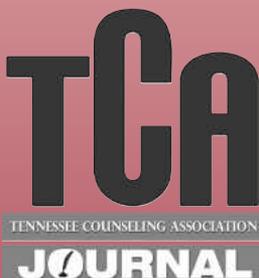


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Tennessee Counseling Association Journal

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Letter from the Editors

Dear Reader,

We are proud to announce that the *Tennessee Counseling Association Journal* won “Best State Journal (small branch)” at the 2008 American Counseling Association (ACA) conference in Honolulu, Hawaii! This success is to be shared by all of you who have supported *TCAJ* through state leadership and contributed by submitting and reviewing manuscripts. Thank you for your effort in supporting the state’s counseling journal, sharing your scholarly work, or serving as a reviewer. *TCAJ* is a success because of the collaborative efforts by Tennessee counseling professionals and counseling professionals outside Tennessee.

This is the second publication year of the *Tennessee Counseling Association Journal*. The editors extend their appreciation to the Tennessee Counseling Association (TCA) Governing Board’s continued sponsorship and support in publishing *TCAJ* as a hardcopy journal. This format gives *TCAJ* a visible and professional face while encouraging counselors to read and distribute *TCAJ* to fellow counselors and helping professionals.

The purpose of the *Tennessee Counseling Association Journal* remains constant: to promote professional growth and creativity of TCA members, Tennessee counselors, counselors nation-wide, and other helping professionals. We hope the empirical research and expository ideas shared in this journal hearten readers to provide best practices to clients, expand notions of counseling, and share innovative counseling strategies with peers.

The target audience for this journal is counselors in all specialty areas, and we invite manuscripts of interest for professionals in all areas of counseling. We welcome manuscripts that: (a) integrate theory and practice, (b) delve into current issues, (c) provide research of interest to counselors in all ar-

The Editors would like to acknowledge the following people for their contributions to and support of this edition of the *Tennessee Counseling Association Journal*: Jan Turner, President, Tennessee Counseling Association; Anna Shelsky, Past-President; Becky Murray, Executive Director; and Mary Brignole, President-Elect.

eas, and (d) describe examples of creative techniques, innovations, and exemplary practices.

Sincerely,

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Counselors' Continuing Education: An Exploratory Assessment of Activities and Perceived Value

S. Christian Smith, PhD & James M. Benshoff, PhD

A random sample of 597 National Certified Counselors was surveyed to assess counselors' continuing education activities. Recent and intended future choices of delivery methods, motivation for choosing activities, and value ratings of recent activities are described.

This article describes methodology and results of a national study of participation in continuing education by National Certified Counselors (NCCs). In addition, it presents an overview of the existing literature on continuing education and discusses the implications of findings for continuing education providers, counselors, counselor educators, and credentialing organizations (such as NBCC and state counselor licensure boards). This study is the first one to examine counselors' preferences for types of continuing education experiences and for delivery methods (e.g., online, workshops).

Participation in continuing education has grown substantially in the last three decades. Approximately 90 million Americans annually complete some form of professional learning to increase their professional knowledge, skills, and abilities (Kim & Creighton, 1999). This trend is also reflected in the counseling profession. Professional counselors are required to pursue continuing education activities by their membership organizations, licensure boards, and voluntary certification boards. The American Counseling Association (ACA) and its divisions encourage counselors to seek continuing education. Moreover, the importance of continued professional learning is reflected in professional ethical standards (e.g., American

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Counseling Association, 1995) that require professional counselors to upgrade their knowledge, skills, and abilities through ongoing learning. As key gatekeepers of the profession, counselor educators are in a unique position to influence the quality and direction of continuing education by emphasizing for new professionals the importance of continual learning. As leaders in the profession, counseling faculty influence the continuing education requirements of associations, certification boards, and licensure boards. Finally, as a primary source of continuing education activities, counselor educators have direct control of the quality of programs they offer.

State licensure laws also typically require continuing education. Because the goal of counseling licensure laws is to protect the public, requiring continuing education helps assure that counselors' professional knowledge is current, allowing them to offer services consistent with the latest clinical, legal, and ethical standards. ACA endorsed and published a model licensure law in 1995 (Glosoff, Benschhoff, Hosie, & Maki, 1995) that recognized the need for continuing education requirements to ensure ongoing quality of services by licensed professional counselors. This model legislation further required regular, documented continuing education as a requirement for licensure renewal. Authors of this model legislation also recommended that state licensure boards adopt the ACA Code of Ethics and Standards of Practice, which state that counselors have ethical obligations to continually upgrade and maintain their knowledge and abilities. By requiring licensees to upgrade their knowledge, skills, and abilities on an ongoing basis, states help assure that counselors are providing an acceptable level of service to the public (Kim & Creighton, 1999; Levy, 1990).

The National Board for Certified Counselors (NBCC), which certifies professional counselors in the United States and internationally, requires 100 hours of continuing education every five years for National Certified Counselors (NCCs) (Leary, 2000; NBCC, 1997). NBCC has developed an approval process for continuing education providers who offer training to counselors. This comprehensive approval process entails submission of a written application and fee, samples of previous continuing education offerings, plans for future offerings, qualifications of activity leaders, and a renewal process.

It is clear, then, that the master's degree is only the beginning of the education process for counselors (Levy, 1990).

Once a counselor graduates, he or she has a lifetime of continuing education ahead. NCCs must document an average of 20 hours of annual continuing education. Since there are almost 43,000 NCCs at present (NBCC, n.d.a), this means that NCCs alone must spend close to 860,000 hours annually in continuing education activities. If each of the more than 100,000 clinically trained counselors in the United States (Peterson, West, Tanielian, Pincus, Kohout, Pion et al., 2001) completed 20 hours of continuing education annually, over two million hours would be spent in (and on) continuing education by these professionals each year. Given this, it is reasonable to assume that counselors spend millions of dollars annually on continuing education activities. As mental health needs of our society are increasingly recognized and addressed, continuing education is a critical professional obligation to help assure that counselors are prepared to meet these evolving needs (Kim & Creighton, 1999; Levy, 1990).

Continuing education for professionals continues to change both in content and in delivery format. Continuing education activities are one important way that counselors access new information to help them develop new knowledge and skills (Kim & Creighton, 1999; Knox, 2003; Rubel, Sobell, & Miller, 2000) and meet the changing needs of their clients. One example of these changes is the growth in the number of older Americans and the resulting need for counselors with gerontology training (Lehrmann & Shreve, 1996). Catastrophic events, such as the terrorist attacks of September 11, 2001 and Hurricane Katrina, directly or indirectly affect thousands of people. Following these two events, there was a noticeable increase in the number of continuing education offerings on grief, trauma, and crisis response throughout the helping professions.

Another area that is changing in continuing education is the medium of delivery. NBCC categorizes continuing education activities into different types: college or university course; seminar, workshop, or conference; publication, presentation, or new program development; supervision or consultation; dissertation; leadership; and home study (NBCC, n.d.b). Counselors typically take advantage of a variety of these continuing education activities. In recent years, there seems to have been an increase in nontraditional methods of continuing education delivery, as opposed to such traditional forms of continuing education delivery as professional conferences and seminars

(Leary, 2000). These nontraditional delivery methods include print-based and online home study offerings. Anecdotal evidence suggests that nontraditional forms of continuing education, which often are more convenient and may require less investment of time and money, are gaining market share over traditional forms, particularly with young professionals (Spivey, 2005).

Although the goals of continuing education vary, a common theme is to enhance the knowledge, skills, and abilities of practitioners (American Association of Marriage and Family Therapists, 2001; American Counseling Association, 1995; American Counseling Association Practice Research Network, 2001; American Mental Health Counselors Association, 2000; American Psychological Association, 2002; American School Counselor Association, 1998; Aparicio & Willis, 2005; Association for Counselor Education and Supervision, 1993; Commission on Rehabilitation Counselor Certification, 2000; Council on the Continuing Education Unit, 1984; International Association of Marriage and Family Counselors, 1998; Levy, 1990; National Commission for Certifying Agencies, 2000). To achieve these goals, continuing education activities must be designed intentionally for adult learners (Creighton, Shafer, & Blaney, 1999). Kirshstein (1996) stated that optimal adult learning requires mutual respect between students and instructors, integration of previous knowledge and experience of adult students, input from adult students when choosing class materials and structure, interaction among students as well as discussion between the instructor and students, the instructor's ability to lead and assist adults in learning, and, finally, a learning environment that recognizes the importance of other life tasks and demands. Because counselors are adult learners, these learning factors are important to consider when assessing the quality of the continuing education learning process.

The purpose of the present study was to explore further the issue of continuing education delivery format and to identify factors contributing to counselors' choices of delivery format. In addition, this study assessed the value counselors assign to the various types of continuing education activities and delivery methods. Results of the study can inform continuing education providers, boards requiring continuing education, and counselor educators. Methodology for this study was approved by the Institutional Review Board at the university with which the authors were affiliated at the time of the study.

Method

Participants

The 596 participants were a sample of National Certified Counselors (NCCs) whose certification was current at the time of the survey and whose names were randomly generated by NBCC from its database of NCC certificants. According to Loesch and Vacc (1993), limiting the subject pool to NCCs is appropriate given that the NCC population represents a broad spectrum of persons who identify themselves as counselors. Participants received a postcard informing them about the study, followed by the survey packet with a postage-paid return envelope. One week later, a reminder letter was sent to all participants whose surveys had not been received; a reminder e-mail was also sent to all participants (with a valid e-mail address) whose surveys had not been received. These procedures resulted in 359 completed surveys, for a return rate of 60.2%. The majority of respondents were women (76.3%, $n = 274$). Most indicated that their highest counseling-related degree was a master's (78.6%, $n = 276$), while 12.3% ($n = 43$) held doctorates and 9.1% ($n = 32$) held educational specialist degrees. The overwhelming majority of respondents were white (87.7%, $n = 315$). Clinical work was the most common job responsibility (46.5%, $n = 167$), while 23.7% ($n = 85$) of respondents indicated that education was their primary responsibility.

Instrumentation

For purposes of this study, an instrument was created to measure the desired variables (see Appendix A). This instrument was developed based on related studies, relevant literature, and continuing education materials published by NBCC. A cover letter outlined the protocol and instructions of the study. Participants were then asked to respond to demographic questions and to several questions about factors that were important to them when choosing continuing education activities. Participants also responded to several items concerning their past and intended future choices in continuing education activities. Response choices to these questions were based largely on NBCC's recertification standards, since respondents were current certificants of NBCC and therefore required to document their continuing education activities in this format.

Finally, participants were asked to provide detailed information about two continuing education activities they had completed within the 12 months prior to receiving the survey. The first question for each activity asked participants to indicate the type of continuing education activity. They were then asked to rate the extent to which the activity was consistent with factors that contribute to a successful adult learning event. These questions were largely based on adult learning theory and factors that have been identified as important to a successful adult learning event (Kirshstein, 1996), including participants' opportunities to use previous knowledge and experiences; provide input into structure and learning materials used; participate meaningfully with the instructor and other participants, and have individualized instruction outside of normal scheduled activity times. A subsequent question assessed the perceived value of the activity in terms of developing counseling-related knowledge and skills, as well as personal interest or enjoyment. Participants were then asked whether they would recommend this activity to others, a commonly used measure of customer satisfaction. Finally, participants were asked how the activity might have been improved.

Results

When asked to identify important factors when choosing continuing education activities, counselors indicated a variety of factors. Most often selected factors were cost ($n = 305$; 86.9%), practical content ($n = 286$; 81.5%), and distance to activity ($n = 275$; 78.3%). Factors chosen least often were desirability of activity location ($n = 112$; 31.9%) and opportunity for interaction with other professionals ($n = 124$; 35.3%). When asked to identify the single most important factor when choosing continuing education activities, participants most frequently selected practical content ($n = 115$; 37.7%), cost ($n = 65$; 21.3%), and preapproval of activity by a certification or licensure board ($n = 42$; 13.8%). Factors chosen least often were opportunity for interaction with other professionals ($n = 2$; 0.7%) and desirability of activity location ($n = 3$; 1%). These results suggest that counselors tend to seek out continuing education experiences with practical content that are also convenient in terms of schedule and location.

When participants were asked to identify their continuing education activities during the previous 12 months, the most

common activities reported were attending seminars, workshops, and conferences ($n = 318$; 90.6%), receiving counseling-related supervision or consultation ($n = 116$; 33%), and giving professional presentations ($n = 111$; 31.6%). Seminars, workshops, and conferences were by far the most commonly chosen activities. The least common continuing education activity was completing dissertation work ($n = 3$; 0.9%). Participants were also asked to identify the delivery formats they participated in most often. Attending seminars, workshops, or conferences was by far the most frequent choice ($n = 198$; 63.5%), while completing dissertation work was not chosen by any participants ($n = 0$; 0%).

Participants were also asked about continuing education activities in which they intended to participate during the 12 months following completion of the survey. Attending seminars, workshops, or conferences was selected by more than nine out of 10 participants ($n = 334$; 95.7%), while the least chosen activity continued to be completing dissertation work ($n = 6$; 1.7%). In addition to identifying types of activities in which they intended to participate, participants were asked to identify the intended format for these learning experiences. Once again, attending seminars, workshops, or conferences was the most common choice ($n = 214$; 69.7%). Holding leadership positions ($n = 3$; 1%), completing dissertation work ($n = 3$; 1%), developing new counseling related courses, seminars, workshops, or community programs ($n = 3$; 1%), authoring publications ($n = 4$; 1.3%), giving professional presentations ($n = 5$; 1.6%), and other ($n = 1$; 0.3%) were selected by a surprisingly small number of respondents. These findings are similar to those regarding activities used in the previous 12 months, suggesting that counselors' choices in continuing education activities are not likely to change dramatically in the near future.

Almost two-thirds of participants ($n = 216$; 63.9%) indicated that they received financial support and/or time off for continuing education activities from their employer. This finding is important because of the relatively high number of hours counselors must dedicate to continuing education and the typically modest salaries counselors earn. Participants also were asked how many credentials they held that required continuing education hours. Because all participants were NCCs, they were known to hold at least one such credential. The modal response was two professional credentials ($n = 142$;

44.9%), with nearly 98% indicating that they had four or fewer professional credentials ($n = 309$; 97.8%).

Although another purpose of the present study was to assess counselors' use of online continuing education activities, the number of participants indicating past or intended future use of online activities was relatively small. However, the number of individuals intending to engage in online learning in the future 12 months ($n = 86$; 24.6%) was nearly twice as large as the number who had used them in the last 12 months ($n = 45$; 12.8%). These results suggest that the vast majority of counselors have little experience with online continuing education and do not anticipate participating in such activities in the near future. However, given the anticipated growth rate to nearly one-fourth of counselors using online activities in the next 12 months, online activities still could constitute a significant portion of continuing education in the next 3–5 years.

In anticipation of the relatively low use of online activities, respondents who had not participated in online activities were asked to indicate the factors that had deterred them. Preference for other forms of continuing education was the most common reason chosen ($n = 142$; 54.8%), with slightly over half of respondents selecting it. Concerns about online privacy ($n = 22$; 8.5%) and security ($n = 28$; 10.8%) were the least common choices. Thus, although most respondents did not indicate concerns with privacy and security issues online, they still preferred face-to-face forms of continuing education, including attending seminars, workshops, and conferences. One possible explanation for these results is that counselors who are satisfied with the availability and quality of traditional forms of continuing education may have little motivation or need to seek out online options.

Participants were asked to respond to a series of questions about recent interactive continuing education activities. In addition to indicating type of activity, they were asked to rate each activity on five factors common to successful adult learning events and on four measures of satisfaction. Regarding the adult learning factors, respondents rated the majority of activities highly on using previous knowledge and/or experiences, on having meaningful interactions with the instructor during the course of instruction, and on having meaningful interactions with other participants. These responses may be due in part to the fact that most of the activities were traditional continuing education experiences such as conferences

and workshops. *Took a college or university course and received supervision or consultation* were rated highly in all areas of adult learning theory. These activities were rated lower by most respondents on ability to provide input into structure and choice of learning materials used and on having individualized instruction outside of normal scheduled activity times. These lower ratings are to be expected given the nature of continuing education activities. Continuing education providers typically put together a program and then advertise it to counselors, allowing counselors to select options that meet their interests. Therefore, although providing input into the structure and learning materials used might make for a more effective adult learning event, it may not be feasible given the nature of many continuing education experiences. Similarly, most continuing education activities have specific beginning and ending times; participants pay for the content included in that timeframe, with little to no opportunity for additional individualized instruction.

To assess participants' satisfaction with past continuing education activities, they were asked to rate activities on providing professionally useful knowledge about specific topics, acquisition of new counseling skills, and personal interest or enjoyment. The majority of activities were rated highly in all three of these areas, with acquisition of new counseling skills rated lowest of the three. Additionally, when respondents were asked if they would recommend the activity to others, they indicated that they would recommend more than 9 out of 10 activities. These findings indicate that counselors generally report being satisfied with the vast majority of their continuing education experiences. Continuing education providers, however, may want to consider increasing emphasis on development of new counseling skills through these activities. This is an important finding since most counselors are required to participate in such activities.

Post-hoc analyses were performed to determine which factors were related to past and intended future choices in continuing education activities. A positive relationship was found between the activity used most often in the previous 12 months and the activity intended to be used most often in the next 12 months. In other words, counselors' choices in continuing education activities seem unlikely to change significantly in the near future. This again supports the conclusion that seminars, workshops, and conferences will likely con-

tinue to dominate counselors' continuing education activities, at least in the short term. From an educational perspective this is acceptable, since the vast majority of seminars, workshops, and conferences are rated highly. However, as technology becomes more common in counselor education and in the workplace, counselors' use of online activities should also be expected to increase.

Finally, post hoc analyses were performed to determine if there was a relationship between activity type and five factors common to successful adult learning events. Positive relationships were found between the type of activity selected and the following adult learning factors as rated by participants: the extent to which they felt able to provide input into the structure of the educational experience and learning materials used; meaningful interactions with the instructor during the course of instruction; individualized instruction outside of normal scheduled activity times; and, meaningful interactions with other participants. This finding, combined with those previously discussed, is encouraging, since it supports the value of the vast majority of continuing education activities as adult learning events.

Discussion

Several important conclusions can be drawn from the results of this study. The most important motivating factors for counselors in selecting continuing education activities seem to be practical content, cost, preapproval by a certification or licensure board, and distance to the activity. These results are logical given that the majority of counselors' primary job responsibilities are clinical. Clinical counselors need affordable practical information and training that will contribute to their effectiveness with clients. Activities requiring travel also involve higher expenses as well as time away from their clients, decreased billable hours, or time off from an employer. Fortunately, the majority of counselors receive some type of employer support for continuing education.

Findings about counselors' preferences for the format of continuing education activities were clear and somewhat surprising. Participants in this study still seemed to overwhelmingly prefer seminars, workshops, and conferences to other forms of continuing education. Most respondents had chosen

seminars, workshops, and conferences in the past, and intended to choose these formats again in the future. This likely indicates that the current supply of continuing education topics and formats meets the needs of counselors. In other words, the traditional forms of continuing education that dominate the current marketplace do so because they meet the educational, professional, and social needs of counselors. Results of this study also indicated that, although the use of online formats is currently fairly low overall, counselors' use of online continuing education likely will increase in the short term. Although the primary reason given for not using online activities was preference for other forms of continuing education, this preference will likely change as the number of available online activities grows and as counselors become more accustomed to the format of online learning.

One interesting finding of this study was that although counselors seemed quite satisfied with the quality and adult-learning approaches of their past continuing education experiences, they have little opportunity to provide input into the structure of the activity or to have any individualized instruction. Based on these findings, it appears that continuing education providers could further enhance their programs by creating ways to incorporate more participant input and individualized instruction into these professional learning experiences. By communicating with participants before the event takes place, presenters could tailor the learning experience to the specific needs of the group. In addition, follow-up with individual participants would further the learning opportunities of the continuing education experience.

Two limitations to the present study should be noted. First, all data was self-report, and as such is subject to the constraints of this survey method. Second, satisfaction ratings and ratings related to adult learning cannot necessarily be assumed to correlate with learning levels.

Implications and Recommendations

Results of this survey indicate that the market for traditional face-to-face seminars and conferences will likely remain very strong for at least the near future. The importance of distance and cost to respondents suggests that providers should continue offering local and regional programs at reasonable costs.

In addition, providers should make practical content their top priority, as this is the single most important factor cited by counselors. Perhaps the challenge is for providers to offer the right mix of theoretical and practical, skills-based information in each of their continuing education offerings.

Certification and licensure boards can use this information as they consider updating their continuing education standards. Although the use of online continuing education activities remains low, it appears that the use of such activities could grow substantially in the future. The percentage of respondents who indicated that they intended to use online continuing education activities in the next 12 months ($n = 86$; 24.6%) is nearly double the percentage that said they had in the previous 12 months ($n = 45$; 12.8%). This pattern, coupled with the growth of online counseling and supervision, makes counselors' ongoing technical training a more important issue for certification and licensure boards. To protect the public, these boards must strive to assure counselors' competence in using these new technologies. In addition, the majority of counselors considered board preapproval of an activity an important factor in selecting continuing education options. This demand offers certification and licensure boards an opportunity to endorse the value of their provider-approval processes and to affect positively the quality of their certificants' continuing education activities.

Several outcomes of the present study have implications for counselor educators. The growing use of online continuing education activities is one more example of the importance of technical training. By incorporating technology into their counselor training programs, counselor educators can help assure that future counselors are prepared for the increasingly technical workplace and make them more comfortable with online continuing education. Future studies addressing how well training programs prepare counselors to be lifelong learners may be valuable (Shumway, 2004). Additionally, results of this study may provide a valuable starting point for counselor education programs as they consider types of continuing education activities and delivery options they might offer. Future research also might further explore barriers to these opportunities.

Research that examined reasons for counselors' overwhelmingly positive recommendations of continuing education activities also would be beneficial. For example, counselors may

recommend activities they enjoyed even if those activities did not lead to knowledge or skill development. Conversely, research may show that counselors learn the most from activities they enjoy the least and as such do not recommend them to other counselors. This additional detail would allow for more useful interpretation of satisfaction data. Although results of the present study indicate that counselors would recommend over 90% of continuing education activities to their colleagues, the reasons behind these recommendations were not assessed in this study. This additional information would contribute to a deeper understanding of counselors' reactions to different delivery methods and content areas. Finally, measuring actual changes in counselors' practice following continuing education would have provided valuable information to the present study. Improved practice is the ultimate goal of continuing education and future studies measuring such changes will greatly contribute to the literature.

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4. For the period of the previous 12 months, including this month, select the categories that best describe your continuing education activities.

<u>Activities Used</u>	<u>Activity Used Most Often</u>	<u>Activities</u>
<input type="checkbox"/>	<input type="checkbox"/>	Taken college or university courses
<input type="checkbox"/>	<input type="checkbox"/>	Attended seminars, workshops, or conferences
<input type="checkbox"/>	<input type="checkbox"/>	Authored publications (e.g., article in a refereed journal, chapter in an edited book, published book)
<input type="checkbox"/>	<input type="checkbox"/>	Given professional presentations
<input type="checkbox"/>	<input type="checkbox"/>	Developed new counseling-related courses, seminars, workshops, or community programs
<input type="checkbox"/>	<input type="checkbox"/>	Received counseling-related supervision or consultation
<input type="checkbox"/>	<input type="checkbox"/>	Completed dissertation work
<input type="checkbox"/>	<input type="checkbox"/>	Held leadership positions (e.g., association officer, journal editor)
<input type="checkbox"/>	<input type="checkbox"/>	Completed print based home study activities
<input type="checkbox"/>	<input type="checkbox"/>	Completed online activities
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____

5. For the period of the next 12 months, not including this month, select the categories that best describe your intended continuing education activities.

<u>Activities Intend to Use</u>	<u>Activity Intend to Use Most Often</u>	<u>Activities</u>
<input type="checkbox"/>	<input type="checkbox"/>	Taken college or university courses
<input type="checkbox"/>	<input type="checkbox"/>	Attended seminars, workshops, or conferences
<input type="checkbox"/>	<input type="checkbox"/>	Authored publications (e.g., article in a refereed journal, chapter in an edited book, published book)
<input type="checkbox"/>	<input type="checkbox"/>	Given professional presentations
<input type="checkbox"/>	<input type="checkbox"/>	Developed new counseling-related courses, seminars, workshops, or community programs
<input type="checkbox"/>	<input type="checkbox"/>	Received counseling-related supervision or consultation
<input type="checkbox"/>	<input type="checkbox"/>	Completed dissertation work
<input type="checkbox"/>	<input type="checkbox"/>	Held leadership positions (e.g., association officer, journal editor)
<input type="checkbox"/>	<input type="checkbox"/>	Completed print based home study activities
<input type="checkbox"/>	<input type="checkbox"/>	Completed online activities
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify: _____

6. If you have completed online continuing education activities in the past, please skip this question and go to question 7. If you have not, please indicate the factors that have deterred you from completing online continuing education activities. (check all that apply)

- Concerns about online security
- Concerns about online privacy
- Limited internet access
- Cost of activity
- Concerns about certification or licensure board approval of activity
- Lack of interesting topics
- Prefer other forms of continuing education activities
- Other, please specify: _____

7. How many counseling-related credentials do you hold that require continuing education hours? _____

8. Does your employer provide financial support and/or time-off for continuing education activities?

- no yes

9. Are you currently enrolled in a graduate degree program?

- no yes

Section II

Continuing Education Activity #1

Please answer the following questions about the last interactive counseling-related continuing education activity you completed.

1. Type of activity (check one):

- Took a college or university course (face-to-face)
- Attended a seminar or workshop
- Attended a conference
- Received supervision or consultation
- Completed print-based home-study activities
- Participated in online activities (e.g., online course, workshop, etc.)
- Other, please specify: _____

2. To what extent did this activity allow you to (circle your rating for each item):

	<u>Not At All</u>	<u>A Little</u>	<u>Some</u>	<u>A Great Deal</u>
a. Use your previous knowledge and/or experiences	1	2	3	4
b. Provide input into the structure and learning materials used	1	2	3	4
c. Have meaningful interactions with the instructor during the course of instruction	1	2	3	4
d. Have individualized instruction outside of normal scheduled activity times (e.g., tutorials, one-on-one sessions with the instructor)	1	2	3	4
e. Have meaningful interactions with other participants	1	2	3	4

3. Rate the value of this activity in terms of the following (circle your rating for each item):

	<u>Not At All</u>	<u>A Little</u>	<u>Some</u>	<u>A Great Deal</u>
a. Providing professionally useful knowledge about specific topics (e.g., new regulations or policies)	1	2	3	4
b. Acquiring new counseling-related skills	1	2	3	4
c. Personal interest or enjoyment	1	2	3	4

4. Would you recommend this activity to others?

- no yes

5. How might this activity have been improved?

Continuing Education Activity #2

Please think about a second interactive counseling-related continuing education activity you have completed and answer the following questions.

1. Type of activity (check one):

- Took a college or university course (face-to-face)
- Attended a seminar or workshop
- Attended a conference
- Received supervision or consultation
- Completed print-based home-study activities
- Participated in online activities (e.g., online course, workshop, etc.)
- Other, please specify: _____

2. To what extent did this activity allow you to (circle your rating for each item):

	<u>Not At All</u>	<u>A Little</u>	<u>Some</u>	<u>A Great Deal</u>
a. Use your previous knowledge and/or experiences	1	2	3	4
b. Provide input into the structure and learning materials used	1	2	3	4
c. Have meaningful interactions with the instructor during the course of instruction	1	2	3	4
d. Have individualized instruction outside of normal scheduled activity times (e.g., tutorials, one-on-one sessions with the instructor)	1	2	3	4
e. Have meaningful interactions with other participants	1	2	3	4

3. Rate the value of this activity in terms of the following (circle your rating for each item):

	<u>Not At All</u>	<u>A Little</u>	<u>Some</u>	<u>A Great Deal</u>
a. Providing professionally useful knowledge about specific topics (e.g., new regulations or policies)	1	2	3	4
b. Acquiring new counseling-related skills	1	2	3	4
c. Personal interest or enjoyment	1	2	3	4

4. Would you recommend this activity to others?

no yes

5. How might this activity have been improved? _____

Please return the survey in the enclosed envelope. Thank you for your assistance

Graduation Rates of Professional School Counselors in Tennessee: CACREP Versus nonCACREP Programs

Julie S. Chibbaro, PhD, Susan R. Boes, PhD, & Brent M. Snow, PhD

Council for Accreditation of Counseling and Related Educational Programs (CACREP) and nonCACREP universities train professional school counselors for similar school counseling positions. However, faculty at differently accredited universities operate under different mandates and guidelines. In an attempt to identify if accreditation status impacts school counselor graduation rates, this paper explores the graduation rate of school counseling training programs in Tennessee and nearby southern states from both accredited and nonaccredited universities.

The roots of professional counseling can be traced back to Frank Parsons in 1908, however it is only in the past 25 years, since 1981, that the profession of counseling has created its' own entity for developing and maintaining educational standards (Adams, 2006). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is a voluntary accreditation body that plays a significant role in standardizing the counselor's scope of practice, and serves to elevate the profession as a whole (Paisley & Borders, 1995; Smaby & D'Andrea, 1995). CACREP provides guidelines that reflect the profession's expectations, promotes professional quality, and strengthens the profession's credibility (Accredited Counselor Education Programs, 1982; Bobby & Kandor, 1992). Nonaccredited programs establish their own guidelines

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and curriculum criteria. These guidelines are established by school counseling faculty members who use past school counseling experiences, state requirements, and professional preferences to guide them.

The American School Counseling Association (ASCA) developed the National Standards for School Counseling Programs (Campbell & Dahir, 1997) to ensure counselor training matches the demands of 21st century students. Additionally, the ASCA National Model (ASCA, 2005) was developed as a model framework to provide K-12 school counselors the structure needed to guide their programs and interventions to students. The Transforming School Counseling Initiative (TSCI) preceded these ASCA developments and was “the impetus for seeking and developing the fundamental changes needed to bring the work of school counselors into alignment with the mission of schools for the 21st century” (Martin, 2002, p. 148).

A key factor of the ASCA National Model, the National Standards, and TSCI is an educational focus connecting school counseling programs to the total school program. In this capacity professional school counselors (PSC) work with other educators to fulfill the mandates of the No Child Left Behind (NCLB, 2001) legislation. Curry and Lambie (2007) found PSC are involved in the national standards-based movement and thus are expected to be accountable for providing comprehensive, developmental programs. Because of the demands within the school system and state, PSC need robust counselor education training programs.

In addition to training school counseling candidates in the areas of academic success, career preparation, and social emotional development, PSC in the 21st century must be trained to meet multiple demands. These include being advocates for social justice (Bailey, Getch, & Chen-Hayes, 2007; House & Martin, 1999), bridging the gap and helping with the education of low income children (Amatea & West-Olatunji, 2007), developing diversity training for school personnel (McFarland & Dupuis, 2001), and using and understanding data that effectively demonstrates changes in student behavior and in academics (Stone & Dahir, 2007). PSC must be prepared to meet contemporary students' needs while navigating through the educational landscape of the new millennium.

In January 2008, House Joint Memorial Bill 3 was introduced for legislation. The bill, entitled “Study School Staff Shortage Issues” predicts shortages of school counselors,

nurses, and other professional instructional support personnel in public schools and charter schools. Shifting populations and increasing numbers of school-aged children are discussed as variables contributing to this shortage. The bill purports that some states may have seen a slight increase in school counselors employed during the 1990s; this increase has not kept pace with increased student enrollment. The ratio of students to counselors has remained approximately the same as it was prior to hiring new counselors.

Data collected from the U.S. Department of Education, National Center for Education Statistics (2007) depicts student-to-counselor ratios in the United States. The state of Tennessee has approximately 953,928 students in grades K-12, with a total of 2,023 counselors, which estimates one counselor for every 472 students. Of the 2,023 total school counselors, 1,157 serve in the elementary schools having a 572:1 students to counselor ratio and 866 serve as secondary school counselors with a 320:1 ratio. Data describing Tennessee's neighboring southern states of Florida, Georgia, Kentucky, South Carolina, and Texas show overall student to counselor ratios of 479:1 (FL); 452:1 (GA); 467:1 (KY); 395:1 (SC); and 444:1 (TX). According to ASCA (2005), the recommended maximum ratio of students to counselors for all grade levels should be 250:1. Because graduation rates of school counseling training programs is one determining factor which addresses potential shortages in the profession, this present study compared the sum of school counseling graduates in the state of Tennessee to nearby training programs in the southern United States from both accredited and nonaccredited universities.

CACREP Accredited Programs

As a voluntary accreditation body, CACREP was created for three primary purposes: (a) to provide guidelines that reflected the profession's expectations, (b) to promote professional quality, and (c) to strengthen the profession's credibility (Accredited Counselor Education Programs, 1982; Bobby & Kandor, 1992). Of the scant literature found addressing graduates of CACREP and nonCACREP accredited programs, many of the articles were outdated. Bobby and Kandor (1992) investigated hindrances, which programs identified that kept them from seeking CACREP accreditation. Findings included the 600

clock-hour internship CACREP requirements and the student-to-faculty ratios set by CACREP. Some programs identified by Bobby and Kandor had concerns such as the 48 semester hour program (72 quarter hour), the requirement of a minimum of 2 full-time faculty members (currently 3 full-time faculty members) in an individual program, and the 20–1 (now 10–1) advisor/advisee ratio. These standards are reflective of the 2001 CACREP standards, not the recently accepted 2009 CACREP standards (CACREP, 2006). Adams (2006) reported that counselor educators have been concerned over the past four decades about a myriad of issues surrounding accreditation including required number of hours and required coursework.

Akos and Scarborough (2004) examined internships for pre-service counselors, which CACREP considers, along with practicums, to be the most critical experiences of a program. They investigated both CACREP accredited and nonCACREP programs. A qualitative analysis of internship program syllabi determined vast disparities in nonCACREP program's expectations for students enrolled in internships. Yet, in programs accredited by CACREP, clinical experiences were regulated and adhered to specific standards. After reviewing the literature no studies were found specifically addressing the number of school counseling graduates from CACREP versus non-CACREP accredited programs. However, Milsom and Akos (2007) examined the relationship between school counselors' preparation at programs accredited by CACREP and national certification for school counselors. Their study indicated that graduates of CACREP accredited programs obtained the National Certified Counselor credential, while graduates of non-accredited programs obtained the National Certified School Counselor credential.

Method

The collection of data for this study was based on a review, analysis, and compilation of information found in various directories of members from 1995–2002 published by the American Association of Colleges for Teacher Education (AACTE). Part of each directory includes an analysis of the number of graduates from AACTE member institutions. These member universities and colleges submit an annual report through the AACTE/National Council for Accreditation of Teacher Educa-

tion (NCATE) Professional Education Data System and information is presented for teachers, administrators, and school counselors. The data is approximately two-years-old when published in each directory so information found in the 2002 directory is actually reporting data from 2000, the 2001 directory from data for 1999 and so on. After the 2002 directory, however, information for counseling is not identified specifically but is grouped under “advanced” programs. Information about school counseling graduates (or *completers*, as used by AACTE) was available only through the 2002 directory.

The data collected by AACTE is considerable and is specified for each member institution. AACTE (2002) describes itself as follows:

AACTE and its predecessors reflect educator preparation’s evolution from normal schools to colleges to comprehensive universities. Together, they graduate more than 90% of new school personnel entering the profession each year in the United States. In addition, AACTE has a growing number of affiliate members, including state departments of education, community colleges, educational laboratories and centers, and foreign institutions and organizations (p. 1).

The authors are unaware of any other databases that even approximate the information about school counselors as that collected by AACTE. Clawson, Henderson, Schweiger and Collins (2004), along with predecessors, (Hollis & Dodson, 2000; Hollis, 1997; Hollis & Wantz, 1990, 1994) have gathered considerable information about counselor education programs in the United States. While these authors have delineated helpful information including some data relative to admission and graduation rates, most of the numbers seem to be estimates and these works have not been published yearly with specific data for each year.

Using the database from AACTE, the authors identified colleges or universities located in the southern section of the United States reporting school counseling graduates (i.e., completers). The authors then identified CACREP status of each reporting institution. Those that were accredited were identified with the year accreditation was granted (CACREP, 2001). In the analysis of data, only graduates who completed the school counseling program during or after the year the program was accredited were considered CACREP graduates. Thus, an institution may have both graduates from a CACREP program and graduates from a nonCACREP program.

Results

Currently there are 12 universities having school counseling programs in the state of Tennessee that have reported data to AACTE. Only six universities currently have CACREP accreditation, although others may be in the application process. The number of school counseling graduates from each of the 12 universities is depicted in Table 1.

Tennessee School Counseling Programs

The University of Tennessee was the first program to acquire CACREP status in 1982. It was not until 1994 that the University of Memphis acquired CACREP status followed by East Tennessee State University and Peabody College, Vanderbilt University in 1999. Middle State Tennessee University acquired CACREP status in 2000 followed by the University of Tennessee – Chattanooga in 2003. Those programs not yet achieving CACREP accreditation status in Tennessee include Austin Peay University, Carson-Newman College, Memphis State University, Tennessee State University, Tennessee Technological University, and the University of Tennessee - Martin. The total number of graduates of school counseling programs in the state of Tennessee approximates 827 for the years 1995–2002 (AACTE, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002). Individual program numbers for these reporting years range from seven graduates at the University of Chattanooga to a high of 209 graduates from Tennessee Technological University. After institutions acquired CACREP status, the number of graduates tended to drop due to CACREP requirements and standards.

Top Ten Graduating Programs in the Southern Association of Counselor Education and Supervision Region

Comparing universities within the Southern Association of Counselor Education and Supervision (SACES) region, the top 10 universities with school counseling graduates from both CACREP accredited programs and nonCACREP accredited programs from 1995–2000 include: Eastern Kentucky University, Georgia State University, University of Georgia, University of South Carolina, and the University of West Georgia (CACREP); Georgia Southern University, Morehead State Uni-

TABLE 1
School Counselor Graduates by Programs in Tennessee

University	2002	2001	2000	1999	1998	1997	1996	1995	Total
Austin Peay	5	—	6	—	6	2	4	3	26
Carson-Newman	8	9	6	3	4	—	0	—	30
East Tennessee	—	13	—	—	16	—	10	—	39
Memphis State	—	—	—	—	—	—	—	13	13
Middle State Tennessee	—	5	13	33	22	20	13	9	115
Peabody College	13	11	—	5	5	1	1	0	36
Tennessee State	10	9	8	5	7	17	11	13	80
Tennessee Tech	13	34	38	38	44	13	7	22	209
University of Memphis	7	11	14	8	—	16	20	—	76
University of Tennessee	15	12	—	—	6	7	7	5	52
University of TN - Chattanooga	8	12	15	30	21	9	98	107	300
University of TN - Martin	—	4	10	—	5	—	19	6	44
Subtotal	79	120	110	122	136	85	190	178	1020

Note. These numbers represent the totals as reported to AACTE in a given year. They may not reflect actual numbers for each year as a university may collapse data and report numbers at different time frames. A dash (—) indicates no data available.

versity, Prairie View A&M University, University of South Florida, and Western Kentucky University (nonCACREP). Five of these top producers have attained CACREP status while the other five programs are not accredited. Forty percent ($n = 4$) of these programs are in the state of Georgia and three of these programs are CACREP accredited. Thirty percent ($n = 3$) of the programs are in Kentucky, with one in Florida, South Carolina, and Texas. No university in Tennessee was among the top 10 when considering numbers of graduates in school counseling programs.

During the years of 1995–2002, states included in the SACES region reported the following total number of graduates of school counseling programs: Alabama, 1,097; Arkansas, 619; District of Columbia, 210; Florida, 1,412; Georgia, 2,433; Kentucky, 2,130; Louisiana, 966; Maryland, 860; Mississippi, 1,155; North Carolina, 1,529; South Carolina, 1,300; Tennessee, 827; Texas, 3,434; Virginia, 1,951; and West Virginia, 497 (AACTE, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002). It is interesting to note the contrast between states in the SACES region regarding equal number of institutions and total number of graduates. For example, the states of Arkansas and Kentucky each have seven statewide institutions offering programs in school counseling, yet Arkansas has graduated 619 students and Kentucky has graduated 2,130 students during the years of 1995–2002 (AACTE). The SACES region also has states such as Louisiana and Tennessee with 14 and 12 institutions respectively, graduating totals of 966 and 827 school counseling students for the 1995–2002 time periods.

The total number of school counseling graduates in the SACES region from CACREP accredited institutions for the 1995–2002 periods was reported to be 8,741; and the nonaccredited programs reported 11,679. School counseling graduates from nonaccredited programs exceeded the number of students from accredited programs. Nonaccredited programs in the SACES region graduated 57% of school counseling graduates during the 1995–2002 time periods while 43% percent of school counseling graduates graduated from CACREP accredited programs. During the 1995–2002 years of AACTE data, the SACES region included 58 universities with CACREP accreditation status and 115 nonaccredited universities. Programs which have achieved CACREP status typically graduate fewer students, yet CACREP accreditation provides graduates

with training which meets or exceeds national standards in the profession of school counseling (CACREP, 2006).

Discussion

Accountability, performance, outcome measurements, and performance based evaluations are all required of graduate students moving from academic classrooms to school counseling positions in the 21st century workplace. The measurement of professional quality is guided by registry, licensure, accreditation, and certification (Adams, 2006). Registry is defined by Bradley (1991) as those individuals who have completed training and experience for membership in their professional group, and licensure is defined as state regulations designed to limit usage of a specific title in relation to specific occupations. Additionally, Bradley described the process of accreditation as approval of formal training programs by designated peers within the professional organizational structure. Certification is defined by Sweeney (1991) as an institutional guarantee or standard. Quality programs uphold the above concepts of professionalism regardless of accreditation status.

It is evident that graduation rates and program size varies in both accredited and nonaccredited school counseling programs in the southern United States (see Table 2). In the state

TABLE 2
SACES Top Producing School Counseling Programs

Top Ten Universities (1995–2002)	N	X
Western Kentucky University (N/A)	931	116
University of West Georgia (2001)	620	78
University of South Carolina (1984)	602	75
Prairie View A&M University (N/A)	517	65
Eastern Kentucky University (2003)	449	56
Georgia Southern University (N/A)	427	53
University of Georgia (1987)	401	50
University of South Florida (N/A)	375	47
Morehead State University (N/A)	367	48
Georgia State University (1980)	349	44

Note. These numbers represent the totals as reported to AACTE in a given year. They may not reflect actual numbers for each year as a university may collapse data and report numbers at different time frames.

Dates: Indicate the year first accredited by CACREP.

(N/A): Indicates nonCACREP status.

X: Mean (number) of graduates annually from 1995–2002.

of Tennessee, institutions that received CACREP accreditation graduated fewer school counselors. The data reflects graduation rates among CACREP accredited programs as typically lower than nonaccredited programs due to CACREP requirements and standards (CACREP, 2001).

According to ASCA (2005), the recommended ratio of school counselors to students is 1:250. Based upon this ratio, non-accredited universities, which graduate larger numbers of school counselors, ameliorate the shortage of available school counselors. Predictive shortages of school counselors may create challenges for CACREP accredited programs because of the fewer numbers of graduates.

Although quality of nonaccredited versus accredited programs has not yet been proven, it is possible that nonCACREP accredited programs may leave graduates less prepared. Exceptional comprehensive school counseling programs may be connected to smaller student faculty ratios, thorough clinical experiences, mandated program semester (quarter) hours, and a minimum of three full-time faculty members in a program. Paisley and McMahon (2001) have described the ideal school counselor as one who has graduated from a CACREP accredited program and is also well versed in the three domains of academic, career, and personal/social development.

In the neighboring state of Georgia, the Board of Regents for the University System of Georgia decreed that all school counseling programs in the state be accredited by CACREP. In the *Regents' Principles and Actions for the Preparation of Educators for the Schools* (2003) section IIB (10) it reads that all programs are to "seek and maintain national accreditation for school counseling programs through the (CACREP)" (p. 7). It is possible that some school counseling programs in the state of Tennessee may desire CACREP accreditation, but lack support at the state level, as in Georgia.

Limitations

Limitations of this study should be considered when reviewing information presented. Perhaps the most obvious limitation is that AACTE has not published data relative to school counseling programs since 2002. However, as previously stated, the authors are unaware of any databases that approximate the information about school counselors as that collected by AACTE. Additionally, the study was directed specifically

toward the comparison of institutions' accreditation status and its focus could have been expanded. CACREP accredited programs are not ranked against programs that are non-CACREP accredited so that adversarial relationships are avoided.

Implications

Tennessee has 12 universities with programs training school counselors that have reported data to AACTE; six of the 12 programs are accredited by CACREP. According to the reports to AACTE (1995–2002), most programs in Tennessee graduate less than 20 students per year. Given the relatively few numbers of school counseling graduates in the state of Tennessee and the predictive enrollment of school-aged children continuing to rise, shortages of Tennessee school counselors could impact the state.

Tennessee school counselors provide needed individual and group counseling and support to their students. Several studies have demonstrated that students who receive social-emotional support and prevention services achieve better in school (Greenberg, Weissberg, Utne O'Brien, Zins, Fredericks, Resnik, & Elias, 2003; Welsh, Parke, Widaman, & O'Neal, 2001). Adelman and Taylor (2006) reported that in order to promote healthy development and prevent problems in schools, resources should be woven into a cohesive and integrated continuum of interventions. Economic gains and benefits of early childhood interventions for low-income children have demonstrated savings for the public in special education expenditures, welfare assistance, and criminal justice as reported by The Institute of Medicine (Shonkoff & Phillips, 2000). Thus, it is imperative that school counselor programs, regardless of accreditation status, graduate school counselors who have been trained to help improve student achievement, work as student and system advocates while guaranteeing equity and access to a quality education for every student (Martin, 2002).

Additional studies are needed to investigate school counseling program quality and outcome comparing accredited and nonaccredited programs. Questions still remain unanswered and need to be addressed by future research. For example, do school counseling students from accredited versus nonaccredited programs implement different quality school counseling

programs? Are students of school counselors who graduated from accredited versus nonaccredited programs impacted differently? Research focused on answering these types of comparative questions would inform counselor educators as to whether they should focus more on quality or quantity when preparing future school counselors.

Conclusion

The current school environments in which newly graduated PSC are entering and practicing expect counselors to demonstrate school counseling program effectiveness in measurable terms (ASCA, 2005). In addition, the ethical standards for school counselors (ASCA, 2004), school counseling literature (Gysbers, 2004), and ASCA's National Model (2005) challenge counselor educators to provide results indicating how students are changed or different as a result of their school counseling program. With 12 school counseling programs at institutions in the state of Tennessee reporting data to AACTE, six with CACREP accreditation, elementary, middle, and high schools in the state of Tennessee are fortunate. Training students for preparedness in 21st century schools will continue to influence and shape counselor education programs.

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The Professional School Counselor and Performance Standards: How Is Time Spent?

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As transformed school counseling programs are emerging, there is a need to understand the types of activities school counselors perform that is integral to the American School Counselor Association (ASCA) National Model®. This study investigated the type of program school counselors were working, activities chosen from the *School Counselor Performance Standards* performed by professional school counselors, and their perception of how well their principal understands their role as a counselor. Approximately 58% of school counselors identified their program as at least “above average” in meeting the ASCA National Model® structure, yet many participants were not performing several tasks that were essential to those supported by this model. Implications for future research are discussed.

The Industrial Revolution ushered in numerous societal changes, and the educational system was no exception. School-aged youth were faced with vocational decisions surrounding novel occupations that had never existed prior to this time. At first, teachers were responsible for providing guidance to these youth, followed by guidance workers, now known as professional school counselors, who were responsible for providing this service (Gysbers & Henderson, 2001). Due to legislation, educational reform, and societal demands, these professionals were given additional tasks and duties that differed among schools, and even among school counselors. During the 1960s, a pupil personnel model (educational professionals with unique skills who provided support to students and teachers) was adopted with the intent to unify the profession and to provide greater job consistency among these professionals (Gysbers & Henderson, 2001), yet task differen-

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tiation continued within this occupation. In the early 1970s, comprehensive, developmental school counseling (CDSC) programs were beginning to evolve, which emphasized the developmental nature of school-aged youth, and outlined specific student competencies that needed to be addressed. Although there was some evidence that students benefited from this type of a program, these programs were slow to emerge (Paisley, 2001).

The Emergence of CDSC Programs

In 1997, the American School Counselor Association (ASCA) created the National Standards to address the differentiation that existed within the role of school counselor. Four years later the ASCA National Model[®] was developed as a prototype for counselors to use in establishing their own comprehensive, developmental school counseling program. This model encompasses four components: Foundation, Delivery System, Management System, and Accountability (American School Counselor Association, 2003). Furthermore, the ASCA developed 13 School Counselor Performance Standards as a tool for self-evaluation and professional development as they work within a CDSC program to meet identified student outcomes (ASCA, 2003). The Education Trust and the Transforming School Counseling Initiative (Education Trust, 2007) promote academic success for all students and identified themes critical to school counselor performance (Akos & Galassi, 2004; Musheno & Talbert, 2002), and integral to the conceptualization of the model include: leadership, advocacy, program development, collaboration, and systemic change.

Are CDSC Programs Effective?

At the turn of the 21st century, educational reform focused on teaching and its impact on learning (US Department of Education, 2007). All educational personnel were under close scrutiny to prove effectiveness and to show how their programs contributed to academic achievement. School counseling programs were no exception.

Although there has been research surrounding aspects of a comprehensive school counseling program, there is controversy as to whether or not this model can do what it is intended to do. According to the ASCA, the “purpose of the school coun-

seling program is to impart specific skills and learning opportunities in a proactive, preventive manner, ensuring all students can achieve school success through academic, career, and personal/social development experiences” (ASCA, 2003, p. 14). Many researchers urge school counselors to be involved in data collection that discloses how school counselors play an essential role in “academic development at the program, school, classroom/teacher, and student levels” (Sink, 2005, p. 3). According to Brown and Trusty (2005b), documenting academic achievement as a result of counselor interventions in a CDSC program is difficult due to the many variables that are associated with achievement. However, Brown and Trusty (2005a) state “causal linkages between counselor activities and proximal student outcomes seem to hold the most promise for supporting school counselors’ worthiness” (p. 4).

Despite the debate as to whether student growth can be directly attributed to involvement in the school counseling program, researchers have been active in examining the advantages of a transformed school counseling model in comparison to a reactive, traditional school counseling program model. Foster, Young, and Hermann (2005) investigated the activities school counselors perform to promote academic, career, and personal/social development of students, the frequency in performing these tasks, and their perception of the importance of these tasks. Study results indicated that respondents were providing interventions within these three domains. In another study (Rowley, Stroh, & Sink, 2005), elementary counselors reported spending more time on the guidance curriculum and less time on individual planning. Conversely, high school counselors revealed that more time was spent on individual planning and less time on the guidance curriculum.

In another study, an analysis of the activities school counselors performed within the delivery component of the ASCA National Model® (delivery system guidance curriculum, individual planning, responsive services, and system support) revealed that novice school counselors employed in an urban setting were involved in activities across each of these areas (Walsh, Barrett, & DePaul, 2007). Pérusse, Goodnough, Donegan, and Jones (2004) investigated tasks that were considered essential by school principals and school counselors, and those regarded as integral to the ASCA National Model®.

The results indicated a discrepancy between the tasks identified as appropriate and inappropriate in a CDSC program, and those tasks acknowledged as appropriate or inappropriate by both school counselors and principals.

Despite some of the research that has been conducted regarding the ASCA National Model® and its components, few studies have investigated specific school counselor activities within the ASCA performance standards and themes. The *School Counselor Performance Standards* (ASCA, 2003) outline basic knowledge, skill, and behaviors for school counselors in all settings.

Purpose

The purpose of this study was to gain an understanding of the number of counselors who are operating within a developmental, comprehensive school counseling framework, to determine the amount of time school counselors spend in identified ASCA Performance Standards, and to ascertain counselors' perception of their principals' understanding of their role. Based on a review of the literature, an element within each of the ASCA *School Counselor Performance Standards* and a theme from the framework were chosen. The activities included: conducting needs assessments, sharing data with stakeholders, providing group counseling, and collecting/analyzing data. In addition, the researchers chose to investigate the theme of advocacy. The research questions included:

1. How many practicing professional school counselors identify their school counseling program as one that is comprehensive and developmental?
2. Are school counselors performing specified activities as outlined in the ASCA school counselor performance standards?
3. What percentages of counselors perceive their principals as understanding their role?

Method

Participants

A questionnaire and a stamped envelope for return were sent to 200 practicing professional school counselors who were

members of the southern region of the American School Counselor Association. Selected participants were asked to complete the questionnaire and to return it within a two-week period. Individuals who received the questionnaire and were not practicing school counselors were instructed to return the questionnaire, or to give the questionnaire to an individual who met this requirement. A self-addressed, stamped envelope was provided for ease in returning the instrument, and a reminder postcard was sent after a three-week period.

Instrument

A cadre of practicing professional school counselors throughout the nation were asked to pilot-test the *School Counselor Program Development* questionnaire, and to provide recommendations for revision. Based on the feedback, revisions were made, and permission to conduct the study was granted by the Institutional Review Board.

The *School Counselor Program Development Questionnaire* consisted of 20 questions divided into two sections: demographics and program development. The demographics section consisted of 11 questions designed to collect data on gender, highest educational degree obtained, employment, years of experience, teaching credential, years taught, professional experiences, school counselor credential, and training and/or work in a developmental school counseling program. For the second section, the researchers chose one element from each of the School Counselor Performance Standards and one theme from the ASCA National Model®. This section was comprised of nine questions on program development. Six of the questions were related to activities that are standards of practice expected from counselors (ASCA, 2003) in each of the ASCA National Model® components and three of the questions were related to noncounseling duties, the type of program in which the school counselor is working, and the principal's perception of the school counseling program. The results of this section were the focus of this study.

The items and definitions included: assisting teachers to meet district goals and competencies (defined as developing and refining curriculum in content areas); conducting needs assessments (defined as surveying stakeholders to understand school needs); providing data to stakeholders (defined as sharing assessment results); conducting group counseling

(defined as leading small groups of students with specific concerns); engaging in research (defined as collecting and analyzing data); serving as an advocate for students (ensuring equity for all students); working in a comprehensive, developmental counseling program (as defined by the ASCA National Model®), performing noncounseling related activities (defined as duties that do not relate specifically to counselor training); and the principal's understanding of the school counselor's role.

The participants were asked to specify whether they identified their current school counseling program as one that was comprehensive and developmental based on the operational structure of the ASCA National Model®, and to respond to selected activities integral to the Model that they perform based on a 5-point Likert-type scale. A 1 indicated the school counselor "did not" conduct this activity, a 2 indicated the activity was conducted "infrequently or below average," a 3 indicated the activity was conducted "to an average extent," a 4 indicated they conducted this activity "frequently or above average," and a 5 indicated school counselors conducted this activity "consistently." Percentages were used to calculate the professional school counselors' perceptions for each of the questions. The percentages do not always add up to 100% because some categories were missing responses. The authors decided that a Likert scale would provide a more accurate indication of time on tasks throughout the academic year rather than using a certain time segment (e.g., 1-4 hours) because certain activities tend to occur more frequently at specific times of the year than others. The researchers believed that the task the counselor was performing most frequently at the time the survey was completed (e.g., testing) would be perceived as a more frequently performed task than it was in actuality.

Results

Seventy-three participants completed and returned this questionnaire, which comprised a 37% return rate. This rate exceeded the 23% rate normally obtained in education and psychology journals (Edwards, Roberts, Clarke, DiGuseppi, Pratap, Wentz, & Kwan, 2002); however, a higher return rate would provide better results since it is not known how nonrespondents may have answered the items in the questionnaire. Females comprised 93% of the responses. The breakdown of counselors by grade level included 24 elementary, 16 middle

school, 21 high school, and 12 who taught across multiple levels. All the respondents held at least a master’s degree. A majority of the respondents (62%) indicated that they had served as a school counselor for seven or more years and 69% held a teaching credential. The results appear below and in Table 1.

Research Question 1: How Many Practicing Professional School Counselors Identify Their School Counseling Program as One That Is Comprehensive and Developmental?

In this study approximately 12.3% indicated that they were working in a program that was not a CDSC program, or believed their program was “below average” in meeting this criterion. Other respondents (28.8%) believed that their program met this criterion to an “average” extent, 23.3%, perceived their program as being “above average” in meeting this criterion, and 34.2% responded that their program was fully operating as a CDSC program.

Research Question 2. Are School Counselors Performing Specified Activities as Outlined in the ASCA School Counselor Performance Standards?

Foundation component. The elements within the foundation component answer the question, “What is a comprehensive

TABLE 1
School Counselor Activity Rankings, Advocacy, Type of School Counselor Program, and Principal’s Understanding of the School Counselor’s Role

Variables	Mean and Percentages					
	M	5	4	3	2	1
Meeting district goals	3.7	18.0	43.1	31.9	4.2	2.8
Conducting needs assessments	3.7	30.1	30.1	20.5	17.8	1.4
Sharing data	3.5	19.2	27.4	38.4	11.0	1.4
Conducting group counseling	3.6	31.5	26.0	20.5	11.0	11.0
Collecting/Analyzing data	2.4	4.1	9.6	31.5	26.0	27.4
Serving as a student advocate	4.7	74.0	20.5	4.1	1.4	0.0
Working in a CDSC program	3.8	34.2	23.3	28.8	8.2	4.1
Performing noncounseling tasks	3.5	28.8	15.1	37.0	15.1	4.1
Principal’s understanding of role	3.9	19.2	57.5	13.7	8.2	1.4

Note. Table 1 shows the mean and percentages for each variable using a 5-point Likert scale; where 5 = “consistently” to 1 = “do not conduct activity.”

school counseling program?" (ASCA, 2003). This component outlines student competencies that relate to the school counseling program and the general school curriculum. Respondents indicated that 2.8% did not assist teachers, 4.2% assisted teachers "infrequently," whereas 31.9% collaborated with teachers to an "average" extent, 43.1% assisted with teachers "frequently", and 18% indicated that they assisted teachers to meet program goals "consistently."

Management component. The management component outlines *where* and *when* activities will be conducted, and *who* will perform these activities (ASCA, 2003). Due to the importance of collecting data, researchers asked participants to respond to "the extent to which they assist in conducting needs assessments." Of all the respondents, 19.2% indicated that they did not assist in conducting needs assessments or "infrequently" engaged in this activity. Other participants indicated that they assisted in conducting a needs assessment to an "average extent" (20.5%), and 60.2% indicated that this was an activity that they conducted "frequently" or "consistently."

The management component also includes sharing program results with stakeholders, communicating program success and student change, and documenting the effectiveness of school counselor interventions. Practicing school counselors were asked to indicate the extent to which they provided documentation of activities to stakeholders. Participants indicated that 12.4% were either not involved in sharing results with stakeholders or performed this activity "infrequently." Counselors conducting this activity an "average" amount of time were 38.4%, "frequently" 27.4%, and 19.2% indicated they collected data on a continual basis.

Delivery component. The delivery system answers the question. "How will the program be provided?" The guidance curriculum, individual student planning, responsive services, and system support (ASCA, 2003) are elements within the delivery component. From the responsive services element group counseling was selected, and participants were asked to indicate their role in providing small group counseling. Responses indicated that 22% do not offer small group counseling or on an "infrequent" basis. Providing small group counseling an "average" amount was 20.5%, "frequently" 26%, and "consistently" was reported by 31.5% of the participating school counselors.

Accountability component. The accountability component includes data collection that reveals changes in student knowl-

edge, attitudes, or behaviors (ASCA, 2003). To determine the numbers of counselors who were engaged in research, professional school counselors were asked the extent to which they were involved in conducting research or outcome studies. Results indicated that 53.4% were either not engaged in conducting research or outcome studies or did so “infrequently.” An additional 31.5% indicated that they were engaged in this practice an “average” amount, “frequently” (9.6%), and on a “consistent” basis (4.1%).

Advocacy. In this study, advocacy, defined as “ensuring equity and access to rigorous education for every student” (Martin & House, 1998, as cited in ASCA, 2003, p. 24), is a theme integral to the ASCA National Model®. The participants were asked the extent to which they served as an advocate for students. The results indicated that 1.4% did not perform this activity or did so “infrequently,” whereas 4.1% performed this role to an “average” extent, and an additional 20.5% advocated for students on a “frequent” basis, and 74% conducted this activity on a “consistent” basis.

Non-counseling duties. Participants were asked the extent to which they performed clerical tasks or other noncounseling related activities. In response to the amount of clerical and noncounseling related tasks performed by the participants, 19.2% indicated that they either did not perform these tasks or did so “infrequently.” Performing these tasks an “average” amount of time was the response of 37%, “frequently” engaging in these tasks was the response of 15.1%, and on a “consistent” basis was the response of 28.8% of the respondents.

Research Question 3: What Percentages of Counselors Perceive Their Principals as Understanding Their Role?

The final research question was designed to determine perceptions of the principal’s understanding of the school counselor role. This question was chosen due to the plethora of literature that indicates principals’ misunderstanding of the school counselor’s role. As a result of this misperception, administrators often assign duties based on his or her perception of the school counselor’s job. The results indicated that 9.6% of the counselors believed that their principal did not understand their role or had very little understanding of their role. An additional 13.7% indicated that their principal had an “average” understanding of their role, 57.5% believed that their

principal had an “above average” understanding of their role, and an additional 19.2% believed that their principal had a “consistent” understanding of their role (Table 1).

Discussion

The purpose of this study was to identify the number of school counselors who are performing in a CDSC program, the amount of time school counselors spend on identified performance standards within this framework, the amount of time these individuals spend on clerical and noncounseling related activities, and perceptions of their principal’s understanding of the school counselor’s role.

Based on these results, 58.3% of the participants identified their program as one that was “frequently” or was “consistently” reflective of a CDSC program, with another 29.2% who responded that their program met this criterion to an “average” amount. These data are encouraging in that it appears more counselors are recognizing the value of CDSC programs. However, it is also noted that the majority of these respondents who indicated that they were operating within a CDSC program also indicated that they were not performing specific tasks that were integral to this type of programming. Yet, it is possible that participants were engaged in activities that were reflective of the ASCA Model philosophy but were not investigated in this study. This discrepancy needs to be investigated in future studies.

A needs assessment was conducted by the majority of the participants, with only 19.2% stating that they did not perform this activity or did so “infrequently.” Based on these responses, it appears that school counselors are making a concerted effort to collaborate with stakeholders in identifying areas in which there is a perceived need. As school counselors continue to work in tandem with their constituents in need identification, it is also essential that this team approach also address these needs. Yet, the researcher’s found it disconcerting that some school counselors do not engage in this practice.

With legislation mandating school accountability, and the ASCA vigorously promoting responsibility for data collection and analysis, no educational program is exempt, including the school counseling program. It appears from the results of this study that school counselors need to be more vigilant in taking a leadership role in collecting these data. Only 13.7% of the

counselors reported that they were engaged in research and outcome practices “frequently” or “above average,” with another 31.5% indicating that they performed this data collection an “average” amount. Perhaps today’s school counseling students will gain more confidence in their data collection and dissemination skills than their predecessors due to the increased emphasis placed on this task, the impact of data on job effectiveness, the focus on student outcomes, and evidence that school counselors are essential to educational initiatives. As more comprehensive, developmental school counseling programs are implemented that emphasize where, with whom they are working, and how well school counselors assist in student growth, a primary outcome of data collection could be the reduction of noncounseling duties and an increase in counseling-related activities. However, school counselors cannot keep these data to themselves; decision-makers need to be informed of how counseling interventions impact school-aged youth.

In this study, approximately 85% of the participants indicated that they provided documentation of activities to stakeholders from at least an “average” amount to “consistently.” The results on conducting research and providing stakeholders with documentation of activities is perplexing in that it appears that more are providing data to stakeholders than are actually collecting these data. However, the differences could be due to the confusion surrounding the perception of the terms “providing documentation” and “collecting outcome data.” It could be that they provide a summation of activities to stakeholders but are not actually engaged in research and outcome activities to determine counseling results.

The importance of accountability cannot be overemphasized. Without accurate documentation and figures that support school counselor roles, activities, and effectiveness, administrators who are constrained by tight budgets are unlikely to support counseling programs. Data collection was critical in one high school when school counselors took a leadership role in responding to community needs by providing concrete information that supported and offered credence to the benefits of school counseling services. As a result of these efforts, decision-makers were given data that were needed to support additional school counselors (Lewis & Borunda, 2006).

Advocacy is a broad, comprehensive construct (Trusty &

Brown, 2005), and 94% of the counselors in this study reported advocating for students from an “average” amount of time to “consistently.” Despite these figures, the researchers found it alarming that some school counselors do not engage in any advocacy activities. Future studies investigating the reasons some school counselors do not advocate for students are needed.

It was heartening to note the number of counselors (90.4%) who perceived that their principal had at least an “average” understanding of their role ranging to a consistent understanding of their role. Yet, it was perplexing that approximately 81% believed that they engaged in clerical and other noncounseling related duties from an “average” amount of time to performing these activities on a “consistent” basis. It seems if the principal truly understood the role and preparation of school counselors that clerical and noncounseling related duties would be reduced. Additionally, with approximately 88% of the respondents indicating that their school counseling program represented a CDSC program from at least an “average” to a “consistent” basis, a question remains as to the reason for the high percentage of time spent on noncounseling related tasks.

Limitations

Although the results of this study provide insight into the number of school counselors who identify their program as one that is comprehensive and developmental, the types of tasks they are performing, and their perception of the principal’s understanding of their role, there are a few limitations that need to be considered when interpreting the results. The participants were regional members of the ASCA and represented only those ASCA members who were practicing school counselors in the Southern region and willing to complete the study. Since the study was limited geographically, a national study would provide more comprehensive results and greater generalizability. Additionally, because the participants were ASCA members, and therefore not representative of all counselors, the respondents may have been more aware of the benefits of a comprehensive school counseling program than were nonmembers. Furthermore, the participants may have been reluctant to admit that their program did not yet reflect the trend of school counseling programs. For instance, a study by Sink and Yilik-Downer (2001) revealed that school counselors

from the Midwest were more concerned about the perception of their school counseling programs than were those from the West and South. It could also be that the school counselors in this study believed that the perception of working in a CDSC program was more important than actually working in such a program and this belief was reflected in their responses. Finally, Likert scale categories are subjective and personal perceptions and interpretation of the Likert scale categories may influence results.

Implications and Conclusions

Future studies are needed to compare the types of activities practicing school counselors working at the same grade levels perform. In addition, future studies could investigate whether novice school counselors are more likely to take a leadership role in transforming the school counseling program in comparison to those school counselors who are experienced members of the profession. In other words, are newly trained school counselors who learn about the benefits of a CDSC program more likely to take the lead in this transformation, or are the more experienced members more willing to take this lead? Although 62% of the participants in this study revealed that they had at least seven years of school counseling experience, and 82% indicated that their program was a CDSC program to at least an "average" extent, future studies could compare activities performed based on years of school counseling experience.

Although advocacy is multilayered and difficult to define (Trusty & Brown, 2005), school counselors are in a pivotal position to provide leadership to reduce the educational inequities and discrimination that impair student development (Bemak & Chung, 2005; Trusty & Brown, 2005). Although counselors at all levels reported engaging in advocacy activities, it is unclear as to the specific advocacy activities they provide. As stated in Bemak and Chung (2005), school counselors are often hired by administrators to challenge the policies and structure that could inadvertently create injustice. A greater understanding as to the reason some school counselors are not advocating for students (or for their profession) is needed.

A more comprehensive study is needed to identify additional school counselor activities and time spent within the framework for school counseling programs of the ASCA National

Model[®]. In this framework 13 school counselor standards were identified that align to the ASCA National Model[®] and include: (1) program organization, (2) school guidance curriculum delivered to all students, (3) individual student planning, (4) responsive services, (5) systems support, (6) school counselor and administrator agreement, (7) advisory council, (8) use of data, (9) student monitoring, (10) use of time and calendar, (11) results evaluation, (12) program audit, and (13) infusing themes (ASCA, 2003). As reported by the American School Counselor Association:

These school counselor standards accurately reflect the unique training of school counselors and their responsibilities within the school system. Although used for performance evaluation, the standards are also an important tool in the school counselor's own self-evaluation and will help focus personal and professional development plans. (p. 63)

As school counselors engage in activities to transform traditional school counseling programs into a CDSC program, additional studies will be needed to determine the types of tasks counselors most frequently perform due to training and/or perceptions of self-efficacy, and how the building administrator responds to data that reveals school counselor efforts. Just as society responds to issues that impact citizens, educators respond to concerns that influence students. School counselors need to be aware of changing trends and provide a leadership role in responding to these transformations so that students will benefit.

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Social Anxiety: A Comparison of Counseling Students and Students in a Non-Mental Health Graduate Program

Brittany A. Bingeman, MEd & John R. Charlesworth, PhD

There is some speculation that mental health professionals and mental health students-in-training experience more psychological difficulties than individuals in other fields. To investigate this issue, social anxiety was investigated in counseling students at a small southeastern university. The Interaction Anxiousness Scale (IAS) (Leary, 1983) and a demographics questionnaire were administered to 116 counseling students and 86 educational leadership students. Counseling students scored significantly higher on the IAS than educational leadership students. Additionally, significant differences were found according to gender. Findings suggest a need to assist students with social anxiety and to explore methods for increasing student participation in class.

Meader (1989) suggests that professionals in mental health fields experience emotional difficulties and choose their professions in an attempt to deal with their emotional wounds. Prior to Meader's suggestion, researchers investigated the psychological well-being of mental health professionals. Self-report surveys and observations have revealed that depression, emotional disturbances, and relationship problems commonly exist among therapists, psychiatrists, and psychotherapists (Bermark, 1977; Deutsch, 1985; Ford, 1963). As counseling is one sector of the mental health field, a few studies have extended the investigation of psychological well-being to counseling professionals and counselors-in-training. Studies conducted on counselors-in-training have produced conflicting results, lending support for further investigation in this population (Hanshaw, 1998; White & Franzoni, 1990). Thus, the present study compares one component of psycho-

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logical functioning—social anxiety—in graduate students in a counselor training program and graduate students in educational leadership, a nonmental health graduate program.

Leary (1983) defines social anxiety as “the state of anxiety resulting from the prospect or presence of interpersonal evaluation in real or imagined social situations” (Leary, 1983, p. 67). Although most people have experienced feelings of discomfort, apprehension, self-consciousness, and nervousness prior to or during a social interaction with others, research indicates that a spectrum of social anxiety exists of mild, moderate, and severe (Dell’Osso et al., 2003; Flora, 2005). Severe social anxiety, or social anxiety disorder, often results in distress and impairment of functioning (Dell’Osso et al., 2003). Given the vast spectrum of levels of social anxiety that exists, it is important to note that the present study does not attempt to determine the presence of social anxiety disorder, or extreme social anxiety, within the sample populations, but instead compares the levels of social anxiety present within the two sample populations; graduate counseling students, and graduate students in a nonmental health program.

Literature Review

Although no research could be found investigating levels of social anxiety in graduate counseling students, studies have examined general psychological well being of counselors-in-training in comparison to the general population. White and Franzoni (1990) examined the mental health functioning of counselors-in-training with the administration of seven scales of the Minnesota Multiphasic Personality Inventory (MMPI), an instrument used to measure psychological and social competence. The seven scales used were the Hypochondriasis scale (Hs), the Depression scale (D), the Hysteria scale (Hy), the Psychopathic Deviate scale (Pd), the Paranoia scale (Ps), the Psychasthenia scale (Pt), and the Schizophrenia scale (Sc). Counselors-in-training scored significantly higher on six of the seven MMPI scales, all with the exception of the Hypochondriasis scale (Hs), in comparison to average adults. White and Franzoni (1990) suggest results might indicate the need to identify students displaying psychological concerns and make counseling services available to them.

A study by Hanshew (1998) reinvestigated psychological

well-being in counselor trainees. General areas of mental health functioning were assessed using the restandardized Minnesota Multiphasic Personality Inventory (MMPI-2), and two additional factors of mental health well-being; shame and guilt were measured by the Test of Self-Conscious Affect. Findings were not significant when compared to a national sample of the general population. Hanshew (1998) notes that results indicate counselors-in-training do not experience higher levels of psychopathology and are not more likely to experience shame and guilt than average adults. However, he also states that 74% of participants reported receiving personal counseling services at some time in their lives, which may have contributed to their positive mental health functioning.

Studies have investigated demographic characteristics such as gender in individuals who experience intense social anxiety, or social anxiety disorder (Dell'Osso et al., 2003). Many studies on gender indicate females are more likely to experience high levels of social anxiety, or social anxiety disorder, than males (Dell'Osso et al., 2003; Keller, 2003). Similarly, an overview of community surveys in 2002 reports three women to every two men were found to have social anxiety disorder (Furmark, 2002). However, a study investigating social anxiety in older adults found no differences according to gender (Gretarsdottir, Woodruff-Borden, Meeks, & Depp, 2004).

Studies investigating the prevalence of social anxiety disorder in relation to marital status have produced conflicting results. A study conducted on callers to the Anxiety Disorder Association of America found individuals with social anxiety disorder were less likely to be married than individuals without an Axis I psychiatric disorder (Zhang, Ross, & Davidson, 2004). Similarly, community surveys in 2002 indicated social anxiety disorder was more common in unmarried than married individuals (Furmark, 2002). However, Furmark, Tillfors, Everz, Marteinsdottir, Gefvert, and Fredrikson (1999) found no significant difference in the presence of social anxiety disorder according to marital status.

Several studies have reported a higher prevalence of social anxiety disorder in younger than older individuals (Furmark, 2002; Zhang et al., 2004). A survey of Swedish adults indicates a decrease in social anxiety disorder according to age within the age groups surveyed, 18–34 years, 35–54 years, and 55–70 years (Furmark et al., 1999). Furmark (2002) suggests the possibility that as people age and mature, they become less

concerned with evaluation in social interactions, and are thus less likely to experience social anxiety.

The present study is part of a larger study examining the relationships between social anxiety, self-esteem, and body image in graduate students. Each variable, social anxiety, self-esteem, and body image, was then examined individually in a separate study. Thus, the primary purpose of this study is to investigate levels of social anxiety in graduate master's level counseling students in comparison to master's level educational leadership students. Secondary research aims include investigating differences in levels of social anxiety between: (a) community counseling students and educational leadership students; (b) school counseling students and educational leadership students; (c) school counseling students and community counseling students; (d) males and females; (e) married individuals and unmarried individuals; (f) students who have previously received counseling services in their lifetime and students who have not; (g) those who were currently receiving personal counseling services and those who were not; (h) African Americans and Caucasians; and (i) individuals ages 20–35 and those ages 36–50.

Method

Sampling

The target population for investigation included students who were currently enrolled in a master's level school or community counseling program or a master's level educational leadership program at a small southeastern university. Educational leadership students were selected because enrollment was comparable to the counseling program. Using a list of courses and names of professors in each department, professors were contacted and asked to assist researchers in administering surveys to students in their graduate classes. The total number of completed surveys from both programs was 202. A total of 116 surveys were completed by counseling students, including 25 surveys completed by community counseling students, and 91 by school counseling students. A total of 86 surveys were completed by educational leadership students.

Instruments

The present study includes a demographic questionnaire and a social anxiety measure that were administered as part of a

larger study, which included two additional instruments. Thus, only the two instruments utilized in this study will be discussed.

Demographic information. A demographics page was created to gather information about individual participants for comparison purposes. The instrument asked participants to indicate characteristics pertaining to them including gender, race, current height and weight, age, marital status, and degree program. Height and weight measurements were obtained for use in the larger study, which included a perception survey of body image, however, the measurements were not used in the present study.

Another question included asked respondents if they currently held a teaching degree and if so, how many years they had been teaching. Finally, the survey contained a question that asked if individuals had in the past, or were currently receiving services from a helping professional such as a counselor or psychologist. This question was added in response to the Hanshew (1998) study, which posed that receipt of personal counseling services possibly contributed to overall mental health and thus influenced results.

Social anxiousness. The Interaction Anxiousness Scale (IAS) was used to measure levels of social anxiety in the two populations of students and allow for comparisons (Leary, 1983). This measure consists of 15 items answered on a Likert rating scale (1 = not at all characteristic of me to 5 = extremely characteristic of me). Statements include items such as "I often feel nervous even in casual get-togethers" and "Parties often make me feel anxious and uncomfortable." Higher scores indicate higher levels of social anxiousness, however, a cut-off score is not provided to determine if social anxiousness reaches the level of social anxiety disorder (Leary, 1983). Thus, because the instrument used does not provide a cut-off score for researchers to determine the presence of social anxiety disorder, this study does not attempt to determine presence of a disorder, but instead simply compares levels of social anxiety between two populations.

The literature provides evidence of the psychometric properties of the scale. The instrument displays high reliability with test-retest reliability of 0.80 over an eight week interval and internal consistency greater than 0.85. Construct validity was demonstrated through comparisons with instruments designed to assess the emotional and behavioral component of

social anxiety. Specific correlations between the IAS and the Social Anxiety Disorder Scale, the Shyness Scale, and the Social Anxiety subscale of the Self-Consciousness Scale range from 0.71 to 0.88. Finally, evidence of criterion-related validity was determined through interviews, which explored the relationship between scores on the IAS and self-reported anxiety before and during interactions (Leary & Kowalski, 1993).

Data Collection

Researchers collected data for the study during January and February 2006. A letter was either hand-delivered or e-mailed to professors of courses in the two departments including an explanation of the nature of the study and a request for administration of surveys to students in their classes.

An envelope was then distributed to each professor containing one survey packet for each student enrolled in the class. The packets were arranged with the survey instruments in various orders to control for the order effect. Explicit directions for survey distribution and return and a script to read to participants before administration were also included in the envelope to professors.

The letter asked professors to inform the participants that the research purpose of the study was to survey attitudes of graduate students at the university. Participants were not informed that the instrument was specifically asking for attitudes about social anxiety, as this would have possibly influenced results. Professors then explained the confidential and voluntary nature of participation. A reminder was given to students to read the informed consent statement and to pay particular attention to the direction of responses (i.e., least likely to most likely) for each of the Likert-type rating scales. Survey instruction and completion time was approximately 5–10 minutes. Respondents placed completed surveys in a manila envelope to be sealed and professors returned the packets to the department secretaries to be collected by researchers.

Data Analysis

Survey packets were collected and those completed by students that were pursuing master's degrees in counseling, either school or community, and educational leadership were utilized

in the study. Surveys completed by students in other master's degree programs were not utilized. Demographic data was coded numerically in order to be entered into a statistical program. For example, male and female were coded as M = 1, F = 2. Item numbers 2, 3, 6, 10, and 15 on the IAS were recoded as (1 = 5, 2 = 4, 3 = 3, 4 = 2, and 5 = 1) to be scored in the same direction as the remaining items. The scores for each item were summed to obtain a total score on the IAS.

Items were coded for missing values if only one item was missing a value; however, if two or more items were missing, the data were not used. In order to determine the sum when a value was missing, a prorating system was used. The remaining 14 items were summed and the result was multiplied by 15/14. Data was entered into an Excel spreadsheet and then imported into a statistical software package, SPSS. Descriptive statistics were run for demographic characteristics and group comparisons. Independent Samples t tests were selected for analyzing differences between groups based on the primary research hypothesis and additional research questions posed at the start of the study.

Results

Descriptive Statistics

A total of 202 students were surveyed, with a slightly higher percentage of counseling students ($n = 116$, 57.4%) than educational leadership students ($n = 86$, 42.6%). Further dividing counseling students, 12.4% of the sample ($n = 25$) were community counseling and 45% ($n = 91$) were school counseling students.

Splitting the sample population into subsamples of counseling (school and community) students and educational leadership students allows comparisons to be made between demographic characteristics of the two groups. In both populations, students are predominantly female, 90.5% in counseling (school and community) and 69.8% in educational leadership. The racial make-up of counseling students primarily consists of Caucasians (65.5%) and African Americans (30.2%) with one Asian student, one Hispanic student, and two students who reported to be multiracial. Similarly, all of the educational leadership students were Caucasian (53.5%) or African American (46.5%).

There were some differences in demographic characteristics between the two populations, counseling students and educational leadership students. Of the counseling students, the percentage of unmarried (46.6%) and married (42.2%) were relatively equal, with a few students (10.4%) indicating they were divorced or widowed and one no response. However, a higher percentage of educational leadership students were married (67.4%) in comparison to unmarried (25.6%) with five students (5.8%) reporting being divorced and one no response. Perhaps the greatest discrepancy between the two populations of the sample is the difference in age of respondents. In general, the counseling students were a younger population than educational leadership students. The majority of counseling students (67.2%) were between 20 and 30 years of age while the educational leadership students were typically between the ages of 26 and 40 (68.7%) as indicated in Table 1.

A final demographic factor reveals that around half of both populations have consulted a helping professional at some time in the past for counseling or psychotherapy, while a very small number are currently receiving services. Among counseling students, 58.6% have consulted a helping professional at some time, however, only 8.6% are currently receiving services. In the educational leadership population, 44.2% have previously received services, while only 2.3% are currently seeking counseling.

Statistical Analysis

In order to investigate the primary research hypothesis and additional research questions, independent samples *t* test were used and the hypotheses were tested at a 5% level of significance, $p = 0.05$. The primary null hypothesis, that there is no difference in levels of social anxiety between master's

TABLE 1
Age of Respondents in Counseling (School and Community) and Educational Leadership

	N	20-25	26-30	31-35	36-40	41-45	46-50	51-55	NR
Counseling	116	41	37	11	12	9	5	1	0
Educational leadership	86	9	20	25	14	7	7	3	1

Note. Ages are in years. NR indicates No Response.

level counseling students, including school and community counseling students, and master's level educational leadership students, was examined. Analysis of the two populations revealed that mean scores on the IAS for counseling (school and community) students (Mean [M] = 39.59, Standard Deviation [SD] = 10.21) were slightly higher than the mean for educational leadership students (M = 35.10, SD = 9.94). There was a significant difference in levels of social anxiety between counseling (community and school) students and educational leadership students, $t(200) = 3.119$, $p = 0.002$. Thus, the null hypothesis of no difference between the two populations is rejected at the 0.01 level.

Secondary research questions sought to determine if there were differences in levels of social anxiety between community counseling and school counseling students separated by program in comparison to educational leadership students (see Table 2 for Means and Standard Deviations). Dividing the counseling students by program, the mean for community counseling students (M = 42.16, SD = 11.69) was slightly higher than that of school counseling students (M = 38.88, SD = 9.72) and both means were higher than educational leadership students (M = 35.10, SD = 9.94). There was a significant difference between levels of social anxiety in each of the groups of counseling students in comparison to educational leadership students. The difference was slightly more significant between community counseling students and educational leadership students, $t(109) = 3.00$, $p = 0.003$, than between school counseling students and educational leadership students, $t(175) = 2.55$, $p = 0.012$.

Similarly, another research question addressed possible differences between levels of social anxiety between the two groups of counseling students (school and community). However, although the mean level of social anxiety for community

TABLE 2
IAS Mean Scores and Standard Deviations According to Program

	<i>N</i>	<i>M</i>	<i>SD</i>
School counseling	91	38.88	9.72
Community counseling	25	42.16	11.69
Educational leadership	86	35.10	9.94

counseling students ($M = 42.16$, $SD = 11.69$) was slightly higher than for school counseling students ($M = 38.88$, $SD = 9.72$), there was no significant difference between social anxiousness in these two populations.

To examine the remaining research questions, each demographic factor or personal characteristic (i.e., gender, marital status) was selected as the dependent variable and compared to the sum on the interaction anxiousness scale as the independent variable in independent samples t tests using the entire sample of respondents ($n = 202$). Only for gender, was a significant difference found between the two groups, $t(200) = -2.01$, $p = 0.046$. The mean score for females ($n = 165$), ($M = 38.36$, $SD = 10.15$) was slightly higher than males ($n = 37$), ($M = 34.62$, $SD = 10.61$) within this population. A comparison between individuals according to marital status (unmarried or married) revealed no significant difference between the two groups, $t(181) = 1.01$, $p = 0.31$.

The next two research questions sought to determine if levels of social anxiety differ in individuals who have or have not at some time in their life received personal counseling services. There was no significant difference in levels of social anxiousness based on whether they had or had not received personal counseling services in the past, $t(199) = 0.88$, $p = 0.38$. Similarly, when the sample was divided between individuals who were currently receiving counseling services and those who were not, no significant difference was found between levels of social anxiousness in the two populations, $t(198) = 1.08$, $p = 0.28$.

To determine if levels of social anxiousness differ according to race, the sample was divided into two groups encompassing the majority of respondents, Caucasian and African American. The few respondents that were of a different race were excluded, as the sample of other races was not large enough for comparison. No significant difference was found between levels of social anxiety in Caucasians and African Americans, $t(195) = 0.93$, $p = 0.35$.

In order to investigate levels of social anxiety according to age, participants were clustered into two groups of age ranges (i.e., 20–35 and 36–50) for comparison purposes as these ranges were similar to those in previous research and the majority of respondents' ages fell into these categories. There was no significant difference in levels of social anxiety in individuals ages 20–35 in comparison to those ages 36–50, $t(195) = 1.06$, $p = 0.29$, in this population.

Discussion

Testing the primary research hypothesis revealed that there was a significant difference in levels of social anxiety between counseling students (school and community) and educational leadership students, with counseling students having a higher mean score. This suggests that counseling students have higher levels of social anxiety than educational leadership students. Higher levels of social anxiety possibly relate to lower levels of mental health functioning including emotional well being, management of anxiety and stress, and ability to form healthy relationships as found in counseling students in previous research (White & Franzoni, 1990). However, as the instrument used does not attempt to detect the presence of social anxiety disorder, nothing can be said about pathology in this population. Only a comparison between the two populations can be made.

When counseling students were divided by program into school and community counseling, there were significant differences found between the separate groups and educational leadership students. In both comparisons, the means for counseling students were higher suggesting both groups of counseling students have higher levels of social anxiety when compared separately to educational leadership students. However, a comparison between the two groups of counseling students, school and community, revealed no significant difference in levels of social anxiety between the counseling students.

Of the remaining secondary research questions, gender was the one variable in which a significant difference was found, with females ($n = 165$) having a higher mean score on the IAS than males ($n = 37$). This suggests that females in this population have higher levels of social anxiety than males. This finding is consistent with Dell'Osso et al.'s (2003) research of an adolescent sample of males and females or Furmark et al.'s (1999) research using community surveys. The remaining demographic variables were not found to be significant. Additionally the comparisons of social anxiety in individuals who had previously or were currently receiving personal counseling services in comparison to those never receiving or not currently receiving services revealed no difference between the groups.

Limitations and Suggestions for Future Research

This study has limitations that might be addressed in future research. First, the sample size of certain sub populations was small for comparison purposes, including the number of community counseling student participants and the number of males who participated in the study. Second, professors were asked to administer the surveys to graduate classes and therefore it is likely that instructions were not presented uniformly. Third, the instrument used in this study did not provide a cut-off point to determine if social anxiety reached the level of social anxiety disorder. Thus, future research is needed using an instrument with a cut-off point to indicate the presence of social anxiety disorder in counseling students. Fourth, the study was conducted with a relatively small sample at one university. Future studies could include a larger population of graduate counseling students at one university or across several universities. Finally, educational leadership is a field that is somewhat similar to a helping profession, therefore, a comparison between counseling students and other students in master's level programs outside the college of education might be beneficial.

Conclusion

The few studies that have examined mental health functioning of counselors in-training have produced mixed results (Hanshew, 1998; White & Franzoni, 1990). This study attempts to reexamine psychological well-being in counseling students by specifically focusing on social anxiety. Findings of higher levels of social anxiety in counseling students in comparison to another graduate student population have implications for counselor educators. Findings suggest a need to help counselor educators become more aware of the symptoms of social anxiety to better enable them to identify students exhibiting these signs. Professors might be encouraged to meet with students displaying symptoms individually to explain observations and to ask if the student believes social anxiety is a concern for him or her. Professors could then ask each student if he or she would like to be provided with resources to decrease social anxiety, such as referrals for counseling through on-campus student development centers, community agencies, or private practitioners. Finally, as social anxiety can hinder a student's

participation in the classroom and prevent a student from gaining maximum benefits of instruction, professors might explore with students strategies to make them more comfortable in the classroom and increase involvement in discussions.

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The Experience of Being Diagnosed with Multiple Sclerosis: Implications for Counseling

Ellen Carruth, PhD & Marianne Woodside, EdD

This article explores the disease of multiple sclerosis (MS), especially the initial diagnosis, and describes many of the issues confronted by those who are diagnosed. Presented are stress and coping theories and developmental theories as they relate to a case study of a woman with MS. In addition, the authors presented literature on counseling those with MS and suggested counseling approaches and techniques that address the concerns of those with the disease.

Chronic illness includes the experiences of diagnosis, symptoms, and treatment (Falvo, 2005); these will impact an individual's ability to relate to others and to participate in activities of daily living. Characterized by stress and uncertainty, chronic illness "is often related to concerns about an unknown future, erratic symptoms, the unpredictability of the progression of the disease, or ambiguous symptoms" (Falvo, 2005, p. 13), as well as the emergence of stress related physical symptoms, new financial pressures, and, at times, a diminished self-concept (Pakenham, 1999; Shuman, 1996). In addition, factors such as the nature of the condition, the individual's phase of lifespan development, personality traits, and the social context frame the experience of the chronic illness (Falvo, 2005; Lapham & Shevlin, 1986; Pakenham, 1999).

Diagnosis marks a memorable time in an individual's experience of chronic illness (Miller, 1997) as it culminates medical examinations and tests and results in the naming of a medical condition. Whether preceded by multiple symptoms and a lengthy examination process or a relatively short period of exploration, diagnosis creates a perspective shift that requires those diagnosed to "adapt to their condition" (Falvo, 2005, p.

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2); reality changes and individuals begin their accommodation of a new worldview (Falvo, 2005). For many the diagnosis denotes the beginning of the story or narrative of the illness (Miller, 1997), as the individual uses narrative to make sense of the experience (Bruner, 2002). Rather than a report of the event, in this case diagnosis, the story or narrative becomes a way of constructing reality that makes the human condition appear to be more stable (Brockmeier & Harre, 1997).

Multiple sclerosis (MS) is one of the most commonly acquired neurological diseases for young adults (National Multiple Sclerosis Society [NMSS], 2005). The focus of this article was to expand the counselor's understanding of MS, to meet a client with MS, and to suggest ways to focus the counseling process for individuals with this disease.

Multiple Sclerosis

Multiple sclerosis, literally translated as "many scars" (Weiner, 2005, p. 6), affects over 400,000 people in the United States (NMSS, 2005). Chalafant, Bryant, and Fulcher (2004) defined MS as "a chronic neurological disease of the central nervous system that affects both the brain and spinal cord by destroying the myelin sheath that protects the nerve fibers and by leaving plaques or scars on the damaged sites" (p. 423). Because of the nature of the disease, symptoms are varied (Chalafant et al., 2004; Falvo, 2005; Weiner, 2005). Many times a person will experience symptoms or health problems long before an actual diagnosis is made (Shuman, 1996). Symptoms of MS may include poor balance, immobility, weakened limbs, bladder and bowel incontinence or loss of control, heat intolerance, abnormal fatigue, shaking, loss of vision (Chalafant et al., 2004), muscle spasms, difficulty speaking and/or swallowing, cognitive difficulties, sexual dysfunction (Nichols, 1999), facial weakness, emotional lability, and tonic seizures (Rosner & Ross, 1992).

Diagnosis

The process of being diagnosed with MS is complex. The neurological evaluation necessary for accurate diagnosis includes a definite course of symptom exacerbation and remission as the first criteria, along with evidence of lesions in the central

nervous system (CNS) (Aikens, Fischer, Namey, & Rudick, 1997). Many times, individuals can experience symptoms of MS for an undetermined amount of time with or without the presence of lesions in the CNS. Three categories are used in diagnosis: definite MS, probable MS, and possible MS, all of which have specified criteria (Rosner & Ross, 1992). To be diagnosed with definite MS, an individual will have a history of attacks and resurgence, signs and symptoms of lesions in more than one location of the CNS, and one of three diagnostic tests showing typical signs of MS.

Diagnosis of MS occurs within the context of a specific time in the lifespan, most probably in young or middle adulthood. Young adulthood, as a period of adult development, has its own implicit stressful events such as forming families and establishing professional identity (Adderly & Levine, 1986; Cavanaugh & Blanchard-Fields, 2006; Falvo, 2005). Similarly, the middle adult years represent developmental stressors, such as caring for future generations and making meaningful contributions to humanity (Cavanaugh & Blanchard-Fields, 2006; Falvo, 2005; Lapham & Ehrhart, 1986). Regardless of the specific stage of development, the impact that MS has on psychosocial development is well-documented (Anderson, 2006; DiLorenzo, Halper, & Picone, 2004; Heidrich & Powwatana, 2004; Lapham & Shevlin, 1986). For instance, the stress of the illness may decrease an individual's ability to attend to developmental tasks (Falvo, 2005), as adaptation to the disease becomes the focus of an individual's coping (Aikens et al., 1997; Bensing, Schreurs, De Ridder, & Hulsman, 2002). Depression or other emotional reactions may interfere with individual actions (Aikens et al., 1997; Brown, Tennant, Dunn, & Pollard, 2005; Chalafant et al., 2004), and emotional or psychological consequences may progress into pathological conditions (Pakenham, 1999). Complications and complexities related to family, social, and work relationships may further impede an individual's ability to work on developmental tasks (Anderson, 2006; DiLorenzo et al., 2004; Heidrich & Powwatana, 2004; Lapham & Shevlin, 1986).

Prognosis

According to the research literature, once the diagnosis has been established, the individual is faced with the realization of

an uncertain and limited future (Falvo, 2005). Not only does the individual experience the physical complaints that forced him or her to seek medical attention, but, according to Miller (1997), he or she is hurled into a world of uncertainty, fear, and loss. There is evidence of depression in MS patients (Aikens et al., 1997; Brown et al., 2005; Chalafant et al., 2004; Falvo, 2005), as well as different psychosocial implications of living with MS (Blackstone, 2003; Brown et al., 2005; Chalafant et al., 2004; DiLorenzo et al., 2004; Grytten & Måseide, 2006; McCabe, McKern, & McDonald, 2004; Miller, 1997; Noy, Achiron, Gabbay, Barak, Rotstein, Laor, et al., 1995; Pakenham, 2005; Steele, 2005). Studies of quality of life issues (Hopman, Coo, Brunet, Edgar, & Singer, 2000) and impact on relationships (Falvo, 2005; Miller, 1997) indicated several difficulties individuals with MS encountered.

Treatment as It Relates to Counseling

Research related to counseling and MS centers around concepts or models that help inform the professional counselor, as well as research that directly relates to the effectiveness of theories and techniques that can be used to help individuals with MS (Livneh & Antonak, 2005; Wu, Minden, Hoaglin, Hadden, & Frankel, 2007). These counseling strategies include working with the individual, families, caregivers, and children. For the purposes of this review, two concepts (i.e., quality of life and mental health counseling) that are related to providing services to those with MS are included here, as well as a summary of the research on theories and strategies used with MS clients.

A salient issue for individuals with chronic illness, and in particular for those who have been diagnosed with MS, is quality of life (Wu et al., 2007). Defined in terms of eight health domains (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health) and as measured by the self-report Health-Related Quality of Life (Ware, 1995), quality of life can be “enhanced by removing barriers to MS care, general health care, and mental health care; meeting needs for help with activities of daily living; supporting employment; and improving access to disease modifying agents and symptomatic treatments” (Wu et al., p. 233). This assessment of what is important in the lives

of those with MS can provide a foundation for the counselor's understanding of the client in relationship to the accompanying illness.

Psychological adaptation and response to chronic illness and disability are also salient issues that relate to providing help and support to individuals with MS. A number of models of psychological adaptation undergird current work in rehabilitation counseling and can inform the work of the professional counselor (Livneh & Parker, 2005). According to these models, patients will make cognitive appraisals of self, once diagnosed, in terms of loss, anxiety, sadness, and then behave in new ways, such as retreating from relationships or social situations (Livneh & Parker, 2005). Early reactions to illness have the potential to determine more long-term behaviors. These can work for the patient, if the behaviors are helpful in coping and against the patient if the behaviors are harmful.

The literature focused on working with clients who have MS concurs that mental health counseling is a viable treatment option (Sharoff, 2004). For example, coping strategies, targeted as a way to help individuals recently diagnosed with chronic illnesses that affect the body, include cognitive-behavioral orientations, as well as self-instruction, imagery, metaphors, symbolic gesturing, cognitive orientation with communication skills, peer group counseling, and use of religious beliefs (Foley, LaRocca, Sanders, & Zemon, 2001; Gordon, Feldman, Crose, Schoen, Griffing, & Shankar, 2002; Sharoff, 2004). Depression is a common issue for those diagnosed with MS and has the potential to influence quality of life, as well as indicate, in severe cases, suicidal intent. Research indicated that treatment of any type was more effective than no treatment (Mohr & Goodkin, 1999) and, although cognitive behavioral therapy was a consistent treatment modality used (Litta, 2006), there are a range of psychological treatments that produce positive outcomes for individuals with MS (Litta, 2006; Walker & Gonzalez, 2007). What appears to be critical is the relationship between the client and the therapist (Litta, 2006; Walker & Gonzalez, 2007). There is little information about helping/counseling those recently diagnosed with MS, but mental health and rehabilitation counseling experts do indicate it involves a shift in orientation that requires, at the very least, short term help to handle the psychological adaptation introduced earlier (Falvo, 2005; Livneh & Antonak, 2005).

Case Study: Kermit's Experience

The case of Kermit, based in part upon an interview and described below in the first person, provides a glimpse into the world of an individual diagnosed with MS. Interspersed with Kermit's account are commentaries that tie Kermit's experience to the research and theoretical literature.

Kermit's Case

My name is Kermit and I am 40-years-old; I live in the southeastern United States. I am married and have two children, both of whom live at home. I have a college degree and I work full time. I am also thinking about going back to school to get my PhD right now. I have MS, but I don't have any other serious health problems. But that could change any moment. I have had MS for 11 years, but what I would like to tell you about is what happened to me during the time I was being diagnosed with MS. The diagnosis took five years; I was initially diagnosed with MS, and then told that my symptoms were actually due to another illness. Following that misdiagnosis, I was re-diagnosed with MS six years ago.

Life for me since the diagnosis has been like a roller coaster. Before, I worried about everything, but now I've learned to roll with the punches. I don't think anything in my life has stayed the same since I learned I had MS. When you have a diagnosis like this, not only do you have to change your life, but it has to be constantly changing. It was hard for me, because the job I had done for three years, I could no longer really do. It was hard to come to a realization that something I had done I could no longer do. I have also learned to be cautious, especially of what any doctor tells me. The minute I hear anything, I come home and I research it myself. Stress is very real for me; I am optimistic by nature but sometimes my emotions overwhelm me.

I think, at the time of diagnosis, I was in a little bit of denial, because of the many doctors I had seen, and the times that I had been diagnosed. I was just like, 'Right. This is going to go away, this will be fine.' But, you know, when I was diagnosed I told myself, it really doesn't matter now. I've heard it two times before, and it didn't kill me then, and it's not going to kill me now.

Education has always been a key for me. I think it would be important for anyone with MS to educate themselves. I think the more educated you are, the better you can deal with and cope with the symptoms and the things that happen during MS. Also, to use a support system is important. The self-help groups, I think, worked wonders for me. Seeking outside help and support has made a big difference. My family has been very supportive of me, which helps a lot, but I know that I need professional help sometimes too, to help with the stress and other issues and to help me just live and to go on.

Kermit's Story as It Relates to the Research Literature

Kermit described her life as being “like a roller coaster” since the diagnosis. The unpredictable nature of MS is a common descriptor throughout empirical and anecdotal literature (e.g., Falvo, 2005; Weiner, 2005). Another significant statement Kermit made was that she had become “very cautious of what doctors tell her.” Miller (1997) described two themes that could possibly be related to Kermit’s need to be cautious. First, she described the theme of conflict, in which “the participants described conflicts with physicians, work associates, and family members” (p. 120). A second theme found by Miller was that of control. She stated that “the participants stressed the need to maintain control of their situation and independence in their level of functioning” (p. 118–119). Kermit’s tendency to be cautious with regard to doctors and medical information might have had some relationship with her own sense of personal control through education about MS. She also recognized that she sometimes needs help from others and professional help.

Kermit stressed the importance of education as a personal mechanism of coping. One interesting parallel between Kermit’s experience and the concept of generativity is that many women during midlife will “take jobs outside of the home or return to college to achieve development delayed by marriage and family responsibilities” (Adderly & Levine, 1986, p. 105). Although Kermit spoke of self-education about her illness, she also talked about returning to graduate school to pursue a PhD in her field. Consequently, education may have served a dual purpose for her—first, it allowed her to have some sense of control over her illness, and second, she might have been meeting a developmental need. Lastly, Kermit mentioned the importance of her family and of outside sources of support (i.e., self-help groups). McCabe et al. (2004) explored coping strategies of people with MS and found that many times women are more likely to seek social support than are men.

Stress and coping. Lazarus and Folkman (1984), in their model of stress and coping, delineated two types of coping through which people attempt to adapt to stressful events. Problem-focused coping includes actions taken by the individual to reduce stress through problem-solving activities. Kermit spoke of the importance of education, both career-

related education, and self-education about MS; this was one way she managed stress. Kermit also spoke of the importance of social support through self-help groups and family relationships. Aikens et al. (1997) found that depression was inversely correlated with problem-solving strategies. Kermit's reliance on family, social support, and learning about MS might have helped reduce the impact or presence of depression, a common manifestation of living with MS (Weiner, 2005). But Kermit also stated that she might need to seek help from a professional counselor at times.

Emotion-focused coping, in contrast, involves the use of strategies designed to lessen emotional distress. Such strategies might include denial, minimization, avoidance, or distancing (Lazarus & Folkman, 1984). Kermit spoke about being in denial after receiving the diagnosis. Because of a misdiagnosis, she was reluctant to believe her doctor. While the use of problem-focused coping was one way Kermit adapted to the diagnosis, her emotion-focused coping included self-help groups, her family, and additional counseling services.

Development and adaptation. Adderly and Levine (1986) discussed the acquisition of chronic illness during the middle years of adulthood as unforeseen and uninvited. The impact of such a diagnosis can have devastating effects, which might eventually result in an unhealthy resolution of Erikson's (1959) developmental task, generativity versus stagnation. Kermit used problem-focused coping strategies, to some degree, to resolve some of the early devastating effects of the initial diagnosis, to maintain supportive family relationships, and to continue to pursue her career goals.

One of the issues concerning women and chronic illness discussed by Heidrich and Powwattana (2004) in their exploration of self-discrepancy was the relationship between the ideal self and the actual self. Whenever a person's actual self is not in keeping with their ideal self, then he or she is motivated to realize a closer match between the two. For people with MS or other chronic illnesses, the ". . . body insists that we attend to it" (Shuman, 1996, p. 31). In this state, the desire to become one's *ideal self* may wane, given the amount of time, energy, and strength required to maintain an acceptable level of functioning. Although Kermit reports periods of time in which her ability to function effectively in her job was affected by MS, she speaks of life-goals that she continued to strive for and reach.

Implications for Counseling

Based upon the literature focused on the experiences of clients with MS and, in response to Kermit's description of her experience with MS, counselors can help an individual with MS increase his or her quality of life and enhance how he or she adapts psychosocially to MS. Guidelines for counseling clients with MS include three ways to approach the illness and the client and specific theories, techniques, and interventions that might be helpful. These principles consist of: (a) learning about chronic illness and MS as a specific manifestation, (b) using a holistic model when conceptualizing client cases and client needs, and (c) participating in a coordination of care approach. In this section, the specific interventions described are focused on Kermit's experiences, followed by more general suggestions related to the larger population of individuals with MS.

Guidelines for Helping/Counseling

There is an extensive body of literature that introduces chronic illness and its effects on the client. The more that counselors *understand the nature of chronic illness*—its physical, mental health, and daily living characteristics—the better equipped counselors will be to outline possible needs of their clients and interventions that are designed specifically to meet those needs. This is especially true of the needs generated by the onset and diagnosis of the disease for “the onset of chronic illness . . . is a life-changing event, signifying the beginning of what will be . . . a lifelong process of adapting to significant physical, psychological, social, and environment changes” (Bishop, 2005). Knowledge of specific issues related to having MS can help the counselor better understand the experiences of the client, as well as the issues that could emerge. Some of these include the difficulty of diagnosis, the possible cognitive dysfunction, the effects of central nervous system drugs on cognition and fatigue, the pain correlated with mental health, the vulnerability of men and quality of life, the high rate of suicide and suicidal ideation, and the factors that contribute positively and negatively to quality of life (Oken, Flegal, & Zajdel, 2006).

Because of the complexities of MS, the treatment is complicated, multifaceted, and often involves a number of professionals with varying expertise and treatment responsibilities.

For instance, the following list may be typical of the services required by a person living with MS: (a) 24-hour medical services for individuals who do not require residential or one-on-one supervision; (b) peer counselors to help with insurance coverage, disability questions, legal issues, assistive devices or support groups; (c) psychiatrists and mental health counselors to provide treatment for emotional and psychiatric adjustment, quality of life issues and stress management; (d) continence specialists; (e) gynecologists; (f) educational specialists focused on knowledge and progression of MS; (g) cognitive empowerment; (h) research, medication, and treatment updates; (i) rehabilitation counseling focused on vocational issues, assessment, planning, and employment adjustment; (j) support services for families and caregivers; and (k) financial counseling (Gordon, Lewis, & Wong, 1994; LeHigh Valley Hospital, 2008). As a counselor learns about the multidimensionality of MS and the required treatment, he or she may expand his or her understanding of the client from psychosocial needs to a more *holistic picture* (Woodside & McClam, 2009). Implications for this broader knowledge and view of the client might include a more realistic understanding of the client's world and an increased empathy for the complexities of living with MS. In addition, the counselor, along with the client, will need to determine the role counseling plays in the treatment process. Some clients with MS may be fortunate to receive services from a coordinated team of professionals. Advantages of *the team approach to delivery of services* includes focused plan of care, communication across professionals, individualized service, and attention to multiple needs reducing the likelihood of a crisis approach. Counselors may be asked to participate in the team to varying degrees from attending weekly meetings, to calling a team leader if difficulties arise (Woodside & McClam, 2009).

Specific Interventions

The following suggestions for interventions, categorized by issue, were indicated by Kermit. These include stress and coping, uncertainty of the future, relationships, and positive outlook.

Stress and coping. Kermit alludes to the stress that she experienced at the time of diagnosis and since in describing life

as a roller coaster and in rolling with the punches. In a sense, the allusion to the roller coaster is a metaphor for the stress she experiences and “roll with the punches” indicates her adjustment and coping.

Helping clients with MS cope with the changes in their lives on multiple fronts such as physical disability, changing relationships, a change from helping others to requiring help from others, the stigma of “being ill”, a change in work abilities, and an uncertain future all create stress and require the psychosocial adaptation introduced in the literature review. We recommend three very different approaches, appraisal-, problem solving-, and emotion-focused coping to reduce stress and enhance coping with MS. Counselors may want to try an integrated approach based upon client needs, client match with interventions, and counselor expertise. Because the stress associated with MS emanates from various sources, different interventions may be required for each source of stress (Weiten & Lloyd, 2005).

Appraisal-based approaches can include assessment of personal coping strategies and identifying new strategies based upon: (a) client strengths and past successes, (b) cognitive behavioral therapy, (c) reducing catastrophic thinking, (d) humor, and (e) positive reinterpretation. We will briefly outline the use of the first two interventions that might support the client with MS. First, ask the client to outline in a worksheet format “Times I Am Stressed”, “Ways I Respond to My Stress”, “Outcomes from My Response”, and “Ratings, 1–10 of the Success of the Outcomes.” Reviewing this sheet with the client may help both you and the client construct a visual representation of current stressors and coping strategies. Clients often describe coping strategies of limited value such as giving up, striking out at others, indulging self, blaming self, and using defensive coping, as well as positive strategies such as realistic appraisal, confronting problems directly, learning to recognize and manage destructive emotional reactions, and learning to exert control over harmful behaviors (Weiten & Lloyd, 2005). This very practical applied approach provides the client with MS with a tangible description of stress that validates what is real for the client, places the issues outside the body and onto the physical paper, and provides a place to begin the work (Woodside, personal communication, June 23, 2007). It also moves the client out of the denial phase of the diagnosis, promotes internal locus of control, provides information the client

might share with family or caregivers, and organizes current behaviors, thoughts, and emotions (Woodside, personal communication, June 23, 2007).

Those who work with clients with MS indicate that cognitive behavioral therapy promotes successful outcomes for dealing with stress and coping, sexual intimacy, and depression. Sharoff (2004) has developed a Cognitive Coping Therapy model and relates this therapy to five phases of psychosocial adaptation: crisis, postcrisis, alienation, consolidation, and synthesis. The appraisal work in each of the five stages addresses difficulties clients with MS encounter as they think about and react to their disease. For instance, during the crisis phase, the therapy focuses on denial and rejection of their suffering; during the postcrisis, the issues addressed are identity issues as clients begin to deal with being "ill" or "sick". Cognitive Coping, for the alienation phase, focuses on tolerating uncertainty, addressing bitterness, and dealing with disappointment in and changing relationships. The consolidation phase confronts discovering or rediscovering life meaning and managing limitations. Counselors are encouraged to listen to their clients, and to determine what irrational thoughts and behaviors are undermining positive coping and increasing stress.

Uncertainty of the future. Kermit indicated that things, for her, were continually changing. This uncertainty of the future is a cornerstone of the MS experience (Falvo, 2005), and is the reality of Kermit's world. Very practical problem-solving approaches are strategies that counselors can use to help clients deal with changing health, relationships, work, financial situations, and cognitive abilities, to name a few. Constructive problem solving includes clarifying the problem, identifying alternatives, weighing options, setting a course of action, and implementing the action plan while remaining flexible (Weiten & Lloyd, 2005).

One example of change that Kermit faced just after her diagnosis was a change in her work situation. Clients with MS stated that their two most constant worries related to their jobs were managing their performances and managing their expectations (Sweetland, Cano, & Playford, 2007). For counselors, one important function of working with clients who have MS will be helping said clients to solve problems related to their work performance, such as improving task performance restricted by a mobility limitation and/or fatigue. Additionally, solutions could include arranging for medical

interventions that will help with these problems. Problems could also be addressed by workplace compensation such as moving offices or making workplace adjustments. Issues about expectations related to disclosure of disease, fear of discrimination, and questions about discrimination may be shared during a counseling session. These issues may be addressed in counseling or may require a referral to other members of a team, if such a team exists.

According to the literature, education about their disease is important for those with MS (Lode, Larsen, Bru, Klevan, Myhr, & Nyland, 2007; Sweetland et al., 2007). Kermit indicated this was true for her as well. As counselors, we do not always have the answers to problems that require an expert background and a factual response. But, when working with clients with MS, we can empower them to learn more about their disease, help them find resources, and empower them to seek information and take a leadership role in their own care. Gaining information fits well within the problem solving model, outlining questions and determining where to find answers.

Relationships. Relationships are critical for the client with MS, and become an important component of the social network and of the care setting. Even though it is the individual client that has MS, the family, friends, and other caregivers of the client with MS are profoundly affected. Since the disease is chronic and potentially debilitating, there are short- and long-term effects to be considered by the client and the counselor. Emotion-focused coping directly affects relationships and can provide counselors with interventions that may influence the client's relationships with others. By attending to strong emotions that override the client's ability to think or act constructively and that threaten relationships, the counselor is in a position to help the client increase his or her emotional intelligence, identify, interpret, and understand other's emotions, and use this information to guide thinking and behavior (Weiten & Lloyd, 2005). Strategies counselors can use include teaching clients to release pent-up emotions, to manage hostility, to practice forgiveness, to engage in mediation, to distract self from emotions, and to engage in relaxation and other mind-body connecting activities (Weiten & Lloyd, 2005).

Cognitive behavioral therapy, problem solving, family or group counseling, and family support groups also contribute to positive family and caregiver relationships. Encouraging cli-

ents to include families in learning as much as they can about the disease and participating in conversations with professionals involved in the client's medical and mental health care may improve communication and give family members a part in the MS experience.

Positive Outlook. Kermit indicated a positive outlook and what appeared to be a will to live with MS that developed over time. She also spoke of the stress that, at times, overwhelmed her, and the need for professional help. Researchers indicate that attitude toward the disease, internal locus of control, and a positive outlook on life all promote a positive quality of life for the client (Wu et al., 2007). In the case study, Kermit moved from denial to taking charge of herself rather than letting the disease take charge of her. Helping clients promote a positive outlook and a sense of mastery over the disease may contribute to more effective disease management. Engaging in appraisal-, problem solving-, and emotion-focused interventions that support the client's self-sufficiency and sense of efficacy may contribute to positive outcomes.

The risk of depression in clients with MS (Litta, 2006; Walker & Gonzalez 2007) underscores the importance of this focus. Conducting either an informal or formal suicide risk assessment of clients with MS is critical, followed by focused pharmacological or nonpharmacological treatment or both. Cognitive behavioral therapy, cognitive behavioral therapy delivered by telephone, stress reducing interventions, and the development of communication and other psychosocial skills can address depression with positive outcomes. An encouraging note is that clients with MS usually do not have other psychiatric disorders or a history of depression, and they respond to therapeutic intervention (Litta, 2006).

Summary

Counseling clients with chronic illness is a special type of counseling. Although many counseling approaches may assist those with chronic illness, there are unique features of the illness and multiple needs of these individuals that require knowledge of the particular disease. Counselors working with clients with MS, in particular, need to understand the stresses and coping concerns, potential for depression, realistic fear of an uncertain future, and the importance of a positive outlook.

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New Control for A New Me: Increasing Self-Control and Anger Management Using Relaxation

Laura Hebert, PhD

The author describes the process, experience, and results of completing research using relaxation and imagery in an elementary school. The study examined the efficacy of *Old Me, New Me*, a CD program for children and teens using relaxation and guided imagery to help reduce a number of emotional and behavioral problems including negative thinking, anxiety, worry, frustration, impulsivity, aggression, and Attention Deficit Hyperactivity Disorder (ADHD) behavior (Lupin, 2008). The program gives youth alternative ways of dealing with stress and offers positive coping skills. Five students were placed in an anger management group and six students were placed in a self-control group. The results support the potential value of relaxation and imagery in the reduction of anger, increasing self-control, and most importantly empowering the student.

Increasing Self-Control and Anger Management Using Relaxation

Children experience many stressors in the home, school, and the community. Relaxation and imagery can enable children to deal more effectively with the emotional and psychological challenges of today's society (Allen & Klein, 1996; Braud, Powell, Williams, Lupin, Geyen, & Belcher, 2007; Lupin, 2008; Williams, Braud, & Powell, 2005). Children can learn to calm the body's tension down physically by relaxing the muscles, breathing deeper, and slowly slowing the heartbeat down.

Learning to relax and use imagery can be important skills for children to learn. Relaxation means being able to focus on the body and its physiological responses. Imagery could be described as an "awake" dream state in that the person can close their eyes and imagine they are in a certain place (e.g., a child

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can imagine lying on a cool wet towel on the sand at the beach under the warm sun with a gentle breeze blowing). The child can imagine certain events are going on (e.g., a butterfly passes by and the butterfly provides the answer to any question you have). Within imagery, a person has control and power in the imagery. The school counselor at this school has utilized relaxation techniques and imagery with all of the classes with the goal that students will be able to use these skills during testing times to reduce anxiety.

The program, *Old Me, New Me* (Lupin, 2008), was implemented as the primary therapeutic technique in a small group setting for two groups. Both groups were experimental and there was no control group. The program is a series of short stories on CD using imagery and positive self-talk to teach stress management and life skills. The *Old Me, New Me* program is available for counselors through Director Mimi Lupin, MA, LSSP, LPC at www.oldmenewme.com. The curriculum for the study also included stories, homework, problem-solving activities, and art activities.

This study examined the efficacy of the *Old Me, New Me* relaxation program as the primary therapeutic technique to assist children in small group settings. The objectives of this project included:

- to decrease levels of anxiety in children
- to increase self-control
- to teach recognition of physiological signs of tension
- to reduce anger and aggressive behaviors
- to teach positive behaviors and self-affirmations

Review of Literature

Relaxation and the use of imagery are effective and beneficial techniques to reduce pain, tension, stress, and emotional/behavioral problems in children (Allen & Klein, 1996; Braud et al., 2007; Lupin, 2008; Williams et al., 2005). According to Watson (n.d.), relaxation has been found to be useful in a wide variety of ways with school age children (p. 9). There are many books, activities, and programs available to assist in the use of relaxation and imagery (e.g., *Old Me, New Me* program by Lupin (2008) and Ready, Set, R.E.L.A.X.: A research based program of relaxation, learning, and self esteem for children by Allen and Klein (1996), Jacobson's (1938) Progressive Muscu-

lar Relaxation, Schultz and Luthe's (1969) Autogenic Training, and Benson's (1975) Relaxation Response (Weiten & Lloyd, 1997 as cited in Zalaquett & McCraw, 2007).

Literature on relaxation and imagery is intermittent. Most of the literature in regards to relaxation and imagery is related to the positive results in reducing chronic pain and dealing with cancer. Literature on the use of imagery and relaxation for test anxiety is also increasing with positive results. However, current literature is still limited on the research of the effectiveness in the use of relaxation and imagery with behavioral disorders but with the realization of the effectiveness, much more research is bound to come forth in the near future.

A number of studies report the effectiveness of relaxation in numerous therapeutic interventions (Andreoli, Casolari, & Rigatelli, 1995; Barlow, 1988; Clum, Clum, & Surls, 1993; Deffenbacher, McNamara, Stark, & Sabadell, 1990; Oest & Westling, 1995). A review of a number of studies related to relaxation training with children suggested that it is at least as helpful as other treatment approaches for an assortment of learning, behavioral, and physiological disorders (Richter, 1984). According to the American Psychological Association, simple relaxation tools such as deep breathing and relaxing imagery, can help calm down angry feelings (American Psychological Association, 2006). Throughout the literature, imagery and relaxation created no harmful effects.

The program *Old Me, New Me* is an evidenced based right brain program and has helped hundreds of young people reduce their negative thinking and increase positive feelings and behavior, leading to more peace and joy in their lives (Lupin, 2008). There has been research on the program covering 25 years that demonstrates its effectiveness (Amerikaner & Summerlin, 1982; Braud, 1978; Braud & Powell, 1999; Braud et al., 2007; Lupin, Braud, Braud, & Duer, 1976; Omizo, 1980, 1986; Omizo & Rivera, 1980; Omizo & Williams, 1981, 1982; Williams et al., 2005). The research that has been conducted on the program materials, *Old Me, New Me*, has revealed significant positive results. The research has shown a reduction of risk factors such as ADHD, impulsivity, aggressive behavior, anxiety, stress, and tension, which can lead to self-medication with drugs and alcohol (Lupin, 2005, p. 1). Research conducted on this program has shown benefits not only to the general population, but high-risk populations of children and

adolescents also displayed positive coping skills after participating in the program (Lupin, 2005).

Methodology

Participants

The research participants were students at a primary school in a rural/suburban area of east Tennessee. All of the participants were Caucasian. The “New Me” group included two 7-year-old females, two 7-year-old males, and one 8-year-old male. The “I am in Control” group included three 7-year-old males, one 8-year-old male, one 7-year-old female, and one 6-year-old female.

Method

The school counselor provided the teachers with referral forms for any student that may need any counseling services at the school including self-control, divorce, grief, anger management, and social skill deficiencies. Parents are aware of these services through the teachers, the school’s website, and through the school newsletter. All students in the school had the opportunity to participate in this study. The students in this study were referred by either parents or teachers to participate in the school’s counseling programs.

Students were given an “informed consent” form to take home for parental/guardian approval. Based on the nature of the referral, students were identified for either an anger management/aggression reduction group (New Me) or a self-control skills group (I am in Control). The students signed a consent form after the researcher reviewed the form and verbally explained the concepts in the consent form.

A pretest-posttest group design was used for each group with no comparisons between groups. The anger management group and the self-control group completed the Revised Children’s Manifest Anxiety Scale (RCMAS) before the program started. The RCMAS was developed by Reynolds and Richmond (1978) measure the degree and quality of anxiety experienced by children and adolescents and is also called *What I Think and Feel* assessment. Following the program, the children completed the RCMAS as a posttest. Two months later, the two groups completed the RCMAS again as a follow-up posttest to see if the effects lasted. The researcher verbally

read the scale and marked the scale as the children verbally expressed their answers on the pretests and the posttests. Any concepts that children requested information about were explained by the researcher.

The *Child Behavior Checklist* was completed by the students' teachers before the program was implemented, immediately after the program was completed, and two months later. Last, a copy of the CD materials from the *Old Me, New Me* program that included 11 stories and two different relaxation sessions was given to each parent/guardian to practice the technique at home. Permission had been granted to copy the CD by the *Old Me, New Me* program and Director Ms. Lupin. The self-control and anger management groups utilized the program *Old Me, New Me*. The groups were conducted every Wednesday and every other Friday for 30 minutes for a total of 18 sessions within a 12-week period. A specific curriculum of the program *Old Me, New Me* was followed. The materials included two relaxation exercises and 11 short (15 minute) stories incorporating soothing sound effects, music, and important life lessons. The program's sessions incorporated brief-solution focused counseling (i.e., group discussions of handling a problem in a positive way), art (i.e., draw picture of self when tense, when relaxed, of a secret place), and homework assignments which included listening to specific CD stories at bedtime and practicing relaxation techniques in different situations.

Results

A repeated measures analysis of variance (ANOVA) was used to look at the changes over time (within subject factor: pre, post1, post2) and the group differences (between subject factor) for the two groups. The RCMAS includes the three subscales: Physiological Anxiety, Worry/Over-sensitivity, and Social Concern/Concentration and a Lie scale. The scales were converted into t scores and scaled scores from percentages. On the first subscale of physiological anxiety, there was a significant interaction with the Wilks' Lambda multivariate test between time and group ($p = 0.012$). Both groups self-rated a reduction in physiological anxiety at the first posttest. The self-control group continued to improve throughout the posttesting periods. The anger management group began to regress between the first and second posttest.

The repeated measures ANOVA on the other two subscales appeared only marginally significant. On the subscale of Worry/Oversensitivity, while group and time were marginal ($p = 0.054$) but not significant, changes over time were significant with $p = 0.010$. There were no significant group differences with the Wilks' Lambda multivariate test ($p = 0.711$). The self-control group continued to improve throughout the testing periods and the anger management group improved but then began to regress between the first and second posttest.

On the Social Concern/Concentration subscale, the repeated measures ANOVA seemed to show changes over time ($p = 0.010$) and marginal but not significant changes with the interaction between group and time ($p = 0.098$). There were no significant group differences with the Wilks' Lambda multivariate test ($p = 0.197$). Looking at the means, the self-control group continued to improve throughout the testing periods but the anger management group began to regress a great deal between the first and second posttest.

On the Lie scale (measured the tendency to rate self in a socially desirable way), the repeated measures ANOVA seemed to show significant changes over time ($p = 0.038$). Over time, there was improvement for both groups. According to Blair and Lendell (personal communication), the Lie scale is an attempt to look good, the 50 percentile is average, and 60 or above is elevated (personal communication, February 1, 2006). Therefore, the groups were most likely becoming more honest about their selves in the self-ratings. There were no significant changes with the interaction between group and time ($p = 0.664$) and there were no significant group differences ($p = 0.794$).

The repeated measures ANOVA test seemed to show significant changes over time ($p = 0.001$). Improvement was shown for both groups. There were significant interactions over time for both groups in the multivariate Wilks' Lambda test ($p = 0.014$) and no significant group differences ($p = 0.794$). Overall, total anxiety was reduced for both groups and continued for the self-control group. However, the anger management group did regress between the first and second posttest. A repeated measures ANOVA analysis was run on the Teacher Checklist results. The Teacher Checklist was divided into eight subscales and included: 1) impulsivity, 2) concentration, 3) hyperactivity, 4) low frustration tolerance, 5) conduct disorder,

6) aggression/oppositional, 7) withdrawn/sad/defensive, and 8) anxious/tense/nervous. The repeated measures ANOVA analysis was done on each subscale.

On the repeated measures ANOVA analysis, there were no significant interactions effects, no significant group effect, or no significant time effect for scales: impulsivity, concentration, hyperactivity, low frustration tolerance, and anxious/tense/nervous. Also, there were no significant interaction effects for scales of conduct disorder, aggression/oppositional, and withdrawn/sad/defensive. There was no significant time effect for scale of conduct disorder and the scale of aggression/oppositional. Last, there was no significant group effect for the withdrawn/sad/defensive scale.

The Teacher Checklist was significant regarding the group effect for conduct disorder with $p = 0.043$. According to the ratings by the teachers, the students in the anger management had many more conduct problems than the self-control group. However, the teachers rated both groups with more conduct problems by the first posttest. The self-control group continued to have more conduct problems by the second posttest. However, the anger management group reduced conduct problems by the second posttest.

There was a significant interaction between group and time regarding the scale on aggression and opposition as $p = 0.021$. According to the teachers, the students in the anger management group decreased their opposition and aggression immensely by the second posttest. Last, on the withdrawn/sad/defensive scale, the repeated measures ANOVA showed significant changes over time as $p = 0.012$. Both groups were rated as less withdrawn, sad, and defensive by the second posttest.

Conclusions

This research project was rewarding and beneficial to everyone including the researcher. All of the students enjoyed the program. The teachers observed that the students were less withdrawn, sad, and defensive. The students would have liked to continue on with the sessions and continued to ask when they can do it again. The results of the program may have improved more if the students and the counselor had the opportunity to continue with the program.

The self-control group continued to show improvements at

the second posttest. The anger management group decreased their anxiety level but the positive results of the program seemed to have diminished some by the second posttest. The anger management group's results dramatically diminished on the Social Concern/Concentration scale. This scale is an index of social anxiety and a concern about not meeting people's expectations (academically and socially) and can effect the student's concentration. These students may need additional cognitive-behavioral strategies, resources, and continued practice with the relaxation techniques to see more improvement.

According to the results of the Teacher's Checklist, the teachers did not perceive many positive results. This may be due to the fact that even if some of the students' behaviors (e.g., withdrawn, sad, defensive, oppositional, and aggressive) improved in the class, their tolerance of some behaviors (conduct) had pushed the teachers to their limits. Over the course of the program, the students in the anger management group were less defiant and smiled more (researcher observation). Aggressive and bullying behaviors diminished after the program and the students have not received any disciplinary referrals.

Limitations of this study include generalizations of research findings to other populations. Also, counselors should not be limited by specific relaxation and imagery materials utilized by this study. Many resources are available and should be reviewed before use. Verbiage and contents should be specific to certain student populations. Last, parental involvement was limited. Parents were provided with one or more CDs (to keep at multiple homes if needed) and detailed instructions at the beginning of the study. Although the parents agreed to use the *Old Me, New Me* CD stories at home, the parents used the CD intermittingly or not at all. Parental support could have improved the results of the program. However, the limited or non-existent parental support may be one of the reasons that the students have behavioral issues.

One implication of this study is that relaxation and imagery may be beneficial to students in numerous ways. Second, relaxation and imagery tools may be cost-effective resources for counselors to utilize in-group settings and in individual sessions. More research needs to be conducted on the use of relaxation and imagery with students and how these tools and which of these tools effectively assist with decreasing behavior

problems, improve academic achievement, and improve relationships.

All in all, the benefits of using relaxation and imagery reduced anger and anxiety and increased self-control for the students. The program *Old Me, New Me* was an effective tool that benefited the students. Many children (and adults) in today's world face too much stress and could benefit from relaxation and imagery. Close your eyes, take a deep breath, and imagine the world with more relaxed people.

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