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**From *the* Editors**

# Counselor Self Care: Management of Self

#### “As most men perceive the faults of others without being aware of their own, so insane people easily detect the nonsense of other madmen, without being able to discover, or even to be made sensible of the incorrect associations of their own ideas. For this reason it is highly important, that he who pretends to regulate the conduct of such patients, should first have learned the management of himself. It should be the great object of the superintendent to gain the confidence of the patient, and to awaken in him respect and obedience: but it will readily be seen, that such confidence, obedience, and respect can only be procured by superiority of talents, discipline of temper, and dignity of manners.” John Haslam (p.278)

Counselors know Haslam’s (1809) words are as true today as they were 203 years ago. The first aspect of truth is that self care is a vital need for all of those in the helping profession (Emerson, 2003). Stress, which is inherent in the counseling profession (Dass & Gorman, 1988), can lead to burnout (Maslach, 1982), “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do ‘people work’” (p. 3). At the point of emotional exhaustion, counselors are far less effective and run the risk of feeling the need to begin “cutting back” (p.3) on

interactions with clients. Professional School Counselors start doing more paperwork and testing duties that distance them from direct services to their students and faculty. Counselors in private practice begin to cut the number of hours set aside for client appointments. Agency counselors, especially in the area of substance abuse, switch agencies hoping the change and brief reduction of client load will renew them. Marriage, Couple and Family Counselors have an additional risk of experiencing these inherent symptoms according to Virginia Satir (1987). She warns counselors that utilize the Conjoint Family Therapy process experience far more stress in their counseling relationship with families (Satir, 1987) than other models due to the intensity and speed of the therapeutic experience. Satir (1987) even lists the intensity as a disadvantage of using the model, especially for counselors that are not prepared for the additional stress. This often leads the Marriage, Couple and Family Counselor to cut back on client load if in private practice or working with clients more on an individual basis. At the agency level they will also move around hoping the next agency will be less stressful.

If, however, the counselor does nothing to care for him/herself, then these small changes that are externally based will not have lasting impact, and “compassion fatigue” (Maslach, 1982, p.3) eventually leads the counselor away from the helping profession more

completely and permanently. At this point the process of ‘exhaustion, depersonalization, and reduced personal accomplishment” (p.3) is complete, and the counselor is officially *Burned Out.*

This process of burnout and its associated compassion fatigue are not confined to the examples cited.

According to Maslach, any counselor who is “expected always to be concerned, warm, and caring” (p.6) is at risk of burnout. Maslach also asserts that risk for burnout is further heightened by the lack of support from coworkers and supervisors. Counselors who fail to build a support network for themselves exacerbate the risk even further (Emerson, 2003). A simple self assessment for counselors to use is to simply answer the question based on Maslach’s case studies: Do I feel too much is being asked of me, while too little is being returned? If the question is answered in the affirmative and if they identify with the expectation of always needing to exhibit concern, warmth and be caring, then identifying a self care plan is vital to their longevity in the profession of counseling.

Further, if, as Maslach indicates, counselors experiencing these symptoms also lack support from coworkers and supervisors (1982), the counselor must also depend on him/herself to develop and implement their own self-care plan.

The initial area of any successful self-care plan is for the counselor to examine his/her own attitude.

There is no disappointment we

endure

One half so great as that we are to

ourselves

*Philip James*

*Bailey*

The authors find in their combined 40+ years of supervision

experience that counselors are far harsher giving feedback to themselves than they are with giving feedback to clients or other counselors. The counselor’s own statements are often what tears at the fabric of personal accomplishment more than any statement from a peer. Once the sense of personal accomplishment is diminished or extinguished, then Maslach (1992) warns, burn out is not far from our door. So creating self talk that is healthy and that promotes a general feeling of satisfying accomplishment is a crucial first step. Tables 1 & 2 are exercises for couples that the authors have adapted for use with counselors. Table 1 consists of two simple questions for counseling students and two for those already practicing (which could include Practicum and Internship students).

If you had any A statements then the following exercise, Table 2, can be used to more specifically identify the frequency, type, and intensity of the negative self statements that you use on yourself. It can also identify any supportive statements that you say to yourself, as well as provide the reader with a ratio of negative to positive statements, which will ultimately bring to the reader’s awareness how quickly they are eroding their own confidence in their competence.

After identifying both types of specific self statements, the counselor will contract with self (just as he/she would with a client) to reduce the number of negative self statements and replace them with positive self statements.

A final truth that Haslam (1809) reveals to counselors about themselves is that the counselor is sometimes the last to see and/or acknowledge the issues that they, themselves have. In a school setting, a 6 year old can see through to your soul and can make observations about his/her counselor

that the counselor may have been previously unaware of. An adult client can pick up on your subtle cues as your mood in session shifts and can often confront the counselor with nonverbal responses that the counselor is unaware they are sending.

Sometimes this comes in the form of our clients turning the tables by counseling their counselor. Satir (1988) in an interview once stated that she was “constantly surprised” at the number of counseling professionals that were hurting.

She would see it often at presentations given by mental health experts who were themselves, as Satir puts it, “hurting.” She further commented that these hurting professionals were completely unaware that they were giving off such obvious cues. If everyone from Satir to a 1st grader to a client with multiple diagnoses can see the potential burnout in the counselor, then we as counselors need to acknowledge our own symptoms. The simple answer to Satir’s observation would be congruence, or as Rogers (1961) describes for us, when the “psychotherapist is what he is” (p, 61).

Acknowledging that we are experiencing symptoms of compassion fatigue is the first step in this part of the process. The next is to “talk to someone you trust” (Research Institute of America, 1985, p. 15). Suggestions for counselor self-care include seeking out personal counseling, assessing strengths and weaknesses by completing a wellness survey or stress inventory, seeking additional supervision, and continuing education. Additionally, counselor self-care should include attention to nutrition, good sleep and hygiene practices, physical exercise, meditation, yoga, tai chi, learning to say “no” to external

demands, and having quality time for hobbies/interests. Counselors need to be able to consult, be consoled and just cut loose with other professionals if they are to navigate successfully the stresses inherent in the counseling profession. Seeking out other local professionals and attending professional conferences (Louisiana Counseling Association and the American Counseling Association) is a good starting point.

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**Table 1**

1. **HOW HARD AM I ON ME?**

Students: When I get a test back what do I look for first?

* 1. the 3 questions I missed
  2. the 97 I got correct

What do you remember most about the test?

1. What you missed
2. What you learned

Practicing: When you evaluate your sessions with a client do you focus on?

1. the things you need to change
2. the positive interactions that facilitated growth What do you remember the most about your sessions?
3. What you should have said
4. The growth of your client

Scoring: If you marked A statements then you are likely tearing at the fabric of your accomplishments.

If you marked B statements you are saying supportive statements to yourself.

**Table 2**

**Things I say to me Exercise:**

|  |  |
| --- | --- |
| **List all the self corrections, criticisms I said to myself regarding my work as a counselor (all should, would, could have and self deprecating self talk) in the past 24 hours.** | **List all of the things you said to yourself in support of anything you have done as a counselor in the past 24 hours.** |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |
| 6. | 6. |

-Peter Emerson and Meredith Nelson

Editors

# Section I: Professionals’ Articles

## On-Line Discussions About Self-Injury and Suicide

#### Jennifer Marshall, Associate Professor, Ed.D., LMHC, NCC Trey Fitch, Associate Professor, Ed.D., LMHC, NCC

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College students were surveyed regarding their use of websites and BLOG/discussion boards that promote and/or discourage and treat suicidal and self-injurious behavior. The students surveyed related that they were more likely to use websites and BLOG/discussion boards that discourage and treat suicidal and self-injurious behaviors. The results also indicated that the respondents had a higher percentage of response to acknowledging that peers have been influenced by websites/discussion boards/BLOGS that encourage suicidal and self-injurious behaviors.

Overall, these findings support the notion that the viewing of harmful self-injury websites is not widespread.

The types of information about self-injury and suicide that can be found on the web vary from being preventive and proactive to reactive and encouraging. Whitlock, Powers, and Eckenrode (2006) researched the amount of self-reported internet usage by adolescents in regards to their self- injurious behaviors. The researchers found that the Internet is a sounding board for this population in regards to their self-injury, as it appeared to give individuals a comfort level to share personal stories, exchange support, and voice opinions. The findings also related that these self-injury sites may also normalize and support self-injurious behaviors and also give ideas about possibly fatal behaviors which potentially could be used later. An example of a live journal website dealing with self-injury had the following survey questions which were optional for the website users to answer: Why do you self injure; When was your first time; What did you use; What kind of music do you listen to when you self injure; and What would you do if you found cuts on your best friend (“Pro-SI.livejournal”, n.d.). Many of these sites can be found using a Google search with the following terms:

“pro self-injury, pro self-injury tips, and/or pro self-injury forums.” There are also YouTube videos that can be found when using the same search term. Two examples were found:”Bleed Me Skinny” (Magicalbutterfly365, 2009) and “Pro self harm/suicide websites” (Escapeartist001, 2010). Many of these videos promote awareness of self-injury while also mentioning the harmful effects of these sites. It is difficult to determine whether these sites would have a positive, negative, or neutral effect on clients who are prone to self- injury.

Between 7% and 14% of adolescents participate in self-harming activities (Hawton & James, 2005). Self- harm may include the following: cutting, scratching, burning, punching, and biting oneself, to name a few (Gratz, 2001). The age for individuals who engage in self-injury peaks is middle to late adolescence and usually declines in early adulthood (Briere & Gil, 1998). Additional findings showed that undergraduate college students are also likely to relate that they participate in self-injurious behavior. In a recent study, 14.3% (out of 5,689) of the college student population who participated in the survey were likely to

self-injure (Seras, Saules, Cranford, & Eisenerg, 2010).

Whitlock, Eckenrode, and Silverman (2006) investigated self- injurious behavior in a college population. The researchers received feedback from approximately 3,000 individuals; within that population they found that 17% had engaged in at least one self-injurious behavior within their lifetime, 75 % of those students engaged in self-injury more than once and 39% reported that no one knew about their behavior. This study also revealed that repeat self-injurers were more likely to be less than 24 years of age, female, bisexual, or questioning their sexual orientation. There is a possibility that these behaviors, particularly the repeated self-injury, could lead to accidental or planned suicide (Young, Sweeting, & West, 2006).

The Center for Disease Control (CDC, 2009) related that suicide rates for both males and females had increased during the 2000-2006 years, the rates have especially increased for females ages 25-64 years. Suicide also ranked as the third leading cause of death for individuals aged 15-19 years (U.S. Department of Health and Human Services, n.d.). This increase has lead many to look at ways in which individuals might be getting information about suicidal means and completion. Dobson (1999) found that there were more than 100,000 sites on the internet that focused on committing suicide; and that young people were more influenced by the internet to commit suicide than older people.

Another study completed by Biddle, Donovan, Hawton, Kapur, and Gunnell (2008) discovered more sites on the internet that encourage suicide than offer support. The investigators used four common search engines and identified a total of 240 different sites, of those different sites 19% were

dedicated to suicide, 13% dedicated to suicide prevention, and 12% discouraged suicide. The other percentages involved sites that included news about suicide, general and miscellaneous issues relevant to suicide, and sites not relevant to suicide. It was also found that the first few hits revolved around pro-suicide sites and chat rooms discussing suicide. Clients may be viewing these sites without the knowledge of their counselor. It would be beneficial to discuss the potential positive and negative effects of these sites with clients as appropriate. The purpose of this present investigation is to explain the impact of potentially harmful or potentially healing websites, discussion boards, and BLOGS that focus on self- injury and suicide.

#### Method Sample

A non-random sample of undergraduate college students (n=273) completed the Helping and Hurting Websites Questionnaire (HHWQ), a descriptive survey created for this particular study. A majority (84%) of the sample was female (n=232) compared to males (n=41, 16%). A diverse sample was surveyed including 35 African-Americans (13%), 2 Asian-

Americans (<1%), 218 Caucasians

(80%), 8 Hispanic-American (3%), and 9 (3%) self-identified as other ethnicity or failed to report ethnicity.

Most of the sample (n=142, 52%) reported being in the age range of 18- 21, and the remaining sample reported the following: age 22-25 (n=51, 19%);

age 26-30 (n=24, 9%); age 31-40 (n=33,

12%); age 41-50 (n=15, 6%); and age 51 and older (n=7, 3%). This sample was non-random and was comprised of students at a two-year college in the Midwest.

#### Procedures

Questionnaire results were collected from undergraduate students at two- year open access colleges. Participants were asked to provide consent and complete the questionnaire. Surveys were distributed in various undergraduate classes at two different colleges. More than 30 academic majors were represented in the sample and nursing and education majors were most represented. Potentials participants were recruited during class. The nature of the study was explained and it was stated that participation was completely voluntary. Consent was demonstrated by completing and returning the questionnaire and no signatures were requested in order to protect privacy.

These procedures were approved by the Institutional Review Board. Students who were under the age of 18 were eliminated from the study. There was no compensation and students returned the forms by placing them in an envelope.

#### Survey

A questionnaire was developed to describe the exposure of various websites related to self-injury and suicide. This questionnaire was developed specifically for this study by the researchers. The items were constructed in relation to the research questions of the inquiry. A 5 point scale was used ranging from 1 (Never viewed a site) to 5 (Daily views the site). The following are examples of some questions that were used in the survey: How often have you viewed a website that promotes self-injurious behaviors; and How often have you viewed a website that discourages and treats

self-injurious behaviors?

This assessment addressed questions related to websites that college students viewed that were potentially harmful or were helpful in

addressing self-injury or suicide. The researchers explored how often they viewed these websites or BLOGS and if they believe their peers have been influenced by these websites. The questions were answered by indicating if they viewed one of these sites or BLOGS on a monthly basis or more.

#### Results

The most viewed online sites were websites (4.4%) and BLOGS/Discussion Boards (4.8%) that discourage/treat suicidal behavior. The least viewed sites were websites that encourage suicidal behavior (1.8%) and BLOGS/Discussion Boards that encourage self-injury. These items asked students to rate themselves, however, when asked if these sites have influenced a peer the percentages increased greatly. Students reported that 9.2% of their peers were influenced by website(s)/discussion board(s)/BLOGS that encourage suicidal behavior and 8.9% for ones that encourage cutting or burning (see Table 2).

#### Discussion

Since 7-14% of adolescents engage in self-harm (Hawton & James, 2005) and suicide ranks third in the leading cause of death for individuals aged 15-19 years (U. S. Department of Health and Human Services, n.d.) it is not surprising that some of the respondents visited websites that related to self-injury and suicide. In this current study, fewer than 5% of the college students surveyed viewed these sites on a monthly basis. This supports the notion that the viewing of harmful self-injury and pro-suicide websites is not widespread. Additionally, sites that treat or discourage self-injury and suicide were viewed more frequently than sites that promote self-injury and suicide. These results should be

reassuring to mental health professionals who track trends regarding self-injury and suicide and the internet. This also supports the findings of Hoeppner, Hoeppner, and Campbell (2009) who investigated archival intake records of a university counseling center and found that college students were reporting suicidal ideation and hopelessness during their intakes. The findings showed that student’s reporting of these symptoms did not increase or decrease over the 12 years of data.

However, the 1-5% of students who reported viewing these websites monthly were possibly the same ones who had mood disorders or personality disorders and were in treatment.

Therefore, it is possible that a high percentage of the client population viewed these sites. Another troubling result is the contrast between the self- report figures verses the reporting of a peer using these sites. Twice as many participants indicated that a peer might have viewed and had been influenced by self-injury and pro-suicidal websites as compared to themselves.

#### Implications

Practitioners should be aware that these group sites may provide a safe support group, both negative and positive for self-injury and suicidal behaviors and thoughts. A potential benefit of these group sites is that they might give individuals social support and positive connections. The negative impact is that this safe feeling given from the group site might allow individuals to be open and trusting to others who may give ideas about actual methods and attempts dealing with

self-injury or suicide. A possible way to handle the above is to inquire with clients, especially adolescents, during an intake interview or during a session how often they use the Internet, do they use the Internet to get information, and

do they participate in discussion boards/BLOGS. If the client relates that she uses the Internet often then asking her directly if she uses it to explore the topics of self-injury/suicide might be a follow-up inquiry. Another benefit of this research is to educate individuals who are in helping positions about these websites. A good avenue to discuss these websites would be through a Suicide Prevention Gatekeeper Training where individuals are informed about identifying, assessing, and referring potential suicidal students. Indelicato, Mirsu- Paun, and Griffin (2011) implemented this type of training within a university environment with very positive results that indicated that informing university personnel including students of potential suicidal factors could be beneficial.

#### Future Studies & Limitations

One limitation of this study was the limited population surveyed at a two-year undergraduate college where approximately half of the subjects were non-traditional college age, which was defined by the researchers as 22 years and older. Future studies might expand the population to a four year college as well as high school or middle school. The two-year college student population could possibly account for the decrease in the low percentages of students who viewed the websites, discussion boards/BLOGS. Another limitation of the study was that the survey questions did not ask about specific sites or give examples of the sites to participants. Future studies might actually choose specific websites and have subjects view them, followed by asking their thoughts and feelings in regards to the influences of the websites. A third limitation was that subjects rated themselves much lower on the influence of these websites as compared to the influence they thought

the sites had on their peers. A further investigation into the rationale on why they believe the influence of the websites are stronger on their peers than themselves could show some interesting results.

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## Internal Working Models: A Strategy for Enhancing Counselor Supervision

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Internal Working Models (IWMs) (Bowlby, 1988) provide a viable framework for conceptualizing supervisees’ development within the counselor supervision process. IWMs are the intrapersonal schematic for an individual’s interpersonal relations and significantly influence a supervisee’s interactional dynamics, development, and wellness within the context of both the therapeutic and supervisory relationships. Additionally, IWMs may be utilized within counseling supervision as a strategy to explore a supervisee’s theoretical orientation, case conceptualization, and the transference of theory to practice. This article introduces a supervision strategy grounded in IWMs to support supervisees’ development and offers a case illustration of the tool.

The Internal Working Models (IWMs) (Bowlby, 1988) construct is theoretically grounded in Attachment Theory (Bowlby, 1973, 1988), which offers an understanding of early relationships and their impact on one’s future interpersonal development.

Proponents of Attachment Theory advocate that “early attachment relations come to form a prototype for later relationships outside the family, during adolescence or adulthood” (Chotai, Jonasson, Hagglof, & Adolfsson, 2005, p. 251). More specifically, these primary relationships establish an internal, cognitive framework (IWMs) for the general depth and scope of connection that individuals have with others throughout their lifespan. An individual’s IWM has a comprehensive and profound significance for the overall quality and interpersonal nature of future relationships and is comprised of meanings based on previous life attachment (Belsky, 2002). A sound IWM “produces a sense of coherence that includes a comprehensive

understanding of the world, the motivation to pursue meaningful goals, and a belief in one’s ability to handle challenges and opportunities in life” (Griffith, 2004, p. 163).

IWMs (Bowlby, 1988) offer a framework for conceptualizing an individual’s thoughts, feelings, and behaviors in adult relationships (Fivush, 2006). Counseling supervision constitutes an interactional process and relationship. Further, individual attachment style and IWMs have been found to correlate with salient features of such relationships including (a) communication behaviors, (b) self- disclosure, (c) level of communication competency, (d) empathy, (e) information-processing, and (f) psychological development (Mikulincer, 1998; Mikulincer Shaver, Gillath & Nitzberg, 2005; Vivona, 2000). As a result, supervisees’ counseling and supervision process is likely influenced by their IWM (either positive or impaired) (Neswald-McCalip, 2001). As Miller, Notaro, and Zimmerman (2002) noted, the primary caregiver

attachment is crucial in early life development; however, ongoing attachment bonds with significant others throughout life have critical implications for healthy socio-emotional functioning. Further, inasmuch as primary caregivers provide a safe base for children, a parallel process occurs in supervision between the supervisee and supervisor.

The importance of supervision for counselor skill development has been consistently supported in the literature (Bernard & Goodyear, 2009). Further, Watkins (1997) suggested that the supervisory relationship was the foundation of effective supervision and a necessary prerequisite for promoting development. Supervisors are responsible for establishing an atmosphere of safety and acceptance, allowing supervisees to experiment and grow both personally and professionally. After this supervisory atmosphere is established, supervisors support supervisees in attempting new counseling strategies and behaviors, while processing the counseling experience. Therefore, the importance of a secure relationship (attachment) in one’s healthy development may be applied to the clinical supervision process.

Counseling supervision is a critical factor in supporting counselors’ ethical practice and professional and personal development (Curry & Bickmore, 2012). This manuscript provides supervisors with a supervision tool, grounded in the theoretical tenets of Attachment Theory and IWMs (Bowlby, 1988) to support both supervisees’ psychosocial development and their delivery of counseling services. More specifically, this manuscript (a) reviews the research and theoretical constructs of Attachment Theory and IWMs; (b) introduces a supervision tool grounded in Attachment Theory and IWMs; and

1. offers a case example of a supervisor employing this supervisory tool with a counselor-in-training.

#### Attachment Theory, Internal Working Models, and Clinical Supervision

Three primary attachment styles have been identified: (a) secure, (b) insecure-anxious, and (c) insecure- avoidant (Ainsworth & Bell, 1970; Bowlby, 1988; Hazan & Shaver, 1990). Attachment styles are a fairly stable, lifelong pattern of connection and interaction with people and the environment (Mikulincer et al., 2005). The quality of attachment towards significant others (e.g., primary caregiver, friends, and family) may influence an individual’s adaptability and functionality (Miller et al., 2002).

Attachment styles appear to be pervasive (Hazan & Shaver, 1994), and have been correlated with multiple personality characteristics, states of affect, social and emotional adaptation, and wellness (Sumer & Knight, 2001). Individuals with a secure attachment style display greater interdependence, trust, commitment, and satisfaction; while those with an insecure attachment styles may be characterized by feelings of jealousy, ambiguity, loneliness, and lack of trust (Hazan & Shaver).

Cooper, Shaver, and Collins (1998) found that those with insecure- anxious attachment (sometimes broken into two smaller groups—preoccupied and fearful) tend to be lonelier, experience feelings of shame, anxiety, depression, paranoia, self- consciousness, lower self-esteem and lower self-confidence. Conversely, those with secure attachments have been found to have (a) higher self-esteem, (b) greater emotional adjustment (Moore & Leung, 2002), (c) feelings of competence, (d) increased autonomy (Vivona, 2000), (e) positive

conceptualizations of self and others (Gillath et al., 2005), (f) display less psychological distress, and (g) greater overall well-being and health (Chotai et al., 2005). Additionally, Roney and colleagues (2004) found that individuals with a secure attachment style had stronger interpersonal skills and displayed greater caring for others (desirable counselor qualities).

Within the context of career, attachment style has been linked to occupational choice, job performance, career satisfaction (Roney, Meredith, & Strong, 2004), and home and work life balance (Sumer & Knight, 2001).

Specifically, attachment behaviors may manifest in the workplace with consequences for the employee and their co-workers. For example, insecure-anxious individuals may have difficulty focusing on work and producing quality work as relationships and gaining acceptance are of prominence. Dismissing-avoidant individuals may have preference for working alone and may display more concern for tasks than social-emotional relationships. They may also have difficulty working collaboratively and being part of a team effort. Securely attached individuals explore career options may more deeply, have greater career commitment, and have more

collegial workplace relationships (Roney et al.).

#### Internal Working Models

“During social development, people presumably construct internal affective/cognitive models both of themselves and of typical patterns of interaction with significant others” (Simpson, 1990, p. 971). Early relationships provide the context from which basic core components about the organization of relationships and subsequent beliefs, goals, and strategies are formed (Van Buren & Cooley, 2002). These basic components

serve as a blueprint or framework for the individual when approaching future relationships (Bennett & Vitale Saks, 2006). This blueprint is referred to as the individual’s *Internal Working Model* (IWM) and there is both cross-age and cross-situational support for the pervasiveness of these models (Hazan & Shaver, 1994). The IWM predicates beliefs about whom to trust and to what degree, relationship goals, and strategies for achieving those goals.

These mental schemas are organized and systematic; further, schemas influence the trifecta of thoughts, feelings, and behavior (Griffith, 2004). Further, Cooper and colleagues (1998) suggested:

Working models are thought to include both conscious and unconscious schematic elements that guide perceptions and trigger characteristic emotions, as well as defense mechanisms, or rules for regulating emotion and for processing or failing to process certain kinds of attachment-relevant information. These models are thought to persist across time and exert pressure toward continuity in affective experience and behavior. (p. 1381)

An individual’s IWM influences his or her interpersonal relationships (i.e., counseling and supervision relationships) (Bennett & Saks, 2006). Belsky (2002) noted that while the IWM does serve as a relationship template, it is important to acknowledge that IWMs can and do change over time. Belsky affirmed that the word *working* in IWM signifies that it is a work in progress.

By bringing beliefs and values to the individual’s awareness and challenging faulty conceptions, it is possible to recreate the meanings assigned to individual, historical events. If it is possible for individuals to actively alter these meanings, then it may also be

possible for them to alter their attachment style through retaining cognizance of how their IWM relates to their behavioral functioning when they are under distress and the IWM is most activated (Vivona 2000). However, Hazan and Shaver (1994) suggested that IWMs are difficult to change because new information is assimilated by the individual into existing schemas.

#### The Supervisory Relationship

IWMs (Bowlby, 1988) provide a conceptual understanding for the processes and dynamics of interpersonal adaptation in many life arenas (Cooper et al., 1998). Therefore, IWM processes are not only applicable to caregiver and romantic relationships, but also to working relationships. The supervisory context constitutes a relationship that is the base from which the emotional bonds that are primary for a supervisory working alliance occur, and in which behaviors indicative of that bond facilitate the alliance (i.e. caring, trust, respect) (White & Queener, 2003). Thus, IWMs may significantly inhibit or promote the quality of a supervisee-supervisor relationship (Bennett & Saks, 2006).

The IWMs (Bowlby, 1988) system of an individual is activated when the individual experiences distress or receives information perceived as threatening (Vivona, 2000). As beginning the practice of counseling may evoke anxiety (Bernard & Goodyear, 2009), it is a logical assumption that supervisees will rely on their IWM in interaction with others. Research has supported that people with a secure attachment style are attracted to people-oriented work (Roney et. al, 2004); however, many people enter counseling professions due to their own need to resolve life challenges (Pines, 2004). Specifically, Pines stated that people choose a particular career in order to

unconsciously “replicate significant childhood experiences, gratify needs that were ungratified in their childhood, and actualize occupational dreams and expectations passed on to them by their familial heritage” (p. 67). Supervisees may be unaware of how their early life experiences manifest in their relationships with both supervisors and clients.

Supervisees may exhibit behaviors indicative of any of Ainsworth and Bell’s (1970) three attachment styles. Further, the supervisory relationship replicates, in many ways, the parental attachment relationship and may be conceptualized similarly (Tsong, 2004). Supervisees need to feel supported and encouraged in order to fully explore and immerse in both the counseling and supervisory relationship (Riggs & Bretz, 2006). Exploration is essential to the growth of the developing counselor—promoting the use of more challenging techniques, personal skill assessment, and more depth and awareness in case conceptualization. Indeed, attachment styles impact the supervision process through qualitative differences in supervisory alliance as measured by the degree of bonding and omissions (Tsong, 2004). In addition, the supervisory relationship is predictive of a supervisee’s counseling alliance with clients (White & Queener, 2003), supporting the notion that the counseling relationship is influenced by the bonding process between supervisor and supervisee.

The exploration of one’s environment and trying new behaviors can be exhausting and anxiety evoking (Hazan & Shaver, 1990). Having a safe haven to explore from allows the developing individual to return to a zone of safety in order to rejuvenate, be affirmed, and reorganize one’s thoughts. Supervisors may provide such a safe haven to supervisees in

their counseling preparation (Riggs & Bretz, 2006). Moreover, exploration without the expressive IWM needs of the individual being met is impossible (Hazan & Shaver). This may be particularly true in the development of trust in the counseling supervision relationship. As trust is critical to exploration and feelings of safety (Pistole & Fitch, 2008), trust was described by Mikulincer (1998) as containing three critical dimensions: (a) the trusted individual is seen as reliable and predictable; (b) the trusted individual is concerned with others needs, goals, and desires; and (c) there are feelings of confidence in the strength of the relationship.

IWMs (Bowlby, 1988) may manifest in many ways in the supervisor-supervisee relationship. Pistole and Fitch (2008) suggested that attachment behavior is heightened in situations that the individual perceives as threatening (e.g., practicum level supervisees beginning their first clinical experience). The context of the situation may exacerbate or diminish the individual’s reliance on attachment behaviors as a function of perceptions of safety and crisis (Neswald-McCalip, 2001). Therefore, in supervision, the context of the relationship may prompt qualitatively different reactions from individual supervisees. Further, the interaction between supervisor IWM and supervisee IWM may have implications for the supervisory relationship (Bennett & Vitale Saks, 2006). While that is not the focus of this manuscript, readers wishing to learn more information about supervisor attachment style should consult White and Queener (2003). A description of possible behaviors by supervisee IWMs follows.

***Secure supervisees*.** Hazan and Shaver (1990) suggested that work creates a primary outlet for exploration

and mastery, and that secure individuals have fewer work concerns regarding evaluation and performance—necessary components in clinical supervision. Additionally, secure persons are more trusting and optimistic about their own competence to deal with stress and utilize effective coping strategies for dealing with conflict (Belsky, 2002), such as open and honest dialogue concerning presenting issues in the supervision relationship (Mikulincer, 1998).

Therefore, secure supervisees are more likely to articulate mistakes and challenges without deliberately omitting information that they fear will put them in a negative light. Secure supervisees tend to perceive supervisor feedback as benevolent and constructive. In addition, secure supervisees are likely to self-disclose to supervisors in appropriate and meaningful ways, such as stating supervision needs or concerns (Neswald-McCalip, 2001).

Further, due to their ability to use effective and creative positive coping skills (Myers & Vetere, 2002), secure individuals have been found to have greater resiliency to burnout (Pines, 2004).

***Insecure-anxious supervisees*.**

Hazan and Shaver (1990) purported that insecure-anxious individuals tend to (a) seek praise, (b) become over- obligated as a means of seeking co- worker and supervisor admiration, (c) have difficulty meeting deadlines due to preoccupation with relationships, and

1. feel that their contributions are underappreciated. These individuals lack the confidence to manage challenges in an independent manner (Vivona, 2000), and in supervision they may be jealous of other supervisees, demand constant attention (Tsong, 2004), continually ask for help, and want to be the supervisor’s favored supervisee (Watkins, 1995). Mikulincer

(1998) suggested that insecure-anxious individuals may mentally ruminate on the meanings and causes of negative or stressful events (become “stuck”). These individuals may also be prone to feelings of shame regarding performance, fear evaluation (Cooper et al., 1998), and have a high need for validation (Sumer & Knight, 2001).

Further, they may be overly expressive and may exhibit hostile behavior as a coping mechanism when events are perceived as threatening (Hazan & Shaver, 1994).

More specifically, insecure- anxious individuals are inclined to utilize coping strategies that actually tend to promote greater emotional distress rather than decrease it (Belsky, 2002). Insecure-anxious individuals oscillate between pursuing closeness in relationships and displaying extreme disgust when their needs go unfulfilled (Magai, Hunziker, Mesias, & Culver, 2000). This propensity to utilize negative coping strategies may lead to greater risk of burnout in supervisees that are insecure-anxious (Pines, 2004). Additionally, Mikulincer and colleagues (2005) found that insecure-anxious individuals feel distressed when others are in need, but as a result of internalizing the stress based on their own needs, they are less compassionate and less altruistic. Insecure-anxious supervisees may exhibit self-disclosing behavior; however, they lack the disclosure flexibility and topical reciprocity to fully engage in meaningful and appropriate disclosures pertinent to the supervision relationship (Mikulincer & Nachshon, 1991).

***Insecure-avoidant supervisees***. Insecure-avoidant individuals are more interested in work, avoid relationship development with colleagues, work to the preclusion of social engagements in the work environment, and complete

tasks while minimizing time away from work such as holidays and vacations (Hazan & Shaver, 1994). In addition, insecure-avoidant individuals would be less likely to participate in honest disclosure, a possible barrier in the development of an effective supervision relationship (Mikulincer & Nachshon, 1991) Similarly, Riggs and Saks (2006) found that insecure-avoidant supervisees reported low consensus with their supervisor regarding supervision goals. Further, insecure- avoidant supervisees “may have more difficulty trusting their supervisors, which could impact their willingness to reach mutual agreement about the tasks and goals of supervision and to form a close relationship with their supervisors” (Tsong, 2004, p. 121).

Insecure-avoidant supervisees may also discount the supervisor’s suggestions or blatantly refuse counseling imperatives given by the supervisor (Pistole & Watkins, 1995).

Insecure-anxious supervisees may experience negative events with increased anxiety and ego-fragility; while insecure-avoidant individuals may react to negative events in a dismissing or hostile fashion and decreased ego resilience. Whereas, secure supervisees are more ego resilient, less hostile, and they tend to positively reframe negative events which allows them to perceive these events in a constructive, relationship- enhancing fashion (Simpson, 1990).

Foster (2003) found that counseling supervisors are capable of accurately identifying IWMs of supervisees and awareness of how those differences may manifest in supervision. However, supervisors tend to rate their supervisees as more secure than self- report measures show they actually are—suggesting a supervisor bias in the supervision relationship. Supervisors may utilize IWMs in their supervision to provide a common language and

framework for discussing issues that may arise in supervision. Examples of issues that may be discussed using this IWM supervisory strategy include concerns in the supervision relationship, and assessing the therapeutic alliance between supervisees and their clients.

#### Internal Working Models as a Clinical Supervision Strategy

This clinical supervision strategy may be used in supervision for a variety of purposes as aforementioned, and additionally for (a) case conceptualization, (b) processing purposes, (c) discussing issues of transference and countertransference,

(d) clarification of theoretical orientations, (e) the design of appropriate client interventions with therapeutic intent, and (f) to provide a common language for discussions in group and triadic supervision. In order to use the IWM as a supervisory tool, we utilize a visual template of an IWM adapted from Griffith (2004) (which is presented in Figure 1.). For more information about how the IWM template represents attachment styles, please consult Griffith (2004). We suggest reviewing the primary constructs of Attachment Theory (Bowlby, 1973) with supervisees prior to employing this supervisory strategy. Using the visual template, we introduce supervisees to the progression of manifested behaviors by beginning with past experiences (that have contributed to the development of the IWM itself) and how they influence current beliefs, goals, and strategies. Following that, we discuss how an individual’s current context may inhibit or facilitate reliance on his or her IWM. For instance, a person in high stress (i.e., relational difficulties) may resort to IWM behaviors more than an individual who is not experiencing major life challenges.

We then elucidate what is meant by beliefs, goals, and strategies. *Beliefs* are those thoughts about the self and others which may be either positive or negative (feelings of competence or incompetence such as efficacy beliefs, worth, thoughts about whether or not the world is a safe place, or thoughts about whether people are or are not trustworthy). *Goals* are the individual’s projected measures of optimal functioning and well-being including holistic life domains such as: (a) bio- physical, (b) competency-based/career,

1. social/relational (d) spiritual, and (e) leisure. *Strategies* are the plans that encapsulate both the negative and positive skills individuals utilize in meeting their goals; strategies may be maladaptive (e.g., passive aggressive behavior) or functional (e.g., talking through problems).

Actions and reactions are the behavioral elements of the IWM. The important point to capture for supervisees is that many events and occurrences preempt behavior.

Behaviors are not created in a vacuum, and examining the entire IWM helps underscore this tenet for the supervisee. Further, the IWM template helps supervisees understand the interconnections of past experiences, the current context, beliefs, goals, strategies, actions and reactions. Once the supervisee understands the components of the IWM, it may be used as an application. One application is in getting to know the supervisees and assessing their personal development. After explaining the components of the IWM, we ask about the personal relevance and meaning it has for our supervisees’ ongoing development. The following are sample questions related to each of the components that we use in order to establish an understanding of our supervisees’ IWM and how it may impact the counseling and supervision processes:

* 1. When considering your own past life experiences, what events or defining moments may have influenced your decision to become a therapist? What other issues or concerns have affected your career decision?
  2. When looking at the current context of your life (e.g., family life, work place demands, and system factors), what may inhibit or promote your development as a clinician?
  3. How might your beliefs about yourself manifest in the therapeutic process (i.e. your own self-efficacy, self-esteem, etc.)? How might your beliefs about others affect your relationships with clients (e.g., Do you believe others can be trusted; How do you believe change occurs; Are other people naturally good, evil, or neither)?
  4. In looking at your life domain goals, what areas do you need to concentrate more on to have quality of life balance? What area is your greatest strength at this time? Are your own goals realistic, measurable, and concrete?
  5. What types of strategies/coping skills do you use when problem- solving or dealing with difficulties? How effective are those strategies? What would you like to do differently?
  6. What types of actions and reactions do you have for dealing with your own life challenges? Think of behaviors you have used in the past that were pro- active, assertive, or passive aggressive. What types of behaviors have you had that could be a problem in dealing openly and honestly with challenges in the supervision or therapy process?

Another application of the IWMs supervisory strategy is when working with supervisees on choosing their primary counseling theory. We may give them the IWM graph and ask the following sample questions to explore the intervention intercept of their theory in case conceptualization: (a) If a client comes to you with a concern, which of these areas would you want to investigate first with him or her (past experiences, current context, beliefs, goals, strategies, or actions/reactions)?

1. What is the second area of concern you would explore with the client? (c) In order for change to occur, what must a client work on first: his or her thoughts, feelings, or behaviors? Supervisees, who express that they would begin therapy by exploring the client’s past experiences and feelings as the first component to change, likely have a psychodynamic theoretical orientation. While, supervisees who believes that behavioral change must occur first and chooses to explore actions/reactions likely holds a more behavioral theoretical orientation.

In exploring IWMs in the context of the clinical supervision relationship, the supervisor may ask the supervisee some of the following questions for reflection. These questions may provide insight as to whether or not the supervisee considers the supervisory relationship both a safe haven and a secure base (Pistole & Fitch, 2008):

* 1. Does the supervisee believe that he or she is valued and respected in the supervision process (this is a good time to discuss issues of diversity that may affect the supervision process including race, gender, socioeconomic status, religious values, etc.)?
  2. Is the supervisor appropriately responsive and accessible?
  3. Does the supervisee feel his or her supervisor is an available and trustworthy person?
  4. Does the supervisee feel comfortable to explore counseling issues with the supervisor as a safe-base (does he or she feel free to openly discuss concerns, try new counseling techniques, develop new approaches)?
  5. Does the supervisee think that he or she is being monitored and his or her performance is evaluated judiciously and fairly?
  6. Does the supervisee feel that his or her supervisor is a secure base (trustworthy, dependable, and supportive) in his or her development as a counselor?
  7. Does the supervisee experience the supervision process as flexible inasmuch as his or her input is valued and formative in the decision-making regarding developmental goals?

If the supervisee answers “no” to any of the aforementioned questions, then the supervisor and supervisee may discuss the issues of concern. The IWM visual template may be utilized to discern if the supervisee is accurately reflecting on the current context or if the current experience is being accommodated or assimilated into prior schemas of the supervisee’s IWM.

More importantly, as supervisees gain perspective about past experiences that have influenced the development of meanings precipitating current behaviors and their IWM, they are more likely able to establish new meanings and to expand their strategies for effectively coping with current challenges (Pistole & Watkins, 1995).

One method of recreating these meanings is to assist supervisees in acknowledging that IWM-based behaviors were relevant and necessary during childhood but that they are more competent now to make more functional choices. As supervision may be isomorphic to the therapeutic

process, it is hoped that supervisees learn from the modeled behavior of the supervisor and that they provide a similarly safe atmosphere in the counseling process for clients (Pistole & Watkins). The following case example offers a pragmatic demonstration of this supervision strategy’s application relating to supervisory issues such as transference, countertransference, and supervisee attachment. All identifying information has been altered and pseudonyms have been used to protect the identity of the client and counselor- in-training.

#### Case Example Illustrating Application of Adjunctive IWM Tool in Supervision

The first author utilized this IWM supervision strategy in her supervision with a Masters level counselor-in- training, Brittany. Brittany was a bright, energetic supervisee who always came to supervision prepared with materials, excellent notes, and external research. Brittany was in her mid-30s and was the mother of two elementary- age boys. She was verbally articulate and described her theoretical orientation as Cognitive-Behavioral.

During her beginning clinical practicum experience, Brittany was assigned a male client (Jim) in his late-20s with issues surrounding his history of being sexually abused.

From Brittany’s first session with Jim, she appeared to ruminate on his concerns, often transgressing to preoccupied discourse regarding Jim even during discussions about other cases. She became tearful and frequently cried when describing the abuse Jim had endured and the abject poverty in which he was raised. She spent a disproportionate amount of time preparing for sessions with Jim: reading multiple books, articles, and researching websites every week (displaying more concern for his case

than for her other clients). In the interim between counseling and supervision sessions, Brittany would call me and ask questions about what to do in the next session—indicative of her high degree of anxiety about working with Jim. Brittany would often do web-based research and would expand, very emotionally, on Jim’s history and the details of his abuse during our supervision sessions.

However, in her counseling sessions with Jim, Brittany would attempt to divert him from talking about the emotional aspects of the abuse, prompting him to focus on his thoughts and cognitions whenever he began to express affective aspects.

Brittany’s thoughts and feelings about Jim’s situation began to manifest in behavior that was questionable and, at times, bordered on unethical. For instance, at the end of one session where Jim cried, Brittany asked him for a hug. In addition, prior to the Thanksgiving holiday, Brittany asked me if she could give Jim her telephone number in case he needed extra support or was lonely. After I opposed, Brittany argued that she had read that this was an appropriate counseling strategy in a book written for therapists working with sexually abused clients.

At this point, I decided to use the IWM diagram (as presented in Figure 1) to assess the countertransference that Brittany was experiencing in counseling. I showed her the model and gave her directions for writing a narrative describing each of the components as they pertain to her.

After she had completed the written descriptions, I met with Brittany and we discussed each component of the IWM visual template (Figure 1). What the discussion revealed was overwhelming similarities between Brittany and Jim, including childhood abuse, poverty (issues from prior life experience), and a high motivation to

achieve and improve her status in life. Her current context included being married with two children (both males who were at ages similar to Jim when he was sexually abused). Brittany recognized that much of what was triggering her about Jim’s story were similarities to her own life.

The narrative of Brittany’s beliefs revealed a general distrust of people, low self-efficacy beliefs, and poor self- concept as evidenced in her self- deprecating statements. She was a motivated person and described goals in all domains of the goals component of the IWM that were both measurable and realistic. Generally, her counseling strategies for goal achievement appeared to be proactive, although she admittedly relied on passive aggressive behaviors when angry with authority figures (an approach utilized by insecure-anxious individuals).

Through processing Brittany’s IWM, we were able to discuss (a) her actions and reactions to Jim, (b) why she was experiencing such strong issues of countertransference, (c) her case conceptualization and theoretical orientation, (d) how she and Jim were both similar and different, and (e) what choices she could make that would have therapeutic value based on Jim’s needs rather than her own**.** The IWM visual template assisted me in facilitating a conversation about the similarities between Brittany and Jim that were prompting her countertransference. Further, we were able to talk about the content and the process of this case at a deeper level with her increased awareness. Brittany also appeared to be less defensive and resistant to my supervisory feedback. Brittany stated on several occasions that using the IWM template helped her to “see” what was going on in her relationship with the client.

#### Implications for Clinical Preparation and Supervisory Practice

IWMs (Bowlby, 1988) hold much promise for conceptualizing the clinical supervision relationship. Entering the counseling profession is stressful; it is important that supervisees feel supported and safe to explore, within a secure context (Bennett & Vitale Saks, 2006). It is also vital that clinical supervisors establish an atmosphere of safety, trust, and caring where supervisees feel supported in sharing honest observations and concerns, without harmful omissions and deceit (Tsong, 2004). Additionally, supervisors and supervisees need to have a common language and understanding for discussing client issues, challenges in the counseling process, supervisee concerns, and the clinical supervision relationship itself. IWMs may provide such a language. This manuscript offered a (a) rationale for the use of IWMs in clinical supervision, (b) a visual template of IWMs, (c) examples of how to utilize the IWM template, and (d) a case illustration of the application.

The intent of this article was to elucidate the use of IWMs as clinical supervision strategy; it is not meant to be a standalone model of clinical supervision. Application of this tool should be considered within the greater scope of the supervisory relationship as developed by the supervisor from a grounded theoretical perspective. This supervisory strategy is meant to be integrated based on the supervision needs identified by the supervisor.

Strengths of the IWM supervisory strategy include (a) it is concrete and flexible, (b) it may be delivered within the learning style of the supervisee (visual, dialectical, narrative), (c) it allows supervisees to understand how their own life experiences are synthesized and translated to the supervision process, (d) it provides a holistic approach to working with

supervisees, and (e) assists supervisees in developing awareness about their own behaviors beyond a superficial understanding. Nevertheless, just as models of supervision have definitive limitations, the IWM supervisory strategy may not be appropriate for utilization with all supervisees. In addition, there is a paucity of research supporting this approach, although the use of IWMs to conceptualize the supervision relationship is well supported in literature (Bennett & Saks, 2006). Even with the limitations of the IWM supervisory strategy, we nevertheless believe that this approach holds much promise as a tool within supervision process.

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## Group Physical Exercise, Relationship Dynamics, and Curative Factors: Qualitative Findings from a Kinesiology

Exercise Immunology Course

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Qualitative inquiry was used to examine students’ perceptions of, and experiences in, a Kinesiology Exercise Immunology Course with an experiential marathon training component. Twenty-eight students participated in four focus groups. Data was analyzed according to the themes and patterns that emerged during each focus group**.**

Major themes revealed the presence of, relationship dynamics, interpersonal learning, and multiple curative factors used to develop and enhance the relationship of the educator and student the experiential classroom setting. Implications and recommendations for human service educators are discussed.

Physical activity has been linked to lower incidents of diabetes, heart disease, osteoporosis, and obesity (American Heart Association, 2011; Sigal, Wasserman, Castaneda-Sceppa, & White, 2006). Beyond these physical benefits, the positive mental health affects of exercise have also been well documented and include decreases in symptoms of depression, negative mood states, anxiety, and stress (Atlantis, Chow, Kirby, & Singh, 2004; Gold, Shipp, Pieper, Duncan, Martinez, & Lyles, 2004; Nabkasorn, Miyai, Sootmongkol, Junprasert, Yamamoto, Arita, & Miyashita, 2005; Timonen, Rantanen, Timonen, & Sulkava, 2002). An established link between exercise and mental and physical wellness may be attributed to biological mechanisms such as increases in the secretion of beta endorphins (Goldfarb & Jamurtas, 1997), reductions in volumes of urine cortisol and epinephrine excretions, improved cardiorespiratory fitness as measured by lung capacity and peak oxygen uptake (Nabkasorn et al., 2005), and better quality sleep (Chen, Li, Lin, Chen, Lin & Wu, 2007).

In addition to how physical and biological health impacts mental health, researchers have noted that a positive relationship exists between self-esteem, generalized and specific self-efficacy, self-regulatory coping strategies (such as goal-setting, problem solving, and self monitoring) and participation in physical activity (Fallon, Wilcox, & Ainsworth, 2005; Hu, Motl, McAuley, & Konopack, 2007; Ransdell, Dratt, Kennedy, O’Neill, & DeVoe, 2001; Rudolph & Butki, 1998). Moreover, exercise may potentially improve mental well-being by increasing psychological resources for dealing with future stressors (Meyers, Sweeney, & Witmer, 2000; Rudloph & Butki Stoll & Alfermann, 2002).Given the sufficient support of a positive relationship between physical activity and mental health, there appears to be great impetus for increasing physical activity. In this manuscript the authors review a kinesiology *Exercise Immunology* course where didactic instruction coupled with experiential running groups led to positive mental health and relational gains for participants.

#### Group Exercise and Relationship Dynamics

While there is a significant amount of research on physical exercise and mental health benefits, some researchers have chosen to focus on promotion of exercise at different levels such as the individual, group, community, and environment (Saxena, Van Ommeren, Tang, & Armstrong, 2005). For the purpose of this article, we focus on exercise at the group level and explore the humanistic and relational dynamics that have occurred during the process of group exercise.

Specifically, there is ample evidence to support that mood states, and interpersonal connections, may be affected by structured group exercise. For example, Timonen and colleagues (2002) reported the results of an experimentally designed study where elderly participants who were in an exercise group had significantly greater gains in enhanced mood states compared to a control group of individuals who exercised at home. The researchers speculated that the exercise group provided members with more than just physical activity; participation appears to have given the members a social outlet, encouragement, support and increased positive beliefs about health and fitness (Timonen et al., 2002).

Similarly, Gold and colleagues (2004) found that older women suffering from vertebral fractures showed improvement in anxiety, depression, stress, and positive coping skills when they participated in group exercise. Furthermore, elderly adults with poorly responsive depressive disorder displayed improvements in depressive symptoms within the first 10 weeks of participation in a group exercise class (Mather et al., 2002).

Thus, it appears that utilizing a group exercise format promoted more positive mood mental health functioning for

participants in all of these studies. In sum, the literature reviewed strongly suggests that group exercise not only aids in physical health and development, but also fosters positive mental health benefits and interpersonal learning as well.

For this study, an instructor of a kinesiology exercise immunology course designed a physical training component (training to run a marathon) as a course requirement to assist students in applying what was learned in the class (e.g. nutrition, physical rest, sleep patterns, and immune functioning of endurance athletes). Using process oriented instruction (Vermunt & Vermetten, 2004), the class was allowed to discuss their weekly training experiences, in particular focusing on the learners “process of knowledge construction and utilization” (p. 337) for their own marathon training practice. Within this learning paradigm, the emphasis on the instructor as the purveyor of knowledge shifts to student centered learning (in this case student facilitated running groups), personal reflection and interpersonal feedback.

When designing this study, the authors had to consider how a structured group exercise activity that was a course requirement may or may not benefit students’ physical and mental health, enhance instructional pedagogy and lead to greater student learning outcomes.

The role of the instructor in this study was two-fold, in the classroom she was the teacher imparting knowledge through instruction and curriculum and in the running group she was a coach. How could both of these roles work conjunctively to promote student’s overall wellness and integration of course content? Beyond the previously stated research linking exercise to positive mental health benefits, the dynamics of the relationship between the professor and

the students and the relationships among students were examined to assess outcomes from the Exercise Immunology course (Walters, 2008). Walters contends that teacher- students relationships based on genuineness, empathy and unconditional positive regard are therapeutic and fosters interpersonal learning and improved relationship dynamics. The relationship between students and the instructor provides the grounding for true and meaningful connection with others, relational reparation, and the understanding that disagreeing viewpoints within relationships can be tolerated and may even enhance interpersonal communication (Tantillo, 2006).

These relationships and interpersonal learning were assessed conceptually by examining the Curative Factors (1985) introduced by Irvin Yalom (1985). Specifically, how do these dynamics impact a course where the success of completing the marathon is partially based on interpersonal learning, relationships, and group dynamic? According to Young (2009), the helping process (such as the process of educating another or being in the role of a support coach) includes a therapeutic or mutual learning relationship with provides the conditions that are supportive such as empathy, genuineness, and unconditional positive regard.

Conversely, a relational approach allows the individual in the role of student to have a venue for genuine expression of feelings, with reduced emotionality, and within the context of support and understanding created by the course instructor. The benefit of mutuality between the students participating in the marathon training is that they receive acceptance and unconditional regard through the therapeutic factors of universality, cohesion, and experience of real

expression (Yalom, 1985), which empowers them to guide their own interpersonal learning and individual goal completion.

In the case of this study, the instructor served as coach but also trained for the marathon alongside the students to share the lived experience and the relational process of interpersonal learning and personal growth. Additionally, the instructor of the group in this study used some of the basic principles of Yalom’s (1985) group process approach: she gave autonomy to persons in the group, facilitated learning, stimulated independence in thought and action, offered and received feedback, and found reward in the development and achievement of others. The current study highlights how group relationships can form spontaneously and how group members reap unexpected benefits from this process. While the instructor had an evaluative role and did expect students to complete course requirements, she did not necessarily expect that any particular interpersonal process would occur based on the marathon training experience. As the study was conducted, it became clear that the role of facilitator was congruent with the role of a group leader and many counseling related outcomes were seen as a result of the instructor.

The current study was conducted with college students participating in a kinesiology *Exercise Immunology* course at a southeastern university where they were placed in marathon training groups as an experiential adjunct to course didactic instruction. The component of the study reported here is based on post- course focus groups that were originally designed to ascertain student perceptions of the value of the course in regards to educational/learning benefits as it pertains to student

understanding of endurance training and the impact on the body’s immune system, challenges faced by athletes in the training process (such as proper nutrition, rest, flexibility and more), and constructive feedback for future course design. However, the findings revealed much more about the mental health benefits as reported by the participants; especially in regard to curative factors, and interpersonal relationship dynamics associated with the structured group exercise experience. The major selection criterion for group members is that each person be willing to attend and participate in the experiential marathon training group. However, in addition to the selection criterion, the participants had to have a medical release to participate.

#### Methodology

This study was conducted after students had enrolled in and completed a pilot course on *Exercise Immunology* within the kinesiology program at a public, southeastern university. The course design and curriculum included didactic instruction on exercise and the impact on immune system functioning. In order to integrate student learning and experience, students tracked their own biological indicators throughout the semester (beginning with baseline measures for pre and post comparison) while training for a half or full marathon. The biological data collected by students included: (a) height, (b) weight, (c) blood pressure, (d) heart rate, (e) body composition (body fat percentage, bone mineral density), and

(f) skinfold measurements. Students’ physical fitness was estimated by having them perform a 1.5 mile run/walk test under the supervision of the course instructor. After the fitness assessment, students were placed in training groups for running and were

put on a training schedule. For the purposes of this article, we will not be reporting on the quantitative findings from the biological indicators, rather, we are reporting on the findings from the exploratory study conducted at the conclusion of this course on students’ perceptions of participating in a structured, group exercise experience.

Because this was a pilot course, it was important for the instructor to gain insight about student perceptions of the course through student feedback. The first author (a counselor educator) agreed to design and conduct focus groups in order to illicit students’ responses to the course. According to Breen (2006) qualitative, focus group inquiry is appropriate due to the exploratory nature of this study and as a means to facilitate discussions of small groups of people about the participants’ experiences and perceptions of the course. Questions were written and used as a protocol for facilitating the focus group discussion (Please see Appendix A). Four focus groups were scheduled at various times and on various dates to accommodate as many of the participants as possible.

#### Participants

Participants (n=28) were students enrolled in a kinesiology *Exercise Immunology* course who chose to attend one of the four focus groups offered at the end of the course. There were a total of 33 students in the course making participation in the focus groups 85%. Participants were in different year categories including college sophomores (6), juniors (6),

seniors (12), and graduate students (4). No freshman chose to participate in this study. All of the participants were White, non-Hispanic. The greatest number were Kinesiology majors (17), there was a variety of college majors from other areas including: Biology, Biological Sciences, Finance, Sports

Management, Pathobiological Sciences, Exercise Physiology, Chemical Engineering, and History. Reported sex of the participants revealed that six were male and 22 were female.

Participants ranged in age from 19 to 26 years old (M=22). In regards to exercise participation, 19 of the participants ran a marathon at the completion of the course, eight ran a half-marathon, and one abstained from running due to a sports related injury.

#### Ethical Considerations

Special ethical considerations were made in accordance with the potential risks of participating in a marathon training group. First, Institutional Review Board (IRB) approval was obtained for participation in the class study (specifically for marathon training and for gathering and reporting individual biological data). Prior to participating, students were given informed consent regarding the risks, benefits, purpose of the study, etc. In addition, an IRB addendum was included for the focus group and students signed a separate informed consent to participate in the focus group study.

#### Data Analysis

Data collection and analysis in qualitative research involves the following: setting parameters for the study, collecting information, and establishing a system for recording the information (Creswell, 1994).

Qualitative researchers usually gather data from small, manageable, samples of participants who will inform their study. Qualitative samples tend to be purposive, rather than random (Kuzel, 1992). Glense (1999) stated, “The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth” (p. 29).

The focus group interviews were audio taped and listened to by the first

and second author. The first author summarized the key ideas following the focus groups (preliminary findings), which provided central ideas for the data analysis. The first author and the second authors, using a social constructionism approach, defined the categories and identified the key themes and patterns based on the data from the four focus groups. Each category provided an organizational theme consistent with eight of Yalom’s eleven curative factors. The data was further analyzed using a variation of the Constant Comparative Method (Glaser & Strauss, 1967). These categories were then compared and contrasted for similarities and differences until all of the information was consistently categorized based on the themes and patterns derived from the data. The themes and categories were decided for each focus group individually and then subsequently applied across the four focus groups.

All four focus groups supported the themes and patterns noted in the individual data analysis of each focus group.

#### Findings

Major themes and categories along with subthemes were identified. The major themes were (a) social wellness benefits including relationship dynamics and interpersonal connections, (b) better understanding and integration of course content, and

(c) gains in task and generalized self- efficacy. For the purposes of this manuscript, hereafter we will focus on reporting the findings of Theme A, and will include subthemes with representative, verbatim participant quotes. The subthemes represent 8 of 11 curative factors (Yalom, 1985). The factors identified in this study during theme analysis included: (a) imitative

behavior, (b) cohesion, (c) altruism, (d) universality, (e) imparting information,

(f) instillation of hope, (g) existential factors, (h) interpersonal learning, and

(i) catharsis. Consistent throughout the data, participants reiterated how relationships within the group and between students and the instructor fostered a positive relational environment and other contributions to mental health gains. The following illustrates an explanation of each identified curative and interpersonal gain through each factor as well as representative, participant quotes.

#### Therapeutic Factor A-Imitative Behavior

Yalom (1985) classified imitative behavior as a therapist modeling specific behaviors for clients, and by modeling these behaviors communication patterns in the group are influenced. Bandura (1977) claimed that imitation is an effective means of learning a new behavior. The modeling provided by the instructor became a demonstration of a possible role students may want to emulate in their own interpersonal relationships and behaviors. Participants discussed how the instructor of this course, an experienced marathon runner, provided a wealth of support; according to participants, the instructor was a very positive role model throughout this course including the process of training for a marathon or a half marathon. The instructor’s behavior was encouraging and provided a positive role model for this participant:

*Dr. S------ is an incredible role model for all of us. I went to her office the day before the marathon because I needed some encouragement and I left there feeling it will be okay. She trained with us and was going through the exact same thing we were… she had a way of encouraging people that*

*many professors are not given the opportunity to do.*

This participant discussed how the instructors’ encouragement and guidance assisted her in managing her pain through providing a model for vicarious learning and motivation:

*She provided guidance and helped us get through the [physical] pain. She knew how to handle all the issues because she is a marathon runner. She is very spunky and knows a great deal about all of this stuff…She told us stories and gave us examples to follow in our training.*

According to participants, the instructor was a positive role model and exhibited behaviors that encouraged and supported the participants throughout the semester as they attempted to accomplish their individual goals.

#### Therapeutic Factor B-Cohesion

Yalom (1985) defines cohesion as “the attractiveness of the group for its members.” (p. 48). Cohesion is a sense of connection the individual feels toward the group and thus, prompting individual group members to remain in the group. More precisely, cohesion refers to the members of the group feeling warmth and comfort in the group, a sense of belonging, and feeling that as a member, they are valued and unconditionally accepted and supported by other members (p. 48).

For instance, a positive therapeutic relationship and the establishment of trust are critical for change (Zeeck & Hartmann, 2005). The importance of generating a strong cohesive group is steeped in the interpersonal and relational connection between members.

In particular, participants reported a strong sense of belonging and comfort within their marathon

training group. They discussed being a support system as well as feeling supported throughout the process.

This appeared to foster a cohesiveness that was felt throughout each individual’s experience during the successful completion of the marathon and that culminated during the final class project. This participant discussed the special bond she shared with her classmates in contrast with the bond she shares with her own social circle:

*There is a special bond. You will have these bonds with other friends but that bond is nothing like the bond you develop as you train with these people. You are doing this as a team. We were all in it together and we did it together.*

Another participant described her feelings of cohesiveness with her classmates that stemmed from genuine caring, respect, and empathy felt among group members (Rogers, 1961). She discussed having experiences in the course that gave her an appreciation of the cohesiveness that was evidenced as she attempted to complete her individual goal for the course:

*You develop a common bond.*

*When you get to mile 25 and you are “hitting the wall” your running partner is saying you can do it, pushing you and supporting you.*

*Your classmates believe in you and know you can do it. You believe in you. You develop a respect for your classmates that you could never convey to them. There is no way to describe it. You have to experience it.*

The cohesion that was developed during this course by the participants played an integral part in the participants reaching their individual goals. The participants felt supported and connected both emotionally and

socially to their classmates and their statements consistently evidenced support and trust. One participant described the atmosphere as “family like:”

*This class came together as a family in the end. Everyone worked hard and trained together and ran the same distances. I have never taken a class at this university where at the end of the semester we want to have a barbeque. The support was a family like support for everyone involved in the class.*

#### Therapeutic Factor C-Altruism

Altruism is defined as the intrinsic act of giving during the group process. According to Robinson and Curry (2006), “altruism is the purest form of caring—selfless and non- contingent upon reward—and thus a predecessor of pro-social cognitions and behaviors” (p. 68). In a group setting, altruism manifests as individuals being helpful to one another in terms of offering suggestions, support, insight, and reassurance during the group process (Yalom, 1985, p.12). This type of action is indicative of the outcome of interpersonal learning having occurred. In other words, members of the group had learned new behaviors and roles in their relationships with classmates.

Indeed, the participants in the marathon training groups discussed how significant support and reassurance were during the training process. One participant focused specifically on the support and reassurance being like a “ripple effect” in assisting her in reaching her final goal:

*We were all standing at the finish line waiting for our classmates to finish and cheering. It was really cool to see our classmates/teammates cross the finish line. We all worked really really hard for this and we were all*

*backing each other up. It was very much like a ripple effect.*

As part of their participation in the group, many participants described learning to focus on others by actively encouraging and supporting one another even when it was physically difficult to do so. In this way, altruism does have a component of self-sacrifice and requires the individual committing the altruistic act to have advanced empathy and perspective taking ability (Curry, Smith, & Robinson, 2009). This was evidenced by another participant that discussed altruism in terms of feeling exhausted and in pain, but still thinking of others and wanting to be there for everyone else despite her own personal discomfort:

*You are running for other people beside yourself. During the marathon, at some of my hardest points, when my legs were pounding, literally, I thought about my teammates, my classmates.*

*Whenever I finished the marathon I was hurting pretty badly but all I wanted to do was stand by the finish line and watch my classmates finish. I watched the whole class finish the marathon. I cannot explain how happy I was to watch everyone finish. Their faces all showed a feeling of accomplishment. I teared up. I think it is really awesome to see others finally accomplish their goal.*

#### Therapeutic Factor D-Universality

Universality can be described in the group process as each individual group member realizing they are not alone in their issue or problem; as part of the relational dynamics and interpersonal learning, individuals realize that the process of fostering and developing relationships is shared among group members. There are some common factors that group members

share that contribute to their sense of belonging and self-esteem within the group process. Yalom (1985) describes universality as: “despite the complexity of human problems, certain common denominators are clearly evident, and the members of a therapy group soon perceive their similarities” (p.6). This participant shared her thoughts about the “extra motivation” she experienced as a commonality among her classmates:

*I had a running partner and when we did not run together I would stop and not run the full 8 miles. However, when we ran together, I was thinking ‘If she is not going to stop, I am not going to stop’. It was just having her there. It is something that you are going through together and you don’t want to let the other person down…you just keep pushing, you motivate each other.*

Similarly, another participant added:

*Your classmates that you are running with understand exactly what you are going through. They experience the same challenges you do.*

In finding this type of common ground they assisted each other in reaching their individual goals and in this way the process of interpersonal learning occurred. This is interpersonal because by trying these new behaviors together and recognizing the challenges they were facing as a group, they were able to meet their difficulties through newly planned courses of action that were unfamiliar to them previously and transfer this process to life outside of the classroom experience. Another participant described the similarities in terms of attitudes and support that assisted her in completing her goal.

She discussed the motivating force

behind training on the weekends as a group:

*I needed the class. The support helped me be so determined that I could not give up. At mile 23 I wanted to stop and I saw my classmate/teammate and she said you can do it. You knew you always had people behind you because everyone was in this together. And we were all hurting. It was never an issue of you may not be able to make it this weekend for training it was always, “you can do it.”*

#### Therapeutic Factor E-Imparting Information

Imparting information refers to didactic instruction usually focused on the topics of mental health, mental illness, and general psychodynamics given by the group facilitator or other group members. This information can include but is not limited to: advice, suggestions, or direct guidance (Yalom,

1. 8). From a relational perspective this can also include strategies such as acquiring knowledge and skills for implementing one’s plan of action as well as applying personal construction of meaning by incorporating other skill development such as building mutual empathy, empowerment processes, relationship and building connections with a support system (Tantillo, 2006). One participant described how the information she received challenged her to change her goal and seek some additional assistance:

*In class lectures and discussion we learned things like how to listen to your body. One main message I received through this course is that running is not worth hurting yourself physically. This prompted me to talk with Dr. Stewart and she referred me to a physical therapist. And told me if*

*I needed to do so, I could change my goal from a full marathon to a half marathon and still feel that I have accomplished my goal for the semester.*

The instructor (group facilitator), through her discussions in class, empowered this participant to still have a sense of accomplishment when changing her goal. Another participant described how she will take the information and behaviors learned from her classmates and course instructor and apply them in her own relationships with her clients:

*I have been a personal trainer for a few years and you always want to be a good role model for your clients. This course and the instructor have helped me to be that role model. I really look forward to working with my clients after taking this course. I want to be a good role model for my clients and do what is best for them.”*

This participant utilized the didactic instruction to broaden her personal well being in terms of how she will relate to her clients in the future. This course instructor taught her how to be “a good role model” for her clients in terms of assisting them with their own personal wellness plan and physical fitness.

#### Therapeutic Factor F-Instillation of Hope

Yalom (1985) describes hope as an integral element in the group therapy process. The instillation of hope is the process by which group members feel a sense of “hope” for their specific situation by watching other group members improve their situation. Hope is instilled as group members realize that they can have a positive outcome like their fellow group members during the group process and

through the encouragement and support of teammates. And just as support and encouragement are cornerstones of the counseling process, they also serve to promote hope and other positive feelings in the education process (Rogers, 1969). One participant described how running with her classmates and seeing her classmates finish designated miles motivated her to finish her run. “Hope” for her was seeing her teammates complete their personal goals:

*For me, it was knowing that the group was not going to quit running before completing the assigned miles. Just knowing that my classmates are going to accomplish their goals made me believe that I can do it too.”*

Another participant discussed how important it was for her to have her teammates at the finish line encouraging her to finish. Her “hope” was realizing her teammates had accomplished their goals and were now encouraging and supporting her in her quest to accomplish her personal goal. This instilled a sense of “hope” for her in as she felt she could finish the marathon:

*I heard three people cheering for me. I heard their voices and I could distinguish exactly whom of my teammates the voices belonged to. Their encouragement helped me finish the last three miles of the 26 miles. When I heard them I just knew that I could do it.*

#### Therapeutic Factor G-Existential Factors

Existential factors are described by Yalom (1985) as assuming responsibility for your behaviors and your place in life. The group process assists members in taking responsibility for life and realizing their

individual and group goals. As the group members begin to assume responsibility for self, they begin to discover how important and painful the truth about life can be (Trotzer, 2006). One participant clarifies her individual assumption of responsibility by discussing how she has a sense of accomplishment by completing her individual goal. She qualifies the group activity as an extension of her personal responsibility for completing the marathon:

*This run was all about me. I am proud of my teammates in this room, but I am mostly proud of myself. I feel such a sense of accomplishment. It is okay that it is all about me. I did it for myself and I have never done anything that is just for me. I am proud of that in this moment. In this moment in time being all about me is allowed and accepted.*

She discovers the personal truth that she has “never done anything just for me.” For this participant, assuming the responsibility for completing her personal goals empowered her to realize she has not been responsible for nurturing her well-being.

Another participant discussed how her personal responsibility is intertwined with a higher power. She reflected that she is doing “this work on her own” but her transcendent connection to her higher power assisted her in fulfilling her goals:

*My spirituality helps bring some humility to my running. Thank you, God. It is a privilege to run. Sometimes I found the training schedule hard to do. I was doing this work on my own and I needed that inner strength. I thought I was doing all of this on my own and then I discovered that in no way was I doing this on my own. Knowing you are not*

*doing this alone, you are supported by God, is what brings the humility to running.”*

#### Therapeutic Factor H-Interpersonal Learning

The definition of interpersonal learning can include learning to feel vulnerable in front of others. A notion of realness. A feeling that one has nothing to hide anymore. Being genuine is part of the change process (Rogers, 1961). Interpersonal Learning is described by Yalom (1985) as group members becoming aware of their interpersonal behavior through feedback from others and self- observation (p.43).” Group members become aware of their strengths and limitations through the process of giving and receiving feedback from other group members. One participant described how her strengths and limitations were highlighted through the training portion of this course. She reflected on the “highs” and the “lows” both physically and emotionally of training for a marathon:

*I am really emotional (crying).*

*My classmates believed in me and gave me the support that I needed . And we did it. We all did it. Everyone worked so hard. I watched everyone go through everything you could possibly experience during this process.*

*You saw everyone at their worst, their lowest and highest. I could not have done it without the support of my classmates. I am so lucky to have had this experience.*

This participant definitely illustrates feeling vulnerable emotionally. For her, the course provided a mechanism for emotions and self-reflection. Another participant discussed her feeling of becoming part of a group. She noted how she felt she could be more

extroverted in all aspects of her life including work and future classes:

*The most important aspect of this course for me was becoming part of the group. I was not feeling like an outcast anymore. I was becoming more social in all aspects of my life like work and school.*

#### Discussion

The findings from this study indicate that beyond the physical benefits to participants of this structured group exercise program, the positive interpersonal, relationship dynamics, and learning aspects may be equally, if not more, valuable.

Similar to indications by Losito and colleagues (2006) the motivation and encouragement of group members facilitates therapeutic benefit beyond physical well-being. Like members in the Midtgaard and colleagues study (2006), members in this study articulated many of the benefits usually aligned with the curative factors of group therapy (Yalom, 1985), and Roger’s (1967) relational factors.

Although, not all of Yalom’s curative factors were evidenced in this study, eight of the total 11 curative factors were supported in participant statements.

It is important to note that, though this study was designed to explore student perceptions of the kinesiology *Exercise Immunology* course and not designed to investigate the presence of curative or interpersonal factors, yet 8 of these 11 factors emerged from the focus group data and interpersonal factors and relational dynamics were present throughout the focus group discussions. The participants stated continuously how the creation of the learning group yielded interpersonal learning and cemented of relationships between the

students and the students and instructor.

Overall, the participants reported feeling a sense of group cohesion, connection, interpersonal learning, and accomplishment much like those findings reported by Losito el al. (2006). Another similarity in comparison between participants in this study and the participants in Losito’s study, were reports of shared personal stories, fears, concerns, struggles and supports promoted a sense of connection to the group, learning environment, and the instructor which parallels some of themes illustrated during the counseling process. The current findings also echo some of Midtgaard and colleagues (2006) work with cancer patients in a physical intervention during treatment where participants demonstrated significant gains in feelings of cohesiveness with the group, social, and emotional functioning and mental health as related to interpersonal learning. Another commonality in the findings of this study and Midtgaard et al.’s (2006) is that participants expressed a sense of shared competence through which they could successfully respond to the demands of their situation.

It is possible that increases in social support and the development of feelings of connection with interpersonal learning will foster other secondary mental health and educational benefits that were not addressed in the data of this study (Atlantis et al., 2004). It is difficult to discern at this time if these things occurred as they were not primary discussion points of participants and no quantitative baseline measures were taken to chart potential growth in these areas.

participants, and do not represent the demographic diversity of the larger population, hence, the findings of this study are not generalizable to a larger population (Cameron, 2005; Ivanoff & Hultberg, 2006; Mansell et al.).

However, the data may be transferrable for informing practice in the human services field, education, and teaching pedagogy, designing future research or interventions across populations (Rossman & Rallis, 2003). Other limitations include the reliance on language to convey meaning as all members of the group have a potential to construct diverse understandings of the topics discussed. Moreover, pressure within the group to conform may limit group members from authentically sharing divergent viewpoints due to the emergence of dominant voices in the group that subdue marginalized perspectives (Hollander, 2004; Smithson, 2000). In addition, not everyone enrolled in the course chose to participate in this study; therefore, it is impossible to know the opinions and perceptions of the individuals who abstained. Finally, even when attention is given to rigor and credibility in the group design, data collection, and analysis, the data is eventually filtered through the subjective interpretation of the researchers (Freeman, 2006). One other major limitation was the lack of cultural, gender, and racial diversity among participants primarily due to this course being offered at a predominantly white institution (PWI) in the southeast.

#### Implications

**Limitations**

The focus groups are self- selected, have low numbers of

This study demonstrates that

integration of sports in a Kinesiology- Exercise Immunology course had powerful benefits beyond physical

fitness for participants. However, little is known about how the interpersonal learning, Curative Factors, and relational dynamics might be applied to sports and student athletes in other scenarios. Further, while there is a large body of literature on the relationship between physical activity and mental health benefits, little is known about the relationship between group exercise and curative factors.

This study captured the perspectives of students in a college course, so it is limited in the potential transferability of findings to other groups. More research needs to be conducted on extracurricular and structured group exercise and with a diversity of participants to glean greater knowledge of how these types of interventions may be applied. Gold and colleagues (2004) caution that participation in structured group exercise requires motivation, time commitment, and self-discipline which some participants may need help in developing prior to starting such a program. Moreover, it should also be mentioned that there are many physical activities that are accessible to persons of diverse physical ability; for example, Chen and colleagues (2007) introduced Tai Chi to elderly patients in long term care facilities.

#### Conclusion

Individuals enrolled in an introduction kinesiology course were required to complete a marathon as a course requirement. Upon completion of the course, several focus groups were conducted to discern the participants’ perceptions of their experiences with group exercise, and interpersonal learning, and how this might be used in designing future course offerings.

However, rather than talking about the physical exercise component of the course, participants focused on the social, learning, and emotional benefits

of the integrated marathon training. The participants described their thoughts, feelings, and behaviors as they related to the structured group exercise and interpersonal learning process. Several major themes were identified from the focus group data including: (a) participant gains in overall holistic wellness (physical, mental, spiritual, interpersonal and social/emotional well being), (b) better understanding and integration of course content, and (c) gains in self- efficacy.

In this manuscript we discussed the subtheme findings of curative factors, relational dynamics, and interpersonal learning related to the activity. The goals set and achieved in the course of physically running a marathon for participants were evident; however, the relationships and interpersonal learning developed between students and the instructor personified genuineness, empathy, caring, and unconditional positive regard which served to motivate and empower participants toward growth.

More research is warranted to determine how group exercise may be used as a relational and interpersonal learning adjunctive in counseling practice and human service education.

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## Enhancing Child Parent Relationships Using Child Parent Relationship Therapy (CPRT)

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Child-Parent Relationship Therapy (CPRT) has been growing in research over the past few years. Studies have indicated that CPRT is an effective approach to enhancing the child-parent relationship (Landreth & Bratton, 2006; Edwards, Sullivan, Meany-Walen, Kantor, 2010; Sheely-Moore & Ceballos, 2011). CPRT encourages parents to strengthen and enhance their relationships with their child(ren) based on the development of increased levels of empathy and acceptance. Although there have been quantitative studies conducted to study the effectiveness of CPRT, limited studies have researched qualitative outcomes. This pilot study measures qualitative outcomes of one group of participants over ten sessions using pre/post test data. Findings indicate that parents perceive CPRT is an overall beneficial model to the strengthening their child-parent relationship. Results and future implications are discussed.

#### Introduction Study Rationale and Background

Many parents have reported difficulties within their child parent relationship. Most often, parents are unaware of specifically how to enhance their relationships with their children. While many child treatment interventions focus on the therapist becoming the child’s therapeutic facilitator to decrease the child’s behavioral or maladaptive issues, filial therapy (Guerney, 1967) allows the parent to become the therapeutic facilitator for their child. Filial therapy is defined as “a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children” (Landreth & Bratton, 2006, p. 11).

Several studies have researched the effectiveness of filial therapy. Oxman (1972) found that mothers who participated in filial therapy reported greater improvements in their relationships with their children than mothers who did not participate in filial

therapy. Stover and Guerney (1967) found that children were able to communicate their negative feelings better with the use of filial therapy and mothers were able to develop enhanced reflective and empathetic skills toward their children with the use of filial therpay. Lastly, Bratton and Landreth (1995) found in a study with single parents that parents had increased levels of empathy and acceptance toward their children after participating in filial therapy.

Landreth and Bratton (2006) introduced a shortened version of the filial therapy model: Child Parent Relationship Therapy (CPRT). CPRT is a ten session model which allows parents to receive training to become therapeutic agents for their children in a concentrated session group format.

Several studies have been conducted to show the effectiveness of the CPRT model. For example, Glass (1987) found that parents who participated in CPRT showed significant increases in regard to unconditional love toward their child and significant decreases in their overall perception of conflict in the family system compared to a control

group. Additionally, Ray (2003) reported on the effects of filial therapy on parental acceptance. However, as many of the early studies of CPRT have focused on parental acceptance, empathy, and stress, there has been limited research on the development of child parent relationships based on attachment styles.

This pilot study sought to assess the child-parent relationship before and after completing CPRT. A pre-test/post- test design was utilized with two groups of varying socioeconomic status to seek feasibility data for conducting future research. The pilot study allowed the investigators to explore the ease of recruitment and retention as well as changes in the child-parent relationship. Results from the pilot study could be used to inform future randomized, controlled research examining CPRT effectiveness in enhancing and strengthening child- parent relationships.

#### Method

**Participants**

Participants were recruited with reported relationship difficulties. Participants who reported an interest in the child parent relationship study were additionally requested to meet the following eligibility criteria: the parent must have reported at least one relationship issue between self and child; the child must have been between the ages of four and seven; neither the child nor the parent could have experienced psychotic features, severe agitation or behavioral problems within the previous three months that could have lead to difficulty complying with the protocol; and the child must not have had a current diagnosable disorder such as oppositional defiance disorder, conduct disorder, or attachment disorder. Participants of both genders were to be included in the

study; there were no enrollment restrictions based on race/ethnicity.

One group was formed. A total of twelve sessions were held with the group (one pretest session, ten group sessions, and one posttest session). The pretest and posttest sessions lasted approximately 1 ½ hours and the 10 group sessions lasted approximately 1

½ to 2 hours. The CPRT group was held at a university play therapy clinic.

#### Materials

Two assessments were conducted.

First, participants were asked to complete a Demographic Information Form to provide brief, basic demographic information including age, race, grades completed, occupational status, school attended, annual income, child’s birth order, relationship between adult and child, family status, and religion. Second, participants were asked to complete the Filial Problem Checklist (FPC; Horner, 1974). The FPC consisted of a 108-item self-report checklist which measured child behaviors observed by the parents.

Participants were asked to take part in ten child-parent relationship group sessions provided at no cost.

Participants were instructed with a new skill/technique at each of the group sessions and asked to do homework related to the new skill/technique over the next week with their child.

Participants were asked to videotape practice sessions of themselves and their child weekly. Additionally, participants were asked to review one videotaped session with the group and researcher. If participants did not have personal video equipment, they were informed that they would be able to schedule a time to come to the university play therapy clinic with their child to conduct the session.

#### Results

The results of the study indicated that the summary scores on the Filial Problem Checklist (FPC) were mixed. Participant’s scores were reported as follows:

Participant Pre-Test Score Post-

Test Score

001 34 42

002 48 25

Participant’s (001) score indicated that the total score increased by 8 points. Participant’s (002) score indicated that the total score decreased by 23 points, which was a significant reduction in problems indicated by the FPC.

#### Discussion

Additional follow up was conducted to further examine the results.

Participants were asked the following questions:

* 1. What did you enjoy most about the CPRT training?
  2. What did you enjoy least?
  3. What changes/improvements can be made to the training?
  4. Feedback about your scores, whether they increased or decreased?
  5. Suggestions?

*Question #1: What did you enjoy most about the CPRT training?*

Participant 001 reported, “I enjoyed the small intimate group which made it easy to share personal experiences.

Also, enjoyed the subject matter and learning new techniques to practice at home with son.

Participant 002 reported, “What I enjoyed most was problem solving strategies to live with my child on a day to day basis. I thought you had really good ideas for each individual child and situation. I liked learning/relearning about the choices and advanced

choices. That has really helped me. I felt like you were really interested in both of our kids and not just trying to ‘teach’ us.”

*Question #2: What did you enjoy least?*

Participant 001 reported, “Nothing, I enjoyed everything and the information is invaluable.

Participant 002 reported, “My biggest challenge was the play sessions. I felt they were beneficial and daughter enjoyed them, but they were hard for me. It was a good lesson for me to slow down and not have an agenda.

*Question #3: What changes/improvements can be made to the training?*

Participant 001 reported, “May want to consider meeting after work hours based on schedules of participants.

Once dates have been set, send electronic meeting notices to keep everyone on track. In addition to workbook and homework, provide additional articles on the methods to expand knowledge. I enjoyed the sessions and length of the program, but it might be good to combine the last 2 sessions into one and have a day to recap.”

Participant 002 reported, “No changes, really, except maybe the whole thing could be a little shorter. Although it would have taken more time, I also would have liked more people to be in the group so that I could learn and hear about different issues with kids.”

*Question #4: Feedback about your scores, whether they increased or decreased?*

Participant 001 reported, “Although my summary scores increased, I found the reasoning for the increase to be directed toward my heightened awareness and gaining of insight with my child. Through each of the sessions, I gained more insight into the challenges that my son was facing or presented toward.”

Participant 002 reported, “I felt that my daughter’s scores decreased directly due to the changes and use of techniques learned from the CPRT training sessions.”

*Question #5: Suggestions?*

Participant 1 reported, “Same as Question #3. Thanks again for allowing me to participate in this training. I truly enjoyed the sessions and information sharing.”

Participant 2 reported, “Would it be possible for our kids to come more often? I know that is what the video tape was supposed to do, but since neither of us had a video tape, maybe the kids could have come for observation during a play sessions?

Overall, I thought the class was very beneficial and I am very glad I did it. Thanks so much for your time, insight and patience.”

#### Future Implications

Overall, it was indicated, as reported by the participants, that the CPRT training was beneficial to both participants. Due to the low number of participants it was difficult to conceptualize the overall effectiveness of the study and its implications.

Future studies should consider the following: scheduling of the training, number of participants, inclusion/exclusion of child(ren), combining sessions, provision of additional literature for parents/guardians to take home, and genuineness of the play therapist/trainer. Lastly, participants also reported that receiving feedback from the participants and group leader was invaluable indicating the need for continued group format for the CPRT training.

#### Conclusion

This study produced valuable information to the play therapy literature based on the Child Parent Relationship Therapy training program. In addition, the use of the Filial Problem Checklist indicated that not only the CPRT training program reduced problematic behavior(s), but also allowed the participants to understand why increased scores were significant as well. Although participant’s (001) posttest score increased, it was reported, by the participant, that she was not aware of many of the “heightened awareness and gaining of insight” from the CPRT program. A follow up study with a larger population may yield increased significant results as well as greater insight. In summary, the CPRT training program allows parents/guardians to increase their acceptance as well as gain further insight into their child(ren)’s challenges/problem and learn skills to effectively communicate and attempt to decrease their child(ren)’s indicated problems.

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# Section II: Graduate Students/Professionals’ Article

**Analysis of Author and Topic Trends for the Louisiana Journal of Counseling (LJC)**

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This review will attempt to shed light upon the historical evolution of the Louisiana Journal of Counseling (LJC) by conducting a qualitative analysis of its published articles for the years 1999, 2001-2004, and 2006-2011. In order to conduct this analysis, we noted major author trends including: gender, professional title, and regional affiliation. In addition, we also highlighted five major subject areas that have emerged over the years, including: counselor identity, professional issues, counselor education and supervision, research and counseling techniques, and multiculturalism. From this analysis, we predicted possible future directions for this journal and highlighted some of the major findings.

#### Introduction

There are three ways through which the historical evolution of a journal can be determined; conducting a meta-study, studying special issues or topics published over several decades, or conducting a qualitative review of the journal’s publications over a proscribed period of time (Crockett, Byrd, Erford, & Hays, 2010; Erford et al., 2011). This qualitative review will note trends and characteristics for both author and research topics between years 1999 and 2011 of the Louisiana Journal of Counseling (LJC). The analysis presented in this article is timely, because this year marks the

bicentennial anniversary of the state of Louisiana, the 60 year anniversary of the American Counseling Association, the 45 year anniversary of the Louisiana Counseling Association, and the 25 year anniversary of the Louisiana Mental Health Counselor Licensing Act. Readers should note that the journals for the years 2000 and 2005 will not be included in this analysis.

Over the years, it is easy to see how a journal such as the Louisiana Journal of Counseling has evolved, both through the analysis of author demographics and overall research topic trends. Important author trends to note include occupation, gender, and

regional affiliation (i.e., the state or country where the authors conduct their research); by analyzing these characteristics one can get a better sense of the development and diversification of the contributors to this journal. Along with the evolution of contributor diversity, there is a clear sense of change in the research focus topics. Some of the major topics noted in this analysis include counselor identity, professional issues, counselor education and supervision, multiculturalism, and specific counseling techniques. Some specific examples of articles within these major topic areas include: *Introduction of the Wicca Religion for Counselors* (multiculturalism), *Increasing Counselor’s Professional Identity Through the Use of Supervision Developmental Models* (counselor education and supervision/counselor identity), *The Counselor’s Journey of Marketing a Practice* (professional issues), and *Trauma related Critical Incident De-briefing for Adolescents* (counseling techniques) (Kroll, 2003; Gray & Nelson, 2004; Benedik & Sandoz, 2003; Emerson & Kirk, 2004). When considering all of this information, one can begin to see an overall pattern of growth and development, and perhaps even future directions for this journal.

#### Methods

We examined the Louisiana Journal of Counseling for the years 1999, 2001-2004, and 2006-2011, and

using a qualitative research method we coded for the major author characteristics and major article topic trends. Although there are many different author characteristics to analyze, we focused on gender, geographic location, and professional status for the sake of simplicity.

Likewise, we also chose to glean the

major overall topic focus trends for all of the articles, allowing us to narrow our focus to five primary areas of discussion. Using these methods, we can present a more coherent and cohesive picture of how the Louisiana Journal of Counseling has evolved over the years and offer predictions for possible future directions. In Table 1 we have compiled the different author characteristic frequencies, and in Table 2 we have done the same with major topic areas. Table 3 presents the average number of authors, articles, and authors per articles for 1999,

2001-2004, and 2006-2011.

#### Results

For the years 1999, 2001-2004, and 2006-2011, there were a total of 107 authors. For the years 1999, 2001- 2004, there was an average of 10.4 authors total, and 2.15 authors per article. For 2006 to 2011, there was an average of eight authors total, and an average of 2.67 authors per article. Of the 107 authors, 49 were female

(45.8%) and 58 were male (54.2%); 70 of the authors had a Ph.D or Ed.D. (65.4%), 16 of the authors were Licensed Professional Counselors (LPCs) (14.95%), and 21 of the authors had other credentials such as doctoral candidates, and graduate assistants (19.6%). We elected to separate Ph.D’s and Ed.D.’s from LPC’s even though some had both credentials; therefore, we only listed LPC’s that have less than a doctoral level degree under the LPC classification. A total of 60 (56.1%) of the contributing authors are affiliated with the state of Louisiana, and 47 (43.9%) were from elsewhere. It is interesting to note that one of the authors from the 2010 journal was from Canada, and is the only international author during this time period.

There were a total of 48 articles among the 11 journals that we examined, and through a qualitative analysis we were able to identify five key subject areas: Counselor Identity, Professional Issues, Education and Supervision, Research and Techniques, and Multiculturalism. Of the 48 articles, 3 (.06%) focused on counselor

identity, 14 (29.2%) concentrated on

professional issues, 3 (.06%) discussed

education and supervision, 25 (52.1%) focused on research and techniques, and 11 (2.75%) concentrated on multiculturalism. For the years 1999, 2001-2004, there was an average of

* 1. articles per journal. For 2006 to 2011, there was an average of three articles per journal.

#### Discussion

Looking at the data, we were able to note some important trends in author characteristics. For the years 1999, 2001-2004, there was approximately an even distribution of males and females as contributing authors; however, in 2003 there was only one female author when compared to nine male authors. That is, in 2003 only 10% of the contributing authors were female, when compared to 47.6% for the years 1999, 2001, 2002, and 2004. A majority of the authors had doctoral level degrees, followed by LPC’s, and then followed by other professional types. It is also important to note that all of the contributing authors in 2003 were affiliated with the state of Louisiana, compared to the remaining journals from this time period. However, it is important to note that in 2002, for the first time we see more contributing authors that were not affiliated with the state of Louisiana.

For the years 2006 to 2011, the noticeable increase in contributing female authors continued; in 2006

female authors outnumbered male authors 4 to 3, and in 2008 they outnumbered male authors 2 to 1. That is, in 2006, 57.1% of the authors were female and in 2008 66.7% of the authors were female. For both 2006 through 2008 the professional patterns also continued, with PhD’s remaining the most numerous followed by LPC’s then followed by other professional types. However, for the first time in 2007 none of the contributing authors were LPC’s and a majority of contributing authors had other professional degrees. It is also important to note, that in 2006 all of the authors were affiliated with the state of Louisiana, when compared to 2007, whereas all but one of the 15 authors was not affiliated with another state. For the years, 2009-2011 the noticeable increase in contributing female to male author ratio balances out; that is, male and female authors contribute somewhat equally during this period. For these years an overwhelming majority of the professionals contributing to these journals were PhD’s followed by an even number of LPC’s and other professional types. It is interesting to note that for the first time, the authors not affiliated with the state of Louisiana outnumbered those who were affiliated with Louisiana for all three years. In addition, in the year 2010 we see our first and only international contributing author. One other important characteristic to point out is that in the 2011 LJC issue, there were two sections separated by author type; one section was for practicing professional authors, and the other was for graduate student authors.

Looking at the data, we were also able to note some important topic trends. For the years 1999, 2001-2004, the most common subject areas were professional issues and research/ counseling techniques. That is, in

2003 three out of the five articles focused on professional issues whereas, the remaining journals during this time period focused on research and counseling techniques. In both 2001 and 2004 there was one article that focused on counselor education and supervision, while 2004 also dedicated one article to counselor identity. It is also important to note that 2003 is the only journal in this time period that has an article focusing on multicultural issues.

For the years 2006 through 2011, a majority of the subject areas focused on research and counseling techniques. In 2008, there were only two articles, whereas the remaining years had at least four articles per journal. It is important to note that 2009 was the only year that included an article focusing on counselor education and supervision. Despite the fact that there were only two articles in 2008, it is fair to say that these two articles offer more in depth analysis of multiculturalism and professional issues. For the years 2009-2011, we see a larger distribution of different subject areas, but the most obvious trend that emerges during this time is the preponderance of articles focused on multiculturalism. In 2009, the only major subject area not discussed is professional issues; that is, there is one article on counselor identity, one on counselor education and supervision, one on research and counseling techniques, and one on multiculturalism. In 2010, three out of the four articles focused on multiculturalism, while only one discussed research and counseling techniques. In 2011, for the first time we see the journal take a holistic multicultural perspective and apply it to the other subject areas, rather than including a few multicultural articles per journal issue.

#### Recommendations

Overall, the most important trend to note is the growing emphasis on multicultural issues in counseling. By incorporating a holistic perspective in all the articles in the 2011 issue, the Louisiana Journal of Counseling illustrates how an effective counselor must be multiculturally competent in all aspects of their work. Looking toward the future, it will be interesting to see if this journal attracts more diversification among future contributing authors as well as the general audience. It is important to note that the LJC has historically sought articles from clinicians, researchers, and graduate students from the state of Louisiana; however, in recent years, the LJC has advertised more frequently in the ACA monthly addition of *Counseling Today* for a “call for articles.” In light of this fact, the LJC has seen an increase in both the sample size and diversification of potential authors. The editors would also like to note that in order to be considered for acceptance into the journal, all potential articles must undergo a blind peer review.

Interestingly enough, actually compiling the journals for this analysis was a task in and of itself. Fortunately, this will not be an issue in future analyses as the LJC is now published electronically and accessed on the LCA website in addition to the distribution of printed copies.

From this analysis, we expect to observe a growing focus on multicultural issues as they relate to all aspects of the counseling profession.

We also look forward to seeing more empirically based research as opposed to qualitative analysis in future issues of the Louisiana Journal of Counseling, as well as a graduate student section as highlighted in the 2011 issue of the LJC. The addition of this section

provides aspiring counselors with the opportunity to be heard within the profession, and offers a new and fresh perspective on emerging issues within the field. Another addition we would like to see in the future is a qualitative study of the articles that were not accepted for publication; this analysis would provide insight as to the quality and competitiveness of the journal as well as the vitality of the publication over time. This would also add to the credibility of the LJC by establishing that there is no bias in the selection process based on the author and/or article characteristics. Establishing the similarity of author characteristics between those articles accepted and those not accepted for publication would help to confirm a lack of reviewer bias in the selection process. A qualitative study of the article characteristics could examine if there were significant differences between those articles that were accepted and those rejected for publication. Again, the lack of any significant difference between the articles accepted and those not accepted would verify the lack of bias on the part of the reviewers.

Looking at this year’s issue of the LJC (2012), there were a total of eight article submissions with five of these eight being returned for revisions and ultimately accepted for publication. This would indicate a current acceptance rate of 60% (see Table 4), which provides yet another indication of the quality and vitality of this journal.

The authors encourage use of this article to jumpstart your own research and submit your articles for future publication in the LJC.

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**Table 1**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **#**  **Authors** | **#Female Authors** | **# Male Authors** | **Doctoral level** | **LPC’s** | **Other** | **# from LA** | **# from elsewhere** |
| **1999** | 6 | 3 | 3 | 5 | 1 | 0 | 5 | 1 |
| **2001** | 11 | 5 | 6 | 6 | 2 | 3 | 8 | 3 |
| **2002** | 13 | 6 | 7 | 9 | 1 | 3 | 5 | 8 |
| **2003** | 10 | 1 | 9 | 7 | 3 | 0 | 10 | 0 |
| **2004** | 12 | 6 | 6 | 8 | 3 | 1 | 8 | 4 |
| **2006** | 7 | 4 | 3 | 3 | 2 | 2 | 7 | 0 |
| **2007** | 15 | 6 | 9 | 6 | 0 | 9 | 1 | 14 |
| **2008** | 9 | 6 | 3 | 6 | 2 | 1 | 6 | 3 |
| **2009** | 9 | 5 | 4 | 7 | 2 | 0 | 4 | 5 |
| **2010** | 7 | 4 | 3 | 6 | 0 | 1 | 3 | 4\* |
| **2011** | 8 | 3 | 5 | 7 | 0 | 1 | 3 | 5 |
| **Total** | **107** | **49** | **58** | **70** | **16** | **21** | **60** | **47** |

\*One author from Canada; only international author

**Table 2**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **#**  **Articles** | **Counselor Identity** | **Professional Issues** | **Education/ Supervision** | **Research/ Techniques** | **Multiculturalism** |
| **1999** | 5 | 0 | 1 | 0 | 4 | 0 |
| **2001** | 6 | 0 | 2 | 1\* | 3 | 0 |
| **2002** | 5 | 0 | 1 | 0 | 4 | 0 |
| **2003** | 5 | 0 | 3 | 0 | 1 | 1 |
| **2004** | 4 | 1\* | 0 | 1\* | 3 | 0 |
| **2006** | 4 | 0 | 0 | 0 | 4 | 0 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **2007** | 5 | 1 | 2 | 0 | 1 | 1 |
| **2008** | 2 | 0 | 1 | 0 | 0 | 1 |
| **2009** | 4 | 1 | 0 | 1 | 1 | 1 |
| **2010** | 4 | 0 | 0 | 0 | 1 | 3 |
| **2011** | 4 | 0 | 1 | 0 | 3 | 4\*\* |
| **Total** | **48** | **3** | **14** | **3** | **25** | **11** |

\*This article focuses on both education/supervision and counselor identity.

\*\*All articles in the 2011 journal have an overall multicultural perspective on how to counsel in different contexts.

**Table 3**

|  |  |  |
| --- | --- | --- |
|  | **1999, 2001-**  **2004** | **2006-2011** |
| **Avg. # Authors** | 10.4 | 8 |
| **Avg. # Articles** | 4.83 | 3 |
| **Avg. # Authors per Article** | 2.15 | 2.67 |

**Table 4**

|  |  |  |  |
| --- | --- | --- | --- |
| **Articles Submitted** | **Articles Accepted After Revision** | **Articles Not Accepted** | **Acceptance Rate 2012 Journal** |
| 8 | 5 | 3 | 60% |

Test Questions for Licensed Professional Counselors

A score of 100% is needed on the following items. You need to submit this test along with the request for a certificate to receive hours. Once scored, you will receive a certificate verifying **2.5 Continuing Education Clock hours**

Continuing Education Questions for On-Line Discussion Article:

* + 1. Which is **NOT** common for repeat self-injurers according to Young, Sweeting, and West in 2006?
       1. Female
       2. 24 Years of Age
       3. Questioning of Sexual Orientation
       4. Anorexic
    2. These group self-injury and suicide websites can give individuals social support, positive connections but can also give ideas about actual methods and attempts dealing with self-injury or suicide?
       1. True
       2. False

Continuing Education Questions for Counselor Supervision Article:

* + 1. Only the Internal Working Models (IWMs) of the supervisees affect the supervisory relationship.
       1. True
       2. False
    2. In many ways, the major concepts of Internal Working Models are based on Bowlby’s

Attachment Theory.

* + - 1. True
      2. False

Continuing Education Questions for Physical Exercise Article:

* + 1. How many of Yalom’s 11 curative factors were found to be represented in this study?
       1. 3
       2. 7
       3. 8
       4. 11
    2. Which was not one of the Major themes identified in the findings?
       1. Increased Intergroup competitiveness
       2. Increased Understanding of Course Content
       3. Social Wellness Benefits
       4. Better General Self-Efficacy

Continuing Education Questions for Child Parent Relationships Article:

* + 1. Is CPRT a condensed form of filial Therapy?
       1. True
       2. False
    2. What was one of the primary factors mentioned in the article that kept the study from delivering more effective results?
       1. Method of Therapy
       2. Size of the Group
       3. Relationship Between Parent and Child
       4. Length of the Sessions

Continuing Education Questions for LJC Article:

* + 1. How many international authors since 1999 were published in the LJC?
       1. 3
       2. 1
       3. 2
       4. 0
    2. What is the most important trend gaining emphasis in the field of counseling?
       1. Empirical Validation
       2. Lack of Quantitative Research
       3. Multicultural Issues
       4. Ratio of Male to Female Authors

Credit Verification Form for Licensed Professional Counselors

The Louisiana Counseling Association awards **2.5 Continuing Education CLOCK HOURS** of continuing education for reading the *Louisiana Journal of Counseling (LJC)* and correctly completing the Study Questions. To receive a certificate verifying your participation in this easy and inexpensive way to earn valuable CE Clock hours complete the form below and mail it, **along with $10 and your completed test questions**, to the following address:

#### Diane Austin

**LCA Executive Director 353 Leo Street**

**Shreveport, LA 71105**

I verify that I have read the entire **FALL 2012** edition of the *Louisiana Journal of Counseling (LJC)* and am now applying for **2.5 Continuing Education clock hours** in conjunction with correctly answering the Study Questions for this year’s journal.

**Name** (PRINT – as you wish to have it appear on your certificate):

#### Mailing Address

Street

City State Zip

**Phone** (cell) (other)

#### E-mail

**Signature**

**Date**

\*Make checks payable to **LCA**

A Verification form with your clock hours will be mailed directly to the address provided on this form.

# GUIDELINES FOR AUTHORS

The *Louisiana Journal of Counseling (LJC)* publishes articles that have broad interest for a readership composed mostly of counselors and other mental health professionals who work in private practice, schools, colleges, community agencies, hospitals, and government. This journal is an appropriate outlet for articles that (a) critically integrate published research, (b) examine current professional and scientific issues, (c) report research that has particular relevance to professional counselor, (d) report new techniques or innovative programs and practices, and (e) examine LCA as an organization.

**MANUSCRIPT CATEGORIES**

Manuscripts must be scholarly, based on existing literature, and include implications for practice. The following categories describe the nature of submitted manuscripts. However, manuscripts that do not fall into one of these categories may also be appropriate for publication. These categories were adapted from the American Counseling Association’s *Journal of Counseling and Development (JCD)*.

1. **Conceptual pieces.** New theoretical perspectives may be presented concerning a particular counseling issue, or existing bodies of knowledge may be integrated in innovative ways.
2. **Research studies.** Both quantitative and qualitative studies are published in *LJC*. The review of the literature should provide the context and need for the study, followed by the purpose for the study and the research questions. The methodology should include a full description of the participants, variables, and instruments used to measure them, data analyses, and results. The discussion section includes conclusions and implications for future research and counseling practice.
3. **Practice articles.** Innovative counseling approaches, counseling programs, ethical issues, and training and supervision practices may be presented. Manuscripts must be grounded in counseling or educational theory and empirical knowledge.
4. **Assessment and Diagnosis.** Focus is given to broad assessment and diagnosis issues that impact counselors.

**MANUSCRIPT REQUIREMENTS**

All manuscripts must adhere to the guidelines set forth in the *Publication Manual of the American Psychological Association (6th ed.)*. The APA *Publication Manual* sets forth all guidelines concerning manuscript format, abstract, citations and references, tables and figures, graphs, illustrations, and drawings. Special attention should be given to the guidelines regarding the use of nondiscriminatory language when referring to gender, sexual orientations, racial and ethnic identity, disabilities, and age. Also, the terms “counselor” and “counseling” are preferred to “therapist” and “therapy.”

1. Submit an emailed, electronic, blind copy in Word of the entire manuscript to Meredith Nelson, [mnelson@lsus.edu](mailto:mnelson@lsus.edu), Psychology Dept., One University Place, Shreveport, LA 71115 or three (3) clean, hard copies of the entire manuscript with an electronic version to Peter Emerson, *LJC* Editor, [pemerson@selu.edu](mailto:pemerson@selu.edu), SLU Box 10863, Hammond, LA, 70402.
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guidelines will be returned without review.