note*. $N = 246$. Loadings ≥ |.35| are in bold.

DISCUSSION

The purpose of this study was to answer the call by researchers (e.g., Craig & Hennessy, 1989) to study patterns of expectations about counseling as they relate to theoretically relevant individual differences in personality. More specifically, we sought to identify groups of participants who differed in their patterns of expectations about counseling, as measured by the EAC-B, and then to relate those groups to personality, as organized in the five-factor model (FFM). Results of cluster analysis suggested that people may be classified meaningfully as five distinct clusters or types based on their patterns of EAC-B scores. The five clusters differed significantly and substantively on the three EAC-B factors. Results also demonstrated that the EAC-B clusters differed significantly on important variables (i.e., personality dimensions) that were not used in the formation of the clusters. Significant differences on these variables provide additional validation of a cluster solution (Aldenderfer & Blashfield, 1984). Specifically, neuroticism, extraversion, openness, and, to a lesser extent, conscientiousness, contributed significantly to cluster group discrimination. In the discussion that follows, we offer a brief interpretation of each cluster that integrates information based on the three EAC-B factor scores and the significant personality dimensions. Possible differences among groups, in terms of other individual-difference and counseling-related variables, are discussed based on previous expectations-about-counseling and FFM literature in an effort to consolidate extant research, promote future theory development and empirical research, and guide counseling practice.

Cluster 1 ($n = 46$) consists of participants with high expectations to take personal responsibility for working hard in counseling, above-average expectations that the counselor will establish facilitative conditions, and average expectations that the counselor will be expert. Based on their pattern of expectancies, students in this cluster were labeled "Realistic" because they have relatively positive ex-

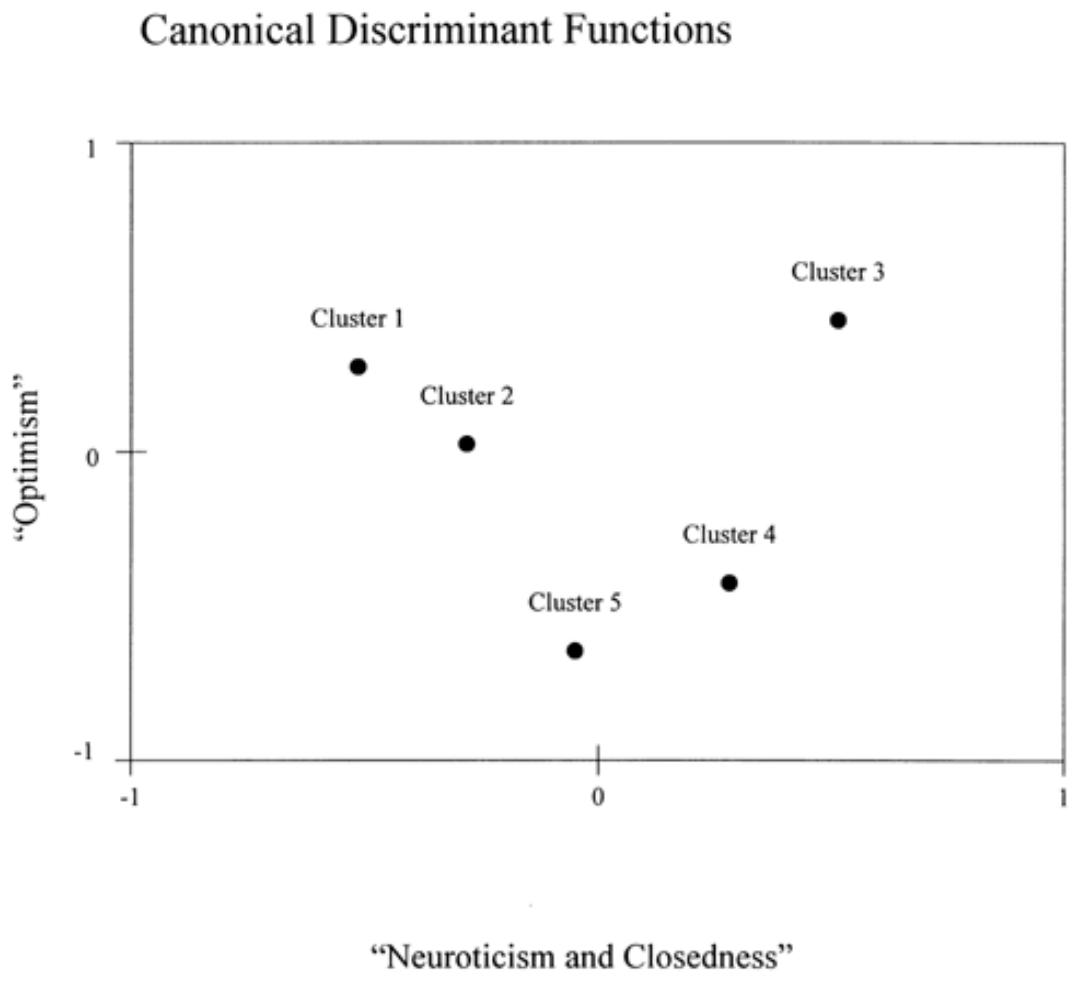

FIGURE 2

Centroid Plot of the Five Clusters on the Two Significant Discriminant Functions

pectations about the efficacy of counseling and about the counselor's ability to help them, but, at the same time, they recognize that a lot of the responsibility for success in counseling is theirs. The most distinctive feature of Realistic types was their very high (almost one standard deviation above the mean) expectations for personal commitment. Interestingly, results of a survey of 72 practicing counselors (H. E. A. Tinsley et al., 1993) revealed that a majority perceived unrealistically high client expectations for personal commitment as having a facilitative effect on counseling. Research also has shown that expectations for personal commitment are positive predictors of client-rated working alliance (Tokar et al., 1996), client involvement in counseling (H. E. A. Tinsley et al., 1994), and students' level of psychosocial development (D. J. Tinsley et al., 1990). These findings suggest that clients with relatively strong expectations for personal commitment, like those in the Realistic group, may be more psychologically prepared for and more willing to be a part of a collaborative counseling relationship.

Cluster 1 participants' Big-Five personality profiles, which were characterized by low scores for neuroticism, and above-average scores for openness, extraversion, and agreeableness, also support the hypothesis that these individuals may be more prepared for and more willing to work hard in counseling. Miller (1991) postulated that clients with personality profiles consistent with those of the Realistic group are likely to respond enthusiastically and collaboratively to the counselor and the counseling process. In addition, Miller suggested that these individuals may respond best to less structure in counseling, and are likely to be receptive to a

wide variety of interpretations and interventions for their presenting concerns. Miller also reported data suggesting a positive relation between extraversion and counseling outcome and an inverse relation between neuroticism and outcome. Thus, it seems reasonable to predict that Realistic clients would experience more positive counseling outcomes than would other types. Given that previous research (i.e., Costa & McCrae, 1980) has established links between extraversion and positive affectivity and between neuroticism and negative affectivity, Realistic types may be portrayed as relatively "happy" individuals who are likely to work hard in and benefit from counseling.

Cluster 2 individuals (n = 72) expected to assume a slightly above-average amount of personal responsibility for success in counseling but had considerably lower expectations that counseling will be facilitative and that the counselor will be effective. Based on their pattern of expectations about counseling, these individuals were labeled "Skeptical." As discussed previously, research has shown that expectations for personal commitment are positive predictors of important indicators (e.g., involvement, working alliance formation) of successful counseling. In addition, Tokar et al. (1996) found that clients' expectations for counselor expertise were inversely related to client working alliance ratings for agreement on tasks. These findings suggest that the clients resembling those in Cluster 2, although somewhat skeptical about the efficacy of counseling and the expertise of the counselor, still may be adept at establishing a working alliance with their counselor, which, in turn, may enable them to benefit from counseling.

The personality profile for participants in Cluster 2 indicates generally average scores for most of the Big-Five factors; however, when compared with those in Clusters 3 and 4, these individuals scored relatively low on the Neuroticism and Closedness dimension. Thus, these individuals were relatively free from trait anxiety, depression, and other negative emotions, while simultaneously approaching life with some openness to novel experiences. Miller (1991) and others (e.g., McCrae, 1991) postulated that clients with personality patterns similar to the Skeptics' should be able to benefit from the process of counseling, which itself is a novel experience for many. Both McCrae and Miller further suggested that individuals relatively high in openness (which also would include Realistic types) may respond most favorably to more experiential or unconventional approaches to counseling. Overall, clients with EAC-B profiles similar to those of the Skeptics are likely to be psychologically well-adjusted and to take personal responsibility for establishing a working alliance with the counselor and for otherwise working hard in counseling.

Cluster 3 (n = 57) consists of people with high expectations about their role in counseling and perhaps unrealistically high (more than one standard deviation above the mean) expectations about the counselor's expertise and role in facilitating counseling. In terms of the FFM, these students scored highest on both the Neuroticism and Closedness and the Optimism dimensions. Given their relatively optimistic, yet neurotic, tendencies, coupled with expectations about counseling that are unlikely to be met in counseling, we labeled people composing Cluster 3 "Idealistic." Idealists' endorsement of high expectations for personal commitment, coupled with their comparatively high level of conscientiousness, is consistent with our initial hypothesis linking these two constructs.

Idealists' high level of neuroticism as well as their extreme expectations about counselor expertise may prove detrimental to their actual counseling experience. Recall that Miller (1991) demonstrated empirically that neuroticism was correlated inversely with counseling outcome. Regarding expectations about counselor expertise, Tokar et al. (1996) found an inverse relation between clients' expectations about expertise and their perceptions of working alliance agreement on tasks. Thus, Idealists may have difficulty agreeing with their counselor on the appropriate tasks of counseling. In addition, Craig and Hennessy (1989) found that clients in Stage 1 of cognitive functioning (characterized by difficulty processing ambiguous, unstructured information) had higher expectations about counselor expertise than did clients in the latter two stages (generally characterized by a higher level of abstractness and greater tolerance for ambiguity). Based on our and previous researchers' findings, we hypothesize that clients fitting the Idealistic profile will be more anxious, more dependent on the counselor for guidance and structure, and relatively less sophisticated about the counseling process. Given that counselors view most unrealistically high expectations (including expectations about counselor expertise) as having a detrimental effect on counseling (H. E. A. Tinsley et al., 1993), counselors working with Idealistic clients may need to discuss openly from the initial session their expectations about the roles they and their clients will assume during the course of counseling.

Cluster 4 (n = 37) consists of respondents who indicated elevated expectations about counselor expertise, average expectations about a facilitative counseling environment, and perhaps unrealistically low expectations to assume personal responsibility for counseling success. Participants in this cluster were labeled "Dependent" because their pattern of expectations suggests a lack of personal commitment and an overreliance on the counselor. H. E. A. Tinsley et al. (1993) described such an unrealistic pattern of expectations as reflecting a "naive, wishful, or magical view of counseling" (p. 50) and reported that counselors perceived this pattern as having a detrimental effect on counseling. D. J. Tinsley et al. (1990) found that students who were lower on expectations for personal commitment, like those in the Dependent cluster, tended to be less developmentally mature than those who recognized the importance of making a personal commitment to working hard in counseling. Research also has shown that individuals who have low expectations for personal commitment and relatively high expectations for the counselor to take responsibility in counseling are more likely to adopt a dependent decision-making style (Leong et al., 1987). Dependent deciders have an elevated need for social acceptance and tend to rely on authority figures to make important decisions for them. Also, research has linked

dependent decision-making style to both neuroticism and low openness (Chartrand, Rose, Elliot, Marmarosh, & Caldwell, 1993), which (in addition to low extraversion) also characterized the Dependent cluster. Based on Miller's (1991) findings that extraversion and low neuroticism related positively to counseling outcome, the prognosis for individuals who fit the Dependent profile is not good.

Relatedly, research suggests that people resembling those in the Dependent cluster also may have trouble establishing a positive working alliance with a counselor. Tokar et al. (1996) showed that clients' expectations about personal commitment were positively related to their ratings for working alliance agreement on tasks and goals, whereas their expectations about counselor expertise were inversely related to working alliance agreement on tasks. These findings suggest that clients with Dependent-like expectations profiles (low expectations for personal commitment and high expectations for counselor expertise) may experience difficulty agreeing with their counselor on the tasks and goals of counseling. Collectively, the extant empirical data suggest that clients fitting the Dependent cluster profile are likely to present as somewhat anxious, have difficulty establishing a positive working alliance with their counselor, have a poor prognosis for improvement, and pull for the "expert" counselor to provide them with straightforward solutions to their presenting problems.

Participants in Cluster 5 (n = 34) were labeled "Pessimistic" because they had very low expectations about their responsibility for the success of counseling, about the presence of a facilitative counseling environment, and about the counselor's effectiveness. The three EAC-B factor scores for this group were well below one standard deviation below the mean. Results from previous research suggest that Pessimistic clients are likely to experience a variety of difficulties in counseling. Satterfield et al. (1995) found that, like Pessimists, clients in a precontemplation stage of change (i.e., who fail to recognize that a personal problem exists and have no desire to change their behavior) also exhibited low expectations for personal commitment and facilitative conditions in counseling. In addition, expectations about personal commitment have been positive predictors of client-rated working alliance variables (Tokar et al., 1996), level of involvement in career counseling (H. E. A. Tinsley et al., 1994), and psychosocial maturity (D. J. Tinsley et al., 1990). Considering these consistent, compelling results, it should come as no surprise that counselors perceived the pattern of expectations characterizing Pessimists to be detrimental to counseling (H. E. A. Tinsley et al., 1993).

In terms of personality, Pessimists scored very low on the Optimism dimension, as well as on the individual FFM factors of extraversion, openness, agreeableness, and conscientiousness. This personality profile suggests relevant counseling implications as well. Extraversion has been positively correlated with happiness and satisfaction in life (Costa & McCrae, 1980) and with counseling outcome (Miller, 1991). Miller also found that conscientiousness was positively correlated with counseling outcome, which suggests that Pessimists may not be predisposed, in terms of their personalities, to benefit from counseling. In addition, Miller postulated that low agreeableness will interfere with the formation of a collaborative working relationship in counseling. In summary, clients resembling those the Pessimistic cluster comprises probably are not psychologically ready to do the work needed for positive change in counseling. It is interesting that most of the students in this cluster (74%) reported never having attended a counseling session, which raises the possibility that such individuals are less likely to ever enter into counseling.

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

A number of limitations are important to consider when examining the results and considering the implications of this research. First, although the current sample contained some racial/ethnic diversity, this was limited; therefore, our results may not generalize to certain groups. Second, although research has revealed nonsignificant differences between students' and actual clients' expectations about counseling (e.g., Hardin & Subich, 1985; R. D. Johnson, 1990), it is possible that clients' patterns of expectations about counseling differ from students' and that they relate differently to the Big-Five personality dimensions. For example, it seems quite unlikely that many individuals currently in counseling would exhibit EAC-B profiles resembling those of students composing Cluster 5 (i.e., Pessimists). Future researchers are encouraged to replicate these findings on a large and diverse sample of clients before confidence can be placed in the typology developed herein and its relation to personality.

In addition, although students' scores for the Big Five significantly discriminated among the expectations about counseling clusters (accounting for 30% of the between-group variance), other factors clearly are explaining much of the variance. It seems possible that other person-related variables may moderate the EAC-B cluster-personality relations. For example, previous research has revealed that gender traits are related both to students' expectations about counseling (e.g., M. E. Johnson & Knackstedt, 1993; Sipps & Janeczek, 1986) and to Big-Five personality dimensions (Lippa, 1995). Given that the EAC-B and NEO-FFI-S scores in the present study were standardized to eliminate gender differences, it is possible that meaningful gender-related influences were eliminated as well. Thus, it may be fruitful for future researchers to examine the interactive effects of personality and gender-related variables to students' and clients' expectations about counseling.

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Social Adjustment Experiences of African American College Students

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Using qualitative research methods, the authors investigated African American college students' social climate experiences. Results expanded previous research on the college transitions and counseling needs of African Americans in predominantly White campus environments. A descriptive model was constructed that identified 4 features of African American student social adjustment to predominantly White campuses: (1) sense of underrepresentedness, (2) direct perceptions of racism, (3) hurdle of approaching faculty, and (4) effects of faculty familiarity. Counseling implications for preventive programs, developmental interventions, and consultation activities are presented. Advantages and limitations of using qualitative designs to examine African American student issues are also discussed.

In the university setting, counselors are providing services for a more racially and ethnically diverse campus constituency (Bishop, 1990; Glauser & Ginter, 1995; Stone & Archer, 1990). Similarly, the counseling literature is placing greater emphasis on the role of race and ethnicity in psychosocial development, adjustment, and client needs (Comas-Diaz & Greene, 1994; Helms, 1994; Santiago-Rivera, 1995; Weinrach & Thomas, 1996). A specific challenge for college counselors is developing services that promote African American student adjustment and success in predominantly White university settings. Growing numbers of African American students are enrolling in college (Ginter & Glauser, 1997; MacKay & Kuh, 1994), and most attend predominantly White institutions (Ginter & Glauser, 1997; Nettles, 1988). At the same time, graduation rates for African Americans at predominantly White institutions have not increased in keeping with growing enrollments (Carter & Wilson, 1991). For example, Steele (1992) reported that more than 66% of African Americans leave predominantly White campuses before graduation compared with about 45% of White students. In turn, college counseling centers are often charged with creating retention and support programs to serve these students (Bishop, 1995).

EXAMINING SOCIAL ADJUSTMENT EXPERIENCES

One critical factor in the retention and success of African American students at predominantly White institutions is the individual's experience of the campus social environment (MacKay & Kuh, 1994; Richardson, Simmons, & de los Santos, 1987; Sedlacek, 1996). According to the literature, college students generally face four demands as they negotiate the transition from high school and home environment to college life (Baker, McNeil, & Siryk, 1985; Baker & Siryk, 1984): *academic adjustment* to college-level educational requirements; *institutional adjustment*, or commitment to college pursuits, academic goals, and eventual career direction; *personal-emotional adjustment*, or the need to independently manage one's own emotional and physical well-being; and *social adjustment* to roommate, peer, faculty, and other interpersonal relationships. Of these, adjusting to the social environment seems to be central to the success of many African American students in mostly White settings. In fact, Watson and Kuh (1996) found that the quality of African American students' relationships with peers, faculty, and administrators tended to be almost as important as individual effort to their achievement.

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Results of several studies suggest that when African American students experience warmer institutional climates—for example, those who enroll at institutions with actively involving and supportive environments (Kuh, Schuh, Whitt, & Associates, 1991; MacKay & Kuh, 1994)—they experience greater satisfaction with college and better adjustment and are more likely to persist through graduation. Similarly, when African American students participate in programs that address existing climate concerns by broadening students' access to a network of supportive relationships, enhanced adjustment and higher retention rates are found (Hewitt, Hart, Jefferson, & Thomas, 1990).

Conversely, negative interpersonal experiences in predominantly White university settings can mediate, or limit, the ability of some African American students to engage in learning, developmental programs, and other opportunities that are a part of campus life. For example, Johnson-Durgans (1994) found that African American students living on campus were confronted with unwelcoming residence hall environments, less friendly peers, and racial problems that were undetected by their White counterparts. In addition, these students perceived the residence hall staff to be less fair and less effective when interacting with African American residents. Sedlacek (1987, 1989) and Tracy and Sedlacek (1985, 1987) similarly found that a key social adjustment task for African American students on predominantly White campuses is developing the ability to recognize and deal effectively with racism when it occurs. African American students often perceive faculty, academic supports, and developmental services to be uninviting and inaccessible (Stage & Hamrick, 1994) and report that their living experiences are less satisfying when they are paired with White, rather than ethnically similar, roommates (Phelps, Potter, Slavich, Day, & Polovin, 1996). Because social adjustment and interpersonal climate seem to be central factors in many African Americans' satisfaction and success on predominantly White campuses, counselors must understand how these issues operate to develop effective interventions for these individuals.

USING QUALITATIVE RESEARCH METHODS

Currently, there is debate about the relative efficacy of different assessment methods for measuring adjustment, development, and persistence among nontraditional student groups, such as African Americans, in predominantly White environments (Levin & Levin, 1993). Greater attention has been given to the potential limitations of information collected by quantitative assessment measures, such as surveys and standardized instruments (Manning, 1992; Patton, 1991). Standardized measures are often based primarily on majority group norms, and therefore are often inappropriate for African American populations (Landrine, Klonoff, & Brown-Collins, 1992). Research designs that compare scores between ethnic group populations, or consider majority scores to be normative, are often inappropriate (Jones, 1994). In addition, standardized data are sometimes insufficient for answering subtle questions about individual experiences or for providing the detail required to guide developmental programming or educational intervention plans (Russell, 1992). Alternatively, there is a trend toward greater reliance on qualitative methods—such as face-to-face interviews (Manning, 1992) and focus groups (Jacobi, 1991; Kaase & Harshbarger, 1993)—to more fully examine questions about the developmental and adjustment questions of nontraditional groups. Qualitative studies usually provide fuller, more detailed descriptions that are more exactly reflective of an individual's experience (Miles & Huberman, 1994). Qualitative methodologies, such as face-to-face interviews and focus groups, allow participants the freedom to choose aspects of student life on which to comment so that it is possible to collect anticipated as well as unanticipated information about their experiences (Manning, 1992).

Previous studies using quantitative measures support the influence of interpersonal factors on African American college students' adjustment. Qualitative methods were selected for the present study to "round out" and build on these findings by gaining a more exact understanding of students' individual experiences. Better understanding the quality of individual experiences was seen as the next step in extending the counseling knowledge base and, in turn, enhancing counseling center responses to student concerns.

PRESENT STUDY

The present study is one in a series of studies examining the college transitions of African Americans. These studies are intended to provide the foundation for the development of a theoretical construct that more inclusively describes the unique college transition tasks that African American students tend to face at predominantly White institutions. Such a theoretical construct would complement the conceptual framework of academic, institutional, personal-emotional, and social adjustment demands described in the literature.

Specifically, this study grew out of an earlier one we conducted using face-to-face interviews to collect information about 1st-year adjustment concerns (Schwitzer & Thomas, in press). Participants in the earlier study were African American 1st-year students using a counseling center peer mentor program. We found (Schwitzer & Thomas, in press) that half of all concerns expressed by these students were in the area of academic adjustment. Examples included managing college class loads and time-management problems, procrastination, and specific educational skills difficulties. Personal-emotional concerns, such as problems with depression and stress, and social adjustment concerns, such as dating problems and issues arising in friendships, were also commonly described. These results matched earlier findings that 1st-year students tend to most commonly experience academic problems and social difficulties (Baker et al., 1985; Schwitzer, McGovern, & Robbins, 1993).

In addition, we found that about two thirds of participants had difficulties either adjusting to the campus racial/cultural climate generally or with specific cross-cultural social relationships. Some described problems with interracial

friendships, dating, or roommate situations. For example, one woman said that she "doesn't like [her White] suite mates because they can't seem to see eye-to-eye because of race differences." Others tended to describe their experience overall. For example, someone said she was "really distraught about the racial climate here." Furthermore, some of the problems described had already affected students' achievement. For example, a student who was having a frustrating classroom problem with an instructor "decided to drop it and try again next semester."

The academic concerns and many of the social difficulties we found in our earlier study (Schwitzer & Thomas, in press) were explained by the traditional four-part model of 1st-year adjustment (Baker & Siryk, 1984). On the other hand, because the students' reports of social climate difficulties occurred in notable concentration and were usually presented in a separate context from other types of concerns, they appeared distinct from the types of adjustment demands traditionally described in the literature (Baker et al., 1985; Robbins & Schwitzer, 1988). The present study used focus groups to expand and clarify these findings by further examining the issue of social climate raised in the earlier study.

RESEARCH QUESTIONS

On the basis of findings of the earlier study and the existing literature, we posed two general questions: First, what were African American students' experiences with the overall social climate on campus? Second, what were students' more specific experiences with classroom environments and relationships with faculty? The first research question allowed participants to comment on aspects of social adjustment they found most salient, because in the earlier study some participants raised peer relationships and others raised faculty relationships as concerns. The second question narrowed the focus to the more specific area of academic relationships, because classroom environment and faculty interactions in the literature seem to have a direct influence on many African American students' college satisfaction and achievement (Nettles, Thoeny, & Gosman, 1986; Thile & Matt, 1995).

METHOD

Participants

Participants in the present study were 4th-year college seniors. There were 126 African American 4th-year seniors at the university in the year of the study. Of these, 22 (13 women and 9 men) participated in the focus groups. Demographic data regarding age were not obtained; however, all participants were traditionally aged college seniors in their early 20s. Fourth-year seniors were selected for this study because they had the greatest amount of experience in the campus social environment. All had lived on campus at least 1 year and had taken courses in several academic departments. Participants were recruited from senior-level, interdisciplinary academic courses and received class credit for their participation. Students were selected from among several advanced classes so that a cross-section of the campus population was obtained. Academic majors (in a few cases students reported a double major) represented included business (8 students), social sciences (5), liberal arts (3), education (3), general studies (2), health sciences (3), and physical sciences (2).

Focus Group Facilitators

Facilitators were recruited from among student leaders and honors college seniors. They received 2 days of training in group facilitation skills, interviewing techniques, and group recording procedures. Training included role-plays and practice sessions to increase proficiency with focus group leadership and recording procedures. They received background information to help them understand qualitative research and focus group methods. In addition, they sat in on "Leadership and Communication" class lectures that addressed group leadership principles.

Focus Group Discussion Protocol

The instrument used in the present study was a discussion question protocol that translated the two research questions into an operational group interview format. The protocol was piloted with a test group comprising facilitator applicants to gain feedback about its utility and was then refined for use in the study. Three stimulus questions were asked. Each question began with an open-ended stimulus, to minimize facilitator influence on participant responses, and followed with specific prompts about the effects of ethnicity. The three questions were as follows:

1. What words *best* describe what it is like to be a student here at this university? In particular, what words best describe what it's like to be an African American student here?
2. To what degree, and in what ways, are the faculty here supportive and helpful—or less than supportive and less than helpful—to individual students? To what degree does race influence faculty supportiveness and helpfulness?
3. To what degree are you comfortable approaching instructors here? Which instructors are the most comfortable or least comfortable to approach? In particular, those of a different race? Same race?

Focus Group Procedure

Participants in the present study attended a large-group meeting held to conduct focus groups for participants in several studies contributing to the ongoing research program. In the large group, one of the researchers provided an introduction, discussed the purposes and procedures for the focus groups, and presented an overview of ground rules (confidentiality, respectful dialogue). Participants were then assigned to 1 of 11 focus groups. Groups were formed so that

each had a combination of female and male students. Focus groups comprised both African American and White students. (Each group comprised two participants in this study, along with five White members participating in other parts of the research program.) Facilitators were paired on the basis of race and gender combinations so that each group had one African American and one White facilitator, and had one female and one male facilitator. For each discussion question, one facilitator took primary responsibility for discussion leadership and one for recording. Focus groups met for 90 minutes, followed by a large-audience debriefing.

Data Analysis

The data were analyzed using constant comparative methodology (Glasser & Strauss, 1967; Lincoln & Guba, 1985). The *constant comparative method* is an inductive process for forming a categorical model to describe the data collected in a study. The method "stimulates thought that leads to both descriptive and explanatory categories" (Lincoln & Guba, 1985, p. 341). The analysis moves in a continuously developing process from examining individual units of information to constructing a descriptive model. Inductive methods are often the most appropriate for analyzing qualitative data.

The data were organized and reorganized, over a series of steps, into progressively fewer but more meaningful categories to construct a model that was a progressively better fit with the situations described (Glasser & Strauss, 1967; Lincoln & Guba, 1985). First, to ensure the reliability of the data recordings, each facilitator pair independently reviewed the data and resolved any record-keeping discrepancies. One of the researchers reviewed each recording with the facilitator pair who produced it, and then a trained undergraduate assistant converted handwritten recordings into word processed form. In the second step, a team of two undergraduates, who were working with two of the faculty researchers and were familiar with college experiences, performed a coding task that involved assigning participant responses to categories on the basis of similarity. Third, a team comprising one undergraduate from the previous step and one faculty researcher completed another round of sorting by examining relationships among the categories generated in the first coding step and grouping different categories into a smaller number of more meaningful, key categories. When continued review produced no new descriptive value, categories were defined to be sufficiently well-represented or "saturated" (Lincoln & Guba, 1985). Fourth, an additional faculty researcher reviewed the present analyses and compared them with findings in the existing literature. The entire research team then reviewed the analysis and provided feedback to refine the model that emerged.

Credibility

Credibility in qualitative research is equivalent to internal validity in traditional research (Lincoln & Guba, 1985). There is the potential for high internal validity with qualitative methods when the analyses proceed directly from the data. Several strategies were used in the present study to increase credibility (Lincoln & Guba, 1985; Miles & Huberman, 1994). First, focus group interviewers were selected who were sufficiently familiar with the institutional environment to understand its culture and the context of participant responses and to establish working relationships with group members. This is referred to as "prolonged engagement." Based on their familiarity, interviewers were also able to make "persistent observations"; in other words, they were able to sort out aspects of the group discussion that were relevant or irrelevant to the research questions. Next, a modified type of member check was used. *Member-checking* actually involves reviewing the data with the respondents who provided it; in this study, data were reviewed with the facilitators who obtained it. Finally, a peer debriefing strategy was used. *Peer debriefing* is the use of multiple researchers to analyze the data to produce analyses that are relatively free of individual researcher bias. The approach used in this study was to introduce at each stage of the analyses one new analyzer who had no investment in outcomes of the previous steps and who could therefore serve as an unbiased consultant-peer to audit and clarify the work done earlier in the analysis.

RESULTS

The present study resulted in a descriptive model. The model identifies four key features that tend to constitute African American students' social-adjustment-to-college experiences. These are presented in Table 1. As can be seen, the first two features identified by the model are two Aspects of Adjusting to the Institutional Climate as a Whole, which are (1) sense of underrepresentedness and (2) direct perceptions of racism. The next two are specific Influences on Academic Relationships With Faculty, which are (3) hurdle of approaching faculty and (4) effects of faculty familiarity. These four features are described and illustrated with participant quotations in the following sections.

Sense of Underrepresentedness

The first area of social adjustment that tended to define African American college students' experiences concerned being an African American student in the environment generally. Sixteen participants reported feeling "underrepresented," "isolated," "alienated," or in the minority numerically.

Respondents tended to feel distinctly less supported than they had in their home and high school communities. They said they felt "unsupported" and "different" and that the transition to the institution's social climate had been "hard," "difficult," "a struggle," or "unhappy." As an illustration, one African American student said she "always felt isolated. When you enter a room, you look for another Black person and you always speak." A male student similarly described "how uncomfortable it was to walk into a room." Others said "The first time I felt like a minority was at this school" and "It's weird to feel like a minority." They variously felt "frustrated," "overlooked," or "misunderstood" by others on campus because of their race.

TABLE 1

Four Features of African American College Student Social Adjustment: A Descriptive Model

Feature	Key Quality	Exemplar Responses
	Area I. Aspect of Adjusting to the Institutional Climate as a Whole	
Aspect		
Sense of underrepresentedness	Uncomfortable feelings of being isolated, alone, numerically underrepresented	"The first time I felt like a minority was at this school."
Direct perceptions of racism	Experiences of racial problems, incidents of racism, or institutional racism	"Black roommates don't get the same treatment." "Black organizations are stereotyped."
	Area II. Influence on Academic Relationships With Faculty	
Influence		
Hurdle of approaching faculty	Ambivalence about initiating student–faculty interactions	"It's intimidating." "Professors will think I need help because I'm Black."
Effects of faculty familiarity	Increased comfort approaching more similar or familiar professors	"I'm more comfortable with Black professors because they have my best interests in mind." "Other professors make Black students feel uncomfortable."

In addition, they perceived a problematic separation of racial groups on campus. This was reflected by one female respondent as follows: "The campus is more segregated. People are more comfortable around similar ethnic groups." Similarly, a male respondent noted that "a lot of arrangements here often have people of the same culture, and minorities, stick together. We need to work to mix people together more." Another commented that adjusting to campus "has to do with where you came from. You need to have people who you know." Related to feeling underrepresented, they often said the institution was less friendly and warm than they had anticipated, and some felt deceived that "the school says they're more diverse than they really are when you get there."

Direct Perceptions of Racism

Another aspect of social adjustment that tended to define students' experiences of the environment as a whole was dealing with situations, statements, or actions perceived as racist. The phrase "direct perceptions of racism" was selected to describe this aspect to separate it from the more general, less event-specific, day-to-day feeling of underrepresentedness. The key quality of the responses that fell into this category was that—beyond a feeling of being isolated or alone—the behavior of others in the environment seemed to the student to contain racist qualities. In fact, the reports that fell into this category almost always referred explicitly to "racial problems," "racial struggle," or "institutional racism." Sixteen participants discussed this experience.

Students usually described specific problems they had encountered relative to the racism they perceived. As an illustration, one male described hostile reactions of hall residents when he entered a White female student's dorm room. He said "I was feeling uncomfortable coming into [the White female student's] room. I had never thought about that before." Still another said she "feels bad when Black roommates don't get the same treatment" from White roommates in her suite. Several others described feeling "hurt" by "negative experiences" related to racism. This was illustrated by one students' comment that "it was obvious this school is in the South."

In addition, several respondents raised the campus-specific issue that the institution continues to maintain separate African American and White fraternity/sorority systems. They were concerned that African American and White organizations were "segregated not integrated," that African American organizations were "stereotyped," and that the two systems were set up in competition with one another for university funding. These students perceived this to be an example of institutional racism.

Hurdle of Approaching Faculty

The first feature of social adjustment related to African American students' relationships with faculty concerned a sense of hesitation, uncertainty, or difficulty when initiating interactions with faculty. Student initiative taking was described both as a necessary step in establishing working relationships with faculty and as an obstacle to be overcome. A central theme among these responses was that, because of the ambivalence and difficulty associated with approaching teachers, students were sometimes less likely to obtain the classroom support, academic advising, or career guidance to which they were entitled. Seventeen participants discussed this issue.

Respondents began by saying "professors don't volunteer to help," "often teachers are helpful if you take the initiative," and "approaching faculty should be an effort on the student's part." Many participants agreed that although "most [faculty] are inviting and encouraging . . . some don't make

an effort to become personal with students." At the same time, respondents also said that approaching a professor was "kind of intimidating" or "felt too uncomfortable." One person said she "feels dumb. He talks above me." Another felt his faculty advisor "doesn't really care about students." Several people said they evaluate an instructor's approachability by his or her classroom behavior. For example, one person said that in certain classes, "professors make it seem like you can't ask them questions."

Furthermore, respondents talked more directly about their concerns that being African American might negatively affect their relationships with faculty. As an illustration, one women said, "If I need help, I need help. Some professors feel I need help because I'm Black." Another said that she feels "intimidated going to the teacher when a class is White and male-dominated." Several also believed faculty members were uninformed or inexperienced in relation to African Americans. For example, they said "professors need to be aware of student differences. Some are not aware, especially older professors," and there is a "need to educate teachers [about diversity]" so that approaching them would feel less risky to some African American students.

Effects of Faculty Familiarity

Another aspect of social adjustment emerging from the data was the mediating effect that familiarity tended to have on students' ambivalence about initiating faculty relationships. Here, respondents modified their comments about the hurdle of approaching instructors by expressing greater comfort when interacting with faculty who were perceived to be more similar or familiar to them—on the basis of race, gender, academic department, or field of study. The phrase, "effects of faculty familiarity," was selected to describe this variable in the model. The student's confidence about approaching an instructor seemed to increase when either (a) the pair was perceived to be more demographically similar (when they were of the same race or sex), (b) their interests or area of study were similar or familiar (for example, English majors would prefer approaching English instructors), or (c) the student had more extensive previous experience with the instructor and therefore had become more familiar with him or her. Fifteen respondents discussed this issue.

As an illustration, one woman said, "I feel more comfortable approaching teachers in my major. Also, same race because they have my best interest in mind. It feels more comfortable approaching same race professors." Other women said the following: "Black professors are very nice. Other professors make Black students feel uncomfortable," "I feel more comfortable with same sex instructors," and "With Black female teachers it's easier to know where I'm coming from."

Many respondents commented that there were too few opportunities to work with more similar professors. One male said, "The faculty isn't against minority students. There are just too few minority teachers. Getting more minority professors in this part of the country would help." A female student said, "I feel more comfortable with the same sex, but I don't have a real basis to say because my major is political science [with a predominantly White male faculty]." Similarly, one student said she "hasn't worked with much diversity here. Mostly White males. Executive officers are exclusively men."

Generally, there was agreement with one student who said, "In high school, teachers look out for you. In college, you use teachers as resources, but they do not look out for you." Respondents tended to feel ambivalent about approaching their instructors as resources, assessing the institution's faculty overall as follows: "good on the whole"; "some are good and help, but some are also bad"; and "some teachers are disrespectful." In addition, many felt more confident that the interaction would go well when they felt some familiar connection with the instructor on the basis of, variously, race, gender, or academics.

DISCUSSION

This study resulted in a model for describing African American students' social adjustment to college. Participants in the study described adjusting to a general feeling of aloneness, isolation, or underrerpresentedness at the institution, as well as confronting specific incidents of racism. The general feeling of underrepresentedness was captured by students who described "always looking for another Black person when you walk into a room." Most said they had felt more supported in their home and high school community so that the underrepresented feeling was a new, unexpected experience. The specific incidents of racism were associated with cross-cultural roommate pairings, friendships, and dating, along with perceptions of institutional racism in the separation of certain student clubs and organizations. In addition, although participants described hesitation about approaching faculty for consultation, they also expressed greater confidence when the faculty member seemed more familiar. Initiating faculty interactions seemed to be associated with a risk that faculty would view them as needing help as a direct result of being African American; moreover, students felt that the majority of faculty members were simply unfamiliar with African Americans. Familiarity seemed to mediate these students' ambivalence when they felt a similarity to the faculty member on the basis of race or gender or both, or when they were more familiar with the faculty member through their major or previous classes.

The four-feature descriptive model constructed in this study seems consistent with the existing literature. According to the traditional model (Baker et al., 1985; Baker & Siryk, 1984), two of the central tasks associated with successful college matriculation and persistence are establishing successful interpersonal relationships in the campus environment (social adjustment) and effectively interacting with faculty in and outside the classroom (a component of academic adjustment). Sedlacek (1996) and Tracy and Sedlacek (1987) reported that members of nontraditional groups, such as African American students, tend to need a variety of abilities to accomplish these tasks at predominantly White institutions. They tend to need both "synthetic"

abilities to interpret information accurately in new contexts (such as the college environment) and "systemic" abilities to understand and use the environment advantageously (Sedlacek, 1996; Sternberg, 1985). For example, the synthetic abilities to maintain a positive self-concept and to maintain a realistic self-appraisal of one's performance are required to make sense of, put into context, and incorporate positive and negative feedback (Sedlacek, 1996). Similarly, the systemic ability to understand and deal with racism requires being neither inappropriately submissive nor aggressive regarding existing wrongs, and skill at handling a racist institutional system (Sedlacek, 1996; Tracy & Sedlacek, 1987). In turn, maintaining a positive self-concept and accurate self-appraisal would be important when facing the social distance of underrepresentedness and when facing the ambivalence and risk of negative reactions associated with approaching instructors. Similarly, an ability to understand and deal with racism would be required to make good decisions and respond effectively when incidents of racism are perceived.

The qualitative findings of this study seem to support and potentially extend the existing knowledge base. For example, students in the current study confirmed the assumption made in earlier work that African Americans would tend to experience predominantly White campuses as "more hostile" and "foreign" (Tracy & Sedlacek, 1987, p. 182). Students in this study went further to define their experience more specifically as an uncomfortable day-to-day feeling of social distance (or underrepresentedness) among others at their institution. In addition, an important finding was that the feeling of underrepresentedness tended to be a new, unexpected, or surprising experience—so that students tended to be initially unprepared for it. Because college students generally set unrealistically high expectations for themselves and their institutions (Baker et al., 1985), this may tend to include unrealistically high expectations of social climate for African American students. Furthermore, because college students have unrealistically high self-appraisals, they often do not seek out available supports when adjustment concerns do arise (Schwitzer, Grogan, Kaddoura, & Ochoa, 1993; Schwitzer, Robbins, & McGovern, 1993; Schwitzer & Thomas, in press). An implication may be that African Americans, in particular, often do not seek out support for distressful feelings of social distance or underrepresentedness when they occur.

Earlier work also suggested that although supportive faculty relationships tend to be important to African American students' academic success (Nettles et al., 1986), the students often do not engage in teacher–student interactions (Sedlacek, 1987). Students in the current study seemed to clarify that the key obstacle to working relationships with faculty was the ambivalence and risk they felt about making the initial contact. They often described being somewhat immobilized by their ambivalence toward taking the step of approaching their instructors. At the same time, they believed instructors to be relatively passive about establishing relationships with students and felt it was the student's responsibility to initiate faculty interactions. This apparent dilemma seems to more exactly describe the difficulty some African Americans may have in successfully associating with supportive faculty. Those in the current study also clarified several types of familiarity influences that could potentially mediate the riskiness of making initial approaches.

Counseling Implications

Several implications for college and university counselors emerged from the descriptive model constructed in this study. Specifically, the model's four features provide potential targets for prevention, developmental intervention, and consultation activities. In the college setting, preventive intervention strategies are usually used when there is a possible or probable susceptibility to a particular problem, to forestall or prevent the onset of adjustment difficulties (Drum & Lawler, 1988). When counseling center staff are charged with enhancing the adjustment of African American students, one prevention goal is to forestall the difficulties associated with unwelcome feelings of underrepresentedness that may emerge. For example, prevention methods that broaden students' access to supportive relationships with familiar or similar others—such as training and supervising upper-level African American students to provide peer mentoring (Schwitzer & Thomas, in press) or coordinating mentor programs that match new students with ethnically similar faculty, staff, or graduate assistants (Thile & Matt, 1995)—are found to promote improved social adjustment among African American students. In fact, participants in these programs demonstrate positive adjustment and improved academic performance even 1 and 2 years after their program participation. Supportive workshops and counseling groups conducted in naturally occurring social settings, such as in residence halls or for student organizations, are also recommended as prevention methods (Drum & Lawler, 1988). In addition, counselors can modify orientations, class presentations, and other programming so that they more inclusively address the social climate issues that African American participants might be experiencing.

A second prevention goal suggested by the model is improving African American students' comfort with initiating faculty relationships. For example, this topic can be raised in peer and faculty mentoring pairs, and at orientation or support programs. Similarly, general offerings of 1st-year adjustment workshops, orientations, and other student programs will be more inclusive when they address specific topics such as ambivalence about approaching instructors.

Next, developmental intervention strategies are usually used in the college setting to facilitate normal psychosocial development by assisting individuals to add new skills or dimensions to their lives (Drum & Lawler, 1988). When counselors provide developmental interventions for African American student populations, some issues that might be addressed are the impact of self-concept and self-appraisal on one's adjustment to social climate in predominantly White institutional environments. Brief individual counseling and supportive, theme, or special population groups are

all counseling modalities in which these issues might be raised. In addition, typical counseling center developmental offerings on topics, such as identity, young adult autonomy, self-esteem, and intimacy in relationships, all provide opportunities to include intervention components that address adjusting to underrepresented social climates and ambivalence about approaching important others. Skill-building workshops on the topic of "handling racism" might also be piloted.

Finally, community-level interventions (Pace, Stamler, Yarris, & June, 1996) may be attempted with the goal of improving faculty and staff understanding of the features that often comprise African American student social adjustment experiences. For example, workshops for residence hall staff and 1st-year advisors might address issues of social isolation and handling racism. Workshops for course instructors might address student–professor relationship dynamics. Consultation activities for academic departments might address the ways in which nonacademic concerns sometimes interfere with a student's ability to perform adequately in the classroom. In addition, collaborative interventions may be used that address student issues in natural settings. For example, Schwitzer, Smith, and Robbins (1990) reported that African American students tended to have greater satisfaction with social climate, better grade point averages, and higher retention rates when they participated in a classroom environment intervention program that paired counselors with academic faculty to colead first-semester courses. The courses had a specific focus on improving cross-cultural peer relationships and classroom social climate and the specific goal of providing African American students with positive early experiences interacting with faculty and staff.

Limitations

This study was limited in several ways. Qualitative results are generally accepted to be generalizable to others outside the study when sampling is appropriately done and when the results are credibly drawn from the data (Glasser & Strauss, 1967). The model produced in this study was based on the experiences of a small group of successful 4th-year seniors at one institution who were motivated to participate in the project by either the topic or class credit received. The sample was predominantly female. To more confidently generalize the model to other students and different institutions, further study is needed with additional samples made up of individuals who are at different points in the college experience, represent various levels of success, and come from multiple institutions. In addition, using an "open sampling" technique (Strauss & Corbin, 1990), or adding new participants and reconsidering the model under construction throughout the research process, would strengthen future qualitative studies in this area. In contrast, in the current study, all participant information was collected at one time and then analyzed in retrospect.

Data were drawn from a semistructured group interview protocol. Qualitative researchers attempt to safeguard participant responses from research bias (Lincoln & Guba, 1985). Although open-ended questions were used in this study, the interview structure had the potential to influence the shape and scope of participant responses. In addition, the focus group format used in the study required participants to share experiences in small groups comprising African American and White men and women. Follow-up study that relies on ethnically similar and same-gender group compositions may produce new, additive, or modified information that could enhance or alter the model constructed here.

In addition, one limitation of the counseling implications drawn here is the difficulty counseling staff tend to have when they attempt to attract clientele for preventive and developmental programming. Students who participate tend to be those who are already experiencing higher levels of adjustment and, in turn, apply adequate internal resources by seeking out the enhancement programs that are available to them (Schwitzer, Robbins, et al., 1993). Correspondingly, counselors must continue to seek ways to understand the self-appraisals and help-seeking behaviors of those students who are most in need, to better attract them to preventive and developmental interventions. Further studies may confirm or revise the descriptive model so that it becomes a useful guide for counselors who are charged with responding to the concerns of African American students at predominantly White universities.

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Sex Differences in the Relationship of Anger and Depression: An Empirical Study

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A comparison of mean scores on the Beck Depression Inventory and State-Trait Anger Expression Inventory scales revealed that women scored significantly higher than men on depression, whereas there were no significant differences on any of the 6 anger scales. Separate multiple regression analyses revealed that there were statistically significant relationships between the linear combination of anger scales and depression for both groups. A comparison of zero-order correlations of depression with the anger scales revealed that Anger-In correlated significantly more highly with depression among women than men. Finally, Anger-In correlated significantly with 4 of the 5 other anger scales for women, but only with one for men.

The notion that there are substantial differences between men and women in the experience and expression of anger has been widely advanced in the theoretical literature in counseling and psychology (Fischer et al., 1993; Sharkin, 1993). "Theories about the female experience of anger tend to share a common theme: Women are emotionally expressive, with the exception of anger" (Sharkin, 1993, p. 386). It has been hypothesized that expressing anger is more difficult for women because of its incompatibility with the feminine gender role. Women experiencing anger supposedly struggle not only with the unacceptability of anger in terms of their own internal standards, but also may fear real or perceived social sanctions for violating societal expectations. Sharkin (1993) described a very different pattern for men: "In contrast to women, men are generally viewed as emotionally inexpressive with the exception of anger" (p. 386).

Theories of male anger hypothesize that anger is the primary male emotion and, as such, is very consistent with the masculine gender role. It has been suggested that other painful or "less masculine" emotions may actually be transformed into anger. Due to their supposedly greater difficulty in expressing anger, it has been widely suggested that women are more likely than men to suppress anger (Kopper & Epperson, 1996). This suppression of anger has, in turn, been believed to be linked to a variety of negative affective consequences (e.g., depression, anxiety, guilt).

To a large extent, theoretical notions of male and female anger have arisen from clinical observations (Sharkin, 1993). However, the degree to which hypotheses have been examined empirically has been rather limited. Among the studies reported to date, there seem to be few if any systematic patterns of gender differences across anger dimensions (Fischer et al., 1993; Kopper, 1993; Kopper & Epperson, 1996). In summarizing the results of a series of eight related studies, Deffenbacher et al. (1996) concluded the following: "In general, results suggest that, within the limits of methodologies employed, men and women are angered by similar things and to similar degrees, express themselves in similar ways, and suffer similar consequences" (p. 146).

Anger has long been believed to be a contributing factor in depression. Early psychoanalytic formulations conceptualized depression as "anger turned inward" (Johnston, Rogers, & Searight, 1991). It has been well established that depression occurs more frequently among women than among men (Frank et al., 1988; Ingram, Cruet, Johnson, & Wisnicki, 1988; Sayers, Baucom, & Tierney, 1993; Stoppard & Paisley, 1987). Not surprisingly, many explanations have been offered for this observation. The popular clinical concepts of "female anger" and "male anger" (Sharkin, 1993) could be used to predict that the learned *inhibition* of anger by women compared with the *over-expression* of anger by men would lead to differential levels of depression. However, there are continuing questions regarding the overall relationship of anger to depression. Although the two constructs have long been related in theory and in clinical lore, empirical evidence has not established that a causal relationship exists (Smith, 1992).

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It seems possible that examinations of sex differences that rely only on mean differences could be misleading. This may be particularly true in light of the extreme heterogeneity of gross groupings like "female" and "male." It seems quite possible that women and men may experience very similar *levels* of anger, but that the *function* of the anger in relation to other experiences could be quite different. As noted earlier, common clinical wisdom has suggested that women internalize/repress anger (Lerner, 1988), whereas men tend to externalize/over-express anger (Long, 1987). It seems reasonable that even in light of similar anger levels, the function or role might, indeed, prove to be quite different. Sharkin (1996) suggested that underlying differences may be subtle. In an earlier study, Mook, van Der Ploeg, and Kleijn (1990) examined the interrelationships of anxiety, anger, and depression in samples of college students and adults. Although men and women scored very similarly on all three measures, sex differences in the intercorrelations among measures were found. Interestingly, the anxiety–anger, anger–depression, and anxiety–depression relationships were all significantly different for men and women in the adult sample, whereas no such differences were found in the student sample.

In general, this study was designed to provide answers to several questions relating anger and depression and sex. The first question posed simply asked if men and women were significantly different on mean levels of anger and depression. The second question asked if the experience/expression of anger was significantly correlated with a measure of depression for men and women as a combined group. The third question asked if a linear combination of anger scales would be significantly related to depression for men and women as separate groups. The fourth question asked if there were any differences in the strength of relationships between depression and anger scales for men and women. The fifth, and final, question asked if the internalization of anger correlated with other dimensions of anger. Regarding this last question, we were particularly interested in whether internalized anger related differently to state and trait anger, and whether these relations differed for men and women.

METHOD

Participants

Participants were solicited from an organized pool of students enrolled in undergraduate classes at a large southwestern university. In all, 436 students voluntarily agreed to participate in the study. Due to missing data, 41 participants' responses could not be used. Complete data sets were obtained for 226 women and 169 men. The sample was 74% White, 9% African American, 7% Asian American, 5% American Indian, and 3% Hispanic (2% did not report). Ages ranged from 17 to 46 years, with a mean age of 19.7 years and a median age of 19 years. Of students in the sample, 59% were freshmen, 23% were sophomores, 12% were juniors, and 6% were seniors.

Variables

State-Trait Anger Expression Inventory. The conceptual background for the development of the State-Trait Anger Expression Inventory (STAXI; Spielberger, Jacobs, Russell, & Crane, 1983; Spielberger et al., 1985; Spielberger, Krasner, & Solomon, 1988; Spielberger & Sydeman, 1994) to measure both the experience and expression of anger has been well documented. The STAXI consists of 44 items that require respondents to make self-ratings along a 4-point scale. The six scales from the STAXI used in this study are briefly described from the manual as follows: (a) "State Anger—'The intensity of angry feelings at a particular time,' (b) Trait-Anger Temperament—'a general propensity to experience and express anger without specific provocation,' (c) Trait-Anger Reaction—'the disposition to express anger when criticized or treated unfairly,' (d) Anger-In—'the frequency with which angry feelings are held in or suppressed,' (e) Anger-Out—'how often an individual expresses anger toward other people or objects,' [and] (f) Anger–Control—'the frequency with which an individual attempts to control the expression of anger'" (Spielberger, 1988, p. 1).

The manual reports coefficient alphas for these scales ranging from .73 to .93. Internal consistency reliabilities for STAXI scales computed for this sample were as follows: State Anger (.92); Trait-Anger Temperament (.89); Trait-Anger Reaction (.72); Anger-In (.79); Anger-Out (.75); and Anger-Control (.83). The empirical structure of the STAXI items seems to match the scale structure extremely well (Fuqua et al., 1991). Additional validity evidence can be found in positive correlations of anger scales with other measures of anger or hostility (Spielberger, 1988), the ability of anger scales to discriminate high and low anger groups (Lopez & Thurman, 1986; Spielberger, 1988), and the relation of anger scores to hypertension and Type A behavior patterns (Van der Ploeg, van Buuren, & van Brummelen, 1988).

Beck Depression Inventory. The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) consists of 21 items that require respondents to rate themselves along a 4-point continuum of severity. Scores may be classified as *none or minimal* (0–9); *borderline* (10–14); *mild to moderate* (15–20); *moderate* (21–30); *severe* (31–40); *very severe* (41–63). Concurrent validity of the BDI has been demonstrated in studies in which BDI scores were found to correlate significantly with psychiatric ratings of patients (Beck, 1970; Bumberry, Oliver, & McClure, 1978). The BDI has literally been used in hundreds of published research studies as a global measure of depression (Ponterotto, Pace, & Kavan, 1989), so evidence of its construct validity is extensive. Beck, Steer, and Garbin (1988) reported an average coefficient alpha of .86 across a variety of groups, as well as test–retest coefficients ranging from .48 to .86. Internal consistency reliability for the BDI computed for this sample was .88. There have been questions raised about the internal structure of the BDI, but these questions may not distract from the use of the BDI total score to represent a general syndrome of depression (Beck et al., 1988).

Procedure

Participants were solicited on a voluntary basis from several undergraduate courses. Data were collected in groups ranging in size from 50 to 100 members. Following a brief explanation of the study and of informed consent, participants completed the instruments along with a brief demographic questionnaire. Students received course credit for their participation in the study.

RESULTS

First, a Hotelling's T^2 was computed to test the null hypothesis that the mean vectors represented in Table 1 were not different. This test led to the rejection of the null hypothesis, $F_{exact}(7, 387) = 2.38$, $p < .05$. We then proceeded to an examination of the univariate *t* tests.

The means and standard deviations for women and men on the depression and anger scales are summarized in Table 1. The results of the independent *t* tests reported in Table 1 indicate that there was a statistically significant difference between women and men on depression, with the mean depression score for women being higher. As can be seen in Table 1, there were no significant differences between women and men on any of the six anger scales from the STAXI.

Table 2 presents the Pearson product–moment correlation coefficients between the BDI and the STAXI scales. As can be seen in the Table 2, the BDI correlates significantly with all anger scales except Anger-Out. Correlations among the anger scales, most of which were statistically significant, were in the low to moderate range.

Table 3 was constructed to summarize two forward multiple regression analyses: (a) the six anger scales predicting the depression score for women only, and (b) the six anger scales predicting the depression score for men only. For both women and men, there was a statistically significant relationship between the linear combination of the anger scales and depression. Examining the statistics for the increments in R^2 at each step, one can easily see that in both equations, no significant prediction is gained after the third variable was entered. The Anger-In and State Anger scales entered first and second, respectively, for both the women's and men's groups. At the third step, Trait Anger-Temperament entered for women whereas Anger-Control entered for men. However, this difference seems to be highly related to multicollinearity.

Table 4 was constructed to summarize six *z* tests comparing zero-order correlations of the six anger scales with depression for women and men. It is obvious from the table that 11 of the 12 correlation coefficients were statistically significant. However, only the correlation coefficients for the Anger-In scale were significantly different between the groups ($z = -2.06$, $p < .05$) The Anger-In scale and depression shared 27% common variance for women, but shared only 12% common variance for men. This seems to be a remarkable difference.

Table 5 was constructed to compare the correlations of the Anger-In scale with the remaining five anger scales for women and men. For women the Anger-In scale had a statistically significant correlation with four of the five anger scales, whereas for men only one correlation was statistically significant. This may reflect a tendency for Anger-In to be a broader aspect of the anger experience for women.

TABLE 1

Independent *t* Tests Between Women and Men

	Women (n = 226)		Men (n = 126)			
Scale	*M*	*SD*	*M*	*SD*	*t*	*p*
Beck Depression Scale	8.79	7.34	7.12	7.04	2.27	< .3
State Anger	11.61	3.81	12.11	3.96	1.27	*ns*
Trait-Anger Temperment	6.09	2.60	6.57	2.98	1.70	*ns*
Trait-Anger Reaction	8.96	2.58	9.15	2.80	.67	*ns*
Anger-In	17.07	4.91	16.96	4.52	.21	*ns*
Anger-Out	15.54	4.26	16.18	3.74	1.57	*ns*
Anger-Control	23.86	5.32	22.98	5.01	1.67	*ns*

DISCUSSION

The significant difference between women and men on depression is consistent with other results suggesting that women as a group are more depressed than men as a group (McGrath, Keita, Strickland, & Russo, 1990). However, construct definition alone ought to be considered as a potential source of these differences on depression. On the BDI, items include content related to "crying," "lost interest in other people," physical appearance, and weight loss. One could argue that when these kinds of items are used to define depression, women as a group will score higher due to sex role socialization outcomes. Thus, the constructs of gender and depression may be confused, particularly at milder levels of depression. At the more severe levels, more objective, empirically derived criteria for diagnosis have been well established.

It is critical to compare the meaning of Tables 1 and 3. The mean comparisons summarized in Table 1 would lead to the conclusion that women and men experience anger in similar levels/ways, advancing the case that little evidence exists to support gender differences in the experience or expression of anger (Deffenbacher et al., 1996; Kopper, 1993; Kopper & Epperson, 1996; Sharkin, 1993). However, when examining the relationship of anger internalization to depression, we find clear support for the position that internalized anger plays a more prominent role in depression among women (Collier, 1982; Lerner, 1988). Even though women and men experience similar levels of internalized anger, women may be more likely to convert it to depressed symptoms than are men. It is probably the case, however, that this relationship is more than a simple one-to-one conversion (e.g., Bandura, 1977; Bowlby, 1973; Mook et al., 1990).

These results provide some clear evidence that there is a meaningful relationship between anger and depression, which supports clinical impressions that have lacked much em-

TABLE 2

Pearson Product–Moment Correlation Coefficients for the Beck Depression Inventory (BDI) and State-Trait Anger Expression Inventory (STAXI) Scales

Scale	Beck Depression Inventory	State-Trait Anger Expression Inventory scales					
		Trait-Anger Temperment	Trait-Anger Reaction	State Anger	Anger-In	Anger-Out	Anger-Control
Beck Depression Inventory	—						
STAXI scales							
Trait-Anger Temperment	.28*	—					
Trait-Anger Reaction	.28*	.40*	—				
State Anger	.38*	.30*	.26*	—			
Anger-In	.45	.20*	.35*	.23*	—		
Anger-Out	.14	.59*	.33*	.25*	.13	—	
Anger-Control	–.20*	–.53*	–.21*	–.16	–.01	–.50	—

*$p < .05$.

pirical support (Smith, 1992). Thirty-eight percent of the variance in the BDI was found to be common with a linear combination of the six STAXI anger scales for the women in this study. The same figure for men was found to be 26%. Of course, further research is needed to explicate the precise mechanisms by which these variances are shared, and it may well prove to be the case that there are sex differences in the processes, as well as the amount of variance shared.

An examination of Table 4 would first lead to the conclusion that, for both men and women, most dimensions of anger are related to scores on the Beck Depression Inventory. The correlations there are all in the small to moderate range but do provide some limited evidence for the clinical hypothesis that anger and depression are emotions that ought to be analyzed and considered as potentially concurrent experiences. These results being correlational in nature do not address the many causative models that might account for these relationships. This emphasizes the importance of clinical efforts to help clients individually analyze and understand how anger and depression may be related in their personal experience. An examination of Table 4 reveals that the relationship between anger internalization and depression is significantly higher for women than for men. The theoretical meaning of this finding could be important. Twenty-seven percent of the variance in depression is shared with anger internalization for the women in this study. The same figure for men is only 12%. This provides some evidence that people in general may handle anger in a way that converts it to depression, or perhaps even vice versa. Counselors need to be particularly sensitive to the fact that depression and the internalization of anger are somehow related for women. Given that we have found more than a

TABLE 3

Multiple Regression Summary Table for Women and Men

Step/Variable Entered	Multiple R^2	*F* Equation	Significance of *F* for Equation	*R* Increment	*F* Increment	Significance of *F* Increment
			Women Only (n = 226)			
1. Anger-In	.27	82.89	< .001	.27	82.89	< .001
2. State Anger	.36	61.51	< .001	.09	29.56	< .001
3. Trait-Anger Temperment	.38	45.01	< .001	.02	8.09	< .01
4. Anger-Control	.38	34.39	< .001	.01	1.97	*ns*
5. Anger-Out	.38	27.93	< .001	.00	1.66	*ns*
6. Trait-Anger Reaction	.38	23.25	< .001	.00	0.31	*ns*
			Men Only (n = 169)			
1. Anger-In	.12	22.59	< .001	.12	22.59	< .001
2. State Anger	.20	20.79	< .001	.08	16.86	< .001
3. Anger-Control	.24	17.13	< .001	.04	8.04	< .01
4. Anger-Out	.25	13.93	< .001	.02	3.54	*ns*
5. Trait-Anger Reaction	.26	11.57	< .001	.01	1.83	*ns*
6. Trait-Anger Temperment	.26	9.64	< .001	.00	0.28	*ns*

TABLE 4

Correlation Coefficients of Anger Scales With Depression

Scale	Women (n = 226)	Men (n = 169)	z
State Anger	.44*	.32*	–1.37
Trait-Anger Reaction	.32*	.25*	–0.75
Trait-Anger Temperament	.34*	.23*	–1.17
Anger-In	.52*	.35*	–2.06*
Anger-Out	.21*	.05	1.59
Anger-Control	–.21*	–.21*	0.00

*p < .05.

fourth of the variance in depression for women overlapping with anger internalization would seem to be a mandate for continuing research in this area. We believe studies that would contribute to causal modeling of this relationship would be particularly worthwhile.

The correlation coefficients in Table 5 show that the perceived internalization of anger is related to both state and trait anger for women, but not for men. Although these relationships are not extremely large, they may have potentially important implications. Experimental studies designed to test specific hypotheses regarding these relationships might lead to a more comprehensive understanding than currently exists. For example, can we identify specific environmental cues that affect women and men differently, leading to different methods of expressing anger under aroused conditions? In addition, how do predispositional levels of anger interact with environmental cues and gender? If women perceive fewer choices in anger expression, it makes sense that both state and trait anger would lead to increased internalization. On the other hand, men, who might perceive a broader range of socially acceptable or expected responses, need to internalize angry responses less whether they are situational or predispositional in nature. These kinds of differences may function as internalized gender role socialization as well as operants in the social environment. The reciprocal relationships of internalized and environmental cues might be well worth significant study.

TABLE 5

Correlation Coefficients of Anger-InWith Other Anger Scales by Sex

Scale	Women (n = 226)	Men (n = 169)
State Anger	.32*	.11
Trait-Anger Temperament	.28*	.09
Trait-Anger Reaction	.40*	.30*
Anger-Out	.17*	.07
Anger-Control	–.07	.08

*p < .05.

For clinicians, these results have potentially important implications. For example, we caution against the routine reliance on the same conceptual models of the relationship between depression and anger for men and women. Although this is an exploratory study, these results indicate that subtle yet very important differences exist that may have profound implications for both diagnosis and treatment. Awareness that repressed anger may be linked to depression in women allows clinicians to explore such possibilities with their clients. It may be prudent to simultaneously assess both anger and depression in the early diagnostic stage of treatment. This may be particularly meaningful for female clients for whom socialized role constraints might otherwise preclude the recognition or examination of underlying anger, or both. Counselors should also keep in mind that at present we know little about the causal nature of the relationship between depression and anger. As noted previously, in working with clients, clinicians should attempt to explore the nature of this relationship on a case-by-case basis rather than attempting to apply conceptual models that have not yet been empirically validated. Given the social role prescriptions for women, we expect that depression would more often be the presenting problem than anger. However, clinicians must be aware that proceeding to treat depression without considering the possible role of anger in the client's experience may actually be treating only symptoms of a somewhat different underlying problem.

These findings support further research on functional affective differences between women and men. However, there are several fundamental challenges that ought to be countered in designing further research. Women and men represent grossly heterogeneous groups, and consequently the study of between-group differences will only be marginally satisfying. Sole reliance on self-report affective measures is a limitation that ought to be countered by using direct observation, peer and significant other reports, behavioral records, and so forth. These data were collected while participants were in a relaxed environment. Similar studies with different forms of arousal and behavioral response options are essential to expand and interpret the results found here. This study was also limited by the use of a nonclinical college sample. Replication of this study with clinical samples, in which either or both anger and depression may be substantially higher among participants, should be pursued.

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Attitudes Toward Rape Among African American Male and Female College Students

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The purpose of this study was to investigate how African American male and female college students differ in their attitudes concerning rape. Two-hundred and ten college students completed a 12-item questionnaire designed to measure their views toward this issue. A 2-group multivariate analysis of variance (MANOVA) revealed statistically significant differences between African American men and women, with men being more accepting of stereotypes and myths about rape. These differences are discussed in the context of sexism and rape myths. Strategies for changing students' attitudes toward rape are proposed.

Burt (1980) defined the "rape myth" and tested hypotheses derived from social psychological and feminist theory. She found that stereotypes and myths that can be defined as prejudicial ways of thinking about rape, false beliefs about rape, and stereotypes about rape victims and rapists contribute to sexual assault. Burt provided the following as examples of rape myths: "Only bad girls or women get raped," "any person can resist rape if he or she wants to," "individuals who are raped ask for it," "women like to cry rape only as a manipulation device," and "rapists are sexually deprived and insane" (pp. 217–225).

In an earlier paper, Burt (1978) concluded that these rape myths seem to be part of the belief systems of lay persons and professionals who interact with rape victims and rapists. She further argued that rape myths have been institutionalized within the American legal system and that the tenets of feminist theory, which also draw from social-psychological research, can explain how rape myths contribute to the victimization of women. Specifically, the feminist analysis explores how climates of hostility can contribute to rape where women are blamed for their own victimization.

Burt (1978) also found that there is a relationship among attitudes toward women, gender role stereotypes, and rape attitudes or rape definitions. She noted that gender role stereotyping varies directly with rape myths. These findings are consistent with feminist theory, which maintains that attitudes and beliefs can be part of the ideology that excuses or supports rape.

White (1995) discussed the social-psychological attitudes that are related to African American men who commit sexual violence against African American women. She estimated that 1 out of 4 African American women will experience rape in her lifetime. It should be indicated that few women have been identified as rapists, and the majority of rapists are men (Berkowitz, 1992); nevertheless, men are also victims of rape—mostly by other men and largely in prison settings—but most individuals experiencing rape are women.

White (1995) contended that sociocultural myths concerning sexual violence toward women contribute to the high rates of rape reported in the United States. For example, rape myths such as "she wanted it," "females enjoy rape," and "she asked for it" contribute to violence toward women (Bostwick & Delucia, 1992; Burt, 1978). White's position, which is congruent with feminist theory, concluded that rape myths trivialize sexual violence by shifting responsibility from rapists to their female victims.

Recently, the best-selling African American author, Nathan McCall (1997), in reflecting on sexual assaults that he and his African American male peers committed against African American women during their teenage years, concluded the following:

> From this male's perspective, the pervasiveness of men's problem with sexual aggression suggests . . . there's a major flaw in our cultural

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> conditioning, and that flaw feeds this madness that's corrupted us. After much soul-searching, I'm inclined to believe . . . that even in these so-called modern times, we still uphold a supermacho cultural climate that helps men feel comfortable—even justified—in forcing their attention on the opposite sex. (p. 35)

McCall went on to observe that African American women also fall victim to this cultural conditioning, which remains deeply entrenched throughout American society, and that girls are "socialized to seek happiness by providing the services men value most. Almost from birth, they are well primed . . . to cooperate in this sex oppression thing" (p. 41).

In addition, sexist myths and racist myths have contributed to the maintenance of sexual violence within the African American community. White (1995) suggested that rape in the United States is subsumed under the context of White supremacy; historically, White supremacists have focused on the rape of European American women by African American men who were, in turn, harshly punished for alleged or actual cases of rape. In contrast, European American men are hardly ever punished for allegations or actual cases of rape of African American women (White, 1995); nevertheless, most rapes occur between individuals of the same race and socioeconomic status, and rape victims and perpetrators are of all races (Canterbury, Grossman, & Lloyd, 1993; Chimene, 1993; Foley, 1995).

To summarize, myths based on racism and sexism contribute to sexual violence in America. American sexual myths imply that African American men are rapists and that African American women cannot be raped because they are promiscuous (Foley, 1995). These sexual myths have instilled fear in European American women concerning the potential of their being raped by African American men. Moreover, the manifestation of this fear served as the justification for many of the past lynchings and castrations of African American men (Foley, 1995). Because African American women have not been viewed as capable of being raped, historically, this myth served as the justification for those European American men who raped them at will (Foley, 1995).

In terms of another American institution, the criminal justice system, it is not as protective of African American women as it is of European American women. Specifically, African American men are more likely to receive severe penalties for raping European American women than are their European American male counterparts for the same crime against African American women (Foley, 1995; White, 1995). Similarly, White found that harsher sentences are imposed when European American women are raped—in contrast to African American women being raped—whether by European American or African American men. Moreover, she also noted that rape has a differential impact on the African American community because African American women are vulnerable to rape, less likely to report rape, and are less likely to seek support services in the aftermath of a rape.

Thus, the literature is replete with studies showing that men and women have different attitudes toward rape (Keyes, 1992; Koss, Gidycz, & Wisniewski, 1987; Lenihan & Rawlins, 1994; Muehlenhard & Linton, 1987; Newman & Colon, 1994; Peterson & Franzese, 1987; Quackenbush, 1991). However, the purpose of this study was to assess attitudes toward rape among African American male and female college students. Consistent with feminist theory and literature, we hypothesized that African American male college students would hold significantly more traditional gender role stereotypes than African American female college students on an instrument designed to measure attitudes about rape (.05 significance level selected).

METHOD

Participants

Two hundred and thirty college students at a predominantly African American 4-year college (132 men and 98 women) participated in this study. All of the participants were African American, and they ranged in age from 18 to 21 years. The mean age for women and men was 18 and 19 years, respectively. Ninety percent of the participants were from urban backgrounds, 2% were from rural backgrounds, and 8% were from suburban backgrounds. As part of campus-wide sensitivity training to prevent date rape, all students were exposed to a 2-hour rape prevention program. This program was designed to sensitize students to situations that can lead to sexual assault.

Variables and Procedures

Twelve true/false items from an instrument used by the Planned Parenthood Association of Miami Valley, Ohio were paraphrased (in several cases) and used as dependent variables to assess attitudes toward rape. (This instrument can be obtained from Planned Parenthood at 2314 Auburn Avenue, Cincinnati, Ohio 45219.)

The original items were as follows:

1. Rapists mostly rape young, sexy women.
2. Acquaintance rape only happens in large cities.
3. It is impossible for a man to get raped.
4. Usually weapons are used during rape.
5. Women who are raped must do things that provoke rapists.
6. Rape is a personal problem.
7. Rape is a spontaneous act—it occurs without planning.
8. If a woman becomes submissive during a sexual attack, she must have wanted it.
9. Individuals rape because they cannot get sex.
10. Individuals cannot be forced into sexual acts that they do not want to perform.
11. It takes sexual intercourse for a sexual assault to occur.
12. Only females feel the pressure to have sex.

To determine the equivalence of the paraphrased items to the original ones, three researchers, who specialized in attitude surveys concerning rape, obtained an interrater reliability of .97 that the 12 paraphrased items were parallel to

the original questionnaire. The criterion related validity of the paraphrased items was determined through a random sample of 100 participants who completed our paraphrased scale and the original scale used by Planned Parenthood. Participants' scores from the two scales had a correlation of .90, $p < .01$. Finally, the paraphrased items had adequate reliability and validity. In terms of psychometric properties, coefficient alpha was calculated using all 12 items of the paraphrased version, and it produced a reliability coefficient of .80, $p < .01$.

The items that follow are the actual items used:

1. Rapists usually rape young, sexy women.
2. Acquaintance rape only occurs in large cities.
3. It is impossible for a male to get raped.
4. Usually weapons are used during rape.
5. Individuals who are raped must do things that provoke rapists.
6. Rape is a personal problem. It does not have social implications.
7. Rape is a spontaneous act. It occurs without planning.
8. If a person becomes submissive during a sexual attack, she or he must have wanted it.
9. Individuals rape because they cannot get sex.
10. Individuals cannot be forced into sexual acts that they do not want to perform.
11. It takes sexual intercourse for a sexual assault to occur.
12. Only females feel the pressure to have sex.

The correct response for each item is false. In addition, there is research literature supporting the correct response of each item (Berkowitz, 1992; Burt, 1978, 1980; White, 1995). Berkowitz, White, and Burt found that many male college students held distorted views about acquaintance rape and sexual assault. For example, male college students had the following thoughts concerning rape: Men cannot be raped, individuals rape because they cannot get sex except through force, rape occurs spontaneously and without planning, sexual assault can only occur through sexual intercourse, weapons are used during rape, and rape does not have social implications.

Participants were given instructions that indicated that we were attempting to measure attitudes toward rape. They were given the 12-item true/false questionnaire in their classrooms to complete. Due to various factors (absences, items not answered), this procedure produced 210 useable questionnaires.

RESULTS

A two-group multivariate analysis of variance (MANOVA) comparing men and women on the 12 items produced statistical significance: Wilks's Lambda = .84, $p < .001$. The approximate $F = (12, 197) = 3.21$, $p < .001$. Univariate statistics indicated a statistical significance at the .05 level for Items 1, 4, 5, 6, 9, 10, 11, and 12 (Table 1). The two-group MANOVA compared men and women simultaneously on the 12 items, and reliable overall differences were found. See Table 1 for the items and the significant follow-up tests to the MANOVA.

Men consistently differed from women in their ability to determine the correct response to certain questionnaire items (see Table 2). However, neither sex obtained a mean percentage of 100 on any item. Moreover, the results of the MANOVA and the univariate *F* tests, which were follow-up tests to the MANOVA, revealed that men and women differed when they were compared simultaneously on a 12-item rape questionnaire. Again, men and women differed on 8 individual items (see Table 1).

DISCUSSION

Generally, African American male and female college students differed in many of their attitudes concerning rape. These results supported the research hypothesis. Specifically, when compared with female African American college students, African American male college students held more gender role stereotypes about rape. The literature suggests that these differences are the results of sociocultural factors such as sexism and rape myths. For example, the social image of African American men is one of violence and hypersexuality (Foley, 1995). Moreover, the image of African American women is often one of promiscuity that allegedly renders them incapable of being raped (Foley, 1995; White, 1995).

The results of this study suggest that sexist attitudes concerning rape exist more among African American male college students than African American female college students. Blumberg and Lester (1991) found that students who agree with myths about rape tend to blame the victim. Furthermore, feminist scholars such as Burt (1978, 1980) and White (1995) have stated that certain cultural attitudes seem to condone rape. For example, it is believed that sexist attitudes give rise to men wanting to dominate and exploit

TABLE 1

Follow-Up Univariate *F* Tests of MANOVA of "Attitudes Toward Rape" Among African American Men and Women

Item	*F* (1, 208)	*p*
1 Rapists usually rape young, sexy women.	23.19	< .001
4 Usually weapons are used during rape.	5.56	< .02
5 Individuals who are raped must do things that provoke rapists.	5.26	< .03
6 Rape is a personal problem. It does not have social implications.	4.04	< .05
9 Individuals rape because they cannot get sex.	6.12	< .02
10 Individuals cannot be forced into sexual acts that they do not want to perform.	10.15	< .01
11 It takes sexual intercourse for a sexual assault to occur.	6.48	< .02
12 Only females feel the pressure to have sex.	6.73	< .02

TABLE 2

Means and Standard Deviations of "Attitudes Toward Rape" Among African American Men and Women

Item	Men		Women	
	M	*SD*	*M*	*SD*
1 Rapists usually rape young, sexy women.	.52	.50	.87	.34
2 Acquaintance rape only occurs in large cities.	.93	.25	.95	.22
3 It is impossible for a male to get raped.	.88	.33	.90	.30
4 Usually weapons are used during rape.	.39	.49	.54	.50
5 Individuals who are raped must do things that provoke rapists.	.92	.28	.98	.14
6 Rape is a personal problem. It does not have social implications.	.91	.29	.97	.14
7 Rape is a spontaneous act. It occurs without planning	.61	.49	.64	.48
8 If a person becomes submissive during a sexual attack, she or he must have wanted it.	.88	.32	.93	.26
9 Individuals rape because they cannot get sex.	.72	.45	.84	.37
10 Individuals cannot be forced into sexual acts that they do not want to perform.	.66	.48	.86	.35
11 It takes sexual intercourse for a sexual assault to occur.	.82	.38	.94	.24
12 Only females feel the pressure to have sex.	.73	.45	.87	.34

women. The results of the current study indicated that sexist attitudes that are common in the larger American culture also seemed evident within this sample of African American college students. Specifically, African American male college students held more traditional gender role stereotypes toward rape compared with African American female college students.

COUNSELING IMPLICATIONS

The literature indicates that traditional gender role stereotypes can contribute to sexual assault. This is particularly problematic in the African American community where rates of violent crimes are high (Cornwell, 1994; Sterling, Rosenbaum, & Weinkam, 1994). One way of changing African American male college students' attitudes is to teach them profeminist attitudes (Mills & Granoff, 1992; Porter & Critelli, 1994; White, 1995), that is, to engage in nonsexist relationships with African American women. Antisexist strategies may be useful interventions for changing attitudes of sexual violence toward African American women.

There are two general categories of strategies for changing traditional gender role stereotypes. First, there are strategies that strengthen individuals' capacities, such as sensitivity and awareness training (Mantak, 1995; Sarvela, Holcomb, & Odalana, 1992; Scott, Lefley, & Hicks, 1993; White, 1995). Second, there are strategies that attempt to modify the environment through social change. For example, developing an antisexist African American program for rape prevention is one method that may lead to social change; changing college students' general social attitudes also would fall into this category (Porter & Critelli, 1994; Proite, Dannels, & Benton, 1993; Sawyer, Desmond, & Lucke, 1993).

Another intervention is the use of cognitive-behavioral strategies to change the distorted thoughts of African American men about their African American female counterparts (Foley, 1995; Porter & Critelli, 1994; Sapp, 1996; Sapp & Farrell, 1994; Sapp, McNeely, & Torres, 1998). African American male college students can be taught to subject their thoughts to the scientific method, that is, to see their thoughts as hypotheses that can be tested against objective reality. For example, suppose a student had the following thought: "I can't bear not having sex." This thought can be tested scientifically by posing a simple question, "What evidence exists that shows you cannot bear not having sex?" or "Prove that your hypothesis is true." Cognitive-behavioral interventions may be helpful with African American men who behave in sexist ways.

In summary, it is possible to show African American male college students how to change their attitudes toward rape by using cognitive-behavioral methods. Through such methods or strategies, African American men can discover alternative ways of being masculine. Because their sexist attitudes can promote sexually aggressive behavior, we recommend planned social changes as well as cognitive-behavioral counseling interventions. Thus, young African American men and women could be sensitized to sexism and myths concerning gender roles, and they could be taught cognitively new gender roles. Finally, additional research is needed that investigates the attitudes of African American men and African American women toward rape, and research is needed that explores the relationship between sexist thoughts and behavioral acts of sexism among African Americans (Patterson, 1998).

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Assessment and Diagnosis of *DSM-IV* Anxiety Disorders

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Anxiety disorders, the 2nd most common type of mental disorders, are among the most frequently missed or misdiagnosed disorders (Frances & Ross, 1996). Once they are diagnosed, effective treatments exist for them. This article provides a review of current knowledge on the assessment and diagnosis of anxiety disorders classified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition *(American Psychiatric Association, 1994). Emphasis is on the recognition of anxiety as a dominant symptom, frameworks for determining specific anxiety disorders, and patterns of comorbidity.*

Counselors need to be well versed in the assessment and diagnosis of the anxiety disorders because they are the second most commonly occurring category of mental disorders, after substance abuse (Beidel, 1994, p. 55). The anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (*DSM-IV*; American Psychiatric Association [APA], 1994) consist of a loosely organized collection of disorders that share in common high levels of anxiety, avoidance of anxiety, or both as the central syndrome of symptoms. *Anxiety*, defined by the *DSM-IV* (APA, 1994) as the apprehensive anticipation of future danger accompanied by feelings of dysphoria or symptoms of tension, is experienced by most individuals in stressful circumstances. Anxiety, a multidimensional construct, is most commonly conceptualized as consisting of three dimensions: subjective distress, physiological response, and avoidance or escape behaviors (Beidel & Turner, 1991). What distinguishes an anxiety disorder from "normal" anxiety is not only the severity of the symptoms of anxiety but also the degree to which these anxiety related symptoms impair work, interpersonal, and daily functioning. For example, most individuals experience some symptoms of anxiety when called on to perform before others. However, this becomes the anxiety disorder social phobia only when the individual experiences panic level symptoms and avoids social situations, thus meeting the general *DSM-IV* (APA, 1994) criteria for a mental disorder, a clinically significant behavioral syndrome that is associated with present distress or impairment in one or more important areas of functioning (p. xxi).

Anxiety has long been a recognized symptom in many mental disorders. A specific category of disorders termed *anxiety disorders* has existed only since the publication of the *Diagnostic and Statistical Manual of Mental Disorders, third edition* (*DSM-III*; APA, 1980) and in each revision of the manual since 1980 there have been changes and additions to the anxiety disorders. This recent conceptualization of anxiety disorders, the revisions in criteria in each edition, and the existence of anxiety as a symptom in most mental disorders contribute to another fact about anxiety disorders; they are among the most frequently missed or misdiagnosed disorders (Frances & Ross, 1996). As noted by Beidel (1994), this is unfortunate because well-defined and effective treatments exist for specific anxiety disorders, but proper diagnosis is necessary to provide the most appropriate intervention.

To support a more accurate diagnosis, this article provides counselors with current knowledge on the assessment and differential diagnosis of anxiety disorders in adults. Following the process used during an intake interview, the first section presents the broad assessment of symptoms necessary to determine the presence of an anxiety disorder and then the second section covers the assessment and diagnosis for specific anxiety disorders. To illustrate the complexity of diagnosis, an actual case is reviewed. Readers are directed to books by March (1995) and Wiener (1996) for information on anxiety disorders in children and adolescents.

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ASSESSMENT FOR ANXIETY DISORDERS

Contemporary thought about the origin of anxiety disorders emphasizes multiple causation. Rosenbaum et al. (1993) and Turner, Beidel, and Epstein (1991) concluded that there is an underlying physiological vulnerability to anxiety that is probably familial with some contribution from genetics. This anxiety is often experienced first in childhood and may be triggered by psychosocial or physical stressors or may emerge spontaneously. Once triggered, this predisposition to anxiety may be variably experienced as anxiety disorders across the individual's life cycle.

A central feature in the categorization of mental disorders in the *DSM-IV* (APA, 1994) is that each category will have syndromes or patterns of symptoms that are shared by all disorders in the category. A fundamental process in all of the anxiety disorders is "anxious apprehension." As identified by Brown, O'Leary, and Barlow (1993), anxious apprehension is a future-oriented mood state in which the individual becomes ready or prepared to attempt to cope with upcoming negative events. It is associated with high levels of negative affect, chronic overarousal, and a strong sense of uncontrollability. This process is present in all anxiety disorders, although the content varies from disorder to disorder, for example, the concern with evaluation by others in social phobia versus the fear from recall of a traumatic event in posttraumatic stress disorder. The presence of symptoms of anxious apprehension should alert the counselor to the possibility of an anxiety disorder.

Assessment of Symptoms

The first step of assessment when anxious apprehension is present is to inquire in detail about the cognitive, affective, and behavioral symptoms being experienced. Diagnosis will require knowledge of the frequency, duration, and onset of each symptom and the antecedents and consequences of these symptoms. The anxiety disorders are the most "behavioral" of disorders in that the specific diagnosis often rests on the presence or absence of antecedents (i.e., stressors) or the type of behaviors (consequences) in response to the anxiety, such as rituals or avoidance behaviors.

Within the anxiety disorders in the *DSM-IV* (APA, 1994), two symptom syndromes are identified with criteria sets that must be met as a first step in diagnosis. Panic attacks are discrete episodes of intense fear or discomfort accompanied by symptoms such as palpitations, shortness of breath, sweating, trembling, derealization, and fear of losing control, or dying (p. 395). Panic attacks (not to be confused with the diagnosis panic disorder) are common to a number of anxiety disorders and the link of the panic attack to an antecedent helps differentiate the type of anxiety disorder. Panic attacks may be unexpected (uncued) as in panic disorder, situationally bound (cued) as in social phobia or specific phobias, or situationally predisposed as occurs later in the course of panic disorder or in posttraumatic stress disorder (First, Frances, & Pincus, 1995). It is important to note that the experience of an isolated panic attack is not unusual and by itself does not warrant a diagnosis of an anxiety disorder.

The other central syndrome that may occur in anxiety disorders is avoidance as a means of protecting the individual from experiencing anxiety (Fauman, 1994). The avoidance may develop into the full syndrome of agoraphobia that is characterized as anxiety about being in places or situations from which escape might be difficult or in which help might not be available if panic-like symptoms occur (APA, 1994, p. 396). Agoraphobia may be associated with panic attacks as in panic disorder or stand alone as a syndrome as in agoraphobia without history of panic disorder. Other forms of avoidance are obsessive or compulsive rituals or avoidance of social situations as in generalized social phobia.

The remaining sorting and information gathering during this first step in assessment is to determine the content of the anxiety. It is important to establish what the individual is afraid of, the situations that are avoided, and whether the anxiety is in response to an identifiable stressor. The organization of anxiety symptom patterns in *DSM-IV* (APA, 1994) anxiety disorders is outlined in Table 1.

As information is collected about both anxiety and avoidance symptoms, it is important to remember that the client with an anxiety disorder will often have a much narrower conceptualization of the presenting complaint than the actual clinical situation (Beidel, 1994). Thus, the client with panic attacks will talk at length about the attacks but fail to mention a significant life trauma that occurred 6 years ago that could be part of the clinical picture. Conversely, the authors have found that individuals with anxiety disorders tend to focus on and catastrophize their physiological and emotional symptoms, thus presenting a more acute picture of their symptoms (more intense, longer duration) than actual monitoring reveals. These characteristics of clients' presentations make it critical that in the initial assessment the

TABLE 1

Patterns of Anxiety Symptoms Among Anxiety Disorders

Discrete Panic Attacks	High Anxiety Levels
Uncued	Related to fears
Panic disorder	Obsessive-compulsive disorder
Anxiety disorder due to general medical condition	Related to stressor
Substance induced anxiety disorder	Posttraumatic stress disorder
Cued	Acute stress disorder
Specific phobia	Generalized
Social phobia	Generalized anxiety disorder
Situationally predisposed	General medical condition
Panic disorder	Substance induced anxiety
Posttraumatic stress disorder	

counselor fully explore all aspects of the client's daily life, recent life history, and current environmental and psychosocial situation for factors that may be associated with the anxiety symptoms. To accurately assess the symptoms, the client should be asked to self-record anxiety symptoms for at least a week.

Consideration of Cultural, Age, and Gender Related Variations

To accurately assess the presence of a potential anxiety disorder, it is essential that the counselor be familiar with cultural, age, and gender related variations in client presentation of anxiety symptoms. We note just a few general variations but strongly encourage counselors to seek out more in-depth resources for their particular target populations.

For men of many cultural groups including northern European and Hispanic, signs of fear or anxiety are seen as weakness and not considered "manly." We have noted that many men have difficulty revealing the extent to which they suffer from severe anxiety and the level of impairment the symptoms cause. The intake interview with men will seem full of contradictions because a detailed discussion of the anxiety symptoms may be followed by many statements of how successful the client is and how he persists despite the symptoms or minimalizations of the symptoms. A structured approach to cover anxiety, avoidance, and fear symptoms and attention to somatic symptoms will facilitate a more accurate assessment. Being alert for anxiety related symptoms in men is essential because often it is not the stated reason for seeking help. Frequently men seek medical treatment for anxiety symptoms and then are referred by the physician or seek help for substance, job-related, or family related issues that are part of the impact of the anxiety disorder.

Likewise, some older clients may be unable to recognize or unwilling to verbalize anxiety symptoms and instead find it easier to report the distress as bodily dysfunctions such as shakiness, dizziness, palpitations, upset stomach, or frequent urination (Smith, Sherrill, & Colenda, 1995). Unfortunately, expressing distress in bodily dysfunction places the older person at increased risk for unnecessary diagnostic evaluations and potential iatrogenic complications from unnecessary treatment. In addition to the symptoms mentioned, key terms that an older person may use to describe anxiety symptoms include tension, nerves, worry, irritability, difficulty concentrating, and dread. The counselor should give particular attention to other behaviors that might signal attempts at self-medication of anxiety by the older person, such as regular use of sleeping pills or alcohol.

Culture has a great impact on both the predominant idioms of distress through which symptoms are communicated and in the meaning and perceived severity of the client's symptoms (APA, 1994, pp. 843–844). For example, immigrants from the Caribbean often experience severe anxiety as a curse, the devil, witches, or voodoo (Friedman, Paradis, & Hatch, 1994). Often counselors, unaware of cultural variations, will ignore the anxiety symptoms or misinterpret them. Illustrative of such errors is a study by Paradis, Friedman, Lazar, Grubea, and Kesselman (1992) of the routine diagnostic intake process in an inner city outpatient psychiatry clinic. They conducted intake interviews using the structured Anxiety Disorders Interview Scale (ADIS-R; DiNardo & Barlow, 1988) and assigned *DSM-III-R* diagnoses for 100 African American clients following assessment and diagnosis by regular clinic staff. Of the 100 clients, 23 met the diagnostic criteria for panic disorder (7 with only panic disorder, 16 with panic disorder and a mood or psychotic disorder). An additional 7 had other anxiety disorders (1 obsessive-compulsive disorder, 3 posttraumatic stress disorder, 1 generalized anxiety disorder, and 2 social phobia). When these diagnostic results were compared with the diagnosis assigned by the regular staff, the staff had not identified a single primary case of panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, generalized anxiety disorder or social phobia. Instead, clients were assigned diagnoses of mood and psychotic disorders. Based on these findings, Paradis et al. (1992) supported the use of a structured interview that focuses on physical and cognitive signs of anxiety to help overcome cross-cultural bias.

Consideration of Medical Conditions and Substance Use

The next step in assessment is to determine if a medical condition or substance use may be involved in the anxiety symptoms. Medical conditions, medication, and substance use may exacerbate anxiety (Pollack & Smoller, 1996). What is of particular concern in diagnosis is careful consideration of any medical condition or substance use that could be the direct, physiological cause of the anxiety symptoms such as panic attacks, generalized anxiety, or obsessions and compulsions (First et al., 1995). Many medical conditions are associated with the presence of anxiety disorders. Although hyperthyroidism and mitral valve prolapse are widely known causes of panic attacks (APA, 1994, p. 400), disorders of the neurological, endocrine, cardiovascular, and other body systems can directly cause an anxiety disorder. The Appendix contains a listing of medical conditions identified as potential causes of anxiety disorders.

Anxiety disorders not linked to a stressor tend to occur over the life span, with specific phobias appearing in childhood, social phobia in adolescence, and obsessive-compulsive and panic disorders in late adolescence or early adulthood (Beidel & Turner, 1991). Anxiety due to a general medical condition or substance use should be strongly suspected when a client is over 40 years of age and has no prior history of an anxiety disorder. In older people over 65 years of age, anxiety related to medical conditions is a significant source of illness (Smith et al., 1995). These clients should be referred for careful medical evaluation before a diagnosis is made. It should also be noted that clients who do not respond to initial treatment for anxiety should be reevaluated for the presence of medical conditions. When the anxiety symptoms are related to a medical condition, the

correct diagnosis is anxiety disorder due to a general medical condition (APA, 1994, pp. 436–439). When recording the diagnosis the name of the medical condition replaces the term "general medical condition," for example, anxiety disorder due to thyrotoxicosis. In addition the appropriate International Classification of Diseases (ICD) code and the name of the specific medical condition would be provided by the physician and recorded on Axis III.

Substances can also be directly linked to anxiety disorders. The *DSM-IV* (APA, 1994) defined the diagnosis substance-induced anxiety disorder as "prominent anxiety symptoms that are judged to be due to the direct physiological effects of a substance (drug of abuse, a medication, or toxin exposure)" (p. 439). The anxiety disorder develops while the individual is using the substance or during withdrawal from the substance. In addition to considering substances of abuse, the counselor should ask the client to list all prescription medications and, if indicated, discuss the medication with the prescribing physician. Specific coding and naming for the diagnosis of a substance-induced anxiety disorder reflects the specific substance involved (APA, 1994, p. 443).

In addition to a direct link, many substances have anxiety symptoms as a side effect. Generalized anxiety is a common symptom associated with long-standing alcohol and cocaine use, and the presence of these potential substance use disorders must be assessed. Likewise, clients should be questioned about the use of caffeine, over-the-counter cough and cold preparations containing ephedrine, and appetite suppressants. Othmer and Othmer (1994) provided an excellent chart of medication side effects linked to mental disorders symptoms.

DIAGNOSIS OF ANXIETY DISORDERS

Once the counselor identifies that the client has symptoms indicative of anxiety disorders and has ruled out any potential causation by a medical condition or substance, the next step is to determine the specific anxiety disorder(s). The presence or absence of panic attacks is a key symptom in the differential diagnosis of anxiety disorders (refer to Table 1). Anxiety disorders that consistently feature panic attacks are panic disorder (uncued attacks) and specific phobia and social phobia (cued attacks). If panic attacks are not part of the client's symptoms, then the counselor should focus inquiry on the symptoms of generalized anxiety disorder (excessive worries), obsessive-compulsive disorder (behaviors related to fears), and posttraumatic stress disorder and acute stress disorder (symptoms related to a trauma).

A high rate of comorbidity exists among the anxiety disorders, other Axis I mental disorders, and Axis II personality disorders (Biedel, 1994). Many clients have more than one anxiety disorder or other Axis I disorders. This may alter the presentation of symptoms and complicate diagnosis. The presence of a personality disorder will also affect the presenting symptoms. Thus it is important for the counselor assessing a client with anxiety symptoms to always consider multiple diagnoses. Concurrent depressive disorders and anxiety disorders are particularly prevalent, and knowledge of comorbidity patterns for specific anxiety disorders is essential to ensure a comprehensive assessment and diagnosis. In Table 2 we list comorbidity patterns for specific anxiety disorders compiled from the literature.

Panic Disorder

Panic disorder is defined by the occurrence of recurrent, unexpected panic attacks and the development of fear and avoidance of situations or events associated with previous panic attacks (APA, 1994, p. 397). The panic attacks are thought to be manifestations of the emergency fight-or-flight response that is triggered when no external danger is present. The initial panic episode often occurs during or after a period of stress and development of panic disorder may be influenced by individual differences in biologic reactivity (Otto & Gould, 1996). There has also been some note of the onset of panic attacks in conjunction with a physiologic stressor, such as a medical illness or the use of cocaine, mari-

TABLE 2

Anxiety Disorders and Common Comorbid Mental Disorders

	Comorbid Mental Disorders	
Anxiety Disorder	Axis I Disorders	Axis II PersonalityDisorders
Panic disorder	Social phobia Generalized anxiety Posttraumatic stress Depressive disorders	Dependent Avoidant Histrionic Borderline
Social phobia	Specific phobia Agoraphobia Obsessive-compulsive Panic disorder	Avoidant
Obsessive-compulsive disorder	Phobias Panic disorder Depressive disorder Alcohol abuse Eating disorders	Obsessive-compulsive
Posttraumatic stress disorder	Panic disorder Phobias Depressive disorders Substance related disorders Somatization disorder	Borderline
Generalized anxiety disorder	Phobias Depressive disorders	

juana, or alcohol (Pollack & Smoller, 1996). In addition to the physiological and behavioral symptoms of a panic attack, the client with panic disorder will report cognitions during the episodes of (a) fears of death or disability ("I'm having a heart attack"), (b) fears of losing control or insanity ("I am going to lose control and scream"), and (c) fears of humiliation and embarrassment ("If I fall down everyone will notice."). Beidel (1994) noted that although some clients with panic disorder do not seem to develop extensive patterns of avoidance, careful assessment often reveals aspects of a restricted lifestyle in response to the panic attacks.

Often individuals experiencing panic attacks focus on the physiological symptoms during the attack and go to an emergency room or general medical setting where the correct diagnosis is missed. Frequently the client's complaints will be dismissed, or more often result in unnecessary extensive medical workups (Frances & Ross, 1996). History and background are potential indicators of panic disorder. Panic disorder, which occurs twice as often in women as in men, tends to have its onset in the late 30s or early 40s, but many clients report significant generalized anxiety difficulties since childhood (Pollack & Smoller, 1996). There are no major differences between African American and White individuals in respect to prevalence, age of onset, and sex ratio (Lewis-Hall, 1994). However, Lewis-Hall cautioned that the symptoms of panic disorder in African Americans often include isolated sleep paralysis and hypnagogic hallucinations during awakening or falling sleep accompanied by other panic attack symptoms. Once the brief sleep paralysis passes, the individual often sits up with a start and experiences panic symptoms. The hallucinations may be described by the client as a visitation from a loved one or witch, leading to a misdiagnosis of psychotic thinking.

When the counselor is considering a diagnosis of panic disorder, it is important to assess the specific features of the panic attack, possible antecedents of the attack, possible client misappraisals of the attack, behavioral responses to the panic attack and to anticipation of panic attacks, and other general anxiety symptoms (Craske & Barlow, 1993). As listed in Table 2, rarely does this diagnosis occur in isolation, and it is often comorbid with other anxiety disorders, dysthymia, and personality disorders (Otto & Gould, 1996).

Specific Phobia and Social Phobia

Marked and persistent fears of discernable objects or situations are the essential feature of the phobic disorders (APA, 1994). Exposure to the phobic stimulus provokes an immediate anxiety response of panic. Fears of objects or situations other than fears of public scrutiny (social phobia) or being trapped and unable to obtain help (agoraphobia) that result in impairment in functioning are diagnosed as a specific phobia. Most common types of specific phobia are fears of animals, blood-injury situations, heights, and enclosed spaces. Although they are common in the general population, rarely does an individual present for counseling for an isolated specific phobia (Beidel, 1994). This diagnosis is usually detected when the client is seeking help for other mental disorders or has another anxiety disorder.

The central feature of social phobia is a fear of humiliation in situations in which the individual may be exposed to the evaluation and scrutiny of others (APA, 1994, p. 411). Recent studies suggest that biologically based temperamental factors, such as behavioral inhibition in the presence of the unfamiliar, may predispose children to the later development of social phobia (Smoller & Pollack, 1996). In many ways social phobia is an extreme form of the shyness, performance anxiety, or stage fright that most individuals experience at some point in their lives. Gould and Otto (1996) described three maladaptive cognitions held by clients who experience social phobia. These individuals underestimate their ability to cope in social situations, exaggerate the perceived consequences of performing inadequately in social situations, and rehearse self-defeating and global failure attributions about themselves and their future social behavior. These cognitions lead to avoidance behaviors such as skipping class, avoiding speaking to strangers, or avoiding eating with others. Individuals with social phobia may be fearful of discrete social situations (most common is public speaking) or have the generalized type in which the fears include almost all social situations.

Data from epidemiologic studies indicate that the prevalence of social phobia in the general population is 2% to 3%, making it the most common anxiety disorder (Gould & Otto, 1996). The clinical presentation and resulting impairment may differ across cultures depending on social demands, for example Japanese individuals' fear of body odor giving offense to others in a crowd rather than fear of embarrassment (APA, 1994, p. 413). The disorder is diagnosed equally among men and women, with the onset generally between 15 and 20 years of age. The increasing social pressures and peer scrutiny during adolescence may contribute to the onset at this life stage (Gould & Otto, 1996). Social phobia has a great impact on individuals' lives as they avoid jobs that require social contact, fail to develop sustained friendships and relationships, and forgo career promotions that would potentially require increased social exposure. Despite this impact, Smoller and Pollack (1996) reported that only about 5% of the individuals with social phobia seek specific treatment, and the usual length of time from onset to seeking treatment is 10 years.

Social phobia seems to precede the onset of many comorbid disorders (Smoller & Pollack, 1996) remaining as part of the clinical picture (see Table 2). Because of frequent comorbidity and the reluctance to seek treatment for phobias, clients with phobias usually see the counselor for other issues such as depression or alcohol dependence or are referred for the work-related or family problems the disorder generates. It is impairment in social and occupational functioning related to social interaction and the reluctant and cautious way the client relates to the counselor during intake that should alert the counselor to ask about fears and avoidance patterns.

Because panic symptoms and avoidance are criteria for the diagnosis of both panic disorder and social phobia, the

specific aspects of the fears must be explored. Marshall (1994) offered several helpful questions to differentiate the two, such as "Are you afraid when you are alone?" and "What specifically about crowds or crowded places do you fear?" Clients with social phobia tend to be relatively free from anxiety when alone, whereas clients with panic disorder are typically comforted by the presence of others. The client with social phobia worries about being observed or having to talk with a stranger in a crowd, whereas the client with panic disorder will tend to fear the possibility of a humiliating panic attack there.

Obsessive-Compulsive Disorder

The distinguishing features of obsessive-compulsive disorder are the presence of recurrent obsessions and compulsions that consume more than an hour a day or cause marked distress or impairment (APA, 1994, p. 417). Obsessions are thoughts, impulses, or images that are accompanied by anxiety, whereas compulsions are acts or thoughts that are designed to neutralize the anxiety. From a cognitive perspective, the obsessions reflect an exaggerated sense of danger or harm with common thought content including dirt and contamination, aggression, inanimate-interpersonal objects (e.g., locks, bolts), sex, and religion (Beidel, 1994). Compulsive behaviors are initiated by the person to have a neutralizing or preventive function such as hand-washing, cleaning, checking, counting, and ordering. Frances and Ross (1996) noted that although clients with other mental disorders such as major depressive disorder or generalized anxiety disorder will have ruminations or constant worries, only those with obsessive-compulsive disorder (more than 90%) will have compulsions.

The ability to recognize that the obsessions and compulsions are excessive and unreasonable varies by individual and within an individual over the course of the disorder (Frances & Ross, 1996). The nature of the insight varies from those who readily admit the fear is unrealistic to those who greatly overvalue their beliefs (e.g., importance of cleanliness), to those who seem delusional. Often the loss of insight occurs later in the course of the disorder. The disorder is typed "with poor insight" (APA, 1994) when the person has lost the ability to recognize that the obsessions and compulsions are excessive and unreasonable.

Only a decade ago obsessive-compulsive disorder was thought of as a rare illness with a poor prognosis (Rasmussen & Eisen, 1992). This impression was based on in-patient data and the fact that few clients with obsessions or compulsions seek treatment, fearing shame. Recent epidemiological studies suggest a 1-year occurrence rate of approximately 1.5 % of the population (APA, 1994, p. 420) equally distributed between men and women. Age of onset is typically adolescence or early adulthood (6 to 15 years of age in males, 20 to 29 years of age in females). Hollander and Cohen (1994) believed that the lower prevalence rate in African Americans may reflect misdiagnosis because African Americans are more likely to be diagnosed with schizophrenia and other psychotic disorders. They noted that communication problems rising from the socioeconomic and cultural differences could result in the African American client's lack of insight or overvaluing of the obsessions and compulsions be mislabeled as psychotic.

Like all individuals with anxiety disorders, people with obsessive-compulsive disorder are reluctant to divulge symptoms that seem bizarre or may lead others to see them as crazy. Instead, they seek medical help for problems such as dermatitis (chapped hands from repetitive washing) or consult plastic surgeons (obsessions about the body; Rasmussen & Eisen, 1992). If counseling is sought, it is usually for a comorbid condition or interpersonal or work problems fostered by the obsessive-compulsive behaviors. Unfortunately, counselors often neglect to assess for obsessions and compulsions during the intake interview. To ensure accurate diagnosis, all clients with symptoms of anxiety, depression, and multiple physical complaints must be asked specific questions to probe for obsessions and compulsions. Questions such as "Do you have thoughts that distress you that you cannot get out of your mind?" and "Do you have behaviors or rituals that you do over and over?" are good general probes that can then be followed up with specifics if the answer is affirmative.

Obsessive-compulsive disorder has comorbidity with a number of other disorders (see Table 2). Careful assessment is required because differential diagnosis is difficult. For example, 60% of individuals with obsessive-compulsive disorder experience panic attacks that on careful assessment will be revealed to be triggered by obsessive fears such as touching contaminated objects or of having completed an action that they fear will harm a loved one (Rasmussen & Eisen, 1992). In addition, Frances and Ross (1996) discussed an obsessive-compulsive spectrum of disorders that overlap in symptoms and are difficult to differentiate. The spectrum includes body dysmorphic disorder, hypochondriasis, trichotillomania, and tic disorders.

Posttraumatic and Acute Stress Disorders

Two of the anxiety disorders, posttraumatic stress disorder and acute stress disorder, are distinguished from other anxiety disorders in that the symptoms follow an extreme stressor labeled the "traumatic event." The *DSM-IV* (APA, 1994) defined the *traumatic event* as "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others . . . [and] the person's response involved intense fear, helplessness, or horror" (pp. 427–428). In both of these stress disorders the response to the traumatic event must include reexperiencing phenomena, avoidance reactions, and persistently high levels of anxiety. It is length of symptoms that distinguishes the two; if these symptoms develop within a month after the traumatic event, the diagnosis is acute stress disorder, and if the duration of the symptoms is longer than one month (regardless of when symptoms develop), the diagnosis is posttraumatic stress disorder.

Symptom profiles are remarkably similar among clients of posttraumatic stress disorder regardless of the source of the trauma, for example, combat, rape, or physical assault (Otto, Penava, Pollack, & Smoller, 1996). To date, research on the development of posttraumatic stress disorder suggests that among victims of crime, cognitive appraisal of life threat, physical injury, and rape were found to have independent and additive effects on the likelihood of the development of the disorder (Otto et al., 1996).

Once posttraumatic stress disorder is established there is considerable risk of it becoming chronic (Frances & Ross, 1996). Thus it is desirable to detect, diagnose, and treat acute stress disorder after a traumatic event. Unfortunately, Otto et al. (1996) noted that despite the severity of initial anxiety symptoms, trauma victims often delay seeking treatment because of attempts to minimize evocation of trauma-related memories or emotions. Little is known about acute stress disorder because it is new to the *DSM-IV*. The prevalence rate of posttraumatic stress disorder is estimated as 1% of the population, but among individuals with mental disorders it is 15%, among Vietnam veterans it is 13%, among crime victims it is 27%, and among rape victims it is 57% (Otto et al., 1996). Given the high incidence of sexual assault and its strong correlation to development of posttraumatic stress disorder, it is probable that female victims make up the single largest group of clients with this diagnosis (Calhoun & Resnick, 1993).

Although some clients will clearly link symptoms to a traumatic event during the intake interview, many, particularly those whose trauma was during childhood, will not. The counselor's and client's focus on a prominent symptom dimension (e.g., comorbid depression) may exclude full recognition that the core symptoms of posttraumatic stress disorder are present. When assessing any client with a mixed pattern of anxiety, depression, and substance abuse, careful inquiry about any history of traumatic events and probing for symptoms of reexperiencing and avoidance as well as anxiety are needed. If a client experiences anxiety and impairment in functioning after an identified stressor, but this stressor does not meet the criteria to be considered a traumatic event or the symptoms do not reach threshold level, the diagnosis is adjustment disorder (Frances & Ross, 1996).

Generalized Anxiety Disorder

Generalized anxiety disorder has been characterized by Brown et al. (1993) as the basic anxiety disorder, representing the fundamental process of all anxiety disorders, anxious apprehension. In generalized anxiety disorder this anxious state is associated with high negative affect, symptoms of chronic overarousal, a sense of uncontrollability, and an attentional focus on threat-related stimuli. The *DSM-IV* (APA, 1994) criteria required that the individual experiences daily protracted periods of anxiety accompanied by unrealistic or excessive worry about several life circumstances for at least 6 months. Frances and Ross (1996) stated that although clients with panic disorder have a crescendo effect with attacks beginning and ending quickly, individuals with generalized anxiety disorder experience anxiety as a way of life, a pervasive presence every day.

Despite being characterized as the basic anxiety disorder, generalized anxiety disorder has received little research attention. Current thinking is that individuals with generalized anxiety disorder have higher levels of diffuse arousal and sensitivity to arousal than nonanxious normal individuals (Gould & Otto, 1996). In addition to worries, clients may report a range of nonspecific symptoms associated with heightened arousal and anxiety: muscle tension, gastrointestinal distress, urinary frequency, diaphoresis, or dizziness (Smoller & Pollack, 1996). Because of these symptoms, individuals with generalized anxiety disorder often develop worries about illness and seek diagnosis and relief from a primary care physician.

Cognitive aspects of generalized anxiety disorder include a cognitive bias to view the world as a dangerous place (often precipitated by past life experiences) and heightened beliefs about responsibility, control, and perfectionism (Brown et al., 1993). Typical worry behaviors associated with this disorder include checking, avoidance, and vigilance, for example, repeatedly calling the physician about a runny nose, staying home when it is raining lightly for fear of a car accident (Gould & Otto, 1996). Such behaviors provide immediate relief of anxiety, but in the long term do not allow the individual to learn to set aside worry or manage anxiety. Worry habits and cognitions thus reinforce each other.

One of the most common anxiety disorders with an estimated prevalence of 3%, generalized anxiety disorder occurs twice as often in women. (Gould & Otto, 1996). Clients with this disorder often describe a lifelong history of generalized anxiety with age of onset of the full syndrome late teens or early twenties. Because of this long pattern of heightened anxiety, Brown et al. (1993) suggested that generalized anxiety disorder can be thought of as having a more characterological basis with fluctuation in symptoms corresponding to the presence or absence of life stressors.

Most people with generalized anxiety disorder seek treatment from general medical physicians, focusing on the physiological anxiety symptoms. When individuals finally seek counseling for their anxiety and worry, they have often experienced some recent stressful life-event such as marriage, job promotion, or loss of a parent. The counselor could be misled to see the diagnosis then as an adjustment disorder. However, by asking about the frequency and duration of the symptoms, the counselor will be able to determine that the anxiety is more extensive and widespread than in an adjustment disorder.

Comorbidity seems to be common, and Smoller and Pollack (1996) reported an estimate that among those diagnosed with generalized anxiety disorder, less than 10% have just generalized anxiety disorder and no other psychiatric diagnosis in their lifetime (p. 155). The symptoms of major depressive disorder and dysthymia also overlap with the

features of generalized anxiety disorder particularly the symptoms of ruminative worry, poor concentration, insomnia, and fatigue. The key in making the differential diagnosis is to focus on the symptoms of hypervigilance, autonomic nervous system hyperactivity, and muscle tension that are present in anxiety disorders, but not mood disorders.

ANXIETY DISORDERS CASE STUDY

To further illustrate the process and issues in the diagnosis of anxiety disorders we conclude with a case study accompanied by a discussion of the steps in assessment and the diagnosis.

> Ms. B., a 31-year-old, married White woman was examined by the second author for evaluation for disability benefits. Ms. B. had been shot in the head by an assailant approximately 4 months ago on returning to her home with her husband after an evening out. She reported that as she was unlocking the back gate a young man confronted them both and shot her in the face. The assailant fled and has not been apprehended. Since this event Ms. B has been experiencing nervousness, anger, depression, stress, insomnia, nightmares, loss of appetite, ongoing fear, suicidal thoughts, lack of concentration, and concern for health problems associated with the attack. She has been unable to return to work as a bookkeeper since the crime and reports that she is too afraid to be alone during the day and must have a friend stay with her until her husband returns from work in the evening.

The first step in the assessment process is to identify the major symptom syndromes that seem to be present and the extent of impairment in functioning. In her description of her problems, Ms. B. clearly presents the counselor with many symptoms associated with anxious apprehension, the core of anxiety. The client reports being unable to work, which is considered impairment in functioning in the *DSM-IV* (APA, 1994). The counselor would also note the cluster of symptoms associated with a depressive disorder. Specific questioning about each of these potential diagnostic areas and assessment of all five *DSM-IV* axes follows.

> Ms. B. has completed over 3 years of a bachelor's degree program in accounting. Questioning Ms. B. revealed that after a brief marriage and the birth of her son, now age 9, she divorced in 1987 and remarried in 1988. The son had been living with her, but since the accident has been living with his father. The ex-husband is currently suing Ms. B. for child custody, citing her inability to provide effective parenting since the shooting. Ms. B. is able to perform her own bathing and dressing, but has been relying on her husband to perform housework, cooking, laundry, grocery shopping, and bill paying. She attends church weekly but has decreased her visits with friends saying, "I have a hard time going out and I'm afraid to leave the house and then I'm afraid to come back into the house." She describes her current husband as supportive.
>
> Ms. B. reported that her current physical health is complicated by sensations of confusion, headaches, the head injury from the gunshot, lung problems, memory problems, vision problems, and limited use of her right hand. Her vision in her left eye is 20/100 and her right eye, destroyed by the bullet, has a prosthesis. She has little appetite and has lost 10 pounds since the shooting. She states she wishes she had died in the shooting because she has "lost everything."
>
> The mental status exam was normal for cognitive functioning. In response to specific questions about her emotions and behaviors, Ms. B. was cooperative and detailed in response. She noted that she is easily startled and has nightmares about the shooting. She is often afraid to go asleep because of the nightmares. She becomes tearful, describing her frustration at her lack of progress, and describes "crying spells" over the custody battle for her son and after visits to the doctor. Her husband reports that her crying spells are a daily occurrence, that she has nightmares four to five times a week, and that since the shooting she has become a "totally different person." Ms. B denies use of drugs other than ibuprofen for pain and reports having a total of two to three glasses of wine a week. She smokes one pack of cigarettes a day.

An important consideration in this case, as in many cases with anxiety symptoms, is the possible involvement of a medical condition or substances in the triggering of the disorder. Although depression is often seen following head trauma (see discussion of proposed diagnosis postconcussional disorder in *DSM-IV*, APA, 1994, pp. 704–706), Ms. B. did not have a closed head concussion and has a number of psychological losses that could trigger the depression. The counselor should further explore her reported level of consumption of wine for accuracy because alcohol is often used by individuals to relax or get to sleep, but can actually contribute to feelings of depression and sleep disruption.

The last step in diagnosis is determining the specific anxiety disorder(s) present and other concurrent disorders. Ms. B meets the criteria for postttraumatic stress disorder; she has experienced a physical attack (trauma) and has the required symptoms of reexperiencing, heightened arousal, and avoidance for longer than 1 month. As we have previously discussed, clients with anxiety disorders frequently have other mental disorders, and Ms. B meets the criteria for major depressive disorder, single episode, and nicotine dependence. Further assessment would be needed to identify if she is also developing agoraphobia as suggested by her greatly restricted lifestyle. Finally, with an anxiety disorder diagnosis the counselor should consider the existence of a concurrent personality disorder. There is currently no evidence of a personality disorder, given that both Ms. B. and her husband describe her as independent and well-functioning before the shooting.

SUMMARY

In this review of the assessment and diagnosis of *DSM-IV* anxiety disorders, we emphasized the following points. First, anxiety disorders are very common and frequently missed. The presence of anxious apprehension should alert the counselor to the need for thorough assessment of any panic episodes, fears, avoidance behaviors, and obsessions and compulsions. We presented a logical flow in assessment: establish the presence of anxiety; consider medical conditions, substance use, and age, gender, and cultural variations; establish the presence or absence of panic attacks; and then pursue specific questions for each likely anxiety disorder. Throughout we noted that anxiety disorders are frequently comorbid with other disorders, complicating diagnosis and treatment. For each anxiety disorder there are specific symptoms and comorbidity patterns. The review ends with a case study that illustrates this mix of disorders and symptoms.

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APPENDIX

Medical Conditions Associated With Anxiety Symptoms

A. Neurological disorders
   1. multiple sclerosis
   2. polyneuritis
   3. postconcussion syndromes
   4. temporal lobe epilepsy

B. Endocrine Disorders
   1. hyperthyroidism
   2. hypoparathyroidism
   3. Cushing's syndrome
   4. hypoglycemia

C. Immune and collagen disorders
   1. lupus erythematosus
   2. asthmatic conditions

D. Cardiovascular disorders
   1. anemia
   2. chronic obstructive pulmonary disease
   3. cardiac arrhythmias
   4. mitral valve prolapse

E. Other disorders
   1. nephritis
   2. vitamin deficiencies (B_1, B_6, B_{12}, niacin, folic acid)

Note. Based on Buelow and Hebert (1995) and Othmer and Othmer (1994).

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Louisiana
University Counseling Center
Southeastern Louisiana University, Hammond, LA

Educational Resources & Counseling
Tulane University, New Orleans, LA

Counseling Services
University of New Orleans, New Orleans, LA

University Counseling Center
Louisiana Tech University, Ruston, LA

Maine
Counseling Center
University of Maine, Orono, ME

Maryland
Jewish Vocational Service
Baltimore, MD

Counseling & Student Development Center
Johns Hopkins University, Baltimore, MD

Counseling Center
Loyola College, Baltimore, MD

Counseling Center
University of Maryland Baltimore County, Baltimore, MD

Counseling Center
University of Maryland, College Park, MD

University Counseling Center
Frostburg State University, Frostburg, MD

Counseling Center
Towson University, Towson, MD

Massachusetts
Career Moves
Jewish Vocational Service, Boston, MA

The Counseling Center
Boston University, Boston, MA

Counseling Center
Northeastern University, Boston, MA

Counseling Center
Suffolk University, Boston, MA

Counseling & Student Development
Bentley College, Waltham, MA

Michigan
Counseling Center
Grand Valley State University, Allendale, MI

Counseling & Psychological Services
University of Michigan, Ann Arbor, MI

Counseling & Testing Center
Andrews University, Berrien Springs, MI

University Counseling & Placement Services
Wayne State University, Detroit, MI

Counseling Center
Michigan State University, East Lansing, MI

University Counseling & Testing Center
Western Michigan University, Kalamazoo, MI

Counseling Center
Northern Michigan University, Marquette, MI

University Counseling Center
Central Michigan University, Mt. Pleasant, MI

Career Development & Employment Services
Jewish Vocational Service, Southfield, MI

Minnesota
Counseling & Psychological Services
University of Minnesota-Duluth, Duluth, MN

Jewish Vocational Service
Minneapolis, MN

University Counseling & Consulting Services
University of Minnesota, Minneapolis, MN

Counseling & Related Services
St. Cloud State University, St. Cloud, MN

Counseling & Career Services
University of St. Thomas, St. Paul, MN

Missouri
Counseling & Career Services Center
University of Missouri-Kansas City, Kansas City, MO

Student Health & Counseling Center
St. Louis University, St. Louis, MO

Montana
Counseling & Psychological Services
Montana State University, Bozeman, MT

Nebraska
Counseling & Psychological Services
Creighton University, Omaha, NE

Counseling Center
Wayne State College, Wayne, NE

New Hampshire
The Counseling Center
University of New Hampshire, Durham, NH

New Jersey
Career & Educational Counseling Department
Jewish Vocational Service, East Orange, NJ

Psychological Counseling Services
The College of New Jersey, Ewing, NJ

Counseling Center
New Jersey Institute of Technology, Newark, NJ

Professional Service Department
The 1st Occupational Center of New Jersey, Orange, NJ

Health/Counseling Services
Seton Hall University, South Orange, NJ

New Mexico
Counseling Center
New Mexico State University, Las Cruces, NM

New York
Career Services Department
Jewish Family Services of Buffalo & Erie County, Buffalo, NY

College Counseling Center
Buffalo State College, Buffalo, NY

Counseling Center
S.U.N.Y. College at Cortland, Cortland, NY

Counseling Center
Ithaca College, Ithaca, NY

Psychological Counseling Center
SUNY at New Paltz, New Paltz, NY

Career Development Services
Federation Employment & Guidance Service (FEGS), New York, NY

Career Development, Mental Health Services
The League for the Hard of Hearing, New York, NY

Vocational Services Department
Rusk Institute/New York University Medical Center, New York, NY

University Counseling Service
New York University, New York, NY

Rockland County Guidance Center
Nyack, NY

Counseling Center
Rochester Institute of Technology, Rochester, NY

University Counseling Center
SUNY at Stony Brook, Stony Brook, NY

Counseling Center
Syracuse University, Syracuse, NY

Center for Personal Development
United States Military Academy, West Point, NY

North Carolina
Counseling & Psychological Services Center
Appalachian State University, Boone, NC

Career & Personal Counseling Service (PPCA)
Charlotte, NC

Counseling Center
University of North Carolina at Charlotte, Charlotte, NC

Counseling Center
East Carolina University, Greenville, NC

Counseling Center
University of North Carolina, Wilmington, Wilmington, NC

North Dakota
Center for Student Counseling & Personal Growth
North Dakota State University, Fargo, ND

University Counseling Center
University of North Dakota, Grand Forks, ND

Ohio
Counseling, Testing and Career Center
The University of Akron, Akron, OH

Counseling Center
Cleveland State University, Cleveland, OH

Counseling & Consultation Service
The Ohio State University, Columbus, OH

The Counseling Center
University of Dayton, Dayton, OH

Health & Counseling Center
Kenyon College, Gambier, OH

The Counseling Center
Oberlin College, Oberlin, OH

Student Counseling Service
Miami University, Oxford, OH

University Counseling Center
The University of Toledo, Toledo, OH

Oklahoma
Counseling Services, Oklahoma State University, Stillwater, OK

Pennsylvania
Department of Counseling Services
Clarion University of Pennsylvania, Clarion, PA

University Counseling Services
Kutztown University of Pennsylvania, Kutztown, PA

University Counseling Center
University of Pittsburgh, Pittsburgh, PA

University Counseling Center
Shippensburg University of Pennsylvania, Shippensburg, PA

Ctr. for Counseling & Psychological Services
The Penn State University, University Park, PA

University Counseling Center
Villanova University, Villanova, PA

Rhode Island
Counseling Center
Rhode Island College, Providence, RI

SouthCarolina
Counseling & Psychological Services
The College of Charleston, Charleston, SC

Counseling & Psychological Services
Clemson University, Clemson, SC

Counseling & Human Development Center
University of South Carolina, Columbia, SC

Tennessee
Counseling & Career Planning Center
University of Tennessee at Chattanooga, Chattanooga, TN

Student Counseling Services Center
University of Tennessee, Knoxville, TN

Center for Student Development
University of Memphis, Memphis, TN

Texas
Counseling & Testing Center
Southern Methodist University, Dallas, TX

Corporate & Career Development Services
Career & Recovery Resources, Inc., Houston, TX

Career & Counseling Services
University of Houston-Clear Lake, Houston, TX

University Counseling Services
University of Houston, Houston, TX

Counseling Center
Rice University, Houston, TX

Counseling Center
University of Texas at San Antonio, San Antonio, TX

Utah
Counseling Center
Utah State University, Logan, UT

Counseling Center
University of Utah, Salt Lake City, UT

Vermont
The Counseling Center
University of Vermont, Burlington, VT

Virginia
Thomas E. Cook Counseling Center
Virginia Tech, Blacksburg, VA

Counseling Center
George Mason University, Fairfax, VA

Counseling & Student Development Center
James Madison University, Harrisonburg, VA

Counseling Services
Old Dominion University, Norfolk, VA

Washington
Counseling & Psychological Services
Eastern Washington University, Cheney, WA

Wisconsin
Counseling Services
University of Wisconsin-Eau Claire, Eau Claire, WI

Counseling & Testing Center
University of Wisconsin-La Crosse, La Crosse, WI

University Health & Counseling Services
University of Wisconsin-Whitewater, Whitewater, WI

INTERNATIONAL

Australia
University Counselling Service
Curtin University of Technology, Perth, Western Australia

Canada
University Counselling Services
University of Calgary, Calgary, Alberta

Counselling Services
University of Manitoba, Winnepeg, Manitoba

Counselling Centre
Memorial University of Newfoundland, St. John's, Newfoundland

Counselling Services
University of Waterloo, Waterloo, Ontario

Career Counselling Department
Jewish Vocational Service of Montreal, Montreal, Quebec

CONTACTS FOR STATE LICENSING BOARD INFORMATION

Note. Dates indicate when the original counseling credentialing law passed (licensure or certification). Most states have amended their original laws, some several times (not shown here). For the most current information regarding state counselor credentialing laws, contact the state board.

Alabama—Law Passed 1979
Board of Examiners in Counseling
P.O. Box 550397
Birmingham, AL 35255
(205) 933-8100 or (205) 933-6700 (FAX)

Alaska—Law Passed 1999
AK Div. Of Occupational Licensing
Board of Professional Counselors
P.O. Box 110806
Juneau, AK 99811
(907)465-2551

Arizona—Law Passed 1988
Counselor Credentialing Committee
of the Board of Behavioral Examiners
1645 West Jefferson Ave, Room 426
Phoenix, AZ 85007
(602) 542-1882 or (602) 542-1830 (FAX)

Arkansas—Law Passed 1979
Board of Examiners in Counseling
Southern Arkansas University
P.O. Box 1396
Magnolia, AR 71753-5000
(870) 235-4314 or (870) 234-1842 (FAX)

California
(no licensing board for mental health counseling)
Sacramento, CA

Colorado—Law Passed 1988
Board of Licensed Professional Counselor Examiners
1560 Broadway, Suite 1340
Denver, CO 80202
(303) 894-7766 or (303) 894-7790 (FAX)

Connecticut—Law Passed 1997
Connecticut Dept. of Public Health
Division of Health Systems Registry
410 Capitol Ave.
Hartford, CT 06134
(860) 509-7590

Delaware—Law Passed 1987
Board of Professional Counselors of Mental Health
P.O. Box 1401
Dover, DE 19903
(302) 739-4522 or (302) 739-2711 (FAX)

District of Columbia—Law Passed 1992
Board of Professional Counselors
614 H St. NW, Rm. 108
Washington, DC 20001
(202) 727-9794 or (202) 727-4087 (FAX)

Florida—Law Passed 1981
Florida Agency for Health Care Administration
Board of Clinical Social Workers and Mental Health Counselors
1940 North Monroe St.
Tallahassee, FL 32399-0753
(850)488-0595 or (850) 921-2569 (FAX)

Georgia—Law Passed 1984
Georgia Division of Examining Boards
Composite Board of Professional Counselors and Social Workers,
166 Pryor St., SW
Atlanta, GA 30303
(404) 656-3933 or (404) 651-9532 (FAX)

Hawaii
(no licensing board for mental health counseling at this time)
Honolulu, HI

Idaho—Law Passed 1982
Idaho Bureau of Occupational Licenses
State Counselor Licensure Board
1109 Main St., Suite 220
Boise, ID 83702-5642
(208) 334-3233 or (208) 334-3945 (FAX)

Illinois—Law Passed 1993
Illinois Department of Professional Regulation
Professional Counselor Licensing and Disciplinary Board
320 West Washington St.
Springfield, IL 62786
(217) 785-0822 or (217) 782-7645 (FAX)

Indiana—Law Passed 1997
Indiana Health Professions Bureau
Social Worker and Mental Health Counselor Board
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
(317) 232-2960 or (317) 233-4236 (FAX)

Iowa—Law Passed 1990
Behavioral Sciences Board
Lucas Building, 4th Fl.
Des Moines, IA 50319
(515) 281-4413 or (515) 281-3121 (FAX)

Kansas—Law Passed 1987
Behavioral Sciences Regulatory Board
712 S. Kansas Ave.
Topeka, KS 66603-3817
(913) 296-3240 or (913) 296-3112 (FAX)

Kentucky—Law Passed 1996
Kentucky Division of Occupations and Professions
700 Louisville Road, Suite 2
P.O. Box 456
Frankfurt, KY 40602-0456
(502) 564-3296 x226 or (502) 564-4818 (FAX)

Louisiana—Law Passed 1987
Licensed Professional Counselors Board of Examiners
8631 Summa Ave., Suite A
Baton Rouge, LA 70809
(504) 922-1499 or (504) 922-2160 (FAX)

Maine—Law Passed 1989
Board of Counseling Professionals
State House, Station #35
Augusta, ME 04333
(207) 624-8626 or (207) 624-8637 (FAX)

Maryland—Law Passed 1985
Board of Examiners of Professional Counselors
4201 Patterson Ave., 3rd Floor
Baltimore, MD 21215-2299
(410) 764-4732 or (410) 764-5987 (FAX)

Massachusetts—Law Passed 1987
Board of Allied Mental Health Services
100 Cambridge Street, 15th Floor
Boston, MA 02202
(617) 727-3080 or (617) 727-2197 (FAX)

Michigan—Law Passed 1988
Board of Counseling
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918 or (517) 373-3596 (FAX)

Minnesota
(no licensing board for mental health counseling at this time)
St. Paul, MN

Mississippi—Law Passed 1985
Board of Examiners for Licensed Professional Counselors
239 N. Lamar St.
Jackson, MS 39201
(601) 235-8182

Missouri—Law Passed 1985
Committee for Professional Counselors
P.O. Box 1335
Jefferson City, MO 65102
(573) 751-0018 or (573) 751-4176

Montana—Law Passed 1985
Board of Social Work and Professional Counselors Examiners
111 North Jackson Street
Helena, MT 59620
(406) 444-4285 or (406) 444-1667 (FAX)

Nebraska—Law Passed 1986
Nebraska Professional and Occupational Licensure Division
Board of Examiners in Mental Health Practice
P.O. Box 95007
Lincoln, NE 68509-5007
(402) 471-2117 or (402) 471-0380(FAX)

Nevada
(no licensing board for mental health counseling at this time)
Carson City, NV

New Hampshire—Law Passed 1992
Board of Mental Health Practice
105 Pleasant St., Suite 457
Concord, NH 03301
(603) 271-6762

New Jersey—Law Passed 1992
New Jersey Division of Consumer Affairs
Professional Counselor Examiners Committee
P.O. Box 45033
Newark, NJ 07101
(973) 504-6415 or (973) 648-3536 (FAX)

New Mexico—Law Passed 1993
Counselor Therapy and Practice Board
P.O. Box 25101
Sante Fe, NM 87504
(505) 476-7100 or (505) 827-7085 (FAX)

New York
(no licensing board for mental health counseling at this time)
Albany, NY

North Carolina—Law Passed 1983
Board of Licensed Professional Counselors
P.O. Box 21005
Raleigh, NC 27619-1005
(919) 787-1980 or (919) 571-8672 (FAX)

North Dakota—Law Passed 1989
Board of Counselor Examiners
P.O. Box 2735
Bismarck, ND 58502
(701) 224-8234

Ohio—Law Passed 1984
Counselor and Social Work Board
77 South High St., 16th Floor
Columbus, OH 43266-0340
(614) 466-0912 or (614) 644-8112 (FAX)

Oklahoma—Law Passed 1985
Licensed Professional Counselors Board
1000 NE 10th St.
Oklahoma City, OK 73117-1299
(405) 271-6030 or (405) 271-1011 (FAX)

Oregon—Law Passed 1985
Board of Licensed Professional Counselors
3218 Pringle Rd., SE, Suite 160
Salem, OR 97302-6312
(503) 378-5499

Pennsylvania—Law Passed 1998
Pennsylvania Department
of Professional and Occupational Regulation
116 Pine St.
Harrisburg, PA 17101
(717) 787-8503

Rhode Island—Law Passed 1987
Rhode Island Division of Professional Regulation

Board of Mental Health Counselors
Cannon Building, Room 104
Providence, RI 02908-5097
(401) 222-2827 or (401) 222-1272 (FAX)

South Carolina—Law Passed 1985
South Carolina Dept. of Labor, Lic., and Reg.
Board of Examiners for LPC's and LAC's
P.O. Box 11329
Columbia, SC 29211-1329
(803) 896-4658 or (803) 734-4284 (FAX)

South Dakota—Law Passed 1990
Board of Counselor Examiners
P.O. Box 1822
Sioux Falls, SD 57101-1822
(605) 331-2927 or (605) 331-2043 (FAX)

Tennessee—Law Passed 1984
State Board of Professional Counselors
126 5th Ave. North
Nashville, TN 37247-1010
(615) 532-5132 or (615) 532-5164 (FAX)

Texas—Law Passed 1981
Board of Examiners of Professional Counselors
1100 West 49th St.
Austin, TX 78756-3183
(512) 834-6658 or (512) 834-6677 (FAX)

Utah—Law Passed 1994
Utah Division of Occupational and Professional Licensing
160 East 300th St.., 4th Floor
Salt Lake City, UT 84145
(801) 530-6789 or (801) 530-6511 (FAX)

Vermont—Law Passed 1988
Vermont Office of Professional Regulation
LCMHC Advisory Board
109 State St.
Montpelier, VT 05609-1106
1-800-439-8683 (in Vermont)
(802) 828-2390 or (802) 828-2496 (FAX)

Virginia—Law Passed 1976
Virginia Department of Health Professions
Board of Professional Counselors
6606 W. Broad St., 4th Floor
Richmond, VA 23230-1717
1-888-817-8283 (application info)
(804) 662-9912 or (804) 662-9943 (FAX)

Washington—Law Passed 1987
Washington Department of Health
Div of Health Professional Quality Assurance Division
P.O. Box 47869
Olympia, WA 98504-7869
(360) 664-9098 or (360) 586-7774 (FAX)

West Virginia—Law Passed 1986
Board of Examiners in Counseling
100 Angus E. Peyton Dr., Room 201D
S. Charlestown, WV 25303-1600
1-800-520-3852
(304) 746-2512 or (304) 746-1942 (FAX)

Wisconsin—Law Passed 1992
Wisconsin Department of Regulations and Licensing
Examining Board of Social Workers and Professional Counselors
P.O. Box 8935
Madison, WI 53709
(608) 267-7223 or (608) 267-0644 (FAX)

Wyoming—Law Passed 1987
Mental Health Professions Licensing Board
2301 Central Ave.
Cheyenne, WY 82002
(307) 777-7788 or (307) 777-3508 (FAX)

THE COUNCIL FOR ACCREDITATION OF COUNSELING AND RELATED EDUCATIONAL PROGRAMS (CACREP)

5999 Stevenson Avenue
Alexandria, VA 22304-3300
(703) 823-9800, ext. 301

Council Chair, Mary Thomas Burke
Executive Director, Carol L. Bobby

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is a specialized accrediting body recognized by the Council on Higher Education Accreditation (CHEA). CACREP functions as an independent council whose purpose is to implement minimum standards for counseling and human development graduate-level training programs.

The CACREP Board of Directors is composed of 14 sustaining members who are representatives from the divisions of the American Counseling Association (ACA) and two public representatives. As such, it functions as the accrediting arm for the world's largest professional association for counselors and human development specialists. The CACREP scope of accreditation includes the following:

Entry-Level Programs (master's degrees)
- Community Counseling (CC)
- Community Counseling with a Specialization in Gerontological Counseling (CC/GC)
- Community Counseling with a Specialization in Career Counseling (CC/CrC)
- Marriage and Family Counseling/Therapy (MFC/T)
- Mental Health Counseling (MHC)
- School Counseling (SC)
- Student Affairs Practice in Higher Education (SA)

Emphasis Areas:
1988 Standards
Administrative (A)
Counseling (C)
Developmental (D)

1994 Standards
College Counseling (CC)
Professional Practice (PP)

Doctoral-Level Programs (PhD andEdD degrees)
- Counselor Education and Supervision (CE)

The 1994 standards are published in the *CACREP Accreditation Standards and Procedures Manual*, which may be purchased through the CACREP office.

In the listing that follows, an asterisk indicates accreditation for a 2-year period, a status granted to programs that substantially meet the intent of the standards, but have some minor standards-related deficiencies that the CACREP Board would like to have addressed before a 7-year accreditation cycle is awarded. Brackets indicate the year the program was first accredited; parentheses indicate the year the program will be eligible for renewal of accreditation or to have 2-year accreditation extended to the end of the 7-year accreditation cycle..

Please Note. Some counseling programs at an institution with CACREP accreditation may not be CACREP accredited. Students are advised to check with the CACREP liaison at the institution to determine if a particular area is accredited.

For specific information regarding any program listed in this directory, please contact the institution directly.

ALABAMA

Debra C. Cobia, CACREP Liaison
Counseling and Counseling Psychology
Auburn University [9/86]
2084 Haley Center
Auburn University, AL 36849-5222
Phone: (334) 844-5160
CC, SC, SACC, CE:PhD/EdD (2001)

S. Allen Wilcoxon, CACREP Liaison
Program in Counselor Education
The University of Alabama [3/82]
P. O. Box 870231
Tuscaloosa, AL 35487-0231
Phone: (205) 348-7579
CC, SC, CE:PhD/EdD (2004)

ARIZONA

Teresa Fisher, CACREP Liaison
Division of Psychology in Education
Arizona State University [4/95]
College of Education
Payne Hall, Room 301
Tempe, AZ 85287-0611
Phone: (602) 965-8057
*CC (1999)

Ramona Mellott, CACREP Liaison
William Martin, Chair
Center for Excellence in Education
Northern Arizona University [11/98]
Department of Counselor Education
Box 5774, CEE
Flagstaff, AZ 86011-5774
Phone: (520) 523-6534
*CC, SC (2000)

Patrick Romine, Chair
University of Phoenix [4/95]
Phoenix and Tucson Campuses
4615 E. Elwood Street
Phoenix, AZ 85040
Phone: (602) 966-9577
CC (2002)

ARKANSAS

Larry Burlew, CACREP Liaison
ELCF/Counselor Education
University of Arkansas [11/97]
136 Graduate Education Building
Fayetteville, AR 72701
Phone: (501) 575-7725
*CC, SC, CE:PhD (1999)

BRITISH COLUMBIA

Richard Young, CACREP Liaison
Department of Counselling Psychology
University of British Columbia [3/89]
Faculty of Education
2125 Main Mall
Vancouver, British Columbia, CANADA V6T 1Z4
Phone: (604) 822-5259
*CC, SC, SACC (1999)

CALIFORNIA

Sari H. Dworkin, CACREP Liaison
Department of Counseling and Special Education
CSU/Fresno [4/95]
School of Education and Human Development
5005 N. Maple Avenue, M/S 3
Fresno, CA 93740-8025
Phone: (209) 278-0328
MFC/T (2002)

Raymond Hillis, CACREP Liaison
Division of Administration and Counseling
CSU/Los Angeles [3/78]
King Hall C-1065
5151 State University Drive
Los Angeles, CA 90032
Phone: (313) 343-4253
SC, MFC/T (2003)

Rie Rogers Mitchell, CACREP Liaison
Educational Psychology and Counseling
CSU/Northridge [3/79]

18111 Nordhoff Street
Northridge, CA 91330-8265
Phone: (818) 677-7889
CC/CrC, MFC/T, SC, SAC (2001)

Eugene Zwillinger, Chair
Department of Counseling
San Francisco State University [3/78]
1600 Holloway Avenue
Burk Hall 524
San Francisco, CA 94132
Phone: (415) 338-2005
CC/GC,CC/ CrC, MFC/T, SC, SACC (2002)

V. Skip Holmgren, CACREP Liaison
Counseling Department/Nichols 220
Sonoma State University [3/84]
1801 E. Cotati Avenue
Rohnert Park, CA 94928
Phone: (707) 664-2266
CC, SC (1999)

COLORADO

Don T. Basse, CACREP Liaison
Department of Psychology
Adams State College [10/95]
ES 309- Box J
Alamosa, CO 81102
Phone: (719) 587-7626
CC, SC (2002)

Rich Feller, CACREP Liaison
Counseling and Career Development
Colorado State University [4/97]
Education 215
Ft. Collins, CO 80523
Phone: (970) 491-6879
CC, CrC, SC (2004)

James R. Beck. Department Chair
Counseling Department
Denver Seminary [4/97]
Box 10,000
Denver, CO 80250-0100
Phone: (303) 761-2482, ext. 304
*CC (1999)

Robert L. Smith, Division Chair
Counseling Psychology and Counselor Education
University of Colorado at Denver [4/91]
Campus Box 106/ P.O.Box 173364
Denver, CO 80217-3364
Phone: (303) 556-2563
CC, SC, MFC/T (2005)

Tracy Baldo, CACREP Liaison
Counseling Psychology Program
University of Northern Colorado [3/82]
Division of Professional Psychology
McKee Hall #248
Greeley, CO 80639
Phone: (970) 351-2544
SC, CE:EdD (2003) *CC, MFC/T (2000)

CONNECTICUT

Janine Bernard, CACREP Liaison
Counselor Education Department
Fairfield University [9/86]
Graduate School of Education and Allied Professions
Fairfield, CT 06430-7524
Phone: (203) 254-4000 ext. 2338
CC, SC (2001)

Judith Wilcox, CACREP Liaison
Counseling and School Psychology Department
Southern Connecticut State University [4/95]
501 Crescent Street
New Haven, CT 06515
Phone: (203) 392-5913
CC, SC (2002)

Barbara McNelis, CACREP Liaison
Western Connecticut State University [4/95]
Education Department, Westside Campus
Danbury, CT 06810
Phone: (203) 837-8512
CC, SC (2002)

DELAWARE

Samuel Milioti, Jr., CACREP Liaison
Willmington College
320 DuPont Highway
New Castle, DE 19720
Phone: (302) 328-9401
*CC (2000)

DISTRICT OF COLUMBIA

Roger Beach, CACREP Liaison
Department of Counseling
Gallaudet University [3/93]
800 Florida Avenue NE
Washington, DC 20002
Phone: (202) 651-5515
SC, MHC (2000)

Patricia Hudson, CACREP Liaison
Department of Counseling/Human and Organizational Studies
George Washington University [3/84]
Graduate School of Education and Human Development
2134 G Street NW
Washington, DC 20052
Phone: (703) 549-6935
*CC, SC, CE:EdD (2000)

FLORIDA

Scott Gillig, CACREP Liaison
ADSOE/Counseling Program
Barry University [10/95]
11300 NE 2nd Avenue
Miami Shores, FL 33161-6695
Phone: (305) 899-3711
MHC, SC (2002)

F. Donald Kelly, CACREP Liaison
Florida State University [10/95]
College of Education
215 Stone Building
Tallahassee, FL 32306
Phone: (850) 644-9439
CC/CrC, SC, MHC (2002)

Judith Provost, Chair
Graduate Studies in Counseling
Rollins College [4/94]
1000 Holt Avenue, Box 2726
Winter Park, FL 32789-4499
Phone: (407) 646-1567
CC, SC (2001)

Diane Shepard-Tew, CACREP Liaison
Counselor Education Program
University of Central Florida [11/97]
Educational Services Department
Orlando, FL 32816-1250
Phone: (407) 823-5829
MHC, SC (2004)

Peter Sherrard, CACREP Liaison
Counselor Education Department
University of Florida [3/81]
1215 Norman Hall
Gainesville, FL 32611
Phone: (352) 392-0731, ext. 234
*MFC/T, MHC, SC (2003); *CE:PhD/EdD (1999)

Judith Lombana, CACREP Liaison
Counselor Education Program
University of North Florida [11/98]
College of Education and Human Services
St. Johns Bluff Road South
Jacksonville, FL 32224-2645
Phone: (904) 646-2838
*MHC (2000)

GEORGIA

Michael L. Baltimore, CACREP Liaison
Department of Counseling and Clinical Programs
Columbus State University [11/94]
4225 University Avenue
Columbus, GA 31907-5645
Phone: (706) 568-2222
CC (2001); *SC (1999)

Richard M. Smith, Chair
Counseling and Psychological Services
Georgia State University [3/80]
Atlanta, GA 30303-3083
Phone: (404) 651-2550
*CC, SC, CE:PhD (2000)

Richard Page, CACREP Liaison
Counseling and Human Development Services
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Arthur A. Hitchcock Distinguished Professional Service Award

Howard B. Smith
Carl D. Perkins Government Relations Award

Lawrence Brammer
ACA Professional Development Award

Kailas de Voux
Glen E. Hubele National Graduate Student Award

ACA AWARDWINNERS—1998 (continued)

Bryan E. Robinson
ACA Extended Research Award

Claire H. Usher Miner
ACA Research Award

W. Larry Osborne
ACA Research Award

Report of the ACA Ethics Committee: 1997–1998

Stephen Shumate
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This report summarizes the activities of the American Counseling Association's (ACA) Ethics Committee for 1997–1998. Summary data of the complaints filed and the inquiries received are presented along with a discussion of the other activities of the committee.

Since 1991, the American Counseling Association (ACA) Ethics Committee (American Association for Counseling and Development, 1991; ACA, 1992; Forester-Miller & Shumate, 1998; Garcia, Glosoff, & Smith, 1994; Garcia, Salo, & Hamilton, 1995; Salo, Forester-Miller, & Hamilton, 1996; Smith, 1993; has submitted an annual report of its activities to the membership through the *Journal of Counseling & Development*'s archival edition. These reports provide the membership with summary data concerning complaints filed against ACA members, adjudication results of complaints against ACA members, ethical inquires processed by the ACA staff and ACA Ethics Committee cochairs, and educational activities of ACA Ethics Committee members. This report also includes information relating to other activities of the ACA Ethics Committee.

PROCESSING COMPLAINTS

The ACA Ethics Committee processes ethical complaints submitted against members of the ACA following the *Policies & Procedures for Processing Complaints of Ethical Violations* (ACA, 1997). Complaints are received at ACA headquarters, and the staff liaison forwards the complaints to one of the committee cochairs for an initial review. The committee cochair then determines whether the behavior of the accused, if it has occurred, would violate the *ACA Code of Ethics and Standards of Practice* (ACA, 1995) and whether the committee should adjudicate the complaint. If the cochair determines that the case should be adjudicated, a formal statement indicating the potential codes that may have been violated is sent to the complainant for his or her signature. Once this signed formal statement is returned to the ACA, the statement, all supporting documents, and a copy of the *ACA Code of Ethics and Standards of Practice* (ACA, 1995), which explains the adjudication process, are forwarded to the accused member. The accused member then has an opportunity to respond to the complaint and may submit any supporting documents he or she wants the committee to consider during adjudication. Once all documents are received, the committee proceeds to adjudication.

If the committee determines that an ethical violation has occurred, the committee can apply the following sanctions: (a) stipulate remedial requirements; (b) designate a probationary period of time, which may include remedial requirements; (c) suspend the member from the ACA for a specified time, which may include remedial requirements; and (d) specify permanent expulsion from the ACA. The member has the right of appeal. After the appeals process has been exhausted and in cases in which the member has been found to be in violation of the *ACA Code of Ethics and Standards of Practice* (ACA, 1995), and the sanction is suspension or expulsion, the member's name, the sanctions, and the ACA ethical code sections violated are published in the ACA newspaper, *Counseling Today*.

COMPLAINTS AND INQUIRIES

Ethical Complaints

During the 1997–98 year, the ACA Ethics Committee received 14 new complaints and accepted 5 new cases. Nine cases were denied for lack of substance or jurisdiction. Of these 5 new cases, 2 were ready for adjudication at year end, and 3 remain in process.

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With the ACA Governing Council approval and publication of the revised *Policies and Procedures for Processing Complaints of Ethical Violations* (ACA, 1997), and the subsequent time limits imposed for complainant and accused responses to the adjudication process, the committee was able to close or otherwise take action on a large number of open but dormant cases. The committee moved forward with 34 pending cases. At year end, only 18 cases remained open and 6 cases were ready for adjudication during the committee's fall 1998 meeting. There are no cases presently under appeal.

Two sanctions were applied during the past year. In one case, the member was expelled permanently from ACA membership. In the other, a remedial sanction was extended for a specified time due to extenuating circumstances.

Ethical Inquiries

A significant mission of the ACA Ethics Committee and the ACA Center for Effective Counseling Practice is to provide guidance and advice to members who have ethical questions or dilemmas. During the 1997–98 year, 534 ethical inquiries were received at the ACA. This number reflects a significant increase relative to previous annual reports of ACA ethical inquiries. Part of this dramatic increase represents a more accurate accounting by the ACA of the ethical inquiries it receives. However, there is little doubt that professional counselors are becoming more informed and concerned about ethical issues arising in their practice and the potential legal implications of their professional conduct.

Over one half (276) of these inquiries concerned issues of confidentiality. The second-ranking category of concern was the counseling relationship. This category reflects questions about dual relationships, appropriate counseling techniques, and other subjects germane to the therapeutic interaction between client and counselor. One hundred ten inquiries were received concerning the counseling relationship. Professional responsibility (86), relationships with other professionals (22), assessment and test interpretation (19), and teaching and supervision issues (21) made up the remaining general areas of inquiry.

DISCUSSION

During 1997–98, the ACA Ethics Committee and ACA staff made a concerted effort to resolve a large number of pending and dormant ethics cases left over from previous years. To a large degree, we were aided by the implementation of the revised *Policies and Procedures for Processing Complaints of Ethical Violations* (ACA, 1997), which added specific time limits for complainant and accused procedural responses to the committee. Although these actions enabled the committee to close or otherwise dispose of a large number of open cases, it also created a bottleneck of pending adjudication that the committee and a recently approved ACA adjudication panel must address during the upcoming year.

With the advent of professional counselor certification and licensure comes professional recognition and the reality that as professionals we are an increasingly frequent object of litigation, either as a party or a witness. Consequently, ACA staff and ACA Ethics Committee members now receive a level of ethical inquiry whose numbers rise exponentially each year. This dramatic increase in the number of inquiries strains the ability of committee and ACA staff to respond promptly. As a point of comparison, the American Psychological Association (APA) has approximately nine paid staff members who address ethical issues for their membership. The ACA has only a .5 full- time equivalent staff member dedicated to ethics matters. With the implementation of a separate ACA adjudication board next year, the committee may be able to assist ACA staff in responding to member ethical inquiries in a more timely fashion.

OTHER COMMITTEE ACTIVITIES

Adjudication Panel

During 1996–97, the ACA Ethics Committee designed a proposal for the formation of an independent adjudication panel. The panel was approved by the ACA Governing Council during 1997–98, and the committee was directed to develop an application and appointment process, which should be completed and implemented by the 1998–99 ACA Ethics Committee and ACA president.

Educational Activities

The committee reviewed and revised a final draft of *The Layperson's Guide to Counselor Ethics: What You Should Know About the Ethical Practice of Professional Counselors*. This is a consumer-oriented booklet to be published by the ACA and available for purchase at cost. The final draft of this project will be submitted for ACA Governing Council approval at their April 1998 meeting.

During 1997–98, the committee initiated the formation of an ongoing ethics column in *Counseling Today*. The committee collaborated with *Counseling Today* staff and published two columns by committee members (Gressard & Keel, 1998; Hughes & Ruiz, 1998) during 1998 and continues to assign topics to its members on a quarterly basis and to solicit guest columns from professionals in the ethics field.

Coordination With State Counseling Licensure Boards

Each year, an ACA Ethics Committee member represents the committee by attending the American Association of State Counselor Boards' (AASCB) annual meeting. In addition, the committee has arranged to receive notice from the AASCB of professional counselors who have been disciplined by state counseling licensure boards. During 1998, the ACA received notice of more than 62 active (or at least active during the time of the alleged violation) ACA members who have violated the ethical standards of their respective state licenses. During 1998–99, the committee will decide whether or not ACA Ethics Committee cochairs should initiate com-

plaints against these members pursuant to Section G.1.c. of the *Policies and Procedures for Processing Complaints of Ethical Violations* (ACA, 1997).

Promoting Multiculturalism and Diversity Within the ACA Ethics Committee

During 1997–98, the committee developed and submitted a profile of its multicultural and diversity composition to the ACA president. In addition, the committee decided to submit an annual letter to the ACA president-elect with the standing committee's diversity profile and a strong request that new committee members and the new adjudication panel pool be selected to preserve multicultural and diversity representation.

MEMBERS OF THE ACA ETHICS COMMITTEE

Members of the 1997–1998 ACA Ethics Committee

Each year, two professional members of the American Counseling Association are chosen by the current ACA president and ratified by the ACA Governing Council to serve a 3-year term on the ACA Ethics Committee. The standing ACA Ethics Committee consists of six association members. For the 1997–1998 fiscal year, members of the ACA Ethics Committee were Stephen Shumate (cochair 1996–1998), Sherlon Brown (cochair 1997–1999), Anita L. Hughes, Charles F. Gressard, Linda Keel, and Nicholas Ruiz. Members of the committee wish to acknowledge the hard work and support of ACA headquarters staff, particularly Linda C. Tysl, Michael R. Espina, and Holly Clubb.

Copies of the *ACA Code of Ethics and Standards of Practice* (ACA, 1995) and *Policies and Procedures for Processing Complaints of Ethical Violations* (ACA, 1997) are available from the ACA; download this from the ACA web site at www.counseling.org, or write to the ACA Ethics Committee, c/o Michael R. Espina, American Counseling Association, ACA Center for Effective Counseling Practice, 5999 Stevenson Ave., Alexandria, VA 2230 (e-mail: cecp@counseling.org).

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