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The Use of Narrative Therapy with Latina/o Students Pursuing Higher Education: Implications for School Counselors and Counselor Educators

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For the 2012 edition of the Arizona Counseling Journal, we are excited to feature an article from German Cadenas, a young man who is a DREAMER. German's story is quite inspiring, and a testament to the contributions that immigrants bring to our country. Our state is embroiled in a highly divisive and provocative immigration debate. This contentious issue impacts the daily lives of Latino(a)s, along with members of all other international groups.

The Arizona Counselors Association is determined to promulgate a social justice agenda. As our organization and membership grows, we will be able to more effectively advocate for professional counselors, both individually and collectively. The Arizona Counselors Association is guided by the American Counseling Association mission: "...to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession and practice of counseling to promote respect for human dignity and diversity."

Jennifer A. Walker, Ph.D., L.P.C., President, Arizona Counselors Association
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"A life is not important except in the impact it has on other lives."

Jackie Robinson

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AN UNFINISHED DREAM

GERMAN CADENAS

Why do we try? Would you embark on an uncertain road without knowing the destination? My name is German Cadenas, and I am 23 years old. I was brought to Arizona from Venezuela when I was 15 years old. My family and I were forced to stay in the U.S. due to the unstable political climate of my country. When we came here, the citizens of Venezuela were boycotting all industries and brought the country to an economic stall hoping that the president would resign. The fear of a civil war as well as political and social crisis in our country, made staying in the U.S., even without status, the only alternative for our family.

I acculturated very fast since I had a deep respect and admiration with America. I enrolled myself in an English learning program back in my Venezuela two years ago, which helped me feel comfortable during our relocation. I grew up watching American television shows and movies, listening to rock and pop music, as well as dressing up as a “gringo” kid. I was enchanted by American life. It was the orderly manner in which things simply work, the respect and mannerisms civilians display on the streets, the peace that people are guaranteed, and the opportunities available to anyone who dares to try and to reach their potential. I also became very active. By the time I graduated high school, at the top of my class, I took AP classes, was involved in different student clubs, was one of the fastest swimmers in the high school team, vice president of a student club, a peer counselor at a social justice and diversity retreat, and worked full time while enrolled in classes full time. I also volunteered much of my time to community service and involvement in the community.

I applied to Arizona State University (ASU), the university of my dreams, when I was a junior in high school. I was denied admission due to my immigration status. I was deeply disappointed -- thinking all my effort and hard work was for nothing. My family and friends encouraged me to continue trying, thinking eventually a solution would appear for my limiting problem; a solution to let me step up to new opportunities. I enrolled at Mesa Community College (MCC) and excelled in my courses. Once again, I took a full time load while working over 50 hours a week. At MCC, I became highly interested in research methods and psychology. I applied to ASU a second time two years later. Once again, I was denied admission because of my status. This time I felt fueled by this rejection and kept going with more drive and spirit. I kept hearing “no,” but that was not the answer I was going to take. I kept knocking on the same doors even though they were slammed in my face each time. I finished two Associates degrees with distinction at MCC. During graduation, I stared at the American flag; the symbol of freedom, unity, opportunity, and justice. I stared as if asking for a chance. After all, had I not proved myself already? My family and I were not criminals; we are hardworking people who wanted a peaceful life like everyone else. I just wanted a chance to be “normal” and give back to this country through education and service.

Third time is the charm. I applied to ASU a third time, and in the middle of the summer I received a letter that reignited my hope in this country. I was admitted. I remember that as a happy day! I received the envelope from ASU, and all noise became silent as I started to breathe slowly. I felt in my bones the letter contained good news. After enrolling, the challenge became paying out of state tuition, which I could not afford. I spent all of my savings paying for classes, and by the time I was a junior in college I lost my job. My friends thought I was insane to spend all I saved to pay for a public school. Some suggested I go back to my home country and attempt

to do something with those small savings. I was convinced I was on the right path, and I believed in education so blindly that I knew my future was about more than money. I knew my decision to stay at ASU would pay off in the end. An education is the one thing I knew could never be taken away from me. With only about a month until I was out of my job, with my bank account almost empty, and with nothing but naïve hope to keep me motivated, I received an envelope with the news that dissolved all of my fears. I was awarded a privately funded scholarship that helped me cover the costs of tuition. During my senior year at ASU, I was the founding vice-president of the local chapter of a national student organization (Sigma Alpha Pi), maintained a full time school enrollment (taking over 21 credits, six and seven classes, both semesters), and worked seven days a week at night. Most importantly, in that same year, I found a group of students who held the same unclear status situation as me. We were tired of living in the shadows and in fear of simply being here, so we organized and advocated for our own cause. We became the Arizona DREAM Act Coalition, and I was a founding member in the original executive board of what was then S.U.F.F.R.A.G.E. The DREAM Act is a bill that would allow students in my situation to gain status if we finished college or joined the armed forces. In May 2009, I graduated from Arizona State University Magna Cum Laude with a Bachelor's degree in Psychology as well as Business Administration. Graduation week was the time I felt most accomplished, and the time I understood I can attain what I envision. I can do this, especially with the right type of support and people like my family and friends by my side to believe in me. Graduating reminded me that anything was possible in this country for those who try, but still, this was a bitter sweet victory because I could not use my degrees after graduation. My status was once again the highest barrier; I was my own limit. What was all of this work and struggle for?

Over the summer, I continued to organize for the DREAM Act. I directed my own short-documentary featuring real stories of DREAM Act students. I spoke to crowds in the community, and coordinated a conference to inform faith leaders about our cause and to ask them to spread this information within their congregations. Frustrated with the slow moving pace of the bill and staying true to my belief in education, I switched my focus to apply for graduate school. I worked several odd jobs to support myself while volunteering at three different research labs in order to obtain the experience and references I needed. In December of 2009, I attended a movement building training by RIFA (Reform Immigration for America), and became an active volunteer advocating for immigration reform. In April, our advocacy efforts became defensive as the local legislators were attacking the immigrant community by introducing SB 1070. I was one of the seven people who started a peaceful vigil at the Arizona state capitol, and asked the governor to make the moral choice by vetoing bill SB1070. The vigil eventually grew into overnight stays at the lawn of the capital, rallies, marches, and a national movement. During that summer, I also organized a congregation from the vigil to travel to Washington, DC and pray in front of the White House in July. Once there, we asked the president to intervene. During July, the most invasive parts of 1070 were prohibited, and I advocated for the DREAM Act on national news. As a preventive effort, I volunteered much of my time training leaders to register minority voters for the November elections. In September of 2009, as the DREAM Act started to move again, a group of fellow DREAMers and I decided to camp outside of Senator McCain's office overnight for almost a month and asked him to support the DREAM Act as he had in the past. We called this project DREAM army as students performed military drills and patriotic acts outside of Senator McCain's office and demonstrated their love for this country and their will to join the military. This will was impeded by their status. After the DREAM Act passed in the

House of Representatives, I traveled to Washington, DC in December to participate in a one week lobbying effort that resulted in the Senate vote on the DREAM Act. I was in the Chamber of Congress when the bill was defeated by a few votes. That was an emotional day, and I cried for the first time in years. I saw Washington, DC and the congress buildings taken over by hundreds of students wearing caps and gowns, visited their local legislators, and supported by millions of voters, faith leaders, activists, business people, and politicians. To see the students' enthusiasm and optimism being crushed by strict, unprogressive thinking is what brought me to tears. All of this hard work, what for?

I was admitted to graduate school and worked towards a Master's in Counseling degree. I can only afford to take two classes due to paying out of state tuition. I raised this money by working two jobs and tutoring for over a year, yet I still could not afford a full semester of classes. I also volunteer as a board member of the Arizona Counselors Association, as well as being the director of student advocacy with the Graduate and Professional Student Association at ASU.

After all years of hard work, I finally understand how to recognize a new opportunity. After knocking on the door for so long, it has finally opened. I have been admitted to a PhD in Counseling Psychology program and will start in the Fall of 2011. I intend to do research in preventive science, multicultural counseling, and, of course, work with DREAM Act students. I want to design preventive programs that would give at-risk youth the skills they need to become resilient and further their education, like many DREAMers. All of this hard work was part of a tremendous learning experience that shaped me into a person with high purpose and the desire to help others. I truly desire to be the best citizen I can be and contribute to my community, as well as my country. This is the country I always believed in; the country I always knew was the right fit for me. Being undocumented has made me a stronger and hardworking person who lives with less fear and appreciates the value of each day, as I know each day could be my last one in America. My struggle continues, and the stakes are higher each day. I am still challenged to find ways to fund my education, and there are still many things I would like to accomplish in this state for the sake of social justice. I do not know how far I will go, but all I can do is try.

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THE USE OF NARRATIVE THERAPY WITH LATINA/O STUDENTS PURSUING HIGHER EDUCATION: IMPLICATIONS FOR SCHOOL COUNSELORS AND COUNSELOR EDUCATORS

JAVIER CAVAZOS JR., MARY LOUISE HOLT, AND BRANDÉ FLAMEZ

The techniques of narrative therapy show promise when used with Latina/o students in the pursuit of higher education: defining the problem, mapping the influence of the problem, evaluating the effects of the problem, identifying unique outcomes, and re-authoring the story (White & Epston, 1990). This report provides a case example illustrating these narrative techniques in counseling and discusses the implications for school counselors and counselor educators.

It is well documented that the Latina/o population was one of the fastest growing groups in the United States (U. S. Census, 2005). In addition, Latina/o students have the lowest high school completion rates in the United States (American Council on Education, 2008), and 21 out of 100 Latina/o elementary students enrolled in college (Castellanos & Gloria, 2007). As noted by Vela-Gude et al. (2009), “because of the growing Latino student population and their risk of dropping out of school, it was important to provide services to help Latino students pursue higher education” (p. 272). Given the growing Latina/o population and their low academic completion rates in high school and college, the purpose of the current article was to illustrate how school counselors can use narrative therapy to help Latina/o high school students pursue higher education. First, a literature review regarding challenges to Latina/o students’ success and the effectiveness of narrative therapy was presented. Second, a case study was offered to provide school counselors and counselor educators with practical applications of narrative therapy for this population. Finally, recommendations for practice and research were suggested.

Review of the Literature

Recent attention in the literature was given to the challenges that impede Latina/o students from pursuing higher education. Based on this research, a number of challenges were identified, including tracking away from higher education, low expectations, discrimination, and lack of college information (Cavazos, 2009; Cavazos & Cavazos, 2010; De Jesus & Antrop-Gonzalez, 2006; Gandara, 1995; Garza, 2006; Immerwahr, 2003; Martinez, 2003; Malott, 2010; Valencia, 2002; Valencia & Black, 2002; Vela-Gude et al., 2009; Zalaquett, 2006; Zalaquett & Lopez, 2006). All of these studies pointed to the importance of school counselors increasing awareness of the challenges that impede Latina/o students from pursuing higher education.

In high schools throughout the United States, there appeared to be a system of tracking based on students’ perceived abilities of potential success (Cavazos, 2009; Flores-Gonzalez, 2005; Gandara, 1995; Valencia, 2002). Tracking included names such as: general track, non-college preparatory track, college preparatory track, college bound track, advanced placement (AP) courses, and special programs within high schools (Cavazos, 2009; Flores-Gonzalez, 2005; Gandara, 1995; Jodry, Robles-Pina, & Nichter, 2004; Vela-Gude et al., 2009). Perhaps as a result of placement in non-college preparatory tracks, teachers and counselors had had low expectations of Latina/o students. For example, in perhaps one of the first efforts to look at tracking in U.S. schools, Gandara (1995) found that a percentage of Latina/o students tracked away from higher education at one point in their academic careers. Although these students eventually attained professional degrees (i.e., professional, law, or medical), the effects of

tracking included lower expectations from teachers than students who were in “higher” academic tracks. In addition, A. G. Cavazos (2009) kept a journal of her experience as a student-teacher in a predominantly Latina/o high school. As part of her responsibilities, she taught AP and “regular” courses and found that “regular” Latina/o students were not expected to attend college. Cavazos (2009) provided the following perspective to illustrate how students internalized low expectations:

When I have assigned the students in my eleventh grade English classes activities, they have mentioned how they are not in a CP [college prep] or AP [advanced placement] class to complete these difficult activities...Some students do not believe me and they ask if I truly believe they can learn or even attend college. (p. 77)

As illustrated in the aforementioned comment, it was possible that these Latina/o students learned to become helpless about their educational endeavors (Seligman, 2006). Other research also has found that Latina/o students have been discouraged from higher education at one point in their academic careers (Davison-Aviles, Guerrero, Barajas-Howarth, & Thomas, 1999; Malott, 2010). For example, Malott (2010) illustrated how Latina/o high school students did not believe teachers were supportive of their academic potential, which was described as lack of attention in the classroom.

It was well documented that Latina/o high school students perceived low expectations from high school teachers and counselors (Malott, 2010; Martinez, 2003). For instance, A. G. Cavazos and Cavazos (2010) found that non-AP Latina/o students were exposed to low academic standards. A student in this study provided the following account:

My teachers would judge me on GPA and that would hurt me. ‘You’re not in AP. You’re not in an AP class, so therefore you’re not smart.’ I think districts become obsessed with this mentality of AP only and AP are the best. (p. 102)

It was important to mention that although this student was subjected to low expectations from his high school teachers, he pursued higher education and maintained a high grade point average during his undergraduate studies (Cavazos & Cavazos, 2010). Additionally, Malott (2010) interviewed 20 adolescents of Mexican origin to examine their perceptions of the strengths and challenges of their ethnic background. Some students stated they were exposed to low expectations from teachers and counselors, as indicated in the following comment, “They all expect you to do bad in classes and they do not pay attention to you because they all think you’re going to fail anyway” (Malott, 2010, p. 16). Another student in this study noted that his counselor did not have high expectations of his academic potential based on his Mexican background. This was demonstrated when this student had aspirations to pursue a university in the Big Ten conference, and he was encouraged to look “at smaller schools” (Malott, 2010, p. 16). This finding is similar to an example in Vela-Gude et al. (2009) study in which a Latina student was not encouraged to pursue elite universities.

Previous research found that Latina/o students have experienced discrimination in K-12 school settings. For example, in a study of Chicano/Latino students who left high school, Davison-Aviles et al. (1999) noted that some students perceived differential treatment “based on race” (p. 469). Additionally, Martinez, DeGarmo, and Eddy (2004) examined the experiences of 564 Latino and non-Latino students and their parents. They noted that approximately 50% of Latino students reported discriminatory experiences. Also, Malott (2010) illustrated how

adolescents of Mexican descent experienced various forms of prejudice and discrimination from teachers, counselors, and other members of the community. Participants in this study provided vivid accounts of discriminatory practices, including educators having low expectations based on perceived stereotypes. Finally, Edwards and Romero (2008) explored the experiences of adolescents with Mexican descent and found that approximately 50% of the adolescents in their study reported “at least one experience of discrimination that they ranked at a level 3 (quite a bit stressful) or 4 (very stressful)” (p. 30).

A lack of exposure to college information is another challenge that impedes Latina/o students from higher education (Garza, 2006; Immerwahr, 2003; Zalaquett, 2006; Zalaquett & Lopez, 2006). A participant from Zalaquett’s (2006) study with Latina/o college students provided the following story:

“My major obstacle was that my parents couldn’t help me with any of my applications because neither of them went to school and neither spoke English” (p. 39).

Also, in a study of Latina/o high school students, Kimura-Walsh, Yamamura, Griffin, and Allen (2009) highlighted that some students did not receive college information from high school personnel. A student provided the following perspective: “...for some of my friends...they wanted applications, but they were denied applications because they weren’t ranked [in the top 10%]” (Kimura-Walsh et al., 2009, pp. 11-12). As illustrated in the aforementioned example, it appeared that students were exposed to differential treatment based on their academic placement. To further the point, in a study of Latina/o undergraduate students, Zalaquett and Lopez (2006) noted that some students were “somewhat misinformed about the certain aspects of college entry” (p. 348). As one example of misinformation, Immerwahr (2003) found that some Latina/o students were unaware of college application deadlines.

In summary, the review of these qualitative studies revealed that Latina/o students face a number of challenges to higher education, including tracking away from higher education, low expectations, minimal college information, and discrimination. Although previous research focused on the use of narrative therapy to help Hispanic students overcome mental health issues, including substance abuse, depression, anxiety, and conduct behavior problems (Malgady & Constantino, 2003), there is a dearth of literature on the use of narrative therapy to help Latina/o students pursue higher education. In addition to helping Latina/o students with mental issues, it was our contention that school counselors can use narrative techniques to help Latina/o students identify coping responses to overcome academic challenges. Therefore, this article extended the literature by illustrating how school counselors can use narrative therapy to help Latina/o students overcome academic challenges to higher education. A description of narrative therapy was presented next.

Fundamental Principles of Narrative Therapy

White and Epston (1990) described narrative therapy as an approach to help clients change their life stories. In this post-modern approach, clients are encouraged to externalize their problems not only to provide distance between themselves and the problem, but also to provide space to talk about strengths and the potential to overcome challenges (Butler, Guterman, & Rudes, 2009; White & Epston, 1990). In addition, Flamez, McNichols, and Oliver (2009) noted that people give meaning to their experiences as a result of communicating with others. In order to make meaning of their experiences, it was important for clients or students to share their

stories and experiences with counselors and teachers. Using narrative therapy as a theoretical background, the following techniques can be used to facilitate story-telling: defining the problem, externalizing the problem, mapping the effects of the problem, searching for alternative outcomes, and re-authoring stories (White & Epston, 1990). Given that Latina/o students perceive a plethora of academic challenges to higher education, narrative techniques can be used to help Latina/o students not only identify challenges to academic success, but also coping responses to overcome such challenges.

First, defining the problem involves a collaborative approach between school counselors and students to identify the problem plaguing behavior (Butler et al., 2009). In addition to defining the problem was the practice of externalization, which involved helping students separate themselves from the problem (White & Epston, 1990). Second, mapping the influence of the problem included how the problem affected context or vice versa, such as in school and relationships (Butler et al., 2009; White & Epston, 1990). For some students who focus on the negative parts of their respective lives, school counselors could help them focus on unique outcomes in which the problem does not exist. Further, students are encouraged to change or re-author their life story or the next chapter in their life. That is, students are encouraged to look for ways to change the title of their story or the next chapter in their lives, such as adding the aspect of pursuing a college education (Butler et al., 2009; White & Epston, 1990).

Research on the Use of Narrative Therapy

A number of studies have documented the effectiveness of narrative therapy (Anderson & Hiersteiner, 2008; Fraenkel, Hameline, & Shannon, 2009). For example, Anderson and Hiersteiner (2008) interviewed 27 adult sexual abuse survivors to provide space for the discussion of their stories and experiences. The authors provided the following perspective based on their findings from group interviews: “Recreating a life story that goes beyond recovery from childhood sexual abuse may assist an adult survivor to consider a future full of possibilities, including a story book ending” (Anderson & Hiersteiner, 2008, p. 423). Also, Fraenkel et al. (2009) documented the effects of narrative therapy with families who are homeless. Using externalization and searching for unique outcomes, these approaches helped families strengthen their identity as a family and hold on to hope for the future (Fraenkel et al., 2009). Narrative therapy also has been used to work with (a) parents of gay and lesbian adolescents (Saltzburg, 2007), (b) counselors-in training (Whiting, 2007), and (c) students with learning disabilities (Lambie & Milsom, 2010).

Narrative therapy has been used to help adolescents cope with personal challenges. For example, Butler et al. (2009) demonstrated how puppets have been used with children to externalize a presenting problem. Drawing from a case example with an eight-year-old child, Eric, the following techniques were used: defining the problem, mapping the influence of the problem, evaluating the problem, looking for unique outcomes, and re-storying or re-authoring the story (Butler et al., 2009). First, the counselor began the initial session with the goal of trying to identify the problem. Following a collaborative discussion with Eric and his mother, anger was identified as the presenting problem (Butler et al., 2009). Second, in order to map the influence of the problem, the counselor asked Eric to describe what happens when he becomes angry. At this point, he mentioned trouble and punishment at school and home. Third, an evaluation of the effects of the problem included a discussion about “annoyance” that prevented Eric from participating in activities that he enjoyed (Butler et al., 2009). Fourth, the counselor introduced a puppet to “externalize” the problem and help Eric separate himself from the

problem plaguing behavior. Next, the counselor asked Eric to describe unique outcomes or moments that did not involve anger. During the week prior to the session, Eric mentioned how he did not become upset when his classmate called him a name. Finally, Eric and his counselor discussed ways to re-author his life story by moving away from anger and annoyance (Butler et al., 2009).

In summary, narrative therapy appears to be effective in a number of settings by helping students externalize problems, search for unique outcomes, and re-author their stories. As previously mentioned, research has focused on the use of narrative therapy to help Latina/o students overcome personal issues (Malgady & Costantino, 2003); however, less attention has been given to applications of narrative therapy to help Latina/o high school students pursue and succeed in college.

The fictitious example presented in this article is based on stories and experiences of Latina/o students from samples in previous research. The following story represents the voice of a Latino student who (a) was not expected to pursue higher education (Cavazos, 2009; Cavazos & Cavazos, 2010; Zalaquett, 2006), (b) was subjected to low expectations (Martinez, 2003; Vela-Gude et al., 2009), (c) was exposed to discrimination (Edwards & Romero, 2008; Malott, 2010), or (d) was given minimal college information (Immerwahr, 2003; Zalaquett, 2006).

Case Example of Miguel

I am not sure what is happening in this school. Some students are given college information, and it seems like they are expected to attend college. As for me and the others, who do not take AP courses, it seems like teachers do not expect much from us. For example, in my history class I wanted to leave class five minutes early to look for scholarship information in the library. The teacher indicated that it was a waste of time. And in my science class, I feel as though the teachers judge me because I am not in AP courses. In other words, since I am not in AP courses, they think that I am not smart. You know, Ms. Alvarez (school counselor), I feel sad when teachers do not think that I am smart or have potential. And as a result, I do not have a lot of confidence. Do you know what it is like to have your teachers doubt your ability or potential? Do you know what it is like to perceive discrimination from counselors and teachers? Based on these experiences, I have learned to become helpless about college. I feel like my teachers believe that whatever I do will never be good enough in high school, college, or the workforce. And although I am only 15 years old, I feel like my future has already been written.

Using narrative therapy as a framework, school counselors used techniques described in the current article to help Miguel and other Latina/o students pursue and succeed in higher education. First, it is important counselors allowed students to tell their stories in counseling (Flamez et al., 2009). Based on previous research, some Latina/o students may share stories that involve low expectations from teachers and administrators (Davison et al., 1999; Cavazos & Cavazos, 2010; Martinez, 2003), minimal adult supervision (Immerwahr, 2003; Zalaquett, 2006), or perceived discrimination (Edwards & Romero, 2008; Malott, 2010). As a result of such challenges, students need to have a safe place to share concerns and worries related to their educational experiences. When counselors respect students' perceptions and provide space to share positive and/or negative educational experiences, students may be more likely to work toward their personal and academic goals. Finally, when a safe place for sharing personal

experiences has been established, school counselors can use narrative therapy strategies to help Latina/o students (White & Epston, 1990).

Defining the Problem

School counselors can work with Latina/o students to define the problem (Butler et al., 2009; White & Epston, 1990). Possible problems, as indicated in the aforementioned narrative, may include lack of college information, low expectations, discrimination, or placement in a non-college preparatory track. Although Latina/o students might mention personal reasons (McHatton, Zalaquett, & Cranson-Gingras, 2006) for their educational underachievement, school counselors could help them externalize the problem. For example, cognitive restructuring techniques could be used to help Latina/o students change their self-talk to the following: “At this point in my academic career, I am learning to be successful. I am able to develop expectations of myself that show my academic potential in my high school and college courses in spite of being placed in a non-college preparatory track.” Having students place most of the blame on the school system will not only externalize the problem (Butler et al., 2009; White & Epston, 1990), but also provide an opportunity to identify coping responses to overcome an educational system that perpetuates failure among many Latina/o students.

Mapping the Influence of the Problem

School counselors are encouraged to help Latina/o students map the influence of the problem in domains such as home and social relationships (Butler et al., 2009; White & Epston, 1990). It is possible that their problems influenced their goals related to educational and occupational future. Based on this possibility, it appeared important to map all of the negative influences, including the effects of low expectations on optimism and self-efficacy of students. When Latina/o students discussed feelings and concerns related to low expectations, lack of college information, or tracking away from higher education, the resultant effects could be awareness of (a) educational injustices and (b) coping responses to overcome such problems. Given that research found Latina/o students were aware of the low expectations assigned to them or other Latina/o students (Cavazos, 2009; Cavazos & Cavazos, 2010; De Jesus & Antrop-Gonzalez, 2006; Kimura-Walsh et al., 2009; Malott, 2010), mapping the influence of the problem could provide students with an opportunity to gain an improved appreciation of academic challenges that impede their access to higher education.

Identifying Different Outcomes

School counselors also are encouraged to help Latina/o students identify different outcomes or search for alternative examples (Butler et al., 2009). This is important because it is possible that Latina/o students have not experienced low expectations from all of their teachers. Because Latina/o students may focus solely on experiences with negative teachers, counselors can help them focus on and seek support from teachers who believe in their academic potential. For example, some research suggests that Latina/o students have perceived support and encouragement from high school teachers (Castillo, Conoley, Cepeda, Ivy, & Archuleta, 2010). Therefore, it is important that school counselors encourage Latina/o students to draw on support from those teachers who believe in their academic potential.

Re-authoring

The most powerful part of narrative therapy could be re-authoring the story (Butler et al., 2009; White, 2007; White & Epston, 1990). As previously mentioned, Miguel stated that although he is 15 years old, his life story has been written and therefore cannot be changed. Using re-authoring as a technique, school counselors helped Miguel create or re-author a new ending or next chapter in his life. For example, if Miguel wanted to pursue college, his counselor could help him understand this is a realistic and attainable goal. His counselor placed his story in the appropriate context by giving it a title such as “I am never going to make it.” At this point, Miguel would be encouraged to not only change the title of his book to an affirming or optimistic title, but also search for an alternate ending to his story (Butler et al., 2009; White & Epston, 1990).

Discussion

There are a number of important factors illustrated in the aforementioned case example. First, some Latina/o students are aware of how the educational system placed low expectations on their academic abilities. In the current article, Miguel understood that other students were given college information, thereby leaving him with the impression that his peers received higher expectations related to higher education. Such examples were supported by previous research that found Latina/o students were aware of low expectations given to them by educators (Cavazos, 2009; Cavazos & Cavazos, 2010; De Jesus & Antrop-Gonzalez, 2006; Malott, 2010). Second, Miguel provided a vivid description of the damaging effects of tracking and low expectations. In addition to low self-efficacy, he described a feeling of helplessness and pessimism related to his future. Third, Miguel perceived that his teachers did not believe he has the ability to pursue higher education. In other words, no matter what Miguel did to succeed in high school or beyond, he believed he would not be good enough because his teachers did not believe he had “whatever it takes.” There are a number of studies that have highlighted the detrimental effects of teachers’ low expectations on the hopes and dreams of Latina/o students (e.g., Cavazos, 2009). Such effects could include internalization of failure or fulfillment of a negative self-fulfilling prophecy (Martinez, 2003). Finally, Miguel stated that he had already written his life story even though he was only 15 years old. It was worth noting that although it was difficult to estimate the prevalence of this example, a number of studies showed some Latina/o students in previous research doubted their abilities to pursue higher education (Cavazos, 2009), which possibly influenced their goals related to higher education.

Recommendations for Practice

Given the important connection between narrative therapy and helping Latina/o students pursue higher education, there appeared to be a number of implications for school counselors and counselor educators. First, counselor educators were encouraged to prepare prospective counselors to help Latina/o students overcome institutional challenges to higher education. It was important for counselor educators to modify current curriculum in graduate school to include systemic or institutional challenges that Latina/o students face. Prospective counselors must gain an understanding of how institutional forces negatively affect Latina/o students (Patterson, Hale, & Stessman, 2008; Valencia & Black, 2002). Second, despite challenges to higher education, it was important to note that Latina/o students have potential to overcome institutional challenges and pursue higher education (e.g., Cavazos, 2009; Cavazos, Cavazos, Hinojosa, & Silva, 2009;

Zalaquett & Lopez, 2006). Based on this line of research, it appeared important for counselor educators to introduce prospective counselors to factors that have facilitated the high academic achievement among Latina/o students. Family influence (Castillo et al., 2010; Zalaquett, 2006), intrinsic motivation, internal locus of control (Cavazos et al., 2010; Hassinger & Plourde, 2005), high self-confidence, work ethic (Morales, 2008), and active coping responses (Gloria, Castellanos, & Orozco, 2005; Gloria, Castellanos, Scull, & Villegas, 2009) were identified as some factors that help Latina/o students become academically successful. Given that some factors may not be consistent with family values, school counselors were encouraged to use narrative therapy that is consistent with family expectations. For example, Cavazos et al. (2010) found that some Latina students were not allowed to attend an out of state college. Knowledge of family values and expectations such as those described in the previous examples is important for school counselors to consider for successful use of narrative therapy when helping Latina/o students.

Recommendations for Future Research

There are a number of possible directions for research. First, future research could examine the effects of narrative therapy as described in the current article. Qualitative studies could collect data from school counselors and Latina/o students to determine if narrative therapy is effective. More specifically, research could look at therapeutic outcomes regarding students' sense of empowerment to change or alter their life stories as related to higher education. Additionally, it is important to examine counselors' attitudes toward narrative therapy and Latina/o students (Flamez et al., 2009). Because research has found that some Latina/o students have not received quality services and treatment from their school counselors (Malott, 2010), additional research is warranted to uncover counselors' attitudes toward Latina/o students.

Conclusion

The current article provides school counselors with a framework to help Latina/o students who are (a) placed in a non-college preparatory track, (b) subjected to low expectations, (c) denied access to college information, or (d) exposed to discrimination. The recommendations included in this article could help Latina/o students feel empowered to change their life stories and maintain hope for their academic and personal futures. School counselors can use narrative techniques to help Latina/o students identify coping responses and high expectations of themselves in order to overcome adverse experiences in the educational system. It is also important that future research examines the effectiveness of narrative therapy when helping Latina/o students overcome academic challenges. In summary, counselor educators can train school counselors to use the fundamental principles and techniques of narrative therapy (White & Epston, 1990) to help Latina/o students pursue and succeed in higher education.

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ALCOHOLISM AND OLDER INDIVIDUALS: IMPLICATIONS FOR COUNSELORS

JOHN P. MULDOON AND LISA R. JACKSON-CHERRY

Alcohol use among older individuals is increasing. This social problem will increase as people from the “baby boomer” generation progress into old age. Preeminent concerns for geriatric counselors include identifying risk factors and reasons for use, using screening instruments to assess use and abuse, types of drinkers, treatment approaches and co-existing medical complications. Alcohol use can be related to physical injuries and psychological issues including depression, but the use is not addressed. It is incumbent for clinicians to learn about the extent of the problem and methods of treatment/intervention, to collaborate with families and other entities to accurately address drinking habits, and to make precise diagnoses.

Alcoholism among older individuals has been described as the four U's: underestimated, under-identified, under-diagnosed, and under-treated (Scott & Stelle, 2007). It has also been called the “invisible epidemic” (Sorocco & Ferrell, 2006, p. 454). What is it about alcohol use among older adults that has led to such descriptions? One possible reason that alcohol abuse among older adults was underestimated may be due to the fact that its symptoms are similar to dementia and depression (Nemes, et al., 2004). Sorocco and Ferrell (2006) additionally noted that alcohol abuse is underestimated due to the perceived stigma of alcohol abuse and offered examples. One issue is that alcohol use problems are sometimes overlooked because of biases and stereotypes of health practitioners that lead to fewer alcohol screenings among older adults. A second stigma involves ageism, applying different quality of life standards to various age groups. For example, it is often thought that drinking may be one of the only pleasures older people have in their daily lives.

A relevant variable in the discussion of older people and alcoholism are generational differences between older adults and those of the baby boom generation. Bauman (2008) noted 49% of adults between the ages of 60 to 64 drank within the last month. Boyle and Davis (2006) also noted that 2.8 million people aged 50 and older have used one or more illicit substances in the last year. It is estimated that by 2030, there will be 70 million older adults or “baby boomers” with possible drinking problems (Bauman, 2008).

Among the current older adult population, McPhillips (2002) reported that 2.5 million older adults drank five days a week and 35% of those over 65 drank within the past month. Boyle and Davis (2006) found one-third of older adults over 65 drank alcohol and 10% abused it. Among older adults, 10-15% met the criteria for problem drinking (Bauman, 2008). Whether it is the current older adult population or the pending “baby boomer” generation, these figures are alarming.

Relative to statistics, it is equally important to know that myths about use among older adults exist. One myth is that alcohol use is an infrequent problem. Conversely, the data above suggested drinking among older adults is more frequent than acknowledged. A second myth is that treatment success is limited when a diagnosis is made (Bauman, 2008). However, McPhillips (2002) found that among people with alcohol problems, 21% attained four years of remission, with late onset drinkers being twice as likely to have a stable remission of later life drinking.

There are several reasons for considering the issue of alcoholism among older adults. Bauman (2008) reported older adults are less likely to be noticed, screened, or treated for alcohol use. Bauman (2008) also noted that making a clinical diagnosis is difficult due to co-morbid

cognitive deficits among older adults as well as their use/abuse of prescription and over the counter drugs. Sorocco and Ferrell (2006) added alcohol also mimics other common clinical disorders such as depression and dementia. A third factor is whether use is chronic or situational as chronic use presents additional challenges to clinicians, gerontologists, and families (Bauman, 2008). For instance, complications related to decreased metabolism in older adults, along with general increased sensitivity to alcohol and decreased tolerance, decrease the accuracy of a clinical diagnosis. Not surprisingly, a correlation has been found to exist between falls and alcohol use (Boyle & Davis, 2008). Falls frequently result in broken bones and are a significant contributor to serious health and mobility problems. For this reason, it is important to understand the risk factors for alcohol abuse among older persons.

Risk Factors

Stoddard and Thompson (1996) suggested risk factors to alcohol abuse in older persons include falls, cognitive and sexual dysfunction, incontinence, malnutrition, tremors, weight loss/poor appetite, self-neglect, tobacco dependency and complications related to concurrent drug use. Findlayson, Hurt, Davis and Morse (1988) further stated the number of life stressors, such as retirement or physical health problems, were also risk factors and were almost twice as likely when people started drinking after age 60. Finally, Moos, Brennan, and Moos (1991) included financial difficulties as another risk factor.

Watts (2007) identified other risk factors including psychological, physical, and verbal signs connected with alcohol use among older individuals. Psychological signs included confusion, anxiety, defensiveness, and social withdrawal. Physical signs included impaired coordination, poor hygiene, bruising, broken facial blood vessels, slurred speech, tremors, and fatigue. Hypertension and strokes may be additional signs of alcoholism as are loneliness, abusiveness, and frequent memory lapses. Verbal signs include defensiveness, slurred speech, and expressions of loneliness.

Boyle and Davis (2006) noted alcohol use among older people increases physical problems including skin trauma, such as not being able to feel extremely hot bath water, insomnia, and gastroenterological problems. Scott & Stelle (2007) noted additional physical problems included cognitive dysfunction and complications related to concurrent drug use. Therefore, alcohol use should be investigated when inquiring about memory loss, depression, injuries, labile moods, chronic diarrhea, and isolation (McPhillips, 2002).

Reasons for Alcohol Use

According to McPhillips (2002), older individuals overindulge, in large part, because they have a significant amount of leisure time (Watts, 2007), are retired (Hunter & Gillen, 2006), and often live alone. These factors add or lead to social isolation. Finally, Boyle and Davis (2006) reported acute or chronic pain may lead people to drink to reduce the physical and emotional pain. Bereavement of a spouse, friends, and relatives leads to loneliness, isolation, and increasing overindulgence of alcohol. Alcohol use becomes a coping strategy to drink one's pains away.

Identifying Alcoholism in Older People

The Center for Substance Abuse Treatment (Blow, 1998) has recommended that

everyone over age 60 be screened for alcohol and prescription drug use and abuse as part of regular health care services. Moreover, additional screenings should occur if there is any change in physical or mental health symptoms or if individuals are undergoing life transitions or changes. Conigliaro, Kraemer, and McNeil (2000) suggested the introduction of alcohol-related questions by providing a general overview of the content of the questions, their purpose, and the need for accurate answers. If alcohol-related questions are embedded in a comprehensive health interview, a transitional statement is needed to proceed into the alcohol-related questions. This statement should be followed by a description of the types of alcoholic beverages typically consumed by older persons. One reason for this statement is because older people may not consider drinking to reduce physical pain as potentially problematic. An additional component of the assessment process is to collaborate with physicians who would be able to conduct a medically-focused substance use/abuse assessment.

Physicians also have the ability to identify problematic alcohol use through physiological processes. McPhillips (2002) noted elevated liver enzymes in 18% of older alcoholics. Accurate and timely testing for the presence of these enzymes could facilitate the diagnostic process. Elevated liver enzymes might also indicate alcoholic hepatitis, a strong indicator of alcohol abuse. According to Sarfraz (2003), one of these enzymes is called gamma-glutamyl transpeptidase (GGT), and is induced by alcohol. An increased level of GGT implies prolonged or excessive alcohol use, where the normal level for males should be between 11 to 51 IU/L and 7 to 33 IU/L for females. Another indicator is an individual's blood alcohol level or BAL. If it is over 100mg/dl, it indicates alcohol use. Unfortunately, half of older patients die within one year of diagnosis of an alcohol problem thus the need for early detection and intervention (McPhillips, 2002).

Mersey (2003) also noted medical laboratory tests can be indicators of potential alcohol problems. Mean corpuscle volume (MCV) and carbohydrate deficient transferrin (CDT) have also been used as markers of heavy alcohol consumption. Mean corpuscle volume is less sensitive than GGT in detecting an alcohol problem, but suspicions of an alcohol problem should be raised when both levels are elevated. Estimates note that four to seven alcoholic drinks per day for one week can elevate CDT levels.

Finally, a cyclical problem occurs when a loss of body mass, typical for older persons, leads to a decrease in body water resulting in an elevated concentration of alcohol (Boyle & Davis, 2006). Alcohol is also eliminated slower in older people due to a reduction in kidney and liver functions as well as a decline in stomach enzymes that metabolize alcohol. Therefore, older people may well become intoxicated quicker than younger individuals.

Types

Bauman (2008) described two types of problem drinkers among older adults. The first category is the hardy survivors. They have been drinking for years, possibly stemming from a family history of alcohol abuse, and generally have an early onset. Some of their traits include some degree or history of antisocial behavior. They are typically estranged from their families because of their drinking and/or their antisocial behavior. They also experienced a decline in their socioeconomic status, likely due to retirement. Watts (2002) suspects that about 65 percent of older problem drinkers are in this group.

Bauman (2008) noted that the second group is the later onset type who begins drinking later in life. Approximately one-third of older drinkers are in this category. Later onset drinkers

begin using after retirement, death, separation, decreased income, sleep impairment, and/or family conflict. Watts (2002) referred to this group as reactors and noted they begin using alcohol to self-medicate in order to reduce anxiety brought about by social change, reduced physical/mental capabilities, loss of worth and sleeplessness. Also, alcohol has been used to ease emotional or physical pain and can become a means of justifying drinking. Watts (2002) noted a third type of drinker is the binge drinker. They have an intermittent excessive drinking pattern (Watts, 2002) and are typically defined as having five or more drinks on one occasion (Coombs & Howatt, 2005). Higher levels of disposable income in retirement are a factor which enables older people to indulge in this type of drinking pattern (Watts, 2002).

Assessment of Alcoholism in Older Individuals

Four screening instruments are commonly administered to assess alcohol abuse problems: 1) Cut Down, Annoyed, Guilty, Eye-Opener (CAGE), 2) the Geriatric Michigan Alcohol Screening Test (MAST), 3) the Alcohol Use Disorder Identification Test (AUDIT), and 4) the Alcohol Related Problems Survey (ARPS). Each of these instruments is discussed relative to scoring and relevance of use with older persons.

CAGE consists of four questions that address the frequency and volume of drinking, the extent to which one's drinking affects others, guilt about drinking, and early morning drinking (Conigliaro et al., 2000). The CAGE was developed by Ewing. A "yes" response to any question indicates some degree of an alcohol abuse problem (Conigliaro et al., 2000).

CAGE has been compared with the Diagnostic Interview Schedule (DIS), an instrument used in previous verification studies to evaluate current to lifetime alcohol abuse and dependence. Buchsbaum, Buchanan, Centor, Schnoll, and Lawton (1991) found the accuracy of predicting alcohol problems among older adults for the CAGE and the DIS was 86% and 78% for one "yes" response and 70% and 91% for two "yes" responses, respectively. The likelihood of "yes" responses ranging from zero to four and corresponding to an alcohol problem was 33%, 66%, 79%, 82%, and 94%, respectively (Buchsbaum, Buchanan, Centor, Schnoll, & Lawton, 1991). Similarly, a second CAGE study by Jones, Lindsey, Yount, Soltys, and Farani-Eneyat (1993) found the likelihood of "yes" responses ranging from one to four and corresponding to an alcohol problem was 58%, 92%, 100%, and 100%, respectively.

In contrast, Fulop et al., (1993) and Luttrell (1997) reported CAGE having a decreased likelihood of positively identifying an alcohol problem; however, these studies have significant design limitations by using only physician notation of alcoholism (Fulop et al., 1993) and excessive alcohol consumption as comparisons (Luttrell, 1997). Moreover, CAGE does not distinguish between active and inactive drinking problems, has not been validated for hazardous or harmful drinking (Conigliaro et al., 2000), and has not been effective in determining current and past drinking (Mersey, 2003).

Blow et al., (1992) developed a Geriatric screening version (G-MAST), from the initial MAST created by Seltzer. The G-MAST includes 24 questions that are answered in a "yes" or "no" format (Blow et al., 1992). Each "yes" response is scored with a point and a score of five or more indicates a drinking problem (Blow et al., 1992). A 10-item short version of the G-MAST suggests problematic alcohol use if two or more questions are answered affirmatively (Blow et al., 1992).

Conigliaro et al., (2000) reported that the G-MAST includes older adult-specific consequences, but its length may hinder routine use even in its shortened form, the 10-item S-

MAST-G (short geriatric MAST). The authors further stated that the G-MAST holds promise, but further validation studies are needed. Joseph, Ganzini, and Atkinson (1995) reported the G-MAST ranged from 65-93% accurate when used with VA nursing home patients.

The Alcohol Use Disorders Identification Test (AUDIT; Bohn, Babor, & Kranzler, 1995) is widely used and can assess alcohol abuse in older adults. It is a 10-item survey inquiring about patterns of use and effects of drinking (Bohn et al., 1995). Items are scored on a scale of 0 to 4 with a score of 8 or more indicating problematic alcohol use (Bohn et al., 1995). Items are scored on a scale of 0 to 4 with a score of 8 or more indicating problematic alcohol use (Bohn et al., 1995). According to Conigliaro et al., (2000), AUDIT is 80-90% accurate in identifying problem drinkers; however, the AUDIT has performed poorly when used with older adults (Morton, Jones, & Manganaro, 1996). Airaa, Hartikainen, and Sulkava (2008) also reported concern regarding reliability because participants denied using alcohol on the AUDIT, but later reported using it for medicinal purposes.

Fink et al., (2005) developed the Alcohol-Related Problems Survey for use in primary care community clinics. It has 60 items that includes nine categories ranging from medical, psychiatric, gender, and physical health/function to quantity of use and symptoms of alcohol abuse and dependence. Individuals are subsequently categorized as harmful, hazardous, or non-hazardous drinkers.

Fink et al. (2005) determined the test-retest reliability of the ARPS' drinking classifications using a random sub-sample of 78 people aged 65 and older. They completed the ARPS twice, an average of 7 days apart. The result was 0.65 suggesting substantial agreement between the proportions of harmful, hazardous, and non-hazardous drinkers. Fink et al. (2005) also found most participants completed the ARPS with no difficulty understanding its questions, and 90% of respondents completed the survey unassisted in an average time of 16 minutes.

Comparatively, Conigliaro et al., (2000) noted there are advantages and disadvantages with each of the instruments. The AUDIT has the ability to identify problem drinkers, and was designed to identify current disorders; however, the focus on consumption may not be relevant to older individuals and their ability to recall drinking events affects its reliability (Conigliaro et al., 2000). The S-MAST-G is the most favorable of the MAST adaptations. Disadvantages of the MAST-G include it is a paper document; it may not be culturally relevant; and it is lengthy for clinical practice (Blow et al., 1992). CAGE is the most recommended because its brevity ensures clinicians will use it and the time for administration is minimal. It has the ability to effectively discriminate between older adults with a history of drinking problems from those without such a history, and it has been validated in older adults.

Information about assessment instruments is important and is only part of the counseling process. Counselors need to have some knowledge of the treatments available and the outcomes for those treatments. Awareness of types of treatment are essential when considering that many older clients have strong defenses against acknowledging an alcohol abuse problem and often do not realize their drinking is problematic. Therefore, the next topic is what types of treatment are available, what these treatments entail, and how counselors assist clients.

Treatment

Consider an older individual with an alcohol use problem. A primary counseling technique to use with the client is to offer gentle feedback when addressing the problem. It is also helpful to review medical and psychological test results in the same manner and use the data as an opening to discuss the adverse consequences of excessive alcohol use.

Blow and Barry (2002) recommended brief alcohol interventions as one method of treatment. Brief interventions are designed to empower the client to choose between drinking in moderation or abstinence. The goal is for the patient to choose between decreasing and eliminating alcohol consumption. Fleming, Manwell and Barry (1999) documented the effectiveness of brief interventions by incorporating advice, education, and/or contracting into a 10-15 minute counseling session. Results included reductions in seven day alcohol use (consumption reduced by 62%) when compared to control groups at 3, 6, and 12 month follow-ups. If brief interventions are unsuccessful in assisting clients to decrease their consumption, formal counseling treatment must be addressed.

Another objective of treatment is to determine the motivation for change strategies. Part of this process is to educate clients about alcoholism and to identify its signs and symptoms. A counselor must offer an honest assessment and direct feedback about the individual's strengths and motivation to change. Typically, a contract with measurable goals can be mutually determined to empower clients to engage in behavior modification strategies. These strategies might include bereavement support groups (noting that the spouse and many friends and relatives may be deceased), effective pain management (understanding physical ailments), and completion of a drinking diary. In most treatment settings, abstinence would be the goal for those with severe problems. Some individuals would benefit from participation in a 12-step program attendance (McPhillips, 2002). Bauman (2008) asserted that brief interventions are effective in addressing at-risk drinking and has been found to reduce consumption significantly in older persons.

Miller and Rollnick (2009) stated that motivational interviewing (MI) is a collaborative person-centered form of guiding to elicit and strengthen motivation for change. Other authors, including Alexander and Morris (2008) and Kistenmacher and Weiss (2008), stated that MI is intended to allow individuals to focus on increasing their self-awareness about the true effects of their problematic behavior.

The goal of MI, according to Alexander and Morris (2008), is to create a discrepancy or dissonance within the client as to what the target behavior is (i.e., the excessive drinking) and his/her other desired goals (increasing sober social interactions). Miller & Rollnick (2002) stated the ambivalence about change is perfectly natural; resistance, on the other hand, is a function of the interaction—or struggle—between the counselor and client. They recommended counselors avoid confrontation and instead “roll with resistance” by using a client-centered and empathic style, validating responsibility and personal choice, and eliciting self-motivational statements from the client. This focus on enhancing motivation in resistant individuals has been justified empirically by the evidence from substance-abusing populations demonstrating that even highly resistant individuals can benefit from treatment and using techniques such as motivational interviewing (Miller & Rollnick, 2002).

Motivation aside, Stelle and Scott (2007) found relationships between income and referrals to treatment. Individuals with lower incomes are likely to be pressured into treatment by siblings, other family members, or friends. In contrast, individuals with higher incomes are likely to be pressured into treatment by a spouse.

Recommendations for Counselors

It is incumbent upon clinicians to attend continuing education training sessions on the identification of risk factors, treatment techniques, assessment and screening instruments, and collaboration with family members with consent. Additional training will address the needs of

this growing population.

Counselors are advised to inquire about “medicinal use” of alcohol during a comprehensive assessment intake. Pertinent questions could disclose alcohol use which might otherwise be undetected. Airaa et al.’s (2008) participants demonstrated this issue; they responded affirmatively to a direct question about alcohol consumption for “medicinal purposes.” The use of direct questions may provide useful behavior. In addition, Mersey (2003) noted that questions must be asked at the individual’s cognitive level of functioning in order to obtain reliable responses.

Clinicians need to ensure that professional relationships are maintained with physicians and other parties responsible for the older person’s care. Such collaboration will increase the potential that referrals will be made appropriately and timely. A final step is to arrange for treatment to ensure the continuity of care. In order to effectively achieve continuity, counselors need to know about the continuum of treatment for substance abuse, from detoxification to various categories of outpatient therapy (education, outpatient, intensive outpatient) to inpatient rehabilitation (halfway house, partial care, day treatment, and inpatient) and be knowledgeable of programs operating in the local community.

Family Considerations

The dynamics of the family of origin is an important consideration in assessing and treating alcohol use in several respects. First, it is generally accepted that there is a genetic link for inter-generational alcoholism. In fact, a family history of alcoholism can lead to a higher prevalence of lifetime drinking when compared to other predictors such as age, race, and gender (Grant, 1998). Second, Sorocco and Ferrell (2006) noted both patients and practitioners avoid the topic of alcohol because it is uncomfortable to discuss, due to embarrassment. Additionally, families may consider the alcohol problem as a private matter preventing them from seeking help. A third and final issue is that caregivers, who are typically from the current family system, have limited knowledge about the aging process.

One request family members should be advised to do is to inquire if the primary or family physician of their older family members are conducting comprehensive assessments or screenings for alcohol/drug use, whether it be with a formal instrument or with an intake questionnaire. Airaa et al., (2008) found over half of their subjects, all Finnish people aged 75 or older, drank alcohol. Of those who drank, 40% drank for medicinal purposes, including heart and vascular disorders (38%), sleep disorders (26%) and mental problems (23%), suggesting how difficult it is to diagnose alcohol use/abuse when people feel justified in its use. Alcohol consumption for medicinal purposes was equally common in males and females; however, older women found it easier to discuss their alcohol consumption in the context of medicinal use. The most commonly used alcoholic beverages were brandy and other spirits. One consideration is for the client to write or to journal the reasons for their alcohol consumption. If a client is not able to complete this task, a family member would need to record these reasons.

Banta and Montgomery (2007) found that when substance abuse diagnostic or screening instruments were performed by physicians, patients in general were more likely to receive a diagnosis of substance abuse and/or dependence. Moreover, their findings suggested that long-term clients tend to be under-diagnosed for substance abuse compared to first-time patients who were screened initially. Therefore, if family members suspect their older relative or friend is experiencing an alcohol problem or personal circumstances have changed, they need to ensure that the physician is conducting screenings on a regular basis. With accurate information, the

physician can make an appropriate referral. Under-diagnosis, due to a lack of screening in primary care, has occurred among several demographic groups including older adults, as well as young adults, women, and non-Whites.

Finally, the counselor is advised to remind clients that privileged information obtained in a client-counselor or patient-physician relationship is confidential. If a relative or friend wishes to discuss an issue or express concerns, the older person's written consent is required. If someone requests information about an older person, counselors should advocate that they provide or expand on the concerns they have about the person. It is important for the counselor to explain that receiving information is not guaranteed.

Counselors need to discuss informed consent, particularly confidentiality, with the client and the client's relatives/friends. Day (2008) stated privileged communication is the client's right to privacy that he or she can give up if they choose. Day (2008) also listed several situations when confidentiality can be breached, including the occurrence of elder abuse, when the client is suicidal, if the insurance company seeks a diagnosis or treatment update, a court subpoena exists, or when any documents are given to clerical staff for filing. One of the significant issues with older patients is when other physical, physiological, or emotional issues complicate the older person's life/care. For example, if an older person is in counseling and reveals losing his/her balance and falling repeatedly. A counselor needs to assess the safety of the client in that environment.

Counselors also need to remember the five ethical principles and how they apply to older people and their relatives (Day, 2008). Counselors must respect their client's desire for independence yet also ensure that his/her client is not in danger of harming his/her self. If the client is in danger or harm, a report must be made to a relative, nurse/physician, or staff person.

Older Persons in Nursing Homes and Alcohol Use

Increasingly, older people are residing in assisted living facilities, nursing homes, and other supervised venues. Given the four 'U's' discussed previously, counselors are advised to encourage relatives and friends to inquire about a facility's policy about substance use especially considering 1 in 10 individuals in medical settings have an alcohol problem (Bauman, 2008). What policies exist relative to substance use in these venues? Jess and Klein (2002) reported that policies can vary from zero tolerance, including denying admission to anyone with a substance abuse problem, to staff distribution of alcoholic beverages. Accordingly, family members and friends should inquire about a protocol for assessment and screening of substance use, whether it be at intake or as part of regular medical reviews. Jess and Klein (2002) advocate for consumption on the premises through the scheduling of pro-social alcohol events such as a monthly cocktail social.

Finally, Jess and Klein (2002) noted employees at many facilities are not trained to identify alcohol-related health issues despite being able to recognize other problems such as confusion, belligerence, or forgetfulness. It would be incumbent for nursing home staff to also attend trainings about differential symptoms among older persons.

Conclusion

Research indicates older people use and abuse alcohol. Moreover, the abuse tends to go unnoticed and undiagnosed. Physical, psychological, and verbal signs were identified as risk factors for alcohol abuse in older persons. Reasons were listed why older persons may drink

excessively in addition to types of drinking patterns they engage. Resources were discussed regarding identifying alcohol abuse through the use of medical tests and assessment instruments. Counselors were offered theories, techniques, and recommendations for interventions to improve the diagnosis and treatment of older individuals with potential alcohol problems. Counselors were also offered options about interacting with older people and their family members, including a discussion about informed consent and confidentiality. The final topic discussed the role of nursing homes and older persons, especially individuals with alcohol problems. In summary, the older population is continuing to grow, and clinicians must be prepared to address geriatric needs and issues with older persons, their relatives, and their health care providers.

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HOW TO BE HAPPY: A VIRTUAL CONVERSATION WITH SIGMUND FREUD

TIMOTHY C. THOMASON

*Sigmund Freud, the most significant and influential figure in the history of psychology, had a lot to say about happiness. His comments on happiness, particularly in his book *Civilization and Its Discontents*, addressed concerns that are still current today. This article, which takes the form of an imagined conversation with Freud, includes quotations of Freud and paraphrases of his writings.*

Introduction

After World War II, American psychology focused on treating mental illness, and great progress was made in understanding and treating psychological disorders. However, the focus on human weakness meant that little attention was given to the other side of the equation (Snyder & Lopez, 2007). In recent years, much attention has been paid to positive psychology, the attempt to study positive human attributes and develop interventions to promote human flourishing (Seligman, 1998). One major focus of concern in positive psychology is happiness: what is happiness, and how can counselors and psychotherapists help clients become more happy?

One of the new models of happiness proposes that a person's happiness level is determined by three factors: a genetically-determined set-point for happiness, circumstantial factors, and activities that affect happiness (Lyubomirsky, Sheldon, & Schkade, 2005). This model is based on research that suggests genetics account for 50% of population variance for happiness, life circumstances accounts for 10%, and intentional activity accounts for 40% (Lyubomirsky et al., 2005). This model also recognizes that while 60% of our happiness is beyond our control, 40% is subject to our own efforts to become happier (Lyubomirsky et al., 2005). While there is little definitive research on exactly what we should do to become more happy, suggestions usually include such things as having plenty of friends, belonging to supportive groups, helping others, and keeping a gratitude journal (Myers, 2000). Strategies for promoting happiness should address three of life's domains: love, work, and play (Snyder & Lopez, 2007).

When Freud was writing his books in the early 1900's, he was aware that everyone seeks the goal of happiness, and he wrote about how to define happiness, reasonable expectations regarding how happy humans can be, activities that promote happiness, and how psychotherapy can help clients pursue happiness. Compared to much that is written about happiness today, Freud's ideas were quite profound and deserved careful consideration. Although Freud might be accused of being pessimistic regarding the potential for human happiness, it must be remembered that he was writing at a time when there were few effective treatments for any of the psychological disorders. It must have seemed that happiness was a somewhat frivolous topic, given the pressing need to help the many people suffering from mental illness.

Freud suggested that we should seek happiness through love and through work (Strachey, 1989). His opinion was that satisfying love relationships and creative, productive work hold the most value for the person who seeks to be happy. This accords well with the findings of the positive psychologists from the past few years. Freud cautioned against pursuing happiness through hedonism, drug and alcohol use, and retreat from the world. He recommended being active in one's community and working for the good of all. Freud also wrote we should realize there is no one-size-fits-all prescription for happiness.

Counselors will find several practical implications of Freud's ideas about happiness. For example, clients should have reasonable expectations about how much control they have over their own happiness. They should seek to resolve bothersome personal problems while they pursue happiness, and get psychotherapy if they need assistance. They should also specifically work on improving their work lives and their love lives. Freud suggested that even though happiness is a difficult goal, it is in our nature to pursue it, and we must not give up the effort.

Dr. Freud, thank you so much for agreeing to speak with me.

That's quite all right. What would you like to know?

What is the meaning of life?

"This question has been raised countless times and has never yet received a satisfactory answer, so we have a right to dismiss it." (Strachey, 1989, p. 24).

What do you think of the pursuit of happiness?

"The intention that man should be happy is not in the plan of Creation." (Strachey, 1989, p. 25).

What do you say when a patient asks how you propose to help him or her?

"Much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health, you will be better armed against that unhappiness." (Luckhurst, 1989, p. 78).

What is the purpose of psychoanalysis?

The goal of psychoanalysis is to cure gratuitous or self-imposed suffering (neurosis) in order to restore "common" or "ordinary" unhappiness. It is not a cure for fate or a remedy for the human condition. (Luckhurst, 1989, p. 78).

What is your book *Civilization and Its Discontents* about?

The book's central theme is the frustration of man's perennial search for happiness. In fact, my original title for the book was "Unhappiness in Civilization." People show by their behavior that the purpose and intention of their lives is happiness. "People strive after happiness; they want to become happy and to remain so." (Strachey, 1989, p. 25).

What is happiness?

The endeavor to become happy has two sides, a positive and a negative. "It aims, on the one hand, at the absence of pain and unpleasure, and, on the other, at the experiencing of strong feelings of pleasure." In its narrowest sense, happiness is the sensation of pleasure. "What decides the purpose of life is the program of the pleasure principle, the effort to maximize pleasurable sensations." (Strachey, 1989, p. 25).

So the pleasure principle motivates us to seek pleasure?

Yes, but a secondary process I call the reality principle constrains human beings to curb their crude desires for pleasure. The child learns to regulate his demands for immediate gratification and postpone present enjoyment for the sake of later rewards. We weigh the costs and benefits in order to maximize pleasure and minimize pain. (Strachey, 1989, p. 25).

The demand for pleasure is forever at war with reality?

Yes, and it is a battle that the pleasure principle is destined to lose. "There is no possibility at all of its being carried through; all the regulations of the universe run counter to it." (Strachey, 1989, p. 25).

Why is the struggle for happiness doomed?

For two reasons; one is because human desire is insatiable. "What we call happiness comes from the satisfaction of needs which have been dammed up to a high degree. By its nature it is an episodic phenomenon. When any pleasurable situation is prolonged, it only produces a feeling of mild contentment, and then trails off. When one's thirst is slaked, the satisfaction of drink declines. We are so made that we can derive intense enjoyment only from a contrast and very little from a state of things. Thus, our possibilities are already restricted by our constitutions." (Strachey, 1989, p. 25).

And the other reason the struggle for happiness is doomed?

Because of the nature of being in the world. The conditions of existence match our infinite desire for pleasure with infinite possibilities for pain. We are threatened with suffering from three sources: our own body, the external world, and finally from our relations to other people. "The suffering which comes from this last source is perhaps more painful to us than any other." (Strachey, 1989, p. 26).

So to some extent we suffer simply because we live in society?

Yes, the renunciation of erotic and aggressive impulses demanded by civilization exacts a heavy price. Humans are as ready to regard their neighbor as an enemy, as a friend to be loved. "Man is a wolf to man." Society constrains the desire to satisfy aggressiveness on others, but it does so only by redirecting that aggression within. The result is frustration, anxiety, and displaced guilt. "The price we pay for our advance in civilization is a loss of happiness. Civilized man exchanged a portion of his possibilities of happiness for a portion of security." (Strachey, 1989, p. 73).

What are some of the ways that people pursue happiness?

One is hedonism. "The unrestricted satisfaction of every need presents itself as the most enticing method of conducting one's life, but it means putting enjoyment before caution, and soon brings its own punishment." (Strachey, 1989, p. 26-27).

What did you learn from your use of cocaine?

The crudest, but also the most effective means of avoiding suffering is the chemical one, but it falls prey to similar drawbacks. Substances that allow the user to withdraw from the pressure of reality are dangerously attractive and potentially harmful, and waste much energy that might be far better employed. (Strachey, 1989, p. 27-28).

What about pursuing happiness by withdrawing from society?

"Voluntary isolation is the strategy of the hermit. This might secure the happiness of quietude, but it is an admission of defeat. Against the dreaded external world one can only defend oneself by some kind of turning away from it. The same is true of killing off the instincts as is prescribed by the worldly wisdom of the East and practiced by Yoga. If it succeeds, then the subject has given up all other activities as well - he has sacrificed his life, and only achieved the happiness of quietness. A better path is becoming a member of the human community and working for the good of all." (Strachey, 1989, p. 27-28).

What about pursuing happiness through the enjoyment of beauty?

The enjoyment of works of art can induce a mild narcosis, but it is a transient enjoyment. It is one of many attempts to perceive the world through imagination, illusion, or fantasy. (Strachey, 1989, p. 27-32).

Can religious faith promote happiness?

Religious faith is similar to the flight into fantasy of neurotic illness. The religions of humankind are mass delusions. They attempt to procure happiness and protection from suffering through a delusional remolding of reality. (Strachey, 1989, p. 29-30).

If none of these approaches promote happiness, then what does?

I recommend creative and productive work. Work involves sublimation and the displacement of libido. Professional activity that is freely chosen can be a source of special satisfaction. No other technique for the conduct of life attaches the individual so firmly to reality. I especially like psychical and intellectual work. Work is not sufficiently prized by men as a path to happiness, and it deserves to be so. (Strachey, 1989, p. 27-32).

Can love promote happiness?

The strategy of loving and being loved comes naturally enough to all of us. Love is based on a yearning for the satisfactions of infancy as well as our most intense and overwhelming sensation of pleasure - sexual love - the prototype of all happiness. Erotic love perhaps comes nearer to the goal of happiness than any other method. (Strachey, 1989, p. 33).

Does pursuing happiness through love have a downside?

Oh yes, otherwise no human being would have abandoned this path to happiness for any other. "We are never so defenseless against suffering as when we love, never so helplessly unhappy as when we have lost our loved object or its love." Much of the energy of psychoanalysis is devoted to trying to understand the daunting complexities of sustaining love in the face of its many threats. The pleasures of love are seldom uncomplicated. Love and aggression are seldom far removed. (Strachey, 1989, p. 34).

Overall, you sound pessimistic about our prospects for happiness.

"The program of becoming happy cannot be fulfilled. But we must not - indeed, we cannot - give up our efforts to bring the program of becoming happy nearer to fulfillment by some means or other." This is the human predicament. Human beings cannot be happy, but they will struggle for happiness until the end. This is both tragic and noble. Humans refuse to succumb passively to the decrees of fate. (Strachey, 1989, p. 33).

"There are many paths which may lead to such happiness as is attainable by men, even if there is none which does so for certain." (Strachey, 1989, p. 33). Pleasure is better than pain, and there is no reason we should not seek to maximize our happiness. If we cannot remove all suffering, we can remove some, and can mitigate some. (Strachey, 1989, p. 34).

Can psychoanalysis help us be happy?

Yes, in that psychoanalysis is a means for dealing with anxiety and guilt, allowing us to learn to sublimate our aggressive and destructive impulses into healthier, more productive behavior. "Happiness, to the extent it is possible, is a problem of the economics of the individual's libido." So there are as many paths to pleasure as there are people, each of whom

has a unique psychic constitution. The predominantly erotic person would give first priority to emotional relationships, while the narcissist, who inclines toward self-sufficiency, would seek satisfaction in internal mental processes. "Just as a cautious businessman avoids tying up all his capital in one concern, we would do well not to look for the whole of our satisfaction from any single aspiration. Every man must find out for himself in what particular fashion he can be saved." (Strachey, 1989, p. 34-35).

Thank you for this interview.

You are most welcome.

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BROADENING MULTICULTURAL COMPETENCE: UNDERSTANDING AND ADVOCATING FOR INDIVIDUALS AFFECTED BY POVERTY

KARRIE L. SWAN

Broadening multicultural competency through social advocacy is becoming increasingly important in the field of counseling. Despite research proposing the importance of understanding diverse cultural constructs, few studies have investigated the role poverty and social class plays. More consideration must be given to understanding issues surrounding classism and intrapsychic bias toward low-income clients. Counselors should be heedful of how one's social class worldview influences the process of counseling and the counseling relationship. The purpose of this article is to examine poverty as a cultural construct, and gain insight into macro-level challenges that reinforce oppression for clients living in poverty. The article ends with a discussion of the ACT model, which provides counseling strategies for making changes at the macro-level. As proposed in this article, counselors can use the ACT model to engage in social justice practices to improve the lives of individuals affected by poverty.

Ethically and professionally competent counselors must comprehend and respond to the interplay of poverty in the worldview of a client. The American Counseling Association (ACA) Code of Ethics obligates counselors to understand their own values and beliefs and how they may reinforce the inherent inequalities that exist in society (ACA, 2005). Sue, Arrendondo, and McDavis (1992) asserted because sociopolitical influences complicate poverty, counselors are called upon to engage in advocacy activities that promote client development and advance social justice.

The scant research on poverty in counseling highlights counselor intrapsychic bias toward low-income individuals and focuses only on micro-level implications for the counseling relationship. Particularly, Shapiro (2004) interpreted from a study with 181 respondents that clinicians' belief in a fair and just world correlates to negative attitudes toward those in impoverished circumstances, negatively affecting their ability to be helpers in the counseling relationship. Similarly, Toporek and Pope-Davis (2005) indicated that among 158 graduate level counseling students, increased exposure to multicultural training corresponded to counselor explanations of poverty from a systemic perspective. In contrast, counselors with limited exposure to multicultural training were more likely to attribute the cause of poverty to individual choices and behaviors (Toporek & Pope-Davis, 2005).

Attempts to understand counselor beliefs about the causes of poverty are relatively new to the field of counseling; however, political scientists and economists have focused on this dilemma for decades. As counselors are ethically obligated to understand the rich complexity of the diverse cultural backgrounds of clients, it is imperative that professionals in the field of counseling understand the macro-level challenges presented to individuals affected by poverty (ACA, 2005).

Macro-level Challenges of Poverty

Sue et al. (1992) recommended counselors acknowledge the sociopolitical reality by recognizing that counseling processes exist within a larger political, social, and economic framework. Sue et al. (1992) also suggested that counselors should be aware of how the counselor-client relationship is linked to oppression and the status-quo transmission of values. Thus, understanding societal transmission of oppressive beliefs about individuals living in poverty is necessary to developing ethical multicultural sensitivity and understanding (Sue et al.,

1992). Particularly, it is important for counselors to increase their understanding of how the tenets of individualism, capitalism, and classism influence their worldview and their view of individuals affected by poverty.

Individualism

The dominant ideology of individualism in American society impacts greatly one's perception of the causes of poverty (Kluegal & Smith, 1986). Oyserman, Coon, and Kimmelmeir (2002) defined individualism as "a worldview that centralizes the personal—personal goals, personal uniqueness, and personal control—and peripheralizes the social" (p. 5). Extrapolated from this philosophy is the assumption that wealth and higher social class are the rewards of the hard-working and determined whereas poverty awaits those who lack thrift and diligence (Smith & Stone, 1989). Hence, from an individualistic framework, poverty is the accepted reflection of individual character flaws. Although few research studies have examined the relationship between the belief in individualism and the effectiveness of counseling individuals from lower social class groups, Ivey (1993) and Kelley (1989) posited the counseling profession is rooted in individualism and propagates the transmission of individualistic beliefs and values.

Particularly in a meta-analysis of individualism as a worldview construct, Oyserman et al. (2002) found that one's worldview of individualism influences attribution style, self-concept, well-being, and relationality. Specifically, Oyserman et al. (2002) found that among 40 studies, the worldview of individualism had a moderate to large effect on attribution style, meaning that individuals who believe in individualism tend to attribute the cause of events to factors related to one's character and choices. Even Shapiro (2004) found that counselors subscribing to a belief in an individualistic cause of poverty tend to have negative attitudes toward people from lower social class groups. Thus, Oyserman et al. (2002) and Shapiro (2004) supported increased understanding of the influences of the cultural construct of individualism on theories of helping relationships and the counseling process.

Capitalism

In 1776, Adam Smith introduced the concept of laissez-faire capitalism. Smith (1776) theorized that capitalism was the most efficient economic system in the instance of a reliance on the private ownership of the means of production and an enforcement of private property rights. In a pure capitalistic society, every individual has the liberty to pursue any interest and compete with any individual (Smith, 1776). In free market societies, scarce resources are allocated through a market exchange in which buyers and sellers have the freedom to exchange goods and services through the standard of value. Hence, the assumption in market societies is that all individuals have access to the economic and social structure (Rawls, 1972), and that economic success, or lack thereof, is largely the result of one's attempt to build wealth within the confines of the free market system. A critical examination of the assumptions in capitalism revealed how the market ideals have impacted the upward mobility myth central to the heart of middle class values (Rawls, 1972). Although counseling researchers have not examined the relationship between a capitalist worldview and counseling, Liu and Ali (2005) argued that capitalist beliefs influence the upward mobility bias reinforced in secondary school and higher education. Therefore, Liu and Ali (2005) urged counselors to have a contextual understanding of the "sociostructural (e.g., legal, education, and economic systems)" (p. 3) influences that oppress

individuals from lower social class groups.

Social Class and Classism

Social class and classism are interdependent cultural constructs that have objective consequences and subjective meanings (Liu & Arguello, 2006). According to Liu and Arguello (2006), classism is the assignment of ability and worth based upon the perception of social class. In downward classism, individuals from higher social class groups hold individuals from lower social class groups in lower regard (Liu & Arguello, 2006). Downward classism in counseling may occur when counselors fail to engage in self-awareness about their own class values and rules and instead, require that counselees follow the unspoken middle-class guidelines (Sue & Sue, 2003).

Consequently, Liu et al. (2004) explained that counselors might come to blame the counselee when counseling interventions prove unsuccessful. Liu et al. (2004) suggested ignoring the influence of social class in a client's worldview denies the importance of class and demonstrates a lack of multicultural competency. More important, the 2005 revision of the *ACA Code of Ethics*, allotted greater attention to multicultural and diversity issues (ACA, 2005). The publication offered an expanded definition of non-discrimination to include spirituality, gender identity, marital status, and language preference (Kocet, 2006). Although the Code Revision Task Force attempted to broaden the scope of multiculturalism, this development appeared to lack acknowledgement of the impact of social class in one's worldview.

Moreover, Liu et al. (2004) indicated the utilization of "socioeconomic status" in the stead of "social class" confuses and minimizes the importance of social class and poverty as cultural constructs that are reinforced by societal beliefs and institutional policies. As a result of confusion among counseling researchers regarding the definition of socioeconomic status, there exists an underlying denial of a social class system in American society. This academic void generates the urgency to expand acknowledgment and understanding of the impact of social class in the ethical code and profession of counseling (Liu et al., 2004). Additionally, Sue and Sue (2003) encouraged counselors to increase their influence in social justice by becoming involved in social policies at the local, state, and national level.

Institutional Reinforcements of Poverty

In American society, one's socioeconomic status, gender, and race largely influence access to education, occupation, and health care. Despite outward attempts to equalize access to institutions in society, the unavoidable reality is that poverty exists within the structured framework of racism, sexism, and elitism in what Tate (1999) referred to as the "chronicity of oppression" (p.18). Thus, dominant ideologies and worldviews as well as social and economic institutions reinforce poverty.

Education and Occupation

Education and occupational choices are interdependent dimensions for individuals from lower, middle, and upper social classes; however, individuals from lower social classes have limited access to various options. In *Savage Inequalities*, Kozol (1991) demonstrated how socioeconomic status, race, and wealth determine access to education. Particularly, Kozol (1991) revealed that inherent institutional inequities present academic challenges for individuals living

in poverty. Because public education is funded primarily through the use of property taxes, wealthy suburbs receive greater funding to provide quality education. In contrast, poor suburbs receive little funding to provide quality education (Kozol, 1991).

Numerous research studies have documented the correlation between the quality and level of educational attainment and socioeconomic status. Specifically, Gladioux and Swail (1998) found, in a longitudinal study on socioeconomic status and college completion, 6% of students from the lowest income quartile graduated from college as compared to 40% of students from the middle quartile. The work of Gladioux and Swail (1998) seems to contradict the metatheory of individualism and the notion of upward mobility in American society. Their research also lends support to the concept that a lack of monetary resources leads to limited accumulation of academic, social, and cultural capital (Liu et al., 2004). Consequently, Liu et al. (2004) argued it is important for counselors to have an understanding of the relationship between social, academic, cultural capital, and educational attainment.

Consistent with Liu et al. (2004), Sue and Sue (2003) suggested that when counselors neglect the complex relationship between educational attainment and socioeconomic status, they ultimately deny the importance of social class, power, and privilege. Thus, Liu et al. (2004) urged counselors to have an understanding of how the upward mobility myth and protestant work ethic in educational institutions exacerbates classism and complicates the process of counseling for individuals from lower social classes.

Health Care

Burns et al. (1995) discovered a parallel between poverty and higher incidence of mental health disorders, severe mental health symptoms, depression, and poor self-care. Even Rice (2001) noted limited access to health care played a prominent role in mental and physical illness, preventative care, and stable employment. Consistent with Rice (2001), the Surgeon General's report on mental health indicated that because of a lack of health coverage, the needs of lower social class groups are largely unfulfilled. This research appears to indicate that health care reinforces the inequities of education, income, and social class.

Access to health care greatly depends on the market availability of a higher paying occupation to an individual, and the attainment of a higher paying vocation greatly depends on one's educational achievement and health. To address the unequal distribution of health care, Gonzalez (2005) recommended mental health professionals advocate and lobby for school-based mental health services and for the improvement of Medicaid and Medicare managed care. ACA Code of Ethics (2005) urges counselors to offer pro bono services to clients and to use bartering if deemed appropriate. Thus, at both a micro and macro level, counselors are encouraged to engage in an aspirational level of professional responsibility and social justice activities that will improve the lives of individuals affected by poverty.

ACT: A Model for Advocating for Clients Affected by Poverty

The amelioration of social problems inherent in poverty requires policies that distribute liberty, income, wealth, and opportunity equally (Rawls, 1999). With increased attention to diversity and multicultural competence in the counseling profession, counselors are in a unique position to engage in social justice activities that enhance equality for all individuals in society. Numerous writers (Sue & Sue, 2003; Baggerly, 2006, Constantine, Hage, Kindaichi, & Bryant,

2007) have encouraged counselors to extend the scope of their influence beyond a micro-level focus by attending to the social and cultural contexts that significantly influence client welfare. Constantine et al. (2007) asserted counselors can engage in social advocacy by becoming knowledgeable of diverse cultures and the avenues through which values transmit oppression and discrimination. Particularly, counselors can use the ACT model to serve as agents of change at the macro-level and to promote social justice for individuals affected by poverty.

Assess Beliefs and Experiences Regarding Class Issues

The first step counselors can take when they are advocating for economically disadvantaged clients is to assess their own beliefs and experiences regarding class issues. The American Counseling Association Code of Ethics (2005) and Sue et al. (1992) remind counselors to have awareness of their beliefs and emphasize the importance of integrating issues of multiculturalism. Counselors can strengthen their awareness of social class issues by engaging in peer and triadic supervision (Gatmon, Jackson, Koshkarian, & Martos-Perry, 2001). Through supervision experiences, counselors and supervisors could discuss the similarities and differences in their social class experiences and discuss how their experiences affect the supervisory relationship (Ancis & Ladany, 2001). Counselors and supervisors can also address how social class differences and similarities affect helping relationships (Ancis & Ladany, 2001). The following questions may promote awareness of group membership and class beliefs and values among developing counselors.

What social class group did you belong to as a child?

What social class group do you belong to currently?

What are the causes of poverty?

How do people find themselves in impoverished conditions?

Do you believe people can change their social class group easily?

What must one do to change their social class status?

After counselors have acknowledged and processed their feelings of social class issues, they may begin to assist clients in uncovering how their experiences of perceived discrimination and classism affect their sense of worth and worldview (Liu & Arguello, 2006). During initial interviews, counselors can elicit clients' access to community resources and help them explore how community organizations impede or assist their state of functioning (Brown, 2002). Counselors can use this information to work "toward organizational change in the service system" (Frankel & Frankel, 2006; p. 57).

Collaborate with Community Members

Constantine et al. (2007) indicated counselors can minimize the effects of discrimination and oppression against individuals from lower social classes, including poverty, by engaging in community collaboration. In the 2005 revision of the *ACA Ethical Code*, the title of section A.1.d was changed from "Family Involvement" to "Support Network Involvement," indicating a responsibility for counselors to collaborate with any individual or organization involved in a client's well-being (Kocet, 2006). Counselors and counselor educators can engage in community collaboration by working closely with professionals from service systems, institutions, and organizations. Specifically, counselors can facilitate awareness of class bias and address class

barriers by conducting psycho-educational group seminars, workshops, and trainings (Frankel & Frankel, 2006). By engaging in this form of collaboration, counselors assist professionals in understanding oppressive beliefs about and highlight how a community benefits from skills and life experiences of economically disadvantaged individuals (Frankel & Frankel, 2006)

Another important facet of community collaboration is service-learning. Counselors and counselor educators can play a powerful role in poverty-inflicted neighborhoods by engaging in service-learning (Constantine et al., 2007). Through service-learning, which integrates volunteer community service and reflection, counselors and counselor educators not only positively influence the impoverished neighborhood but also enhance multicultural competency (Baggerly, 2006). Burnet et al. (2004) and Hagan (2004), who found service-learning activities increased multicultural counseling competency among graduate level counseling students, supported this theory. Baggerly (2006) also indicated service-learning provides opportunities to serve individuals who have limited access to resources, and through the process, counselors can learn about the rich complexity of cultures that differ from their own. Although the research on service-learning in the counseling literature focuses solely on graduate student work, it is likely that all counselors would benefit greatly from volunteer learning experiences that enhance multicultural competency.

Target Areas that Strengthen Client Capital

Scholars have suggested social and cultural capital influences one's academic achievement (Moschetti & Hudley, 2008), sense of belonging (Tramonte & Willms, 2010) and personal well-being (Kim & Kim, 2009). Increased social capital processes aimed at targeting the accumulation of networks and relationships between individuals, industries, and institutions tend to lead to increased educational attainment (Tramonte & Willms), employment (Stokes, Stacey & Lake, 2006), and community partnerships (Stokes et al., 2006). By assessing client's social capital, counselors and clients can devise strategies for increasing the quality and quantity of client's networks and partnerships. Counselors and clients can also focus on specific skills that enhance social capital, including engaging in new activities and establishing new networks.

Another important capital for counselors to address is cultural capital. Bourdieu (1986) defined cultural capital as the collection of knowledge and skills, and further proposed that individuals acquire cultural assets through acculturation. Accumulation of cultural capital tends to influence one's procurement of resources and affects occupation, education, and wealth (Stokes et al., 2006; Lee & Bowen, 2006). By discussing client's cultural capital, counselors and clients can discuss strategies for navigating novel social arrangements and structures. Specifically, counselors may need to provide information pertaining to standards within social structures and connect clients with resources that enhance their cultural capital (Stokes et al., 2006). For example, counselors working with adolescent clients affected by poverty may need to provide information pertaining to college preparation, including how to traverse the educational system and access SAT preparation courses. By addressing social and cultural capital in counseling, counselors and clients may begin to break through invisible barriers perpetuating social inequalities. Further, counselors can use the ACT model to not only expand their professional capacity, but also gain a greater understanding of the social and cultural constructs influencing the well-being of individuals living in poverty.

Conclusion

Poverty is a social problem influenced greatly by dominant ideologies and structural barriers. In working with clients affected by poverty, competent counselors are ethically and professionally encouraged to understand their own worldview and how their values may transmit oppression and discrimination. With the numerous challenges presented to individuals living in impoverished conditions, counselors are in a unique position to act as social justice change agents through community collaboration, service-learning, and social policy involvement. Ultimately, counselors can enhance the lives of individuals from lower social groups by focusing not only on individual change but also societal transformation.

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A RUBRIC FOR USE IN TRAINING AND EVALUATING EMPATHY SKILLS

VALLERY COATS

This study evaluated the usefulness of a definitional rubric for cognitive, affective, and interpersonal dimensions of empathy. Undergraduate students in 14 sections of a course in Interpersonal Effectiveness across campuses of a national university participated: 95 students received an empathy training video, and 68 received the usual course material with discussions on empathy. Students were pretested and posttested on empathy skills using a definitional rubric for empathy skills developed for this study. Results showed significant improvements on all dimensions of empathy scores for the video training group ($p < .0001$), but significant improvement ($p < .01$) only on interpersonal empathy skills among the control group. The usefulness of the rubric and related training procedures for empathy skills is discussed.

After many years of controversy regarding how to define and operationalize empathy, researchers have largely moved to a multidimensional view that incorporates affective, cognitive, and interpersonal elements. Watson (2001) stated that 60 years of research has consistently demonstrated empathy as the most powerful determinant of client progress in therapy. According to Watson (2001), when empathy is operating on the cognitive, affective, and interpersonal levels, it is one of the most powerful tools counselors have at their disposal.

Rogers (1975) defined empathy as the ability to accurately perceive the internal frames of reference of clients and then to accurately communicate those feelings back to them. Rogers (1975) saw empathy as involving key abilities: the ability to see the world through others' eyes; to be sensitive to clients' changing felt meanings whether clients are afraid, angry, tender, or confused; to be able to sense their pain and perceive the source of their feelings including their cognitive meanings and their emotional or affective components. Rogers (1975) further challenged practitioners to courageously enter the private interpersonal world of the client's perceptions and become comfortable there without losing one's self.

THE THREE ASPECTS OF EMPATHY

Cognitive empathy

Part of the empathy skill requires the capacity to understand the client's view of the world. Mead (1934) suggested this was done through the process of cognitive role taking. Rogers (1957) suggested this was done by imagining. For example, if clients are discussing intellectually complex material it would be important for counselors to track the clients' verbalizations in order to determine the empathic response. Clients who are explaining complicated intellectual material may benefit from the validation of counselors who are able to empathize with this complex, cognitive process. Examples of this may be clients who need to explain complex procedures they do at their jobs, intricate sequences of events, or complicated medical procedures they have to undergo. Clients may benefit from knowing that counselors have the intellectual capability and interest to help them through these complex events.

Affective empathy

Another aspect of empathy requires that counselors have the capacity to imagine what clients are feeling and the ability to reflect these feelings and emotions back to clients in an accurate way. For example, if clients are expressing a highly charged emotional issue, it would

be important for counselors to carefully watch and listen to clients' verbal and non-verbal communication in order to formulate an appropriate affective empathic response. Clients in an emotional state may benefit from the empathy skills of counselors who are able to sit with this affect and not rush to solve or deflect from their feelings.

Interpersonal empathy

The final aspect of empathy refers to the ability to help clients feel safe, supported, and heard; this is done through interpersonal empathy. Watson (2001) wrote that this sense of safety enables clients to focus on their concerns within the session. There are times during a session when clients may simply need to be shown human kindness. Examples of this might be having awareness of clients' state and reflecting that understanding back to them, paying attention to their needs as a host, and offering kind, supportive gestures. Counselors can also communicate interpersonal empathy non-verbally by showing a concerned look, leaning forward, being attentive, maintaining direct eye contact, and being quiet so their clients can talk.

TRAINING OTHERS IN EMPATHY SKILLS

Even though empathy is seen as a vital skill for professional counselors, there are several problems related to the teaching of empathy for counselors in training such as having broad and numerous definitions of empathy (Bodenhorn and Starkey, 2005; Bohart, Elliott, Greenberg, & Watson, 2002; Davis, 1994; Encina, 2007; Hoffman, 2000; Hojat, Mangione, Nasca, Rattner, Erdmann, Gonnella, & Magee, 2002; Ivey and Ivey, 2003; Markakis, Frankel, Beckman, & Suchman, 1999; Watson, 2001), empathy skills being embedded in course readings (such as Corey, 2009) rather than directly demonstrated and honed in counseling or psychology programs (e.g., Acme University, 2007), and accreditation bodies requiring specific skill sets which include empathy (e.g., related to helping relationships and multicultural counseling), but do not address the manner in which this content should be taught (Council for Accreditation of Counseling and Related Educational Programs, CACREP, 2009).

Purpose of the Current Project

This project sought to develop a rubric to aid in the definition, evaluation, and training of empathy skills. It was hypothesized that a focused, rubric-based training procedure for empathy would result in greater gains in empathy skills, as measured by a standardized, rubric-related assessment tool, than more traditional embedded classroom training techniques.

METHODS

Participants

The 163 participants in this study were undergraduate students enrolled in a course in Interpersonal Effectiveness, an eight-week class that is required for Psychology and Business majors during their first semester after enrollment at the host university, a large, private university. The groups were randomly selected from the 25 sections that were being conducted at the same time across the multi-state system of campuses. Undergraduates were selected instead of graduate students to reduce the probability of previous training specific to empathy skills.

Participants were primarily female (89%), white (63%; 13% non-white Hispanic; 13% Hispanic; 13% African American; 3% Asian American; < 1% Native American), and ranged in age from 18-55 years, per the instructors' estimates (the majority of undergraduates at this institution are 25 years or older, with a median age in the mid-thirties; Acme University, 2007). The majority (90%) had some college experience prior to this class with 7% completing an Associate's degree. Each class had a range of 4 to 18 students in attendance the week of the procedure. Classes were located in 14 different campuses.

Instrumentation

For this study, empathy was defined as the ability of the counselor to imagine what the client is going through as if it were happening to the counselor and the ability to reflect this knowledge back to the client in an accurate way. General empathy was further conceptualized as incorporating three elements or dimensions: cognitive, affective, and interpersonal.

Definitional rubric for empathy

The initial task was to develop a rubric for identifying and clarifying the characteristics of the levels of empathy competencies for each of the three dimensions. Three levels of competencies were identified: unskilled, becoming proficient, and advanced. Using a revised version of Bloom's classic taxonomy, descriptions were developed by the author for each of the nine combinations of empathy dimensions and levels of competition (Anderson & Krathwohl, 2001). Scoring procedures were as follows: unskilled responses were given no points; responses in the "becoming proficient" category were given one point; and "advanced" quality responses were given two points. Scores that did not match the full criteria for any category were given a half point. Therefore, the lowest score on the measure would be zero and the highest score would be six.

Training lecture material

Instructional material was written to provide a lecture which would describe and give examples of each of the three dimensions of empathy. The content was designed to parallel the model used in the rubric to evaluate empathy skills. This material would be presented in the training video to be employed in this study.

Content validity checks for the rubric and lecture

The empathy rubric and the subsequent lecture material were sent to seven subject matter experts (SMEs) in the field of counseling, social work, and psychology. All found the material to be clinically sound, but also offered comments and suggestions they felt would make the content have more depth or be clearer to understand. After studying these SME responses, the following changes were made to the training module materials: the word "synthesize" was added to the rubric because it better conveyed the researcher's definition of competency with cognitive empathy, and the word "track" replaced "active listening" as a more precise descriptor in the rubric. Minor adjustments were made to the wordings in both materials to incorporate these suggestions. The final rubric for empathy skills is presented in Table 1.

Empathy skills assessment (ESA)

The task developed to assess empathy skills consisted of a questionnaire which presented three client vignettes. One version was for the pretest and a very similar version was used for the post-test. Respondents were instructed to read each vignette and to write their responses with the direction, "Please give your empathic response to this client." The materials were constructed so that each scenario primarily focused on cognitive, affective, or interpersonal dimensions of empathy.

Cognitive skills

The first vignette depicted clients who were presented with a complex problem at their place of employment.

Pretest: "I'm pretty overwhelmed, but excited. I may land this big contract with Acme Manufacturing, but first they would want me to help them figure out how to modify their work stations to accommodate the addition of an experimental platinum powder coating process for their anemometer brackets."

Posttest: "I just got a call this morning from the president of Acme Laboratories, and my head is just spinning about the whole thing. I might get hired by Acme to lead their bio team, but I have to get all the literature together to explain to them in technical terms that there are correlations between whorl depth of healthcare workers and the increase of nosocomial infections."

Affective skills

These vignettes depicted clients who were experiencing a painful loss due to death of a beloved pet or a close family member.

Pretest: "I'm feeling very sad and tired and unfocused today. I've been crying off and on since yesterday because I had to put my dog to sleep. He was like a child to me. I'm just so sad."

Posttest: "I've never felt this sad and lonely. My husband was my world, my everything. I just don't know what I'm going to do without him. I feel so lost."

Interpersonal skills

The interpersonal scenarios depicted clients who have arrived late for their appointments after an extremely hectic day along with a series of stressful events such as heavy traffic or car trouble.

Pretest: "I am lucky to only be 3 minutes late! I squeezed in a quick workout at the gym, but then got stuck in traffic, and I'm running low on gas, but I didn't want to take the time to stop. I had no water in the car with me, and my cell phone battery died so I couldn't call you. I'm a bit frazzled."

Posttest: "You wouldn't believe how hectic it's been this afternoon. My boss called a noon meeting I couldn't get out of so I've had no lunch. When I got to my car I noticed my back tire was almost flat so I had to stop to put air in it. I got six voice mails and four text messages on the drive over here, but the traffic was so crazy I couldn't even check who sent them. I'm completely stressed!"

Discriminant validity check for empathy skills assessment and scoring rubric.

In order to evaluate whether the empathy assessment tool and the scoring rubric were valid for discriminating actual level of empathy skills, the materials were pretested on samples presumed to represent different levels of empathy skills based on varying levels of professional training and experience: 11 undergraduate students enrolled in a beginning psychology course; 12 graduate students enrolled in a group counseling course; and seven licensed professionals in private practice in the community. If the assessment tool truly measures empathy skills, it was predicted the licensed professionals would have the highest quality of empathic responses followed by the graduate students, and then the undergraduates. The researcher, who was blind to the participants' training and experience, scored these initial pretests using the rubric.

A one-way analysis of variance (ANOVA) compared the empathy skill scores across the three groups. As predicted, the overall total empathy scores varied significantly across the three groups ($F(2,27) = 7.07, p < .005$). Post hoc testing using Tukey's Honestly Significant Difference test (Gravetter and Wallnau, 2008) indicated the total scores for the undergraduates ($M = 2.2, SD = 1.33$) were significantly lower than the other groups, and the scores of the graduate students ($M = 3.9, SD = 1.2$) were significantly lower than those of the licensed counseling professionals ($M = 4.3, SD = 1.47; p < .01$). Scores across the professional ($M = 1.50, SD = .41$), graduate ($M = 1.4, SD = .56$), and undergraduate ($M = 1.0, SD = .42$) groups also differed significantly on cognitive empathy skills ($F(2,27) = 12.11, p < .0001$). However, post hoc tests indicated the difference between the cognitive empathy scores for graduate students and professionals was not statistically significant. Scores were also in the predicted direction on the other two dimensions of empathy, although the differences were not significant. On affective empathy skills, undergraduates scored lowest ($M = 1.0, SD = .63$), graduate students in the middle ($M = 1.4, SD = .56$), and professionals highest ($M = 1.57, SD = .53; F(2,27) = 2.4, n.s.$), and similarly on interpersonal skills (undergraduates: $M = .7, SD = .75$; graduate students: $M = 1.1, SD = .43$; professionals: $M = 1.21, SD = .70; F(2,27) = 1.79, n.s.$).

Empathy training video.

This study employed a training video to ensure consistency across the experimental classrooms. The author presented information contained in the lecture transcript in an informal format. The video was 20 minutes in length and did not include actors or actual clients. It was filmed in the researcher's office using one digital camera. A media professional later added the visual text overlays after the video was recorded. The overall quality of the video was good and was evaluated as part of the manipulation check for this study. Once complete, the video was stored on a private professional website to ensure easy access and minimize technical problems for the instructors.

Manipulation check.

A questionnaire was developed to be completed by those in the experimental condition who viewed the training video. This questionnaire presented five questions with a Likert-type rating scale (1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent) and five open-ended questions to inquire about the student's evaluations of the training. Instructions were: "You have just viewed an empathy training that is being evaluated for a doctoral dissertation. Please complete this short survey to give your honest opinions about the training. Circle the answer that most describes your opinion. Your answers will be kept anonymous." The first four quantitative

items asked them to rate how “helpful” the training was in teaching them about “empathy,” “cognitive empathy,” “interpersonal empathy,” and “affective empathy,” and the final item asked them, “After watching this training how would you rate the improvement in your overall empathy skills?” The open-ended questions asked what they liked most about the training, liked least about the training, and for suggestions about improving the training.

Procedure

As the purpose of this study was to evaluate the effectiveness of a standardized training tool for empathy skills, groups of students attending the same course were divided into two experimental conditions: those who received the video training exercise and those who received the usual curriculum content presented by their classroom instructors. The specific class meeting selected was week four of the standardized curriculum, which focused on discussing empathy in the context of interpersonal effectiveness.

Classroom implementation.

After receiving permission from the university's Institutional Review Board, letters of inquiry were sent via email to 19 campuses across the multi-state system to identify instructors of the Interpersonal Effectiveness class who were willing to participate in the study. In total, seven classrooms were randomly assigned to be experimental groups, and seven classrooms served as control groups. Instructions for the pretest and posttest were forwarded to all instructors, and those in the experimental condition received additional instructions regarding the use of the training videotape. Those in the control condition were given specific directions to help them present information and gather signed copies for informed consent, administer the pretest version of the assessment of empathy skills, conduct their class meeting as usual, and then administer the posttest version of the assessment. Those in the experimental condition were instructed to use the same procedures to present information and to gather signed copies for informed consent, administer the pretest, present the training video, and then administer the posttest. After completing the posttest on empathy skills, those in the experimental condition also completed the manipulation check questionnaire. All classrooms in the study had internet access and audio visual equipment that made this process possible. The link to the training video, which was only live during the study, was included in the instruction sheet. All experimental group instructors were able to access the video without difficulty for presentation to the class. Prior to the administration dates, the instructors in both conditions were not aware of the contents of the empathy skills assessment tool or of the video. The activities in both conditions took approximately 50 minutes. Instructors gathered and mailed the completed assessment materials to the author immediately following the classroom procedures. Instructors also completed a brief demographic report form to describe the number of males and females, the general age range, race classifications, and previous education completed by students in the class.

Scoring the empathy skills assessment (ESA)

To minimize bias in the scoring, two independent raters were selected and trained by the author to aid in scoring the pre- and post-test ESA responses. During the initial training, raters were provided with an overview of the study, an explanation of the empathy training module, and an instruction on how to score the tests. After the training, raters, along with the researcher, scored a randomly selected sample of 15 pre- and posttests to help determine interrater

reliability. Following the protocol for use of the rubric developed for this study, responses that met the criteria as “unskilled” were given no points; responses in the “becoming proficient” category were given 0.5, 1, or 1.5 points, depending on the number of criteria met for that category; and “advanced” quality responses were given two points. Therefore, the lowest total score possible on an ESA administration was zero and the highest score was six. The three raters’ scores from the 15 sample pre- and posttests ESAs were evaluated for interrater reliability using two methods, Spearman-Brown correction and Krippendorff’s alpha. The Spearman-Brown correction (Whiston, 2008) evaluated the average measure intraclass correlation for the split-half reliabilities and resulted in an acceptable interrater coefficient of .935. Similarly, Krippendorff’s alpha, a preferred statistic for intercoding reliability for content analysis (Lombard, Snyder-Duch, & Bracken, 2010), was calculated and resulted in an acceptable value of .90. The raters proceeded to score all participants’ pre- and posttest responses. Differences were resolved through mutual agreement.

RESULTS

The purpose of this study was to compare the relative impact of a rubric-based training video on the training of empathy skills. It was predicted that watching the rubric-based training video would lead to an increase in empathy skills relative to the group which did not receive the rubric-based training video, but did attend the “training as usual” style of classroom discussion.

In order to evaluate this prediction, scores were calculated for both the group pre- and posttest administrations of the ESA. Scores of interest were the total empathy skills score as well as the scores for each of the sub dimensions: cognitive, affective, and interpersonal empathy skills. Overall, group pretest and posttest scores were used for analysis because information returned to the researcher did not allow for evaluation of change in the scores collected for each participant.

After data were evaluated to ensure that they met assumptions for use of parametric statistical analysis, student t-tests for independent means were performed to compare the experimental and control groups’ ESA scores on both pretest and posttest administrations of the empathy assessment tool. Results are shown in Table 2.

First, it was noted that the experimental and control groups did not differ in their empathy skills, as measured by ESA scores, prior to any class activities; however, marked differences were noted after the introduction of the rubric-based training video. The experimental group’s total ESA posttest score ($M = 3.51$, $SD = 1.53$) was significantly higher than that of the control group ($M = .68$, $SD = .68$; $p < .0001$). Similar between-group findings were observed for each of the three ESA sub dimension scores where the group receiving the video training had significantly higher posttest scores than those in the control group (see Table 2).

As would be expected from the previous analyses, posttest ESA scores were significantly higher than pretest ESA scores for the total ESA scores and on each of the sub dimension scores ($p < .000$ on all comparisons). Interestingly, there was one sub dimension of ESA scores where those who received the standard classroom discussion improved significantly. Although much less of a change than that observed among the experimental group, those in the control group showed a significant improvement in their knowledge on interpersonal empathy skills ($p < .01$).

Manipulation check

Seventy-five of 95 participants in the experimental group returned the survey given after

the posttest. In general, responses indicated 44% of these students described that their empathy skills improved due to watching the video while the remainder reported no change. Other comments indicated a general appreciation of the video, with some suggestions made regarding production elements. As mentioned, the production quality of the training video was adequate, but it was not professionally made and therefore the participant suggestions were accurate and appreciated for future videos. These suggestions included ways to improve the video through better quality sound and lighting, more graphics, and the use of actors in addition to the speaker.

Conclusions

This study demonstrated support for the hypothesis that a focused, rubric-directed training procedure for empathy will result in greater gains in empathy skills than more traditional embedded classroom training techniques, as measured by a standardized. An analysis of the posttest responses presented data that showed participants gaining knowledge of cognitive, affective, and interpersonal levels of empathy.

Overall, the results indicated that entry level students were deficient in cognitive, affective, and interpersonal empathy skills, but can gain informational knowledge in all three dimensions when presented appropriate content in a videotaped lecture without actual interactional exercises. Interestingly, those who received the more traditional classroom presentation and discussion showed advancement only in knowledge regarding interpersonal empathy skills. This suggests that a more traditional in-class approach may lack proper attention to the knowledge of cognitive and affective elements of empathy.

Although not studied specifically in this research, it would be suggested that live exercises, including student dyad work, instructor-student dyad work, and empathy skill activities in a live classroom laboratory group could be a highly useful, adjunctive training element to this focused lecture material. With much of undergraduate and graduate training in academia, including counseling, being completed via distance education and online coursework (Allen & Seaman, 2003), a rubric-based training video, such as the one used in this study, could enhance basic foundational knowledge in empathy skills, which could then be expanded in the student's practicum experiences. The rubric can also be very useful to those who develop course objectives and content or supervise trainees whereas the assessment tool used in this study may provide a model for evaluation.

Implications for Further Study

Since the experimental group took the pretest, watched the video, and took the posttest all within an hour, it is difficult to know if these gains in empathy skills will endure. A follow up study could help determine this by offering a second posttest at a later point in the course or thereafter.

Given that the demographic profile for this study was fairly limited, future studies should include a more diverse population. Future research studies could evaluate the empathy training module in a variety of training settings, such as counseling programs and medical schools, as well as those for chaplains or religious leaders, educators, and other professional groups.

It might be beneficial to conduct an expanded qualitative study of empathic responses to various scenarios by those who are at various levels of training and expertise. The contents of these responses could be analyzed for categories or themes and coded in order to provide even more information for refining and modifying the skill definitions in the rubric.

Further research should also focus on translating rubric-based training in empathy into training curriculum and activities, including course materials, training activities, and evaluation procedures. As Rogers (1975) suggested, empathy should be measured from the client's perspective. Future studies should measure empathy skills as perceived by an actual client. The logistics of this type of research are obviously more complicated due to legal and ethical implications, but may contain a wealth of information from the client's perspective.

Finally, the results of this study offer insights into the "empathy" styles that new trainees bring with them. For example, many participants in their pretest responses wished the client good luck or affirmed their belief in the client's abilities whereas others offered clichés and platitudes or expressed sympathy towards the client. Even though these were likely meant to comfort the client, they do not necessarily reflect the client's perspective or demonstrate an attempt to imagine what the client is feeling. This information can help counselor educators and curriculum planners identify patterns to address in their training activities. Overall, this study provided support for continuing to develop and to refine a theory-based rubric for defining and assessing empathy skills as well as for improving training activities that follow from this kind of systematic rubric-based approach.

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ABOUT THE AUTHOR

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Table 1

Author Empathy Skills Rubric

Criteria	Unskilled	Becoming Proficient	Advanced
Cognitive	Does not track or acknowledge	Validates content with own words	Validates using clients words
Empathy	<p>complex content</p> <p>Does not ask client to clarify</p> <p>Wordy, disorganized comments</p> <p>Identifies with client "same thing happened to me"</p> <p>Rush to problem solve</p>	<p>Attempts to clarify by guessing rather than asking client</p> <p>Comments are clearer wordy</p> <p>Relates things back to self e.g., "I knew someone who does that"</p> <p>Identifies problem for client</p>	<p>Clarifies words/topics; asks client</p> <p>Differentiated; tracks client's issue without reference to self</p> <p>Brevity of words to make point</p> <p>Inquires what is important to client and synthesizes comments</p>

<p>Affective Empathy</p>	<p>Does not track client feelings</p> <p>“What kind of dog was he?”</p> <p>Rush to fix it “Have you thought about getting a new dog?”</p> <p>Over identify: “When my dog died... I understand how you feel”</p> <p>Uncomfortable: “Don’t cry. It’ll be okay” (or changes subject).</p> <p>Optimism: “Look on the bright side or At least he’s not in pain”</p>	<p>Tracks feelings but uses own words</p> <p>“You must feel lonely”</p> <p>Tracks feelings but generalizes or tries to fix or advise: “You’ll feel better in time or Take some time off work or It would probably help you to do a grief ceremony”</p> <p>Tracks feelings but minimizes: “You must be less sad than yesterday”</p>	<p>Tracks feelings using the client’s words “I’m sorry for your loss. I can [see, hear] how sad you are.”</p> <p>Sits with client’s feelings</p> <p>Is differentiated “Fido was a member of your family”</p> <p>Reflects level of [sadness] back to client</p> <p>Validates “If I were in your shoes...it’s understandable...”</p>
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<p>Interpersonal Empathy</p>	<p>Skips over/ignores client needs Unaware client is stressed; begins with topic of counselor choice Makes it about self "I always just take Route 51, it's faster" Problem solve, directive, or blame "You need to allow more time"</p>	<p>Attempts to validate; rushes "Well at least you're here" Hears but minimizes or jokes "That's rush hour for you!" Hears but identifies with client "The same thing happened to me" Attempts to help "Do we need to change your schedule?"</p>	<p>Aware of client state; reflects what client has been through Differentiated; flows with client's need in client's words Attentive to client's needs, offers kind, supportive gestures as a host Reflects state and offers positive, supportive words, gestures.</p>
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Table 2

Pretest and Posttest Empathy Scores for Experimental and Control Groups

Empathy Dimension	Pretest Score		Posttest Score		Pretest-Posttest t-value (Pre-Post)			
	N	Mean	SD	N	Mean	SD		
Cognitive	Experimental Group	95	0.21	0.29	95	1.19	0.63	$t(188) = -13.87, p < .0001$
	Control Group	68	0.18	0.27	68	0.17	0.25	$t(134) = 1.31, n.s.$
	Between-Group t-value	$t(161) = -.76, n.s.$			$t(161) = 12.65, p < 0.0001$			
Affective	Experimental Group	95	0.33	0.42	95	1.08	0.6	$t(188) = -10.15, p < .0001$
	Control Group	68	0.36	0.4	68	0.24	0.33	$t(134) = 1.86, n.s.$
	Between-Group t-value	$t(161) = .44, n.s.$			$t(161) = 10.46, p < 0.0001$			
Interpersonal	Experimental Group	95	0.19	0.41	95	1.23	0.68	$t(188) = -12.77, p < .0001$
	Control Group	68	0.11	0.26	68	0.26	0.38	$t(134) = -2.78, p < .01$
	Between-Group t-value	$t(161) = -1.41, n.s.$			$t(161) = 19.35, p < 0.0001$			
Total Empathy Scores	Experimental Group	95	0.73	0.81	95	3.51	1.53	$t(188) = -15.68, p < .0001$
	Control Group	68	0.65	0.66	68	0.68	.68	$t(134) = -.27, n.s.$
	Between-Group t-value	$t(161) = -.71, n.s.$			$t(161) = 18.33, p < .0001$			

n.s.