VOLUME 33
NUMBER 1
AUGUST 2005

DIMENSIONS of COUNSELING

Research
Theory
&
Practice

Journal of the Michigan Counseling Association

Dimensions of Counseling: Research, Theory and Practice

Vol. 33 • No. 1 • August 2005

Michigan Counseling Association
530 West Ionia, Suite C, Lansing, Michigan 48933
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Articles

Dimensions in Counseling: Research, Theory and Practice (ISSN # 1533-2438) is published biannually by the Michigan Counseling Association, a state branch of the American Counseling Association, 5999 Stephenson Avenue, Alexandria, VA 22304. MCA members receive the journal as a benefit of membership.

From the Editorial Desk

Erin Radtka, M.A., LLPC
Editor

From the Editorial Desk:

This is my first issue of the journal as sole editor, and it has been a pleasure to work with the authors and the review board to choose and polish the best of our submissions for this summer edition. All of the articles in this issue offer strong implications for the counseling profession, particularly in terms of counselor education.

Arnold Coven, Katherine Van Hull, Stacey Yaklitch, Kahdija Ali, and Jina Enwiya offer some practical active approaches for facilitating a group for persons with Traumatic Brain Injury (TBI). The article also calls for counselors to be adequately trained and prepared to counsel clients with a variety of disabilities.

The second article, submitted by Dr. Jeremy Linton, compares and contrasts a number of training models for group supervision. He offers the strengths and the limitations of these various models, and a synthesis of what would seem to work best when supervising counselors-in-training. This topic of counselor supervision is especially important as Michigan begins its requirements for the training of counselor supervisors.

Finally, Dr. Robbie Steward, Dr. Robin Powers, and Dr. Hanik Jo explore demographic and cultural factors that affect and individual's ability to express empathy. Their findings suggest that these variables need further investigation, and that interventions relating to these variables should be incorporated into counselor training programs.

Erin Radtka, M.A., LLPC, is a school counselor at Belleville High School and is the current Editor of Dimensions of Counseling: Research, Theory and Practice.

Editorial Review Board 2004–2006

MCA GUIDELINES FOR AUTHORS

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Reviews: These articles consist of reviews of current books, appraisal instruments and other resources of interest to counselors. They should not exceed 600 words.

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The Use of Active Group Interventions with Persons with Traumatic Brain Injury

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Counselors are continually challenged to become more knowledgeable and skilled in assisting persons with disabilities. This article describes group work with persons with Traumatic Brain Injury. Active group interventions were utilized to modify cognitive, affective, and behavioral deficits that affect independent living, vocational adjustment, and interpersonal relationships. The knowledge, skills, and training needed by group counselors in order to use active interventions are identified. The active interventions are discussed in the context of group developmental stages, and key therapeutic factors are illuminated. The experience demonstrated that active group interventions may have potential for persons whose mobility and movement in life have been blocked.

The National Institute of Health Consensus Statement (1998) estimates that 1.5 to 2 million persons per year sustain brain injuries and 70,000 to 90,000 experience long-term loss of functioning. These individuals often seek counseling groups for emotional support, work adjustment difficulties, alcohol and drug abuse issues, and relationship problems. Ben-Yishay et al. (1985) suggested that a small group setting for persons with Traumatic Brain Injury (TBI) can serve as a natural learning environment to restore and refine clients' interpersonal communication skills, such as listening, making eye contact, and increasing empathic abilities. Because of the need for such counseling, counselors need to expand their knowledge of effective group counseling strategies and the special issues posed by clients with traumatic brain injury (TBI).

Corey (2000) and Gladding (2003) point out that group counseling can produce both educational and therapeutic outcomes. Their assumption is that people truly become human through their interactions in groups. Although there is accumulating evidence of the efficacy of group counseling, there is little mention of group counseling for persons with disabilities in several major rehabilitation texts (Gandy, Martin, & Hardy, 1999; Maki & Riggar, 1997; Roessler & Rubin, 1998; Rubin & Roessler 2001). However, chapters on TBI are in medical and psychological aspects of disability texts (Rosenthal & Ricker, 2000; Schwartz, 2002)

A chapter on group counseling with persons with disabilities in a recently published group counseling handbook (DeLucia Waack et. al., 2004), and numerous articles in various journals have appeared on this topic. The Association for Specialists in Group Work (ASGW) devoted an entire journal issue on group counseling with persons with disabilities (1995). Prigatano and Ben-Yishay (1999) indicated that counseling techniques must be modified so that persons with TBI can understand and cope with life in the present. Therefore, the challenge for counselors is to become more knowledgeable and skilled in conducting group counseling with persons with TBI.

The purpose of this article is to explore the use of active interventions in group counseling for persons with TBI by presenting the following: a) The literature describing persons with TBI; b) the potential of group counseling for persons with disabilities, specifically, TBI; c) training, skills, and guidelines for group leaders; d) active interventions that maximize group counseling for persons with TBI; e) setting, participants, and illustrations of active interventions specific to group stages; and f) discussion, recommendations, and conclusions.

Traumatic Brain Injury

Traumatic Brain Injury, as defined by the Brain Injury Association, is an insult to the brain caused by external physical force that may produce a diminished state of consciousness, resulting in an impairment of cognitive abilities or physical functioning. Brain injuries result from various causes, including automobile accidents, falls, gunshots, tumors, and strokes. Males aged 14-24 have the highest incidence, due to risk taking behaviors. The chances of a second brain injury are three times greater for persons who have sustained an initial TBI.

Symptoms of brain injury can be highly diffuse. Fontan, Premuda, Lorenzo, and Quintenos (2002) indicate physical, emotional and cognitive changes post TBI. Some of the physical limitations are difficulty in balance, mental and physical fatigue, persistent headaches and pain, weakness or paralysis on one side of the body, impaired or uncontrollable movements, slower motor speed, and in some persons, seizure activity. Symptoms of brain injury can include depression, agitation, impulsivity, fatigue, passivity, difficulties in concentration, or euphoria with a denial of the effects of traumatic brain injury (Schwartz, 2002).

Cognitively, there can be difficulty in focusing attention, a shortened attention span, and memory loss, such as not remembering new information or keeping track of appointments. In addition, there can be a disturbance in spatial orientation, sensory deficits (e.g., neglect of one side of the visual field), and distorted verbal reasoning, causing difficulty in comprehending conversations. Further, disruption in the sense of time, problematic judgment and ability to make decisions, speech and language difficulties, and especially lack of self-awareness can seriously limit activities that have a cognitive component.

Prigatano and Ben-Yishay (1999) indicate that the major problems of persons with TBI are emotional, motivational, and behavioral. Many have suffered a near death experience which threatens their existence and self-worth (Ben-Yishay et al., 1985). Deficits from the brain injury undermine identity and core sense of self, making it difficult to integrate former self-images with the new self (Schwartz, 2002). Persons with TBI frequently experience impairments in: a) social perception; b) self-regulation; c) ability to express empathy; and d) egocentricity (Forsmann-Falck & Christian, 1989). The cognitive and emotional changes are often invisible to others, whose only indicators of TBI might be any physical changes that occur, but are noticeable to those who have close contact with persons who have TBI (Kay & Lezak, 1990; Prigatano, 1992). Psychosocially, there can be an exaggeration of pre-injury personality characteristics. A survivor can be ego-centric, experience heightened emotional responses, or flat affect; have decreased frustration tolerance, exaggerated impulsivity, lack of initiative, and a significant percentage develop substance abuse disorders (Kreutzer, Witol, & Marwitz, 1996). Epidemiological studies of people with head injuries and cognitive impairments have reported continuing psychosocial problems up to 15 years after the TBI (Livingstone, Brooks, & Bond, 1985).

Kay and Lezak (1990) indicated that limitations are pervasive when there is impaired executive functioning. Frontal lobe damage makes it difficult for individuals to plan and follow through with actions. Further, difficulty in self-monitoring and understanding social situations make them appear unmotivated and disinterested in their vocational rehabilitation and community reintegration. Schwartz (2002) indicated that counseling may not be constructive, because some clients cannot discern pertinent from irrelevant information. Other clients show great insight and understanding, but do not remember

the content of the sessions immediately after the sessions end, which is a challenge for counselors. Fontan et al. (2002) pointed out that if professionals can identify these residual effects, they can then devise interventions that meet the unique needs of persons with TBI.

Group Counseling for Persons with Disabilities

Current interest in counseling for persons with illnesses or disabilities has been stimulated by many studies linking psychosocial factors to positive health outcomes of clients who participated in group counseling. Some experts contend that groups are more effective than individual counseling in producing major changes in coping skills and interpersonal relationships. Persons with disabilities, especially those with newly acquired disabilities, have intense concerns regarding their social functioning. Yalom (1995) contends that interpersonal interaction and learning is crucial in group therapy. He indicates that it helps participants to understand what is missing in their interactions with others, which enables them to change. Promoting interaction and feedback between the members are standard group process techniques, even though they are differentiated from action oriented interventions, such as role-play, behavioral rehearsal, and psychodrama.

The previous exploration of the use of action oriented methods in group counseling for persons with TBI helps show the need for group leaders working with this population to obtain knowledge and understanding of the lives and challenges faced by persons with disabilities. These group examples are congruent with experts' views that leaders need to create a safe environment and remain patient in the face of the slow progress, lack of attendance, and seemingly weak motivation of group members with TBI.

Seligman and Marshak (2004) indicate that although group issues and some procedures may be typical, some themes are unique to people with disabilities. One concern is whether the acquired disability will be permanent, will improve, or will become worse. Another issue is whether clients can accept their disabilities. Besides the threat to their physical well being, doubts about their continued independence, life control, economic self-sufficiency, and relationships are intensified. The goal of group counseling is to help them face these problems to maintain their identity and stability (Falvo, 1999). Group work also enables persons with TBI to deal with emotional issues, particularly the grief associated with their losses. Typically, emotional needs are overlooked because persons with TBI are sometimes perceived as child-like. They struggle with adult emotions and receive little support from significant others.

Group Leaders: Training, Skills, and Guidelines

Training and Skills

Wiener and Oxford (2003) recommend that leaders possess training in psychodynamics, group counseling, and action methods. The first step for leaders is to select members for the group and assess their motivation and commitment for rehabilitation. Pollin (1995) recommends homogeneous groups. When members share a common disability, they experience being an insider with the other members. He suggests that the leader consider the disability type, stage of the disability, condition, age, and gender of the members. Although Pollin recommends embracing homogeneity, Seligman and Marshak (2004) differ, indicating that the personalities of group members are a more critical variable than the disability or stage of rehabilitation.

Stein (1996) indicates a need to modify group counseling techniques for persons with TBI because they experience cognitive and verbal deficits. Seligman and Marshak (2004) identify providing safety as a critical leadership skill due to the traumatic loss experienced by persons who have sustained a brain injury. They also underline the importance of disability knowledge and awareness of the nature of lives of persons with disabilities. Rothenberg (1994) suggests that leaders can promote interaction among the members with TBI by having an individual physically orient toward other group members when they he/she speaking, and then having the other group members echo and repeat back the individual's message. Stein (1996) recommends that the leader summarize regularly and write important themes and messages on the blackboard. Increased structure, along with a problem-solving approach, are needed by those with poor social judgment, and those with TBI who learn concretely. They need help in expressing their perceptions and getting constructive feedback from the other group members. He also recommends regulation of emotional intensity by a graduated, step-like approach.

Wiener and Oxford (2003) contend that counselors can be cross trained to use action methods, thus adding to their repertoire. They indicate that the training is not extensive and can be learned and implemented by group

counselors. Practitioners educate other mental health professionals, because the timing and sequence of action methods takes practice and experience.

Leader Guidelines

Before implementing active methods, leaders are advised to create a group atmosphere in which participants feel safe to take risks. Members who are first to volunteer and share may be the most ready to try an active experiment. Their modeling can encourage the other group members to participate. Group interventions that fit specific group stages, as well as the needs and characteristics of group members, are crucial considerations.

Acting and dialoguing with imagined significant others and physically moving in new ways can be threatening to clients. Clients may find these methods strange and demanding. To reduce anxiety, the leaders can limit beginning experiments to visual imagery or just one experimental behavior before more involved role-play. For example, a group member who states, "I feel tied up in knots" can be encouraged to assume a knot-like physical position (Coven, Ellington, & Van Hull, 1996). The group leader does not know beforehand what will happen when members are asked to role-play. The expectancy has to be open enough to allow expression of the response that emerges (Coven et al., 1977), and the leader must be careful not to judge clients' enactment as right or wrong.

Another guideline is to observe and listen for feelings, thoughts and behaviors that can be enacted. Phrases and metaphors like "I am burdened in life" or "I feel like I have two left feet" have the potential to be acted out. An additional principle is to create physical action and movement. The use of props and room furnishings, like chairs and cushions, can add to the behavioral reality and establish the mood for staging and acting. Room rearrangements help clients learn that it is possible to change the environment to meet one's needs. The group leader can develop the model of how to help members talk about events in the "here and now" (i.e., asking an employer for a job). Members are requested to play the roles as if they are actually happening now to experience the feelings that accompany immediacy. The acting and physical movement can facilitate group members becoming more active in their rehabilitation effort. Another guideline is for members to imagine persons doing an experiment that is opposite to their typical behavior. This approach highlights humans' polar and contradictory tendencies. These active interventions challenge the person to behave in a manner that is new and alters an existing self-perception.

Active Group Interventions

Wiener and Oxford (2003) describe active methods as experiential techniques using physical movement, dramatic expression, and role play that group members engage in with direction from the group leader and group participants. Kipper (1994) believe that active methods approaches of psychodrama, role play, and behavioral rehearsal incorporate counseling activities that emphasize specific, tangible experiences as the basis of interventions. Zinker (1971) postulates that acting well is a rehearsal for living well, and involves the thinking, feeling, and behavior of group members. The assumption is that learning and behavior modification take place more rapidly when the whole person (muscular, sensory, body activity) is involved. Action methods differ from experiential psychotherapy, which typically refers to methods that focus attention and awareness in the "here and now" but do not necessarily involve the physical activity of action methods. The physical movement can mobilize energy, increase excitement, and promote risk taking of group members, reducing their habitual behavior and responses.

Active group counseling methods can help members move from comfortable and familiar behavior to novel ways of interacting and behaving. As a result, new skills, competencies and action insights can be developed (Moreno, 1969). One major advantage of action methods is the engagement of clients who mostly process visually or kinesthetically. The interventions can reduce the emphasis on verbal and intellectual ability, and provide the opportunity to use one's senses. Wiener and Marshak (2003) hypothesize that action methods may facilitate the resolution of psychological trauma and decrease the performance anxiety typically experienced by persons who have sustained a TBI. Operating less at a cognitive level can reduce habitual defenses against the anxiety produced by their impairments. Action techniques can dramatize role relationships and perceptions of others and can lead to new ways of interacting in the safe, supportive group environment. Many counselors believe role-play and practice in group counseling can help a client generalize new behaviors to life in their environment. Thus, active group interventions may have the potential to enable persons with TBI to learn how to modify their behavior and achieve the rehabilitation goals of employment, independent living, and community integration.

Quantitative research substantiating the use of action methods is limited. Even less empirical evidence applying these methods to special populations exists. On the other hand, many case studies and qualitative research have supported the value of action methods (Wiener & Oxford, 2003). The counseling community generally accepts that verbal psychotherapy is not

substantially effective with certain populations. This implies that action methods have some merit and warrant further investigation.

Setting, Participants, and Active Group Methods Specific to Group Stages

Setting and Participants

The participants were outpatients or lived in residencies provided by a rehabilitation center located in Metropolitan Detroit, which provides case and medical management, life care planning, cognitive therapy, and vocational rehabilitation services. The case managers were informed that the group counseling focus would emphasize coping skills, socialization, and vocational issues. They identified 20 clients who might benefit from working on these objectives. Additional criteria were general functioning and ability to relate interpersonally. If the case managers believed the clients would be disruptive, they were rejected as participants. The group leader accepted the case managers' screening judgments. The participants were divided into two groups of 10 each, and 10 sessions were conducted with each group. The male leader, who had 30 years of individual and group counseling experience, was assisted by a female co-leader for each group. One co-leader was a cognitive therapist staff member in the center who had an undergraduate degree in psychology but lacked experience in group counseling. The second co-leader was a doctoral student from the counselor education and rehabilitation counseling department who had group leader experience.

Stages and Illustrations

Groups typically go through four or five developmental stages (Gladding, 2003): Beginning, transitional, working, and termination. For all of the stages, group process has been defined as the interactions of group members as the group develops. Yalom (1995) indicates that process refers to the nature of the relationships between interacting individuals. He identifies 11 factors that are therapeutic in group counseling. Seligman and Marshak (2004) emphasize five of Yalom's therapeutic factors that could be effective with persons with disabilities: a) imparting of information - members and leader sharing information about needed services; b) instillation of hope - members receiving encouragement and recognition for progress from group members; c) universality – members' similarities connect them to one another; they are connected and do not need to define existence by their disability; d) altruism - the effort of group members to increase each others' self-esteem; and e) socialization skills- the interaction of members promoting the development of interpersonal skills.

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Beginning Stage

The leader began the first session by inviting members to share names or nicknames. The members were encouraged to use the pronoun "I" and look and speak directly to the other participants. After a few members had introduced themselves, the leader instructed them to repeat the name of those who had already volunteered. This activity reinforced members' identity and sense of belonging and stimulated interactive functioning (Ben-Yishay et al., 1985). The leader cued the members to use "I" by pointing to his chest. To foster eye contact and direct communication between members, the leader moved his arm in a circular fashion in the direction of all the group members (the name of members have been changed to guarantee anonymity of the participants).

Ivy[1] sat apart from the circle, averted her eyes and did not volunteer. She appeared depressed and distant. When her turn came to introduce herself, she talked proudly about her past job as a flight attendant. As she spoke, her demeanor changed. She became quite animated, and her mood visibly improved. Despite her engagement in this session, she missed subsequent sessions and eventually dropped out. Frank, of Arabic background, was perceived as resistant by the female staff, but was noticeably more self-disclosing to the male leader, which underlines the importance of shared gender leadership. Males who have sustained a disability may perceive their masculinity to be threatened, and can often be defensive with females. It was surprising that Art, who generally isolated himself from everyone else, attended the session. The day before, he had refused to participate, despite substantial encouragement from his case manager.

In summary, members generally shared more information than their names, especially sharing how they sustained their traumatic brain injury. It was interesting that their comments focused on how they functioned before the accident. This could be reflective of the difficult transition they were facing in life.

The participants talked about their general life goals, such as getting a job. One wanted carpentry training, another aspired to become a medical transcriber, and another wanted a job at the rehabilitation center. Several were

unclear about their goals. They tended to be tentative, using the word "maybe," and dwelled on the past. This lack of clarity is typical of the beginning group stage, regardless of whether the members have disabilities. The members expressed lack of confidence in their ability to succeed, which seemed to be the basis for their hesitancy in choosing vocational goals. Several participants recognized that they were unable to return to their previous jobs due to memory, attention, and visual hand coordination difficulties. All of these factors contributed to their uncertainty about present vocational capabilities.

Art attempted to return to printing but failed and nearly injured himself again. Encouraged to continue disclosing, he remembered his successes as a silkscreen printer. Unfortunately his employer went out of business. The leaders emphasized his success.

Common feelings expressed in the beginning stage were depression, sadness, and loss. Ruth especially missed being independent and having control of her life. Her open acknowledgment of loss was contagious as others expressed what they now missed in life. Rachel, a supportive member, expressed that Ruth would tire of crying and would move on with her life. Ruth's difficulty reflected the struggle she and other trainees face to develop a new self-identity and meaning in life. Another group theme was the desire to help each other, which reduced their focus on personal problems. The leaders facilitated intrapersonal and interpersonal sharing to maximize altruism and universality.

Transition Stage

During these sessions, a few members were so sleepy that it was difficult for them to participate and interact in the group. Two members, who exercised daily, advocated that other members visit the nearby fitness center. Although the suggestion was presented in dogmatic fashion, the members seemed open to more physical activity. They liked the leader's suggestion of having an exercise group at the beginning of the day and after lunch. This stimulated one of the first active interventions. The leader encouraged the members to move their legs, accelerate the movement, and loudly voice the phrase "I have to get moving in life." The experiment was concluded by standing and cheering for themselves using their first names. This appeared to mobilize their energy and lift their mood, and underlined the approach of doing the exercise in the here and now, instead of just talking about the fatigue problem. The phrase " . . . moving in life" supported movement toward the rehabilitation goal. The self-cheering reinforced the need to emotionally support themselves. Despite the surge of increased energy and hope, several members continued to be absent from group meetings.

Several group members perceived the medical staff acting as if they did not exist. The medical staff talking directly to the case manager and ignoring the members fostered this perception. The expression of resentment was universal, had cathartic effects, and highlighted the group's growing cohesiveness, a key group therapeutic factor. Members also questioned the leader's motivation. Their trust was somewhat increased when the leader revealed a lack of monetary compensation but a strong desire to learn and share his knowledge. Distrust, resistance, and lethargy are typical reactions of persons with TBI, and of the transitional stage in group counseling (Ben-Yishay et. al., 1985). It is imperative that the leaders remain non-defensive during this "storming" characteristic of the transition stage.

Working Stage

The members were asked to give each other feedback during the working stage. Group experts emphasize how feedback contributes to intrapersonal and interpersonal learning, two additional therapeutic factors identified by Yalom (1995). Positive feedback was shared between two group members who noted each other's progress. John told George that he enjoyed their friendly conversations as roommates, which reflected George's increased sociability. Rachel confronted Errol with her perception that he coasted through life and had the potential to achieve a great deal more. Unfortunately, the challenge and support did not motivate him to seek employment. Ronald appreciated the wisdom of his older roommate, and one participant remarked about a member's "breaking out of his shyness." The co-leaders highlighted the progress they observed in the members. These examples illustrated instillation of hope and altruism.

As the sessions progressed, the active counseling techniques of role play and psychodrama were introduced. Rachel stated she was regressing. She felt trapped in a closet, which confused her. She was willing to do an acting experiment. First, she walked backwards to depict her regression. She then demonstrated where she started at the beginning of her rehabilitation. Next, she walked forward to show the progress she had made, becoming aware that she had not regressed as much as she feared. To portray being in a closet, she placed herself in a corner of the room not visible to the group. She immediately came out, and realized she would not accept being invisible. In the last part of the experiment, she shared one thing she was clear about to each group member. The verbalization of clarity reduced her confusion and frustration, leading to the insight that she had made progress. She was now more motivated to overcome her struggles. Regrettably, the insurance company reduced her benefits, and she was only able to attend the rehabilitation center one day a week. This

environmental reality factor reduced her hope and may have increased member distrust of the rehabilitation staff. She chose the day she could continue to participate in the group.

Jim talked and walked slowly. He showed the group how his left hand and leg were shorter, and contracted, interfering with his dexterity and mobility. The leader, using the Gestalt concept of opposites, asked him to walk at his usual slow gait, and then experiment with walking as fast as he could. The group was amazed at his speed and force in covering the distance in the room. He resembled a speed walker as he triumphantly smiled at the group. The leader suggested that his leg power and energy might have vocational potential, thus emphasizing a new side of his physical self, while simultaneously increasing his self-esteem.

Joe talked about how his life was rapidly snowballing. The snowball was becoming larger, and it represented anger, frustration and confusion. The leader instructed him to imitate the snowball by moving his arms in a rolling fashion with increasing speed. He was able to share with the group one thing that was upsetting and confusing him. The physical movement and verbalization released anger, and increased awareness of being hurt by others. He connected it to being adopted and physically and emotionally abused as a child. Although he was unable to reach out and touch others, he was receptive to group members hugging him. The experiment highlighted the closeness he desperately sought. The group stayed focused on him during this emotional struggle, demonstrating the power of interpersonal interaction and the learning that occurs in a psychodrama.

Throughout the working stage, common themes surfaced. The group members explored their barriers to employment. Several had lost their driver's licenses or did not have an automobile. Lou was afraid to drive, and Sarah questioned her driving judgment, since she had 10 accidents after her TBI. A few had pending lawsuits and perceived work as threatening their financial settlement. Sarah wanted to work but was fearful of losing Medicaid insurance, which financed her $2,000 monthly medication costs. Several expressed appreciation for their rehabilitation center placement, which helped them avoid relapsing into substance abuse.

Active group counseling methods can help members move from comfortable and familiar behavior to novel ways of interacting and behaving. As a result, new skills, competencies and action insights can be developed (Moreno, 1969). One major advantage of action methods is the engagement of clients who mostly process visually or kinesthetically. The interventions can reduce the emphasis on verbal and intellectual ability, and provide the opportunity to use one's senses

The leader noticed that attendance was substantially decreasing in one group and minimally in the second. Several members, with their case manager's assistance, had arranged conflicting appointments with doctors or other therapists. Others were ill or did not show up. In an attempt to identify the reasons for the decrease in attendance and interest, the leader consulted with the staff co-therapist who indicated treatment and training occurred on two different weekdays. Members were reluctant to come to the rehabilitation center an additional day for group counseling. Prigatano and Ben-Yishay (1999) have indicated that persons with TBI typically do not engage in physical, occupational, language therapy or treatment programs aimed at independence and work entry. This reflects the motivational issues that the literature indicates are typical of persons with TBI. Also, the absenteeism may have related to the case managers not understanding the group counseling program. The leader failed to consult with the case managers, a critical component for collaborative treatment in a rehabilitation center.

Closing Stage

During this stage, some participants spontaneously focused on family relationships before and after their accidents. Errol's father abandoned the family and his mother had to care for the seven children. A child assaulted him with a baseball bat in the third grade resulting in his TBI. He eventually abused drugs and alcohol, was placed in several mental hospitals and spent 10 years in jail. He now was interested in janitorial training, and the leader was able to arrange an appropriate referral. Again, he did not follow up on this opportunity.

George's family had been too busy to give him attention and only now recognized him as a person with a disability. Rachel's family moved 27 times. Her mother said she hated her; therefore, she felt ugly and unloved. In a role play experiment, she now responded to her mother with "that's your problem." She no longer tolerated abuse and had learned to stand up for herself. The guideline for the leader's experiment was to give Rachel an opportunity to empower herself in the present. This role play demonstrated Rachel's recapitulation of early family life, another key group therapeutic factor.

During these closing sessions, the leaders were able to give several members positive feedback. Ruth and Ed were praised for their intelligence and verbal fluency. John received recognition for his life and work energy. Lastly, Rachel was commended for her supportive and giving nature. The participants also gave each other feedback and encouragement, especially to Ruth, who mourned her past life. They highlighted her willingness to provide assistance and hope to others.

There was a dramatic change in Art, who said he was waiting to die. He did not venture out and lived like a recluse, due to discomfort with his facial disfigurement. He agreed to receive feedback from the group about his physical appearance. Most thought he had a pleasant face despite his missing eye and small facial disalignment. He verbalized not believing the feedback, but his smile was not congruent. Art concluded the feedback experiment by sharing his positive characteristic of liking people, a sharp contrast to not having an interest in life. The feedback provided the opposing perception, challenged Art's rigid self-view, and increased his appreciation for others. A dramatic discovery was that despite their depression, several believed their accident had helped them become more motivated and caring persons than before the TBI. This may have related to the bonding and support of the group members and the creation of a family atmosphere by the rehabilitation staff.

Recommendations

The need of members to help others seemed related to their near death experiences and subsequent disability, since their appreciation for life and others came up repeatedly in the group sessions. It is recommended that the leader allow the members to respond to each others' sharing of life and problems to maximize altruism and hope. This can strengthen the members' power to be therapeutic and can increase their self-esteem and interpersonal effectiveness. The issues of the members' motivation, low energy, and fatigue seemed intertwined. It was distressing for the leaders when one or two members seemed to be sleeping during the group sessions. Attempts to mobilize energy by increased physical activity did not overcome the lethargy. Daily exercise at the center might help, along with increased center activities. Further, assisting the members to set daily goals might increase motivation. Another technique is for program graduates to visit and share their success. The leader read a story of a successful rehabilitation of a war hero who had sustained a TBI. He was immobilized for two years until he entered a rehabilitation center where psychodrama enabled him to express anger and hurt at his fiancÈ who had abandoned him (Prigatano & Ben-Yishay, 1999). Successful models and bibliotherapy techniques may increase the instillation of hope while promoting the use of psychodrama with group members. Another potentially helpful technique is to conduct the group sessions in job settings, which could reduce the fear of employment.

The previous exploration of the use of action oriented methods in group counseling for persons with TBI helps show the need for group leaders working with this population to obtain knowledge and understanding of the lives and challenges faced by persons with disabilities. These group examples are congruent with experts' views that leaders need to create a safe environment and remain patient in the face of the slow progress, lack of attendance, and seemingly weak motivation of group members with TBI.

The high incidence of absenteeism, fatigue, and slow movement in achieving employment and vocational direction appeared to reflect a lack of engagement in the group process and with the leaders. In retrospect, the group leaders could have arranged individual interviews before the beginning of group sessions. This may have developed stronger relationships with the leaders, which may have increased the engagement of group members and consistent group participation. The action methods and group therapeutic factors appeared to have an impact on but did not increase attendance, engagement, or goal attainment. Ten sessions seemed to be insufficient for persons with TBI, whom experts indicate have persistent social, emotional, and employment difficulties. The promising response by some group members to active interventions underlines the need for empirical testing for the effectiveness of action methods on persons with TBI and other disabilities.

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Ben-Yishay et al. (1985) suggested that a small group setting for persons with Traumatic Brain Injury (TBI) can serve as a natural learning environment to restore and refine clients' interpersonal communication skills, such as listening, making eye contact, and increasing empathic abilities. Because of the need for such counseling, counselors need to expand their knowledge of effective group counseling strategies and the special issues posed by clients with traumatic brain injury (TBI).

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Footnotes

[1] Names of the participants have been changed to ensure anonymity and confidentiality. Written and verbal permission was obtained to use the individual and group illustrations.

Group Supervision: A Review of Practices and Models in Training

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Group supervision is an often used modality of supervision for post-degree and practicing counselors. Despite its wide use, practicing supervisors in the community receive little to no training in group supervision methods and practices. This article is intended to review several key practices and models of group supervision. In total, two practice considerations for forming supervision groups and five models of group supervision are outlined. The article concludes with a brief integration of these models and several suggestions for practice are offered.

Group supervision is a widely used modality of supervision for post-degree counselors seeking licensure as well as experienced practitioners in the field (Altfeld & Bernard, 1997; Borders, 1991; Carroll, 1996; Goodyear & Nelson, 1997; Holloway & Johnston, 1985; Proctor, 2000; Prieto, 1996, 1998; Proctor & Inskipp, 2001; Riva & Cornish, 1995; Stoltenberg, McNeill, & Delworth, 1998). Despite its wide use, few supervisors have received adequate training in group supervision techniques and practices. This lack of training for supervisors is noticeable in community settings where fully-licensed counselors often provide supervision to post-degree practitioners seeking licensure. Because few states have set training requirements for the practice of supervision, virtually any fully-licensed counselor can provide supervision without a demonstrated knowledge or skill set. Much of the supervision provided to post-degree and experienced counselors seems to be conducted in a group format.

The delivery of group supervision services by uninformed, untrained, and perhaps unprepared supervisors is problematic and raises ethical concerns for

the practice of supervision. Untrained or unqualified delivery of group counseling services to clients, for example, would undoubtedly be considered outside the realm of ethical practice. The purpose of this article, therefore, is to introduce practicing supervisors in community settings to several models of group supervision. In total, two considerations for the formation of supervision groups and five models of group supervision are reviewed. This review is not intended to serve as a detailed training in group supervision. Rather, it is anticipated that this brief review will provide a general understanding of several models of group supervision and motivate supervisors to engage in a more detailed exploration of this understudied topic. The article concludes with an integration of these models and several general suggestions for practice are offered.

Considerations for Starting Supervision Groups

Similar to psychotherapy groups, it is important to consider several aspects of group work when forming supervision groups. Bernard and Goodyear (1998) and Locket (2001) have identified the benefits of establishing a group structure and the use of supervision contracts as integral parts of successful group experiences. These are discussed below.

Establishing a Structure

Bernard and Goodyear (1998) described the establishment of ground rules and group structure as pivotal tasks in forming and facilitating functional supervision groups. "Although group structure and ground rules may seem a mundane topic, they can significantly influence the group process" (p. 120). Establishing ground rules and structure includes such tasks as identifying meeting places, frequency of meetings and attendance issues, how group members are to interact (e.g., empathically, collaboratively), the role of the supervisor (e.g., facilitator, process expert, teacher), case presentation and clinical questioning norms, and confidentiality issues. Bernard and Goodyear state that establishing these parameters at the beginning of group is the first step in creating a collaborative, cooperative, and encouraging group atmosphere.

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In constructing group norms, supervisors may find it beneficial to facilitate the development of cohesion, universality, and inclusion early in the life of a supervision group (Bernard & Goodyear, 1998; Linton, 2003). This may entail taking time during early sessions to employ structured or unstructured group building exercises. Additionally, supervisors should guard against corrosive group processes such as competition, conflict, and scapegoating during early group meetings (Linton, 2003; Linton & Hedstrom, in press). This may involve inhibiting any conflict relating to the supervisor discreetly early in the group's life.

Group Supervision Contracts

Lockett (2001) identified the development of group contracts as a useful technique when forming supervision groups. She stated that negotiating contracts with supervisees allows supervisors to explicitly establish group rules and norms, identify the purpose of, and expectations for, supervision meetings, and offer protection to counselor-client and supervisor-supervisee relationships. According to Lockett, effective group contracts identify the following: (a) the supervisor's and supervisees' responsibilities to the group members, (b) negotiated boundaries, (c) place and frequency of meetings, (d) attendance and fee issues (if applicable), (e) case presentation guidelines, and (f) explanations of confidentiality and "duty to care" issues. The contract should also offer supervisees the "opportunity to develop a safe learning climate" (p. 156). Lockett suggested that the group supervision contract be revisited often in order to assure that each group member's needs are being met and to maintain focus during group meetings.

Group Supervision Models

The following five supervision models are exemplars for group supervision, representing both structured and unstructured formats: (a) Structured Group Supervision (Wilbur, Roberts-Wilbur, Morris, Betz, & Hart, 1991), (b) Systemic Peer Group Supervision (Borders, 1991), (c) a case presentation model (McAullife, 1992), (d) an analytic model (Rosenthal, 1999), and (e) Experiential Group

Supervision (Altfeld, 1999; Altfeld & Bernard, 1997). Suggestions for practice are included in the discussion of each model.

Structured Group Supervision

Wilbur et al. (1991) created the Structured Group Supervision (SGS) model in response to the perceived lack of research and practice directives in the area of group supervision. They stated that "the [SGS] model attempts to strengthen the link between group supervision and its justified use in counselor training programs" (p. 91). As a structured model of group supervision, SGS provides a format for case presentations and specifies how supervisees and supervisors are to interact and provide feedback.

The SGS model is a five-phase process designed to assist supervisees in focusing their case presentations during group supervision. During group meetings, supervisees discuss a single case for approximately one hour. In Phase One of the model, a group member makes a request for assistance to the group. Then, in the questioning and identification of focus phase (Phase Two), group members clarify the request for assistance and gather further information about the problem. During Phase Three, group members provide feedback pertinent to the presenter's request. This feedback is provided in an "I statement" format such as, "If this were my client I wouldÖ" In Phase Four, the supervisee responds as to whether the feedback was helpful. In the optional fifth phase, the preceding four phases are processed.

According to Wilbur et al. (1991), the SGS format is "structured for the active involvement and participation of all group members" (p. 92). A pilot study of the SGS model suggested that participants made significant gains in skill and personal development as compared to supervisees engaged in non-SGS supervision groups (Wilbur, Roberts-Wilbur, Hart, Morris, & Betz, 1994). In the author's experience as a group supervisor, supervisees have often reported that they benefit a great deal from the manner in which feedback is provided in Phase Three. When feedback is provided in the form of "I statements," supervisees state that they feel less defensive and more open to suggestions and feedback from their supervisor and peers.

Systemic Peer Group Supervision

Borders (1991) developed the Systemic Peer Group Supervision (SPGS) model to address unproductive and problematic aspects of peer group supervision approaches. She noted that in supervision groups, "peers may be overly supportive and prone to giving advice, and [that] the group may have difficulty staying on task" (p. 248). Borders stated that in order for supervision groups to be effective, "group meetings need an organizational structure" (p. 248).

The SPGS model offers a structure for group supervision meetings. It was created to address the following goals:

> (a) to ensure that all group members are involved in the supervision process; (b) to help members give focused, objective feedback; (c) to give particular attention to the development of cognitive counseling skills; (d) to be adaptable for groups of novice and/or experienced counselors; (e) to provide a framework for supervising individual, group, and family counseling sessions; (f) to teach an approach that counselors can internalize for self monitoring; and (g) to provide a systemic procedure that can be employed by novice and experienced supervisors (p. 248).

The model was developed through applied practice in the training of novice and experienced counselors.

Procedurally, the SPGS model was designed for use with three to six counselors/supervisees and one trained supervisor. During SPGS meetings, supervisors guide group members through a series of six steps. In Step One, a supervisee identifies questions and asks the group for specific feedback about her performance in a videotaped segment of a counseling session. Then, in Step Two, group members are assigned tasks, roles, or perspectives for responding to the presenter's questions. These may include observing body language or a particular counseling skill (task), taking another role, such as that of the counselor or a significant other of client (role), responding to the session via a particular theoretical orientation (perspective), or using a metaphor to describe the counseling process.

In Step Three of the model, the supervisee shows the videotaped segment of counseling mentioned in Step one. Group members then present feedback from their particular tasks, roles, or perspectives (Step Four). This feedback is directed at the supervisee's specific questions offered in Step One. Then, in Step Five, the supervisor facilitates this feedback discussion. Lastly, in Step Six, the supervisor summarizes the feedback presented by the group and facilitates the presenter's evaluation of the feedback. Throughout all six steps, the supervisor's role is to keep the group on task and engage all group members in the discussion.

Critical to the success of the SPGS model is the Step Two process of assigning tasks, roles, or perspectives. Borders (1991) noted that neophyte counselors are often "self-focused," "overly aware of their every move," and "assume that the client's report is the only truth about the problem situation" (p. 249). When other group members respond from these alternate tasks, roles, or perspectives,

supervisees are assisted in reducing self-focus, viewing the case through "a different set of eyes," and broadening their view of the client and counseling session. For instance, if a group member provides feedback from the role of the client's spouse, the presenter's vision of how other persons respond to the client's behavior may be enhanced. Role taking also allows group members to provide challenging and constructive feedback in a less threatening manner.

Research has indicated that supervisees taking part in SPGS supervision groups found it informative and valuable to their professional development (Werstlein & Borders, 1997). Supervisees in SPGS groups also have also reported decreases in confusion and anxiety, clarification of goals, and increased confidence as a result of taking part in a SPGS group (Starling & Baker, 2000). These findings offer preliminary verification regarding the effectiveness of this model.

Given that most counselor-trainees and practicing professionals experience group supervision during practicum, internship, and in post-degree settings, the lack of training received by those who provide group supervision is problematic (Bernard & Goodyear, 1998; Borders, 1991; Riva & Cornish, 1995).

Case Presentation Model

McAuliffe (1992) offered a Case Presentation Model (CPM) of group supervision. This structured model of group supervision is described as most appropriate for use with practicing professionals rather than counselor-trainees. Procedurally, the CPM was designed for use with a small group of experienced counselors led by an experienced supervisor. During each group meeting, one group member presents a single case, in detail, and discusses it with the group.

The format for case presentations in the CPM is a four-stage process described by the acronym *SOAP*. In the *S* stage, the presenter describes the *subjective* aspects of the case, including why the case was selected and specific issues to be addressed by group members. Then, in the *O* stage, objective information is provided, such as the client's background, psychological testing data, and a summary of counseling work to date. Next, in the *A* stage the presenter provides a provisional diagnostic impression. Finally, in the *P* stage, the presenter outlines her current treatment plan. McAuliffe (1992) noted that the four-stage *SOAP* process assists counselors in taking responsibility for their clinical decisions.

After the *SOAP* presentation is completed, group members and the supervisor "ask questions, suggest further information to be gathered, and propose treatment possibilities" (McAuliffe , 1992, p. 168). During this discussion, the supervisor uses reflection and probing skills to keep the group dialogue on track. At the end of the session, the presenter gives feedback as to whether the group's feedback and suggestions were helpful. During the process, the supervisor assumes the role of process facilitator and expert, he/she models professional behavior, diagnostic expertise, and case presentation skills. McAuliffe stated that having an expert supervisor can prevent the likelihood of the "uninformed leading the uninformed," as may happen without the presence of a supervisor (p. 165).

In implementing the CPM model, McAuliffe (1992) suggested that group supervision be explicitly distinguished from other types of staff meetings. Group supervision time, McAuliffe stated, should be reserved for "intensive clinical analysis" of cases (p. 170). McAuliffe also suggested that group norms should be established, which may include the use of group contracts. Finally, each group meeting should entail some degree of peer facilitation and group members should routinely process their work together.

To date, no empirical research has been conducted on the effectiveness the CPM. However, counselor trainees supervised using the CPM have indicated through informal feedback that they appreciate the *SOAP* structure for case presentations and state that the format assists them in organizing their thoughts and clinical impressions in more efficient and effective ways.

Analytic Model

Rosenthal (1999) developed the Analytic Model (AM) of group supervision. The goals of this unstructured model are to assist supervisees in understanding their clients, monitoring their own emotional reactions, and dealing with a range of instinctual forces. As the name suggests, the model is rooted in analytical thought but participation in AM groups is not limited to counselors who adhere to the analytical model of clinical practice.

During AM meetings, supervisors assist supervisees in resolving countertransference resistance, a key impediment to clinical success. The resolution of countertransference resistance involves helping group members to identify their emotional reactions to clients and resolve any problematic emotional reactions. Supervisors using the AM also engage in emotional demonstration, a practice that involves the display of effective analytic skills and techniques. It is thought that

through this demonstration, supervisees can learn important counseling skills. To accomplish these tasks, Rosenthal (1999) stated that the group leader must establish a "fully accepting group climate in which group members will feel free to express all feelings evoked in them without fear of criticism or censure" (p. 203).

Rosenthal (1999) suggested 90-minute supervision meetings with six to 15 group members. She stated that a contract is offered to a new group member at the outset of supervision. The contract conveys that members are to:

> present problems and concerns they are encountering in working with their [clients], are to take their share of time, are to help each other do the same, and are to hold in confidence whatever is discussed in the group (p. 207).

Aside from this, Rosenthal stated that no other formal structure is offered to the group. During group discussions, the supervisor assumes the roles of process commentator, observer of resistance (including non-participation of a group member), and facilitator. Group discussions, then, consist of a free flowing dialogue about clients' and counselors' emotional reactions and countertransference issues. It is expected that supervisees come to group meetings prepared to discuss cases and are not to monopolize entire group sessions. A review of the literature revealed no empirical investigations of Rosenthal's analytic model.

Experiential Group Supervision

Altfeld (1999) developed the Experiential Group Model (EGM), also an unstructured model of group supervision. The EGM, which is analytic in nature, "involves using supervisory group members' interactions as the matrix out of which supervision occurs" (Altfeld, 1999, p. 237). Altfeld noted that the EGM is conceptually different than models that include case presentations as the main focus of supervision time. He stated that several problems are evident in case presentation approaches, including possible shame and guilt reactions in the presenting therapists when critical responses are presented, and feeling overwhelmed by the large amount of feedback offered by peers. Additionally, Altfeld suggested that some issues brought to group meetings may not be of a technical nature or due to insufficient knowledge, which is often the focus of case presentation models. Rather, Altfeld contended that some issues may be related to emotional countertransference blocks. As such, Altfeld suggested that the resolution of these blocks requires a counteremotional experience on the part of the therapist. Experiential group supervision was developed to address these issues.

Altfeld (1999) described the key theoretical concepts of the model as emphasizing a "holding environment, group as a container, the frame, parallel process, projective identification, reassimilation, [and] the general concept of guided unconscious communication" (p. 387). The EGM emphasizes concepts from "object relations theory and from group-as-a-whole dynamics" (p. 239). The essential underlying assumption of the model is that cases described during group supervision elicit both conscious and unconscious reactions in group members. When these reactions are discussed, important emotional issues can be raised and examined.

Procedurally, the EGM begins with a group member describing a clinical case. During this description, group members are instructed to "take note of whatever images, fantasies, feelings, memories, associations, and/or bodily sensations they experience while listening to the material presented" (Altfeld, 1999, p. 240). Group members are instructed to share these associations with the group, no matter how personal, bizarre, idiosyncratic, inconsequential, or unrelated they seem. Prior to the sharing of these associations, the supervisor stresses the notion that each is likely related to the case in some way, and is a "piece of the puzzle" that will help to resolve countertransference issues.

Tantamount to the success of this approach is the supervisory task of helping group members to follow the instructions. As Altfeld (1999) noted, "clinicians are prone to giving opinions, formulations, clinical insights, and so on" (p. 241). When this occurs, Altfeld offered several suggestions for getting the discussion back on track. For example, the supervisor may respond, "Yes that could be rightÖ but did *you* have any feelings or associations related to what the presenter was saying?" This type of supervisor response re-inducts the group members into the experiential group model.

Altfeld (1999) suggested that the EGM may not be appropriate for use with beginning therapists. He stated that neophyte counselors do not have the background necessary for participation in such a group, and the employment of these techniques may result in increased supervision resistance and anxiety. Additionally, Altfeld stated that the model should not be viewed as an "all or nothing proposition," and that it can be equally effective if parts are borrowed and incorporated into other forms of group supervision (p. 252). To date, no research has been conducted on the experiential model of group supervision.

Considerations for Practice

Given that most counselor-trainees and practicing professionals experience group supervision during practicum, internship, and in post-degree settings, the

lack of training received by those who provide group supervision is problematic (Bernard & Goodyear, 1998; Borders, 1991; Riva & Cornish, 1995). Each of the models delineated here provides a well thought-out framework for the practice of group supervision.

When selecting a format for supervision groups, it is strongly suggested that practicing supervisors consider the developmental and experiential levels of the counselors in their groups. As Stoltenberg et al. (1998) suggest, supervisees at different levels of professional development have different supervision needs and goals. The literature on group supervision suggests that structured models of group supervision (e.g., Wilbur et al., 1991) may be better suited for counselor-trainees while unstructured models may be better for seasoned professionals (Borders, 1991; McAuliffe, 1992). The use of sequences and structure in structured models may help to lessen neophyte counselors' anxiety levels, whereas experienced practitioners may be best served when allowed to set their own agenda for group meetings.

The literature on group supervision suggests that structured models of group supervision (e.g., Wilbur et al., 1991) may be better suited for counselor-trainees while unstructured models may be better for seasoned professionals (Borders, 1991; McAuliffe, 1992).

Additionally, recent research on group supervision supports the contention that establishing a supportive group climate and cohesion are important in group supervision. In studies by Christensen and Kline (2001), Linton (2003), Linton and Hedstrom (in press), Starling and Baker (2000), Walter and Young (1999), and Werstlein and Borders (1997), supervisees stated that the supportive and cohesive atmosphere in their groups was important to their professional development. Supervisees in these studies also stated that this type of group climate assisted them in becoming more honest and interactive with their peers and motivated them to become invested in the professional development of their peers. Based on these research findings, it is therefore recommended that practicing supervisors work diligently to create a warm and cohesive climate in their supervision groups. Several of the models outline here address this practice.

Empirical and anecdotal evidence also suggests that peer interactions are valuable and important to supervisee development (Christensen & Kline, 2001; Linton, 2003; Linton & Hedstrom, in press; Starling & Baker, 2000; Walter & Young, 1999; Werstlein & Borders, 1997) and peer interactions are usually noted as important justifications for the use of group supervision (Bernard & Goodyear, 1998; Proctor, 2000). This is not to imply, however, that supervisees do not value feedback received from their supervisors (Linton, 2003). Based on recent studies of group supervision, it is recommended that supervisors create group norms and rules that encourage supervisee interactions and feedback, while also interjecting their own comments when appropriate (Borders, 1991; Christensen & Kline, 2001; Linton, 2003; Starling & Baker, 2000; Walter & Young, 1999; Werstlein & Borders, 1997). This type of group climate will help to assure that group members receive a wide range of feedback from multiple perspectives and may assist supervisees to conceptualize clinical cases from standpoints other than their personal worldview. Each of the models, particularly the structured models, offers mechanisms for achieving this goal.

Conclusion

In conclusion, this article introduces practicing supervisors to several issues related to group supervision practice in order to stimulate professional discourse and investigation to this often used method of training. As models and empirically validated techniques for group supervision continue to be developed, it will be important to keep practicing supervisors informed of advances in the field. Quality training, as well as professional communication through journals and other forms of dissemination, will be critical in these efforts. Ultimately, increased training in group supervision methods will translate to improved, ethical, and competent counseling practices.

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The Influence of Demographic Information, Ethnic Identity, and Pro-Feminist Attitudes on Cognitive Empathy

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A critical overview of the literature provides a frame for the overall purpose of this empirical study, which examines the influence of ethnic identity and attitudes about women on individuals' ability to engage in empathic thinking. Results of a hierarchical multiple regression analysis indicated that undergraduate students' (n=179) ethnic identity and attitudes about women significantly contributed to 23% of the variance in the ability to think empathically. Among the three sets of independent variables (demographic information, attitudes about women, and ethnic identity subscales), ethnic identity was found to be the only significant ($p < .01$) contributor to the model, explaining 17% of the 23% variance in scores measuring ability to use empathy. Findings suggested that individuals who scored higher on the ethnic identity scale, particularly in relationship to the orientation to other groups, had a greater ability to think empathically, as indicated by higher scores on the empathy scale. Implications for training in counseling programs is discussed.

In the general literature of psychology and counseling, the construct of empathy is defined as the ability and willingness to examine one's impact on others, and to commit to the improvement of self and others (Carkhuff, 1987; Egan, 1990; Rogers, 1942; Weitz, 1957). Leaders in character development education purport empathy as an underlying reinforcer of values, attitudes, and behaviors associated with responsibility, honesty, integrity, respect, living peaceably, caring, and civility within the general populace (The Josephson Institute of Ethics, 1992, 2002; Leonard, 1997). Within the general social science

literature, it is considered to be a critical component of civic identity and citizenship within a democracy (i.e., recognition of one's social and legal link to other individuals within society) (Patrick, 1999). Empathy has been found to be significantly and empirically correlated with many positive qualities that benefit the overall, larger social structure: altruism (Jegerski & Upshaw, 1987; Oswald, 1996), ethical-decision making (Foltz, Kirby, & Paradise, 1989), pro-social behaviors, such as nurturance, succorance, and a just orientation (Hoffman, 2000), higher cognitive functioning and cognitive complexity, and social responsibility (Jegerski & Upshaw, 1987; Roberts & Strayer, 1996). The absence of empathy has been linked to both intergroup aggression (Struch & Schwartz, 1989) and social dominance orientation (Pratto, Sidanium, Stallworth, & Malle, 1994).

The construct of empathy has a unique and important position within the professions of Counseling, Counseling Psychology, and other helping professions. First, practitioners use the ability to engage in empathic thinking as a benchmark in the assessment and diagnosis of character or personality disorders. For example, the Diagnostic and Statistical Manual of Mental Disorders (or DSM; axis 2 diagnoses in the third and fourth editions; American Psychiatric Association, 1987) makes reference to complete self-absorption and the absence of empathy or empathy related behaviors as an indicator of psycho-socio-emotional maladaption (i.e., Narcissistic Personality Disorder, Conduct Disorder, Antisocial Personality Disorder, Avoidant Personality Disorder). The ability to empathize with others has been deemed critical to all human relationships (Omdahl, 1995) and "an essential constituent" (Kohut, 1959, as cited in Duan & Hill, 1996, p. 262) of all psychological phenomenon.

Second, organizational psychologists have recognized the importance of attending to the influence of empathy-related behaviors and thinking (i.e., responsibility, ethics, caring, fairness) in organizational functioning and productivity (Leonard, 1997; Levinson, 1997; Kilburg, 1997). Consultants also recognize the importance of the assessment of empathic expression as a means of better understanding issues within human systems in the world of work.

Third, the longstanding and persisting empirical and conceptual link between counselors' ability to empathize and effective counseling and psychotherapy found within the literature (Chung & Bemak, 2002; Duan & Hill, 1996; Farber & Lane, 2001; Fuertes & Brobst, 2002; Gladstein, 1983; Greenberg, Watson, Elliot, & Bohart, 2001; Lambert & Barley, 2001; Orange, 2002; Scott & Borodovsky, 1990) certainly serves as a powerful influence in curriculum development, counseling supervision, and service delivery. More specifically, it has been empirically correlated with the construct, universal-diverse orientation, which reflects an attitude of awareness and acceptance of both the similarities and differences among people (Mivelle, Gelso, Pannu, Liu, Touradji, Holloway, & Fuertes, 1999).

In appreciation and recognition of the power of the effective expression of empathy, both the American Counseling Association Code of Ethics and Division 17 (Counseling Psychology) of the American Psychological Association (APA) have included in mission statements a mandated commitment for professionals to express empathy (i.e., respect and value) to all individuals within society, particularly those who typically are not recipients of such within mainstream society due to racial/ethnic minority status, gender, sexual orientation, and socio-economic status. In addition, the APA has developed specific guidelines on multicultural education, training, research, and organizational change for all psychologists (American Psychological Association, 2003).

Pedersen (1990), a leading scholar in psychology, identified sensitivity to issues of diversity within training and practice as a "Fourth Force" within Counseling Psychology. Subsequently, terms such as cultural empathy (Ridley & Lingle, 1996, p.32; Ridley & Udipi, 2002, p. 322), ethnocultural empathy (Wang, Davidson, Yakushko, Savoy, Tan, & Bleier, 2003), empathetic multicultural awareness (Junn, Grier, & Behrens, 2001), cultural role-taking (Scott & Borodovsky, 1990), ethnic perspective taking (Quintana, CastaÒeda-English, & Ybarra, 1999) and ethnotherapeutic empathy (Parson, 1993) have appeared and used interchangeably in the literature to specifically address the concept of empathy in multicultural settings (Wang, et al., 2003). Practitioners and researchers within the multicultural movement have assumed that the basic construct of empathy, which has long been embraced within counseling, is no longer sufficient or applicable in cross-cultural interactions and the development of new constructs is warranted, along with the development of appropriate measures.

In light of very limited empirical support, others within the profession question and challenge the multicultural movement, which tends to highlight the limitations of 'old ways and practices' (Thomas & Weinrach, 2004; Weinrach & Thomas, 2004; Thomas & Weinrach, 2002(a); Thomas & Weinrach, 2002(b); Thomas & Weinrach, 1999; Weinrach & Thomas, 1998). These leaders in the field perceive the new terms and the development of the associated multicultural competencies as premature and without any substantial empirical support (Weinrach & Thomas, 2002). This means that those who are multiculturally self-aware and culturally knowledgeable may not be any more competent in expressing empathy than those who are not. A healthy challenge and dialogue between members of the two positions have ensued, and more focused research specifically examining the

relationship between the old and new constructs has been strongly recommended and encouraged. This study is one effort to examine the primary question raised in the continued dialogue between the two perspectives within the profession.

In summary, the pervasive influence of empathy, past and present, is well-established in literature, in education, in training, and in practice. A shifting social zeitgeist and an increase in diversity within the general populace, and the profession, have fueled a plethora of empirical research re-examining the construct of empathy and empathy development. It would seem critical that we, as practitioners and researchers in the counseling profession should more clearly identify the significant influences in individuals' development of empathic thinking and expression. Doing so would allow us to more effectively conceptualize and facilitate the development of empathy within the general population and among those who receive our services, to potentially better understand the factors that contribute to the readiness for training, and to hone curriculum that will eventually lead to the most effective service delivery to client populations regardless of race, culture, or gender. The following section provides a brief overview of the literature, addressing the relationship between the ability to empathize and attitudes related to the two most predominant and widely attended to points of diversity within counseling and counseling psychology: ethnic identity and gender.

Undergraduate students who had not been exposed to graduate training in counseling or empathic thinking were chosen for participation in this study, in order to address the impact of students' awareness of and sensitivity to ethnicity and gender. The authors assumed that an undergraduate population would not be as influenced by a press to respond with 'political correctness' as graduate level counseling student populations, and consequently, more accurate reports of attitudes about race and gender would occur.

Ethnic Identity

Ethnic identity influences ways in which individuals conduct their lives, interact with people from other groups, and view society as a whole (Phinney, 1996a). It is a complex construct that involves self-identification as a group member, attitudes and evaluations in relation to one's group, attitudes about oneself as a group member, extent of ethnic knowledge and commitment, and ethnic behaviors and practices (Phinney, 1992). Social identity theory (SIT) proposes that the more strongly one identifies with their group of identity, the less favorable attitudes they have toward dissimilar groups (Tajfel, 1986). Researchers have found that individuals tend to be least empathic in interactions with those who differ from them in race, ethnicity, and culture, for Whites and Hispanics (Negy, Streve, Jensen, & Uddin, 2003); for Whites, Blacks, and Asians (Tzeng & Jackson, 1994); Chinese and Blacks (Lee, 1995). Those who are able to engage in empathic thinking with members of their own group have been found to be significantly less competent in doing so with members of other groups. This phenomenon has proven to be quite resistant to change without strategic intervention (Brewer, 1988; Hamilton & Trolier, 1986).

Interventions designed to enhance empathy, specifically related to points of difference, have been noted by some as the primary source of hope in bridging the rift that exists between the ability to empathize with members of one's own group and the ability to empathize with an out-group or stigmatized group member (Batson, Polycarpou,, Harmon-Jones, Imhoff, Mitchener, Bednar, Klein, & Highberger, 1997). Findings from these studies support the notion that an individual's ability to express empathy to those outside their group of identity is a distinctly different construct from their basic ability to empathize in general (Wang et al., 2003).

In contrast to the social identity theory, multicultural theory (Phinney, Ferguson, & Tate, 1997), which purports that high ethnic identity is the ideal state of development, proposes that an individual's affirmation toward his or her group, particularly with respect to culture, race, and ethnicity, should correspond with higher levels of acceptance toward outside group members (Berry, 1984; Helms, 1984; Messick & Mackie, 1989; Phinney, 1996b). Phinney, Ferguson, and Tate (1997) found supporting empirical evidence for this theory in a study of adolescents and, in the face of questions and challenge, recommendations for future research in support of this theory continue to exist in the literature (Penn, Gaines, & Phillips, 1993).

Gender and Liberal Feminism

As noted above in the discussion of the mandated respect and attention to race and ethnicity within practice and policies of both the ACA and the APA, respect for issues of gender is deeply ingrained within the professions of Counseling and Counseling Psychology. As the gender composition within psychology has shifted to a majority

female population (American Psychological Association, 1995; Boatswain, Brown, Fiksenbaum, Goldstein, Geenglass, Nadler, & Pyke, 2001; Ostertag & McNamara, 1991), feminist philosophy, which first appeared in the discipline over the last three decades, has also become increasingly integrated within the profession, mainstream training, curriculum, and practice (Boatswain, Brown, Fiksenbaum, Goldstein, Geenglass, Nadler, & Pyke, 2001; Enns, 1992; Enns & Hackett, 1990; Fischer & Good, 1994; Janz & Pyke, 2000; Szymanski, Baird & Kornman, 2002; Worell & Remer, 2003). Liberal or mainstream feminism, the focus of this study, evolved in response to the subordination of women in legal, economic, and cultural constraints that blocked access to opportunities available to men. This philosophy advocates ideals of human dignity, equality, self-fulfillment, autonomy, and rationality. Proponents' primary objectives include the reformation of existing legal and political systems that limit individual freedom and the removal of oppression resulting from rigid sex-role conditioning and irrational prejudices (Enns, 1992). The influence of women's increased presence upon the fields of both Counseling and Counseling Psychology appears to be quite evident.

However, the influence of the profession's strong adherence to a pro-feminist perspective seemingly extends beyond professional policy, training, and service delivery to the arena of empirical research as well. Reid (2002) purported that the inclusion of gender as a major descriptor in sample populations is as essential as the identification of ethnicity, social class, religion, sexuality, or family background. However, the multicultural literature has been found to ignore issues of gender and the impact of sexism (Jones, 1991; Gilbert & Scher, 1999; Glick & Fiske, 1999). The direct association between adherence to liberal feminist attitudes and the ability to think empathically within the general population remains relatively unexamined.

The purpose of this study is to examine the degree to which ethnic identity and adherence to pro-feminist attitudes predicts individuals' intellectual or cognitive empathy, the ability to cognitively experience another's state. Because a significant relationship has consistently been found between affective or expressive and cognitive or intellectual empathy (Duan & Hill, 1996), the focus of this study will be what has been considered the necessary precursor to affective or expressed empathy: intellectual or cognitive empathy. One must be able to think in an empathic manner prior to effectively expressing empathy to another. The independent variables, sense of self as a member of an ethnic group in this country, and commitment to liberal feminist thought, were specifically chosen given that these are the training interventions that are most typically visible and strongly recommended in efforts to decrease stereotypical thinking and increase trainees' self and other awareness, knowledge, and interpersonal skill (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Okun, 1987).

In addition, as stated above, issues of ethnicity and gender are components of one of the most recent forces in Counseling and Counseling Psychology. As recommended in the multicultural literature (Arredondo et al, 1996; Munley et al, 2002), demographic variables were relating to age, gender, culture, ethnicity, race, social class were included in this model, as were the variables of educational background and income. Undergraduate students who had not been exposed to graduate training in counseling or empathic thinking were chosen for participation in this study, in order to address the impact of students' awareness of and sensitivity to ethnicity and gender. The authors assumed that an undergraduate population would not be as influenced by a press to respond with 'political correctness' as graduate level counseling student populations, and consequently, more accurate reports of attitudes about race and gender would occur.

Method

Participants

Participants were students enrolled in a small university located in the Southern Region. The student population of this university is 5,746 with a 14% African American representation. Twenty percent of the undergraduate population is 25 years or older. The surveys were distributed to 180 students who were enrolled in undergraduate courses in psychology during the fall semester of the academic year. Of the 179 students who completed survey packets, 141 (78.8%) self-identified as White American and 38 (21.3 %) self-identified as African American; 134 (74.9%) female and 45 (25.1%) male.

The mean age of the sample was 20.35 years (*SD* = 4.31, range = 18-48). The modal age was 21 years, and approximately 70% of the sample fell in the age range of 19 to 25. The distribution of the sample with regard to year in school was somewhat skewed with 92% being either freshmen or sophomores. The mean annual income for participants' families of origin was $55,806 (*SD* = $35,601, range = $9,000-$250,000).

Procedure

Participants were asked to respond to three questionnaires, which were distributed together in individual survey packets to students who signed and returned consent for participation in research. All identifying information was removed from numbered survey packets that were maintained in a locked file cabinet.

Measures

The 115-item Scale of Intellectual Development (SID) (Erwin, 1982) was chosen as the measure of cognitive complexity in this study. The SID, based on Perry's scheme of intellectual and ethical development (1970), was designed to measure the construct of cognitive development or complexity. Each survey item is presented as a four-point Likert scale ranging from strongly disagree (4) to strongly agree (1). Scoring results in four scores related to each of the following subscales: Dualism, relativism, commitment, and empathy. Each subscale describes a particular cognitive "form" in which individuals construe the diversity of the world around them. For the purpose of this study, only the scores on the subscale assessing the highest level of cognitive development, empathy (Stage IV), were included as the dependent variable. The empathy (Stage IV) subscale items measure the extent to which individuals are aware of their impact on other people. Those scoring high on this scale have developed a sensitivity about other people and feel responsibility for improving society in general. This subscale purports to assess ability to empathize, which has been consistently identified as a critical component in counseling training, as well as counseling process (Brammer, Shostrom, & Abrego, 1989; Egan, 1990; Hammer, 1983). This is the only subscale score that will be used in the data analyses, as it is the focus of this study.

Programs might use this study as a model to assess ethnic identity, and plan and evaluate curriculum and training experiences that will facilitate the development of a secure ethnic identity even prior or simultaneously to developing general counseling competence.

Coefficient alpha reliability for this stage is .73. Evidence for construct validity of the scales designed to measure Chickering's vector of identity has been found in Erwin and Delworth (1980), Erwin and Schmidt (1981), and Erwin (1981).

The Multigroup Ethnic Identity Measure (MEIM: Phinney, 1992) was developed to assess ethnic identity attitudes among diverse minority groups. The MEIM consists of 14 items measuring three aspects of ethnic identity: (a) Affirmation/belonging (five items); (b) ethnic identity achievement, including both exploration and resolution of identity issues (seven items); and (c) ethnic behaviors (two items). Item responses are obtained using a four-point Likert scale ranging from (4) strongly agree to (1) strongly disagree. An additional six items are included in the questionnaire to assess other-group orientation.

Reliability coefficients (Cronbach's Alphas) were reported for the MEIM and two of its subscales. Phinney (1992) found that overall reliability of the measure was .81 for the 417 high school students and .90 for the 136 college students. For the five-item affirmation/belonging subscale, reliabilities were .75 for the 417 high school students and .86 for the 136 college students. For the seven-item ethnic identity achievement subscale, reliabilities were .69 for the 417 high school students and .80 for the 136 college students. Reliability was not calculated for the subscale of ethnic behaviors because it has only two items. For the separate other-group orientation, reliabilities were .71 for the high school students and .74 for the college students. In a study of 12 studies incorporating the MEIM, Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya (2003) found ethnic identity and other-group orientation to be relatively distinct, have satisfactory levels of internal consistency, and have moderate degrees of construct and criterion-related validity.

The short form of the Attitudes toward Women Scale (ATW; Spence, Helmreich, & Stapp, 1973) consists of 25 Likert-type items that assess the degree to which individuals adopt liberal or pro-feminist views of women's roles. This short form is developed from a 50-item longer form version (Spence & Helmreich, 1972). Item responses are obtained using a four-point scale ranging from (A) strongly agree to (D) strongly disagree. Sample item stems are: (a) It is insulting to women to have the "obey" clause remain in the marriage service; (b) Women should take increasing responsibility for leadership involving the intellectual and social problems of the day; (c) Women should worry less about their rights and more about becoming good wives and mothers; and (d) Women should be given equal opportunity with men for apprenticeship in the various trades. Higher scores on this scale are interpreted as a greater adherence to pro-feminist consciousness, whereas lower scores indicate more conservative views toward the roles of women in general society.

There has been positive evidence of construct validity, criterion validity, and reliability. An administration of the scale to 258 female and 293 male university students yielded only one major factor, accounting for 23% and 30% of the total variance, respectively. Separate reliability analyses over female and male participants yielded alphas of .90 for the short form. A person correlation between the short and long forms produced a coefficient of .99 (Smith & Bradley, 1980). Relationships between ATW scores and the Sex-Role Egalitarianism Scale (King & King, 1997), the Personal Attributes Questionnaire (Spence, Helmreich, & Stapp, 1974) and the MacDonald

Sex Role Survey (MacDonald, 1974), other measures of attitudes toward the equality of men and women, support convergent, discriminant, and construct validity (Carter, 1990; Honeck, 1981; Jaffa, 1985).

Results

Means and standard deviations were computed for each of the primary variables and Pearson product correlation analysis results are presented in Table 1. A positive and significant correlation was found between participants' age and adherence to pro-feminist attitudes (r = .16; $p <$ .05). This correlation indicated that older individuals within the sample, which included an age range of 18-48, tended to adhere more strongly to pro-feminist attitudes than younger participants. This was the only significant correlation found between the sets of independent variables. All of the correlations between the independent variables of ethnic identity, attitudes about women, and demographic information were low to moderate. These results reduced the possibility of having to address the potential problem of multi-collinearity in the primary analyses.

Table one presents the means and standard deviations by gender and race. To determine whether men and women differed significantly in their scores on the primary variables, t tests were performed. Because of the decision to use multiple *t*-tests , the Bonferoni adjustment to the significance level was used to ensure the significance level for the tests as a group was at the .05 level. The resulting level of significance was .025 (.05/2). A significant gender difference was found on the dependent variable of empathy. Women had a significantly higher total SID Empathy subscale score than did men, $t(179) = 2.1$, $p<.05$. The results mean that, in general, the women in this study are more aware of their impact on other people, have greater sensitivity about others, and feel responsible for improving society more so than men do. In addition, women tended to have more liberal and positive attitudes about women than men, $t(179) = 3.72$, $p<.05$.

To determine racial differences on the primary variables, *t* tests were also performed. Significant differences were found between the two groups on several variables. Annual family incomes for white participants within this sample were significantly higher than those of African American participants within this sample, $t(179) = 4.41$, $p<.05$. In addition, white participants had significantly higher empathy scores than African American participants, $t(179) = 2.22$, $p<.05$. These results mean that, in general, white participants had more affluent family backgrounds and were more aware of their impact on other people, had greater sensitivity about others, and felt responsibility for improving society more so than African American participants did. In addition, African American students' responses indicated significantly more liberal and positive attitudes about women than did white American participants, $t(179) = 2.91$, $p<.05$, and also had an overall stronger ethnic identity than white American participants $t(179) = 5.35$, $p<.05$. No other significant differences were found based upon race and gender. However, these significant *t* test results led to the decision to include gender, race, and socio-economic background as predictor variables in the regression analysis. Given the developmental nature of ethnic identity and cognitive thinking, age was included in the regression analysis as well. Evidence that both constructs are age-dependent has been found in the literature. Individuals' ethnic identity scores and cognitive thinking scores have both been found to increase with age (Phinney, 1992; Brammer, Shostrom, & Abrego, 1989).

On the measure for pro-feminist attitudes, white men scored lowest (mean = 50.90); black women scored highest (mean = 60.39); and black men's scores (mean = 57.60) and White women's scores (mean = 58.06) were most similar. On the empathy scale, black men scored the lowest (mean = 42.13); white women scored the highest (mean = 60.10); black women's scores (mean = 54.65) and

Table 1.
Means, Standard Deviations and Range for Black Females (BF) Black Males (BM), White Females (WF), and WhiteMales (WM)

Variables	BF	BM	WF	WM
1. Age				
Mean	18.90	20.4	20.39	20.79
SD	4.22	2.06	4.84	4.18
Range	18-28	18-24	18-48	18-41
N	31	5	101	39
2. Income				
Mean	23103	46000	39294	64012
SD	24174	26522	40869	38212
Range	$9000-85000	$40000-80000	$12000-250000	$15000-170000
N	22	4	70	38
3. EthnicIdentity Total				
Mean	3.46	3.43	2.99	2.98
SD	.41	.63	.47	.49
Range	2.07-4.0	2.42-4.0	1.5-3.86	2.07-3.86
N 32	5	101	30	
4. Attitudes about Women				
Mean	60.39	57.60	58.06	50.90
SD	6.45	9.50	9.65	12.53
Range	47-71	41-62	28-75	22-71
N	39	39	39	39

Table 2.
Means, standard deviations, range, and Pearson product correlations between each pair of variables.

Variable	1	2	3	4
1. Age Mean = 20.35 SD= 4.31 Range=18 - 48	———	r = -.03	r = -.05	r = .16 *
2. Income Mean = $55806 SD= $35601 Range=$9000-$250000			r = .08	r = -.14
3. Ethnic Identity Total Mean = 3.21 SD = .48 Range = 1.64 - 4.00				r = .02
4. Attitudes about Women Mean = 56.73 SD=10.45 Range=22 - 75				———

white men's scores (mean = 54.51) were most similar. Statistical analysis to compare these differences were not performed due to the vast differences in representation of these subgroups within the sample. Therefore, though these patterns are interesting, future research specifically addressing race and gender is strongly recommended.

Table 2 presents the means and standard deviations of the primary variables and Pearson product correlation analysis results for the overall sample. A positive and significant correlation was found between participants' age and adherence to pro-feminist attitudes (r = .16′ $p <$ .05. Older individuals tended to adhere more strongly to pro-feminist attitudes than younger participants. This was the only significant correlation found between the sets of independent variables. All of the correlations between the independent variables of ethnic identity, attitudes towards women, and demographic information were low to moderate. These results reduced the possibility of having to address the potential problem of multi-collinearity in the primary analysis.

Table 3 presents the Pearson product correlations between each set of the standardized measure scores in the model. Significant correlations were found between empathy and the ethnic identity total scores (r = .15), ethnic identity achievement (r = .16); ethnic identity behavior (r = .12), and ethnic identity other (r = .19). Attitudes toward Women Scale scores were found to be significantly correlated only with ethnic identity other group orientation (r = .26).

A multiple regression analysis procedure was used to assess the degree of impact that each of the independent variables had on the dependent variable of empathy. A hierarchical regression analysis was conducted with demographic variables, ethnic identity, and attitudes about women as the predictors for the total SID empathy subscale score (Table 4). Age, family income, racial status, and gender were entered in the first block because these are primary demographic variables. Ethnic identity was entered in the second block before the other predictor variables because of previous research findings that identified a significant relationship between the ability to think empathically and ethnic identity (Phinney, 1996) and also with attitudes associated with the highest levels of racial identity (Steward, Boatwright, Sauer, Baden, & Jackson, 1998). The effect of ethnic identity was also controlled by entering it on this block. Attitudes Toward Women Scale scores were entered in the third block because this was the variable that had not been examined before in the study of empathy. Interactions between the above variables were entered in the fourth block as suggested by Wampold and Freund (1987). The interaction effects entered in the fourth block included

Table 3.
Pearson product correlations between each pair of variables.

Variable	1	2	3	4	5	6	7
1. Empathy		.15**	.06	.16**	.12*	.19**	.07
2. Ethnic Identity Total			.81**	.89**	.63**	-.05	-.00
3. Ethnic Identity–Affirm.				.52**	.44**	-.17**	-.00
4. Ethnic Identity–Achieve.					.40**	.11*	.03
5. Ethnic Identity–Behavior						-.14**	-.07
6. Ethnic Identity–Other							.26**
7. Attitudes Women Scale							
** p <.01							
* p <.05							

Table 4.
Hierarchical Multiple Regression of Effects of Demographic variables, Ethnic Identity, and Attitudes about Women on Total Score of the Scale of Intellectual Development Empathy Subscale

Variable	R Square	R Square Change	F change	Beta	t
Block 1: Demographics Gender SES Race	.05	.05	.16	-.01	.98
Block 2: Ethnic Identity Achievement Behavior Affirmation Other	.22	.17	5.37	.23	2.79*
Block 3: Attitudes about Women	.23	.006	.33	-.30	-1.07
Block 4: Interactions between variables	.09	.01	.04	—	—

Note. The overall regression model was significant, F(10,121) = 3.57, p = .0004. For Ethnic Identify, a higher score demotes a higher level of ethnic identity or a stronger sense of cultural group identification. On attitudes about women, a higher score demotes a more liberal view of women's roles or a greater tendency to see women as being able to assume non-traditional roles. On the SID Empathy subscale, higher scores denote greater awareness of their impact on other people, a greater sensitivity about others' feeling, and a stronger sense of responsibility for improving society.

** p<.001.*

demographic variables x ethnic identity, demographic variables x attitudes about women, and ethnic identity x attitudes about women.

The overall regression model was significant for the criterion variable of empathy, $F(10,121) = 3.57$, $p = .0004$, as noted in Table 4. 23% of the variance in empathy can be explained by the variables within the whole model. The results of the multiple regression analysis showed that only one of the three independent variables, ethnic identity, was a significant predictor of the total empathy score. In predicting the tendency to think in an empathic manner, none of the interaction effects added unique predictive variance beyond what was accounted for by ethnic identity.

Neither the demographic information (r = .05) or Attitudes toward Women scores (r = .06) accounted for a significant amount of the variance among empathy scores. On the other hand, ethnic identity, which accounted for 17% of the variance, contributed significant incremental variance over demographic information. Table five presents the results of the specific contribution of each of the ethnic identity subscales to empathy. The results supported the hypothesis that students who had a stronger ethnic identity would also report greater levels of empathic thinking than those who do not.

Discussion

The goal of this study was to explore the degree to which the predictor variables of demographic information (i.e., gender, SES, race), ethnic identity, and attitudes toward women might predict college students' use of empathy. Though the whole model was found to contribute approximately 23% of the variance in the SID empathy subscale scores, only one of the three independent variable sets, ethnic identity, was found to be a significant predictor of the subscale scores (17% of the variance).

At first glance of the results, readers might conclude that findings seem to support the multicultural theory that hypothesizes that the overall construct of ethnic identity is positively and significantly correlated with the ability to understand and connect with non-group members (Phinney, 1996; Phinney, Ferguson, & Tate, 1997). However, it is critical to note that only one aspect of ethnic identity, the other group orientation, was the significant predictor, which supports the social identity theory (Taifeo & Turner, 1986). It also supports Allport's "contact hypothesis," which states that contact between groups can promote tolerance and acceptance (DeAngelis, 2001; Wang et al, 2003). These results are similar to those of previous research that established a

Table 5.
Hierarchical Multiple Regression Results of the contribution of individual Ethnic Identity subscale scores (Affirmation, Achievement, Behavior, and Other Group Orientation) to Total Empathy Subscale Scores

Variable(s)	Standardized Coefficient Beta	t	Sig.
1. Affirmation	-.02	-.17	.87
2. Achievement	.15	1.70	.09
3. Behavior	.12	1.47	.14
4. Other Group Orientation	.26	3.58	.00

Note. Of the four Ethnic Identity subscale scores, the only significant predictor of Empathy was found to be the Other Group Orientation subscale.

relationship between other-group orientation and greater understanding and sensitivity (Blanchard, Crandall, Brigham, & Vaughn, 1994; Negy, Shreve, Jensen, & Uddin, 2003).

Based on these results it might be concluded that counseling programs' admission of undergraduate students from institutions who have provided these experiences would certainly increase trainees' readiness for graduate education in counseling and in their effectiveness as members of the counseling profession.

Four important points should be remembered as the results of this study are discussed. First, the only reason that results are interpreted and discussed with reference to black and white students is because of the representation in the sample and we do not wish to make generalizations beyond the scope of these results. The same relationship between variables may or may not be found for other groups and for other campus populations wherein the majority-minority representation is significantly different and in different geographical locations. Second, group differences in beliefs about assuming responsibility for improving society in general and for understanding personal impact on others based on race and gender may be explained in several ways. The most obvious is the limited representation of both males and blacks in this sample. Women and whites made up approximately 75% of the sample. Though some researchers' findings do not support these results (Davis, 1980, 1983, 1994; Monahan, 1989), gender differences have been found in earlier research addressing empathic thinking, with women being found to have greater empathy than men (Hatcher, 1994; Jimenez & Abreu, 2003; Roberts & Strayer, 1996; Sullivan, 1989; Wang et al, 2003). Male participants in this study might tend to have had more qualities that might be identified as masculine, which are not as interpersonally oriented as those qualities traditionally identified as feminine.

Significant racial differences between blacks and whites also may be interpreted in several ways. Differences in gender and race may have had a significant impact on the participants' personal experience, awareness, interpersonal functioning, and social attitudes, as indicated by previous research (e.g., Cross & Phagten-Smith, 1996; Helms, 1995; Miville et al, 1999; Wang et al, 2003). Given that the SID measure does purport to assess levels of cognitive development and identifies the Empathy subscale as the highest form of cognitive development, some might conclude that these findings support the notion that blacks are less cognitively developed than whites. This is not the conclusion of the authors of this paper. Readers must be cautioned to revisit the operational definition of empathy as defined by this measure: sensitivity to one's impact on others and assumption of responsibility for the improvement of society in general. SID Empathy subscale scores may be influenced by the quality of race relations within mainstream America. African Americans may be less likely to have higher empathic thinking scores due to living in a predominantly white environment wherein it might be unhealthy and unproductive to be interpersonally sensitive. Earlier studies have found that in a study of the most successful students, white students believe that they would withdraw interpersonally when in predominantly black settings (Steward, Davidson, & Borgers, 1993), and that black university students in a predominantly white setting who feel least alienated are those who want nothing from white peers (Steward, Jackson, & Jackson, 1990). Given this possible interpersonal dynamic, it makes sense that blacks within a predominantly white setting may not be as interpersonally sensitive as white peers in the same setting.

Black students, as members of a racial minority group, may also not feel as responsible for the improvement of society in general. Given the significant reported family annual income differences, less economically advantaged students may not only experience the powerlessness of minority group membership, but also the powerlessness which might be associated with lower socio-economic status. However, readers must also note that neither race nor family income was found to significantly contribute to the variance in participants' empathy scores. Additional research specifically examining racial differences in empathy on predominantly white campuses, and black campuses too, is certainly warranted.

Third, results of this study are subject to the limitations of any self-report survey. A sampling bias may have occurred, as no information was obtained on non-participants outside of these classes. Also, only attitudinal criterion variables were examined, with no behavioral indicators being included. Consequently, women and white students may overall report empathic thinking to a greater degree than men and African Americans, but in reality only engage in empathic behaviors to the same degree or less. In contrast, individuals may tend to over-report or under-report what their self-report actually reflects. Both men and African Americans may report less engagement in empathic thinking than their behavior reflects.

Fourth, with participants in the sample being located on only one university campus in one geographical region, a generalization to students in other parts of the country may not be merited. It is also not possible to generalize the results of this study to a non-university population. The results also cannot be generalized to the unique set of undergraduate students who would pursue admission into counseling graduate programs. Future research specifically targeting this professional/academic goal would certainly add significantly to the literature.

The direct and significant predictive relationship between ethnic identity and empathic thinking, as measured by the SID, supports an earlier similar research finding linking attitudes about race and empathic thinking (Steward, Morales, Bartell, Miller, & Weeks, 1998). In other words, the degree to which university students have a secure and positive sense of self as a member of their ethnic group in relationship to other ethnic groups (ethnic identity) is predictive of the degree that they will be sensitive to their impact on others and assume responsibility for improvement in general society (empathic thinking). Persons with insecure and negative feelings about group membership in relationship to other groups will be less likely to be socially conscious and interpersonally sensitive.

Findings suggest that efforts to enhance empathic thinking, a critical aspect of maintaining a democratic society, university programs should strategically provide and require curriculum and training experiences to include the following: increase ethnic pride, support good feelings about one's ethnic background, and support happiness with one's ethnic group membership, as well as feelings of belonging and attachment to the group (Phinney, 1992) (affirmation/belonging); guide and encourage students' exploration and resolution of past and current beliefs and attitudes that impede the development of a secure and positive ethnic identify (achievement); provide structured and unstructured social activities with members of one's ethnic group and participate in cultural traditions (ethnic behaviors); and provide structured and unstructured opportunities to specifically identify, address, and resolve negative attitudes, beliefs, and feelings toward other ethnic group members (ethnic others).

Programs might use this study as a model to assess ethnic identity, and plan and evaluate curriculum and training experiences that will facilitate the development of a secure ethnic identity even prior or simultaneously to developing general counseling competence. Providing this opportunity throughout undergraduate education might serve as the baseline experience necessary for the heightened development of cognitive empathy, the precursor of affective empathy, which is the goal of all counseling programs. Based on these results it might be concluded that counseling programs' admission of undergraduate students from institutions who have provided these experiences would certainly increase trainees' readiness for graduate education in counseling and in their effectiveness as members of the counseling profession.

Findings indicate that there is no significant relationship between individuals' attitudes about women and the degree to which one is sensitive to their impact on others or willingness to assume responsibility for the improvement of general society. Though gender-related education may inform and increase awareness and understanding of gender related issues and strengths, the findings suggest that it does not enhance the development of empathic thinking. This is a very confusing outcome given the fact that women had significantly higher empathy scores and African American students had significantly higher Attitudes toward Women scores, which is contrary to findings in earlier research (Silver, 1988). Much continued thought must be given in the interpretation of this finding so as not to encourage readers who conclude that gender is not worthy of note within the context of facilitating the development of empathic thinking.

Steward, Gimenez, and Jackson (1995) concluded that ethnicity and gender should be unique and critical components of training; however, readers must once again take note of the attitudes that are measured by the Attitudes toward Women Scale and significant correlates of such attitudes: politically liberal (Ghaffaradli-Doty & Carlson, 1979) greater self-reported hostility (Gackenbach & Auerback 1975); less social conformity (Johnson & MacDonnell, 1974); inner-directedness (Hunt, 1976); goal-oriented toward non-traditional vocational and educational roles (Redfering, 1979); high self-actualization (Hjell & Butterfield, 1974; Follingstad, Kilmann, & Robinson, 1976); assertiveness and more masculine orientation (Volgy, 1976); outspokenness, ambition, independence, competitiveness, aggressiveness, dominance, self-reliance, persistence, versatility, and willingness to challenge the laws of society (Joesting, 1976). Such descriptors are bound to be heavily culture-based. Subsequently, adoption of the feminist principles, whether defined as liberal or conservative by leading feminist researchers within mainstream academic settings, may be so tightly interwoven within the context and experience as a member of an ethnic group that the degree to which one has liberal attitudes about women becomes insignificant. This hypothesis is further supported by the absence of a significant correlation between ethnic identity and Attitudes toward Women scores. For example, "White American" being identified as an ethnic identity may mask within group diversity among whites. Some participants who identified in this manner may or may not value and embrace an unspoken

or maybe even unknown ethnic group and associated cultural norms with values that support and encourage more conservative attitudes toward women.

The same might be true for those self identified as African American. Future researchers might be aware of the necessity to encourage participants to identify more specifically in relationship to their ethnic group membership. Researchers also might include a measure of religion and/or degree of religiosity in order to provide a more complete picture of participants' backgrounds (Arredondo et al, 1996). This might be very important, given that ethnic group and associated cultural norms typically include well-defined sex-role behaviors with which members are very familiar and comfortable, but that are in no way related to pro-feminist views. Additional information might aid in developing a more comprehensive description of what these cultural norms are.

Nevertheless, a step has been taken to understand that which has been identified as the highest level of cognitive development among some within the profession of counseling. More specifically, findings also more clearly identify how the development of empathy among university populations might be strategically influenced. Many scholars have emphasized the importance of teaching empathic thinking at the university undergraduate level and have developed curriculum that effectively increases students' ability to do so (Gallo, 1989; Gladstein, 1983; Hatcher, 1994). Student orientation, campus program development, and faculty may be more effective in creating an overall socially responsible climate within university populations if ethnic identity is considered within the process of planning the educational experiences of our future educated populations and, in particular, our future counselors.

However, readers must also note that only 17% of the variance in the SID Empathy subscale score can be attributed to Ethnic Identity as measured by the MEIM. This outcome supports prior literature that identifies empathy as a multi-stage process that consists of multiple elements (Barrett-Lennard, 1981; Gladstein, 1983; Wang et al, 2003). Future research is certainly warranted.

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