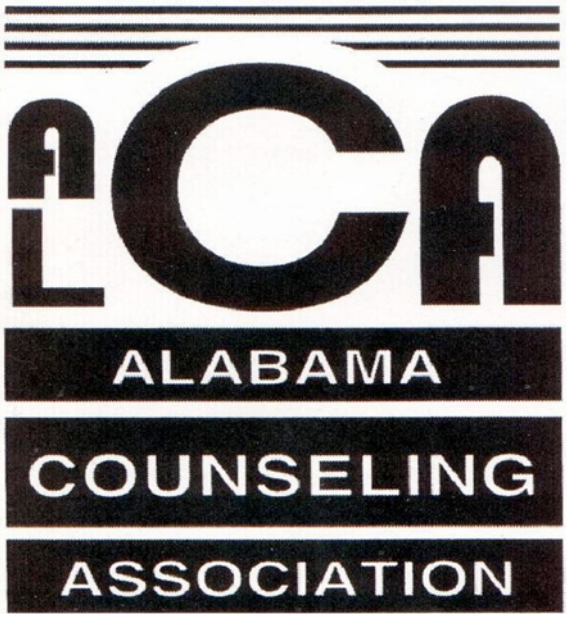
The Alabama Counseling Association Journal



- Enhancing human development through the lifespan
- Promoting public confidence and trust in the counseling profession
- Caring for self and others
- Acquiring and using knowledge
- Respecting diversity
- Empowering leadership
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Volume 30, Number 3

Letter from the Editor

Welcome to Spring 2016! This edition of the ALCA Journal is short but contains a wealth of helpful information.

I would like to thank the authors that contributed to this volume of the ALCA journal. We appreciate very much your efforts in scholarly writing!

The articles in this edition cover a variety of topics from the soul of counseling, to art based strategies to motivational interviewing. We also have a very timely article about gender roles, job satisfaction and our law enforcement personnel.

I hope you enjoy this excellent variety of counseling topics!

Linda

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Gender Role Conflict and Job Satisfaction among Police Officers: Research and Clinical Implications for Counselors and Other Mental Health Practitioners

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Abstract

Many scholars have noted that police culture places a high value on masculine gender ideals. These gender ideals can conceivably create conflict within individuals whose gender identities may not match the ideals of police culture. It is reasonable to speculate that this gender role conflict (GRC) might influence job satisfaction.

The findings from this study suggest that there are complex relationships between biological sex and GRC, biological sex and job satisfaction, and the intersection of GRC, job satisfaction, and policing. Implications for theory and counseling practice are discussed.

Like gravity, gender is an unseen force that shapes our world. While its effects can be felt, its presence is often overlooked. Gender occupies a place in every part of life. As such, the effects of gender can be seen in many aspects of daily life. Buttons are placed on the right side of clothing for men and on the left side for women. Transportation vessels, such as ships and planes, are often named after women and are spoken of as female. Contemporary society is thoroughly structured by gender, even though this construct, like gravity, is virtually invisible. Given the omnipresent nature of gender, people can become psychologically conflicted about their gender roles. For example, a woman may have fundamentally feminine elements to her personality but may find herself in roles where she is expected to act in stereotypically masculine ways. Indeed, research has demonstrated that these types of conflicts are common. These conflicts may even be more pronounced in the workplace because certain work environments incubate structured gender role expectations and demands (Silvestri, 2003). Work environments where stereotypical gender roles are operative are likely a breeding ground for gender role conflict because the rigid demands of the workplace inevitably collide with the natural gender proclivities of some of the employees (Abrams, 1989; Rochlen, Good, & Carver, 2009; Wester & Lyubelsky, 2005). One such workplace environment is the police force, where a strong male gender role is pervasive. As such, studying gender role conflict in police officers could yield valuable information about the ways in which gender issues are internally negotiated by police officers in the workplace. Studying gender role conflict in police officers could likewise shed light on the relationship between job satisfaction and gender role conflict. Notably, however, limited research has been conducted on gender role

conflict in police officers. Therefore, this study investigated the relationship between gender role conflict (GRC) (O'Neil, 1981a) and job satisfaction in police officers (Dantzker, 1994).

Gender Role Conflict

Gender role conflict refers to the distress one feels due to internal or external pressure to adopt incompatible self-definitions of gender (O'Neil, 1981a). For example, if a woman, who has a traditional gender definition of herself, works in a male-dominated industry, where success is defined according to masculine traits, the woman may become conflicted. On the one hand, she may wish to retain her traditional gender role. On the other hand, she may feel pressured to adopt gendered ways of being that feel alien to her. This psychological negotiation of incompatible gender demands is the essence of gender role conflict.

Although the essence of gender role conflict is relatively easy to understand, the theory of gender role conflict has evolved into a complex and sophisticated ideology, which has been influenced by multiple theoretical and empirical sources. Therefore, in order to appreciate the intellectual nuances of gender role conflict theory, the ideological precursors to this theory must be understood. Some of the primary ideological precursors to gender role conflict are theories of masculine ideology and role strain (O'Neil, 2008).

Police Force, Gender Role Conflict, and Job Satisfaction

The rise of modern policing in western society can be traced to the early nineteenth century with the industrial revolution and the forces that packed people together in cities for purposes of production (Kagan, Ozment, & Turner, 1998). As people competed for living space, jobs, and other economic resources, society's elite became more affected by poverty, unemployment, and crime. The upper class felt a need for protection from the threats they

imagined from the lower classes, such as revolts and heightened levels of crime rates that came with the emergence of industrialized cities (Kagan et al., 1998).

The modern police force model emerged first in France and England with the actions of the Prefect of Paris, Sir Robert Peel, and the London Bobbies (Kagan et al., 1998). This modern police force model was also adopted in the U.S. (Kagan et al.). This modern police force is thoroughly infused with male values, including stoicism, control, and striving for power (Silvestri, 2003).

Given the male dominated nature of the modern police force, an important conflict for traditional male-oriented police officers is the widespread entrance of female police officers into the police force, especially because females are now involved in every level of the police command structure. As female police officers have entered this male gendered vocation and culture, these females and subordinate males may feel pressure to conform to the traditional male dominated police culture (Silvestri, 2003). To preserve their power, females and subordinate males can each act in masculine ways that may be contrary to their own values (Silvestri). In other words, to fit in with the police male dominated culture, females and subordinate males may identify with dominant males and enact their own version of male privilege and subscribe to traditional masculine values. In considering O'Neil's (2008) theory, this pressure to assimilate the dominant-gendered values and norms of the workplace is likely to create GRC in many workers.

Non-conformity to the masculine values in the modern police force can cause police officers a host of employment and personal problems (Silvestri, 2003). A primary example of the problem that conformity to traditional male values creates in the police force is the

psychological dilemma police officers face in managing their use power, coercive force, and threats to maintain order on the job without these male-gendered attributes negatively affecting their work and personal life (Woody, 2005). When a police command structure becomes cynical, autocratic, devaluing, the culture of the department or agency can change to mimic these practices and values, encouraging these same actions among its members (Allcorn, 2004). The gendered aspects of the department personality can become the police officer's personality. To that end Allcorn noted:

> Organizational members must not only take up the culture, they must manage to feel less anxious by extinguishing those parts of themselves that conflict with the basic assumptions of the culture. (p. 95)

As such, officers may be particularly susceptible to GRC and its deleterious effects. At an institutional level, GRC in police culture has occurred as a byproduct of the conflict between the modern or traditional police model versus the community policing model (Silvestri, 2003). From its earliest roots, the U.S. police force has been seen as a male gendered, paramilitary organization, which, because of its rejection of traditional or stereotypical feminine values, has rewarded rational over relational behavior (Silvestri). Under the traditional model the man's job is to react to the crime and catch the "bad guys" (Garcia, 2003). As such, in the past male police officers typically worked the street and female officers worked the desk or held administrative positions.

Unlike the traditional model, community policing has similarities to a feminine ethic of care based on relationships rather than one which prizes a masculine ethic of justice (Schulz, 2004). The community policing model, however, has had a controversial beginning, and its

utility to the field of policing has been disputed (Miller, 1998; Schulz, 2004). Specifically, non-command police officers may feel that community policing softens the force, allows civilians too much access to police matters, and feminizes the profession (Schulz). Proponents of community policing (Rosenthal et. al., 2000; Trojanowicz & Harden, 1985; Trojanowicz, Pollard, Colgan, & Harden, 1986) have asserted that fear of crime and crime rates can be reduced by incorporating the following strategies that embody feminine values: decentralization of command, a leveling of police hierarchy, partnerships with the community, and civilian input.

Gender is pervasive and prescriptive. Gender role conflict affects everyone's life, particularly the work that one does. The role of GRC in job satisfaction is not yet completely understood. No published study to date has considered the specific intersection of O'Neil's (2008) GRC and job satisfaction among male and female police officers. Considering the deleterious effects on various aspects of men's lives such as, career, health, family and interpersonal relationships when GRC is high (O'Neil, 1981a,1981b, 2008; O'Neil, Good, et al., 1995; O'Neil & Nadeau, 1999; Wester, Christianson, Vogel, & Wei, 2007) it seems important to study the relationship between GRC and job satisfaction among police officers. To that end, in this research study investigated the multiple intersections via the following research question:

1. Is there a relationship between gender role conflict and job satisfaction in male and female police officers?
    a. Is gender role conflict related to job satisfaction for male police officers?
    b. Is gender role conflict related to job satisfaction for female police officers?

c. If there is a relationship between gender role conflict and job satisfaction, is it the same for male and female police officers?

Research Design

The research design used in this study was a non-experimental (specifically correlational) using a quantitative approach. Research conducted on gender role conflict and job satisfaction as it may apply to male and female police officers has not been reported. Correlational studies allow one to determine the degree that a relationship may exist between two or more constructs and are often used to explore relationships of constructs that are not well known or understood (Myers & Hansen, 1997).

Participants

Participants consisted of police officers. For the purpose of this study, police officers were defined as Michigan Commission on Law Enforcement Standards (M.C.O.L.E.S.) certified law enforcement officers, from the State of Michigan, United States of America. Participant work settings included urban, suburban, rural, and university police departments. Female officers were deliberately over sampled as suggested by Dantzker and Kubin (1998) to compensate for their reduced numbers in the overall population.

First, using Dantzker's (1994) methodology, a list of possible police departments was compiled through a review of all appropriate departments in the State of Michigan. In addition, other pools of participants were considered from the following organizations: Police Officers Association of Michigan, Command Officers Association of Michigan, International Association of Women Police, Michigan Association of Police Chiefs,

International Association of Police Chiefs and local Fraternal Order of Police Lodges, M.C.O.L.E.S. training sessions, Michigan State Police, and Police Academies. To be eligible**,** participants had to meet the aforementioned criterion as M.C.O.L.E.S. certified law enforcement officers (Note: I am ex-law enforcement officer and a member of a police family. Therefore, I am already a part of the police culture, so entry into the culture was not be a problem for me. Entry into police culture would almost certainly be difficult, if not impossible, for someone who is viewed as a researcher, therapist and/or an outsider).

Instruments

The GRCS-I was originally normed with adult males in a United States of America college setting. The GRCS-I (O'Neil, Helms, et al.,1986) is a 37 item self-report instrument that was derived from O'Neil's earlier definition of gender role conflict (O'Neil,1981a) (GRC) and again later stated as the following (O'Neil, 2008):

> A psychological state in which socialized gender roles have negative consequences for the person or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self. (p. 362)

Procedures

The Gender Role Conflict Scale-I (O'Neil, Helms, et al., 1986) for men and the Gender Role Conflict Scale-F (O'Neil, 1997) for women was administered to male and female police officers respectively. The Level of Job Satisfaction Survey (Dantzker,1993a, 1993b) was administered to all subjects. The GRCS-I/GRCS-F were given first and the

Level of Job Satisfaction Survey was given second. The following demographic information was also be obtained as part of the data collection procedures: gender (defined as biological sex), ethnicity, age, rank, name of department, total years of police experience, level of education, current shift, current assignment.

The use of SPSS to conduct multiple regressions to build on basic T-test analyses of gender differences. Analyses examining the relationship between gender conflict and job satisfaction were tested using ordinary least squares (OLS) regression, first for the full sample and then for each gender separately to test whether the relationships observed differ significantly between groups. The test for difference in regression coefficients between independent samples is a z-test.

In these analyses, a test statistic of $z > 1.98$ was considered evidence of a significant difference in effects between male and female police officers.

Results

Biological Sex Differences in Job Satisfaction Items

In addition to other factors the Job Satisfaction survey posed three individual items intended to capture a more generalized sense of satisfaction, namely the following:

1. Self-reported overall Job Satisfaction
2. If I could change police departments without losing seniority I would!
3. If I received an offer for a better paying job outside of policing I would immediately accept it!

Each of the three items was tested for differences between men and women. For these analyses, the guiding hypothesis was: Males will report less job satisfaction than females.

In interpreting these results, it is important to remember that the second and third items are framed in the negative, such that more job satisfaction would translate to a lower score on these items.

For the "Self-reported Overall Job Satisfaction," there were no significant differences between the males and females. However, there were differences for the other two items. For the item "Change Department Without Loss of Seniority," male police officers reported a higher willingness to change departments if they would not lose seniority than did female police officers. This result corresponded with the hypothesized higher job satisfaction for female officers. On the other hand, female police officers reported a higher willingness to leave police work if given another offer than did male police officers. This finding was the opposite of the hypothesized direction. Thus this hypothesis was partially confirmed and partially challenged.

Table 1

Comparison of Respondents by Biological Sex for Job Satisfaction Items

Job Satisfaction Items Outcomes	Male Mean (SD)	Female Mean (SD)	t-value	p-value
Self-reported Overall Job Satisfaction	3.63 (0.93)	3.62 (1.01)	.055	.956
Change Department Without Loss of Seniority	2.87 (1.42)	2.87 (1.31)	3.200	.002**
Would Leave Police Work	2.72	3.34	-2.830	.005**

If Given Another Offer	(1.34)	(1.35)

Note: * p<.05; ** p <.01; ***p<.001

Relating Gender Role Conflict to Job Satisfaction

The hypothesis concerning the relationship between GRC and job satisfaction stated the following:

> An inverse relationship between GRC and job satisfaction in male and female police officers will exist regardless of biological sex, such that higher GRC will be associated with less job satisfaction.

Table 2 shows the standardized coefficients from the regression analyses based on this hypothesis. In this analytic process, each predictor variable (GRC items) was considered with each outcome variable (satisfaction items) independently.

Table 2

Summary of Standard Coefficient – Regression Analysis

	Outcomes						
Predictors	Self-Report Satisfaction	Change Dept	Leave Police	Sat w/ Admin	Sat w/ Job	Sat w/ Equip	Sat/w Extras
Success, Power, Competition	.180*	-.08	.05	.15**	.16**	.11	.12~
Restricted Emotionality	-.050	.10	.07	-.05	-.03	-.05	-.15*
Restrictive Affectionate Behavior Between Same Sex	-.004	.11	.06	-.13*	-.07	-.01	-.13~
Conflicts Between Work and Leisure – Family Relations	-.310***	.19**	.17*	-.15**	-.28***	.04	-.21**

* p<.05; ** p <.01; ***p<.001; ~ p < .10

The results reported in Table 2 partially confirmed this hypothesis. The direction and strength of the relationship hypothesized was only seen clearly for conflicts between work and leisure - family relations. The direction for restricted emotionality and restrictive affection was consistent with the hypothesis. However, the subscale of restricted emotionality only reached significance for the subscale satisfaction with extras. The subscale of restrictive affections only reached significance for the subscale of satisfaction with administration.

In addition to these composite scales, job satisfaction was assessed through three independent items on the survey. As reported in Table 1, the item "Self- reported Overall Job Satisfaction" showed no significant differences between the males and females. However there were differences for the other two items. Male police officers reported a higher willingness to change departments if they would be able to retain their seniority than did female police officers. On the other hand, female police officers reported a higher willingness to leave police work if given another offer than did male officers. This greater willingness by females to leave policing is consistent with reported problems with recruitment and retention of females in the police field (Silvestri, 2003).

Conclusions

As this study has not been replicated, I suggest the findings be viewed with caution, particularly the generalizability of the results. However, I conclude that the findings of this study offers affirmation that more studies are needed that compare men and women on measures of GRC and job satisfaction in the field of policing. As already noted, the significant findings from this study raise questions about the way mental health professionals, police supervisors and police policy makers view men and women with regard to GRC and job satisfaction. For example, the notion that supervision of male and female police officers is generally the same

(Iannone & Iannone, 2001) does not take into consideration the findings of this study and is therefore an antiquated concept. Based on the results obtained on the subscales of success/power/competition and work/leisure and family relations and the various subscales of job satisfaction there are demonstrative differences between male and female police officers.

The findings of this study add to the body of knowledge concerning biological sex differences, GRC, and job satisfaction in policing. However, the findings may indicate that a much more complicated relationship exists between biological sex and GRC, and biological sex and job satisfaction than has previously been presumed.

Professional Counselors would do well to consider the implications presented in the article when conducting career counseling and mental health counseling with police officers and their families. Biological sex differences and gender role conflict may determine the likelihood of the type of job satisfaction officers may report. Additionally, salient questions about the effect of the officer's job on their leisure/family life, and the possibility of changing places of employment or careers may elicit useful clinical material during the therapeutic hour.

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An Applied Model for Using Motivational Interviewing to Treat Individuals that Have Eating Disorders

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Abstract

This article presents an applied model for using Motivational Interviewing (MI; Miller & Rollnick, 2002) with clients that have eating disorders. Practical strategies are offered in an effort to aid practitioners in preparing their clients for change. Also, assessing clients' readiness to change, recognizing change talk, evoking change talk, and transitioning from MI to other methods of therapy are discussed in detail. Last, this article outlines the considerations, and limitations for using this model of MI with clients that have eating disorders.

Keywords: Motivational Interviewing, eating disorders, bulimia, anorexia nervosa, overeating, addiction

Motivational Interviewing (MI) is a method of therapy that was originally developed for substance abuse treatment, but has since been effectively applied to other client populations (Westra, Aviram, Faye, & Doell, 2011). Although MI can function as a stand-alone therapy, this was not the initial intention. Instead, MI was originally designed to work with particular client difficulties, namely motivation towards change (Miller & Rollnick, 2002). The primary goal of MI is to enhance a client's *intrinsic* (i.e., inspiration that comes from within) motivation by drawing forth clients' personal reasons for change. Thus, this approach provides practitioners with techniques and processes for working with clients that are unmotivated or not yet ready to change. Given the nature of MI involves preparing people for change, this method of therapy has shown promise in working with other addicted populations that are often labeled resistant or unmotivated (Miller, Zweben, DiClemente, & Rychtarik, 1992). On such population includes clients that have eating disorders (Gellar, Brown, & Srikameswaran, 2011).

Eating disorders are serious afflictions that, due to their complexity and egosyntonic nature, can be difficult to treat (Warren, Crowley, Olivardia, & Schoen, 2009; Vitousek, Watson, & Wilson, 1998). Eating disorders, which are defined as insufficient or excessive food intake, are often divided into three categories (a) anorexia nervosa, (b) bulimia nervosa, and (c) binge eating disorder (Hudson, Hiripi, Pope, & Kessler, 2007). Persons that fall within one of these categories frequently present with high levels of *ambivalence* (e.g., feeling two ways about the same subject

matter) about recovery (Gellar & Dunn, 2011). Due to their conflicting thoughts and feelings regarding change and participation in the therapeutic process, they are often perceived as resistant or difficult clients (Hudson et al., 2007). Being that MI has been shown to reduce ambivalence and thereby increase motivation for change (Westra et al., 2011), MI can be used to help individuals with eating disorders that are ambivalent about change.

Observing this potential, researchers have explored the use of adaptations of MI with this population. One such study (Gellar & Dunn, 2011) explored an element of MI known as *readiness for change* (i.e., the willingness to modify previous ways of being). One hundred and eighty-one participants with anorexia nervosa, bulimia nervosa, and eating disorder not otherwise took part in this randomized, controlled trial. Each participant was assigned to either treatment group (5 weeks of RMT) or control group (weight listed) conditions. Both groups completed a series of pre and post assessments measuring readiness for change, eating disorder symptoms, and psychological functioning. Results revealed that both groups improved in readiness for change, depression, drive for thinness, and bulimia symptoms over time. However, individuals that received RMT were more likely to have low ambivalence about change (thus higher readiness for change and lower resistance towards change) than individuals in the control group after five sessions. This study suggests MI is effective in lowering ambivalence, decreasing resistance, and increasing motivation for change amongst client populations that have eating disorders.

Similarly, Feld, Woodside, Kaplan, Olmsted, and Carter (2001) discovered the use of Motivational Enhancement Therapy (MET),a variation of MI, increased clients' motivation for change and decreased symptoms of depression within a group for individuals with anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified. In a related study on

bulimia nervosa, Treasure et al. (1999) found that Motivational Enhancement Therapy had a significant impact in reducing behaviors of binge eating, vomiting, and laxative abuse. Therefore, research examining the use of modifications of MI with eating disorders is promising.

In addition to these studies, randomized controlled trials (Bewell-Weiss, Mills, & Westra, 2009; Wade et al., 2009) support the use of MI in increasing adherence to treatment (i.e., clients' willingness to participate in therapy) amongst individuals with anorexia and bulimia. For example, in a study of individuals with anorexia, participants that were receiving group therapy from MI trained practitioners showed significantly lower levels of dropout from treatment as well as increased readiness for change (Feld et al., 2001; Gellar et al.,, 2011; Wade et al., 2009) as compared to control group participants. Thus, researchers that are trained in MI appear to be obtaining encouraging results while using MI within research settings. However, even though the research exploring the use of MI with eating disorders populations seems promising, the majority of these research studies have focused on measuring the effectiveness of MI or adaptations of MI (Westra et al., 2011), without offering practical adaptations for using MI with this population. Therefore, although researchers have recognized the potential for using MI with individuals that have eating disorders, there is a gap in the research literature.

Specifically, practical models for using MI in helping individuals with eating disorders were (at the time that this article was written) both absent and needed. A model (such as the one presented within this article) is essential in order to (a) provide practitioners (that are trained in MI) with a tried and tested method for using MI with individuals that have eating disorders (in an effort to assist their work with clients), (b) inform the helping profession by providing a unique contribution to the research literature, and (c) convey theoretical constructs for using MI with eating disorders populations for empirical scrutiny. Thus, this study presents a practical, applied

model for using MI with clients that have ED. First, we present applications of MI for eating disorders for working individuals that are resistant or ambivalent about change in the paragraphs below. Then we discuss other functional methods for using MI with eating disorders populations such as (a) assessing clients' readiness to change, (b) recognizing change talk, (c) evoking change talk, and (d) transitioning to other methods of therapy. Finally considerations, limitations, and conclusions for this model of therapy are outlined.

Working with Resistance

While treating clients with eating disorders, practitioners often find that clients are reluctant or ambivalent about engaging in the therapeutic process (Gellar et al., 2011). Clients with this particular presenting problem are often pressured to attend therapy by their friends or families (Feld et al., 2001). Thus, they may not be quite *ready*, *willing*, or *able* to engage in therapy. MI provides practitioners with several strategies for working with clients that are not yet ready for or are resistant to change. Without such methods, treatment could be and often is problematic for practitioners (Miller & Rollnick, 2002).

One of the most important of these strategies (of working with clients' resistance) involves a shift in perception on the part of the practitioner. Specifically, instead of classifying clients that are reluctant or ambivalent about participating in the therapeutic process as *resistant*, practitioners continually assess clients on a transient continuum of motivation towards change. Hettema, Steele, and Miller (2005) argue that this reclassification alone (i.e., from a *resistant client* to a client that is somewhere on the scale of readiness for change) will help alleviate frustration on the part of the practitioner and thereby improve the therapeutic relationship. Thus, by teaching practitioners to assess clients on a continuum of readiness for change, MI assists

practitioners in making a cognitive shift that will help improve their work with clients. Although there are several methods for assessing clients from a MI perspective, we discuss three of the most prominent of these methods in the paragraphs below.

Assessing Readiness to Change

As MI considers change to be a process rather than a momentary event, assessment of motivation and readiness for change should be an ongoing practice (Miller & Rose, 2009). MI relies on several methods for assessing the dynamics of client's preparedness for change. Strategies for assessment within MI include both informal (i.e., listening and observation) and formal (i.e., questionnaires, tests, forms) assessment approaches (Young, 2012). The model for using MI with individuals that have eating disorders outlined within this article focuses on adapting and incorporating informal assessments such as the use of the Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1986), recognizing change talk, and the use of readiness rulers.

The first method of assessment mentioned (using the TTM), is paired so often with MI that practitioners often mistakenly believe that MI was founded upon the TTM. Although MI is not based on the TTM (Miller & Rollnick, 2009), MI makes use of the TTM to assess individual's motivation for change. The TTM is a model that describes individuals' motivation towards change in five hierarchal and sequential stages. According to Prochaska and DiClemente (1986), these stages are precontemplation (when individuals do not believe that they have a problem and are not interested in receiving help), contemplation (once individuals are aware of the personal consequences of their behavior(s) and being thinking about changing the behavior), preparation (this stage describes individuals that are committed to making changes and are

planning for these changes), action (the stage when individuals are actively implementing behavioral changes in their lives), and maintenance (when individuals are maintaining these changes). If individuals are in the earlier stages of change (i.e., precontemplation, or contemplation), MI provides strategies for working with clients within each these stages. However, if clients are in the latter stages of change (i.e., planning, action, or maintenance) MI suggests that practitioners transition (this is discussed in greater detail later within this article) to other working forms of therapy. Incorrect stage to intervention matching may lead to resistance (Miller & Rose, 2009). Therefore, proper assessment of clients' stage of change is critical.

Given studies (Geller, Cockell, & Drab, 2001; Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004; Geller & Dunn, 2011; Treasure & Ward, 1997) suggest the majority of individuals with eating disorders are in the early stages of change (i.e., precontemplation or contemplation) when they first come to treatment, thus they are not yet ready to change, several researchers have recognized the benefit of using the TTM with this population. Not surprisingly, several research teams (Geller & Dunn, 2011; Price-Evans & Treasure, 2011; Treasure & Schmidt, 2001; Treasure & Ward, 1997; Troop & Treasure, 2011) proposed detailed models for assessing individuals that have eating disorders by using the TTM. Therefore, we will not go into depth regarding the use of the TTM and instead refer readers to existing models (citations noted above) of practically applying the TTM with this population. Instead, the model proposed within this article focuses on practical applications of MI (and not the TTM).

One such application of MI includes *recognizing change talk*. This involves the use of both active listening skills and purposeful questioning. Throughout the therapeutic process, practitioners listen for indications of clients' *readiness*, *willingness*, and *ability* to change (Miller & Moyers, 2006). For example, a client struggling with anorexia nervosa might say, "I think that

I could start eating more often (ability), but I want to wait until next week (readiness)." From this statement a practitioner could assess the client would be higher on the ability scale and lower on the readiness scale. Another example might be if a client with bulimia were to say, "I really want to stop binging (willingness), but I don't think that I can (ability)" a practitioner could assess that the client was likely high in their willingness to change, but low on their ability to change.

In order to get a more accurate depiction of clients' readiness, willingness, and ability to change, a practitioner might follow up with focused questions such as, "On a scale of 1 to 10, with 1 being not ready at all and 10 being you are completely ready, how ready (or willing or able) are you to make this change?" Miller and Rollnick (2002) deemed scaled questions, such as the one previously mentioned, *readiness rulers*. If a client that is overeating answered the previous question, "I would put myself at a six right now. I think that I am ready, but I still have a lot of doubt." Counselors might follow up with strategic questions such as, "What keeps you from rating your readiness a five?" or "What would it look like if you were at a seven?" These questions, which borrow concepts from Solution Focused (De Shazer, 1988) therapy, aid in eliciting and strengthening change talk. However, before a practitioner can *elicit change talk*, they must first be able to recognize change talk.

Recognizing Change Talk

Recognizing change talk is another essential concept of MI that involves the process of focused listening. Change talk is divided into two categories known as *preparatory change talk* and *implementing change talk* (Miller & Rollnick, 2002). Whereas preparatory change talk refers to clients that are preparing to take action or make changes in their lives, implementing change talk indicates a higher level of commitment towards change (e.g., making changes or will take action).

Counselors using MI can make use of the pithy acronym D.A.R.N. C.A.T in remembering key words and phrases that will help them recognize change talk within a client's dialogue. Attention to these key statements will help practitioners assess clients' dedication towards change. This acronym stands for **D**esire, **A**bility, **R**easons, and **N**eed, which indicates *preparatory change talk* and **C**ommitment, **A**ctivation, and **T**aking steps, which is indicative of *implementing change talk* (Miller & Rollnick, 2002). For example, if a client were to report, "If I don't stop purging, my doctor says I am going to permanently damage my esophagus (reason)." a practitioner would recognize a clients' *reason* for change within their dialogue and can infer that this statement is indicative of *preparing* for change. If a client were to be *implementing* change, a client might report, "I have stopped taking laxatives (taking steps), but I am not ready to eat more often." Rather than becoming distracted by the non-change talk (i.e., I am not ready to eat more often), practitioners would recognize the client is *taking steps* towards change. However, simply recognizing change talk is not enough. Strategies of MI maintain that practitioners *evoke change talk*.

Evoking Change Talk

The strategy behind *evoking change talk* evolved from research (Miller & Rollnick, 2002) that demonstrated clients typically talk about changing before making overt behavioral changes. In addition, studies (Bem, 1965) propose the more that individuals verbalized their intentions, desires, and plans to change, the more likely they were to make those changes. This concept (that individuals are more likely to make changes upon discussing these changes) is grounded in Daryl Bem's (1967) Self-Perception Theory. This theory of human behavior suggests that one's own behavior shapes one's thinking. In other words, what we *do* influences what we *think*. Therefore, by encouraging clients to discuss their reasons for change (thereby *evoking* change talk), practitioners are (theoretically) supporting clients in increasing the likelihood that they will make the changes that they are discussing.

Although practitioners seek to strengthen client's commitment towards change by *evoking* verbal statements that favor behavioral change, MI is not a method for manipulating clients (Miller & Rollnick, 2002). If clients do not innately have some motivation for change, MI cannot produce motivation for change. Counselors utilize strategies from MI to recognize and strengthen client's own arguments for making changes, not imposing someone else's arguments for or about change (Miller & Rollnick, 2009). More than any technique or skill, practitioners using MI should honor client's *autonomy* rather than assume the role of an authority, *collaborate* rather than confront, and *evoke* rather than educate (Miller & Moyers, 2006; Moyers et al., 2007). The three principles insist practitioners adopt a system of beliefs towards the client, rather than the utilization of specific techniques. The adoption of these beliefs would be visible within the session through practitioner's behaviors. Thus, MI uses a collaborative, respectful approach in assisting clients to make behavioral changes through the method of *evoking* change talk.

While there are several strategies for *evoking change talk*, some of the methods this model (of using MI to benefit clients with ED) uses includes (a) using E.A.R.S., (b) looking forward and looking back, and (c) coming alongside the client (Miller & Rollnick, 2002). The first method that we will explore within our proposed model of using MI with eating disorders involves the use of E.A.R.S. Miller and Rollnick (2002) insist that when practitioners hear change talk, they use their **E**.**A**.**R**.**S**. This acronym, which entails the use of client centered (Rogers, 1979) counseling skills, stands for **E**voke, **A**ffirm, **R**eflect, and **S**ummarize. The first of these skills, *evoke* requires practitioners to ask evocative questions which necessitate that clients will likely answer with change statements (Miller & Rollnick, 2002). For example, if a client with bulimia were to say, "Although I know that I need to stop throwing up after I eat too much, I am afraid that I will gain weight if I stop." A practitioner would *evoke* change talk by asking, "What are two reasons why you would want to stop?" or "How important is making this change to you?" or simply "What makes you think that you need to stop?" Thus, by evoking a client's personalized reasons for changing, clients are more likely to change their behavior.

In addition to evoking change talk, the second acronym within **E**.**A**.**R**.**S**. insists practitioners **A**ffirm client's change statements. Affirmation includes supportive statements on the part of the practitioner that confirm the belief that a client is capable of making changes in their lives (Miller & Rollnick, 2002). Some examples of affirmation as applied to an individual with anorexia include statements such as, "You seem proud that you were able to eat more this week." or "You are capable of eating more throughout the week." or "You have made similar changes to your diet in the past, so you have evidence that you can make this change." Thus, practitioners using MI affirm client's commitment towards change by expressing agreement, support, or encouragement.

The third step of using **E**.**A**.**R**.**S**. (when a practitioner hears change talk) incorporates the intentional use of **R**eflections. Beginning practitioners learn the art of reflecting (or the act of verbally expressing aspects of clients' communication in one's own words) clients' thoughts, feelings, and meaning (Young, 2012). This basic therapy skill is both foundational and essential to the majority of theories of therapy (Pedersen & Ivey, 1993). MI makes use of this skill in a directive and intentional manner. Specifically, practitioners using MI listen for change statements and reflect only the side of change. This intentional use of reflection aids in evoking change statements from the client thereby increasing the likelihood that the client will make changes (Miller & Rollnick, 2002). An example of using this method of reflection with an individual that has bulimia includes if a client were to say, "I feel so ashamed after I overeat. I don't want to feel that way, but I don't think that I can eat just a little, without devouring everything I see." a practitioner using MI would recognize and reflect *just* the change talk, "You would like to be able to eat smaller meals." Through the intentional use of this basic therapy skill, clients would be more likely to discuss goal-oriented (i.e., eating smaller meals) rather than focusing on problem-oriented talk (i.e., feeling guilty, not feeling in control of eating behaviors, not feeling capable of change). Thus practitioners use reflections purposefully and in a way that guides the session towards the discussion of behavioral change.

The final step of **E**.**A**.**R**.**S**. involves the use of **S**ummaries. The use of summarizations (i.e., or practitioners' concise overviews of client's pervious statements) is another skill that is foundational to the art of helping (Young, 2012). When used from a MI perspective, summaries can be used to deliberately focus (i.e. a *focusing summaries*), plan (i.e. a *recapitulation summaries*), or present themes (i.e. a *thematic summaries*) within the therapy session that favor behavioral change (Miller & Rollnick, 2002; Young, 2012). For example, a *focusing summary*

might be used to begin the therapeutic session by providing a collaborative, goal oriented opening to the therapy session by focusing on previous change statements that were made by the client. While using a *focusing summary* (from an MI perspective), a practitioner might say something to the effect of, "During our last session you agreed to begin eating according on the schedule that we discussed. Tell me about your progress toward that behavioral change over the past week."

Similar to a *focusing summary*, a *recapitulation summary* directs the therapeutic session towards change. However, unlike a *focusing summary*, a *recapitulation summary* has been described as a big bouquet of all of the client's change talk that has occurred over the duration of therapy (Miller & Rollnick, 2002). This (recapitulation) summary is commonly followed with a *key question* such as, "What are the next steps?" The purpose of this summary is to guide the session towards goal setting once the client is in the planning stages of the TTM (Prochaska & DiClemente, 1986). However, Miller and Rollnick (2002) remind practitioners that are using MI that the use of *recapitulation summaries* involves careful timing and accurate assessment of clients' stage of change. As previously mentioned, if practitioners mismatch a their interventions with clients' TTM stage of change, then this can lead to resistance on the part of the client. For example, if a client with bulimia does not believe they have a problem (thus they are in the pre-contemplation stage) and a practitioner attempts to use a *recapitulation summary* followed by a key question such as, "In summary, you mentioned your mother and father think that you have an eating disorder and that you are angry with them for accusing you of purging after you eat (recapitulation summary). What would you like to work on first (key question)?" then the client is likely to answer this stage-intervention disparity with a resistant statement such as, "I'd like for them to mind their own business! Can we work on that?" Thus, although a *recapitulation*

summary can be beneficial when used properly, it requires careful timing and accurate assessment.

The final type of summary presented within this model of MI for clients with ED, is deemed a *thematic summary*. A thematic summary is a succinct restatement of all of the noted change themes inherent within clients' statements. For example if a client with anorexia were to discuss feeling angry because they do not believe that they have much of a say over what they do and do not eat, and in another session they were to discuss feeling helpless when they are unable to sustain the desire to eat, and at yet another time within the therapeutic process they were to discuss feeling guilty and ashamed when they eat too much, one possible thematic summary might be, "I could be wrong, but I am noticing a theme. It seems you have a strong desire to have control over your food intake and when you do not feel capable of managing your eating, you feel angry with yourself." Thus, thematic summaries help connect clients' previously verbalized desires, abilities, reasons, or needs to change and encourage clients to explore their desire change in greater depth (thereby potentially strengthening the likelihood that they will change).

In addition to using E.A.R.S., this model proposes the use of the techniques of *looking back* and *looking forward* (Miller & Moyers, 2006) in order to evoke change talk. *Looking back* requires practitioners to prompt the client to reflect on times when their issue was not a problem for them. *Looking forward* aids the client in examining what their life would be like (a) if their behaviors persist, and/or (b) if they make a change. An example of *looking back* with a client that has anorexia might be, "Tell me about a time when you did not fear weight gain." or "Tell me about the last time you looked in the mirror and liked what you saw." Given the potential health and systemic consequences of degenerative eating disorders, the strategy of *looking forward* can be a powerful intervention when used effectively. With this strategy practitioners

may ask, “How do you see your life five years from now if you continue binging and purging?” or “What are the best results you could imagine if you begin eating balanced meals each day?” While it is essential to maintain a respectful (knowing the client is in charge of making or not making their own behavioral changes), empathetic, and curious perspective while utilizing these strategies, they are helpful in exploring and potentially enhancing clients’ motivation toward change.

The final technique for evoking change talk presented within this model is called *coming alongside* the client. This method calls for the practitioner to side with the status quo. Rather than opposing the way the client is currently behaving, which would likely evoke resistance, practitioners paradoxically argue against change (Miller & Rollnick, 2002). Although this seems counterintuitive, this method is both simple and effective. For example, if a practitioner were to insist a client with anorexia change their behavior (this is *not* a method endorsed by MI) by saying, “It seems that you are aware that there are really good reasons for you to start eating balanced meals. Specifically, you mentioned that if you continue with your behavior that there is a good possibility that you would end up in the hospital or worse. What keeps you from changing?” The likely answer to this question would be a resistant statement (or statement that does not favor change) such as, “I am afraid of gaining weight.” or “I am afraid I will not be able to regain control of how much I eat once I give in to my desire to eat.” However, if a practitioner were to *come alongside* the client by saying something to the effect of, “It seems that there are some really good reasons why you do not want to eat more often. Perhaps abstaining from meals is so important to you that you will not ever change.” then the client would be much more likely to answer with change talk such as, “Have you not heard what I have been saying? I could die if

I do not eat more!" As the practitioner contends that things stay the way that they currently are, this intervention paradoxically evokes change statements on the part of the client.

Transitioning from MI to Other Methods of Therapy

All of the methods presented within the paragraphs above have been tried and tested with individuals that have eating disorders. In addition, although these methods work well with individuals that are not yet ready for change and are therefore in the early stages of the TTM (Prochaska & DiClemente, 1986), if individuals are in the latter stages of change (i.e., planning, action, or maintenance) it is necessary for practitioners to incorporate other methods of therapy (such as client-centered counseling, cognitive behavioral therapy, behavioral therapy, solution-focused therapy, or other methods that are empirically effective with this population). MI is not intended to be a stand-alone method of therapy (Miller & Rollnick, 2009). Instead, MI is intended to provide strategies for practitioners to work with client resistance and prepare clients for change. Therefore, after clients with eating disorders move into the latter stages of change and begin planning to change or taking action towards behavioral change, MI recommends that practitioners transition to other methods of therapy.

Conclusion

This model of using MI with clients that have eating disorders provides a clear, practical framework for therapists. Practitioners can use this model in order to help prepare clients for change. Additionally, this model offers considerations for facilitating a relationship of respect and collaboration between the practitioner and client, navigating clients' resistance, recognizing clients' readiness for change, and enhancing and strengthening clients' motivation towards change. This model is grounded in an empirically based method of counseling (i.e. MI), which

was founded upon client-centered (Rogers, 1979) theoretical tenets. Therefore the theoretical constructs inherent in this model of therapy have been empirically supported. In addition, this model of therapy provides practitioners with practical and applied interventions for working with clients that have eating disorders (i.e., anorexia nervosa, bulimia, and overeating).

Although the theoretical tenets and techniques of MI have been empirically supported, the use of MI to prepare individuals with eating disorders for change has not yet been researched. Further work needs to be conducted in order to assess the use of MI with this particular population, particularly in regard to preparing this population for change. In addition, a more detailed description of each of the therapy interventions is necessary for the purposes of research.

In conclusion, article offers an applied model of using MI to prepare individuals with eating disorders for behavioral change. Theoretical tenets from the empirically-based method of therapy, Motivational Interviewing (Miller & Rollnick, 2009), were used to present this tried and tested therapy approach. Strategies for individuals at the early stages (pre-contemplation, contemplation, and planning) of the TTM (Prochaska & DiClemente, 1986) were presented in concurrence with MI. In addition, this model recommends transition to other strategies of therapy with clients in the latter stages of the TTM.

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The Soul of Counseling

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Abstract

This article explores the necessity of providing an interfaith/ interspiritual or pluralistic approach to spiritual and religious issues that arise in counseling. Using theories put forth by Carl Jung as well as the theories of other notable modern-day theorists, a case is made for adding the spiritual element to the old bio-psycho-social model of practice and for the necessity of providing counseling that includes a deeper more spiritual approach as a primary part of the counseling endeavor.

Keywords: Counseling, Carl Jung, spiritual problem, religious problem, integration, individuation, self, soul, transcendent self-actualizer, wellness, assessment, treatment, mental health, wholeness, interfaith/interspiritual, pluralistic approach.

Is it possible that counselors are often leaving out a critical element of the counseling endeavor—that of the deepest essence of human psyche—the spiritual component of psychology? Indeed, a language for religious or spiritual problems was largely left out of counseling education curricula for many years. This move away from the natural spiritual component of counseling began early in the 20th century:

> The founding figures of psychology saw no reason to separate spirituality from psychological study and practice. Eminent leaders of the field, from William James to G. Stanley Hall, took the root meaning of the word psychology, from psyche (soul) and –ology (study of) quite seriously and focused their attention on a variety of religious phenomena, most notably conversion and mysticism. In the

> early 20th century, however, this picture began to change as the attitude of those in the field regarding religion shifted from interest and openness to suspicion and hostility. Under the influences of the positivistic philosophy of the time, psychology moved quickly to ally itself with the natural sciences and thereby distinguish itself from its embarrassingly close disciplinary kin, philosophy and theology (Pargament, 2011 p. 271 Kindle version).

More recently, however, there has been more research and discovery regarding counseling and spirituality. New spiritual approaches to counseling and therapy have taken hold over the past several years, ranging from Psychosynthesis and Transpersonal Counseling to Mindfulness-Based Cognitive Therapy. Clients may also choose from the specifically religion-oriented therapies such as Christian Counseling, Buddhist, Muslim, or Hindu Therapy. Pargament (2011) tells us that the shift has included a change in clinical language:

> … a new set of spiritually friendly terms has begun to enter the psychological lexicon, terms such as "mindfulness," "acceptance," "virtues," "detachment," "being present." Nevertheless, promising as they are, these are recent developments, and our discipline remains largely a psychology of control (p.351 Kindle version).

Both the DSM-IV and V use a V-code for "Religious or Spiritual Problem," which may be used when:

> …the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involved loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution (American Psychiatric Association, 2014, p. 725).

This allowance for treatment of these issues has given counselors "permission" to engage the spiritual element of counseling since 1994 when the V code was entered into the publication of the DSM-IV. Over the twenty-one years since that diagnostic category was created, however, how many times have counselors actually made use of that code? Further, the American Counseling Association approved "Competencies for Addressing Spiritual and Religious Issues

in Counseling" in 2009, which may be found online at: http://www.aservic.org/resources/spiritual-competencies. What the creation of these competencies clearly demonstrates is that as a unit, counselors have already put a lot of thought into inviting spirituality into the counseling session. Taken from an individual and day-to-day perspective, however, are counselors generally and as a matter of routine truly offering and taking advantage of the training, supervision and consultation necessary to increasing competencies to the level required? Do counselors readily recognize spiritual or religious issues when they arise in a counseling session? What do counselors generally do when a spiritual issue is recognized? Is referral all too commonly the first option?

Inclusion of the Spiritual/Religious Dimension of Counseling

Carl Jung (1875-1961), though until recently largely unstudied in counseling curricula, has given us a viable theoretical and foundational model for the inclusion of the spiritual/religious dimension of counseling. He wrote, "General conceptions of a spiritual nature are indispensable constituents of psychic life" (Jung, 1933/2001, p. 194). If that is true, then the work of counseling is best provided when it includes the spiritual nature indispensably constituent to psychic life. Indeed, Jung called himself a "doctor of the soul" (Jung, 1963/1989), and in one of his letters wrote this:

> You are quite right, the main interest of my work is not concerned with the treatment of neurosis but rather with the approach to the numinous. But the fact is that the approach to the numinous is the real therapy and inasmuch as you attain to the numinous experiences you are released from the curse of pathology. Even the very disease takes on a numinous character (Dunne, 2000, p. 134).

He defined the numinous as "Rudolf Otto's term (in his *Idea of the Holy)* for the inexpressible, mysterious, terrifying, directly experienced and pertaining only to the divinity" (Jung, 1963/1989, p. 397). This would mean, first, that the numinous cannot be ascribed to only one

religion, faith, ritual, tradition or path. Second, it would mean that this experience must be directly experienced by the client. Third, many of the elemental progressions of the counseling endeavor hold this mysterious, terrifying and sacred or divine quality. How do people really heal? As counselors bear witness to the suffering and work of their clients there is often at least some recognition of this mysterious and sacred, if not also terrifying, quality of the healing process to which counselors are often but observers.

Jung (1959) tells us:

> Unity and totality stand at the highest point on the scale of objective values because their symbols can no longer be distinguished from the *imago Dei.* Hence all statements about the God-image apply also to the empirical symbols of totality (p. 31).

If this is true, how then will we provide counseling to the whole person without considering the symbols of unity and totality or wholeness relative to a person's *imago Dei* or God-image? Clearly Jung is asserting that one arrives at wholeness through the connection with the numinous, as he says:

> To the patient it is nothing less than a revelation when, from the hidden depths of the psyche, something arises to confront him—something strange that is not the "I" and is therefore beyond the reach of personal caprice. He has gained access to the sources of psychic life, and this marks the beginning of the cure. (Jung, 1933/2001, p. 248)

Just as it is impossible to describe the wind by other than its manifestations, it is impossible to describe this strange something that is beyond the "I" yet is clearly found within the individual. Clients come into therapy in variant stages of their own developmental processes; some perhaps even at the stage where they might encounter this numinous stranger beyond the "I". Are counselors, as a general rule, prepared to facilitate such an encounter? Would they know what to do if such an encounter began to occur prior to their intervention?

In another letter, Jung wrote:

> Of all my patients past middle life, that is past thirty-five, there is not one whose ultimate problem is not one of religious attitude. Indeed in the end every one suffered from having lost that which living religions of every age have given to their believers, and none is really cured who has not regained his religious attitude, which naturally has nothing to do with creeds or belonging to a church (Dunne, 2000, p. 134).

Jung used the terms religion and religious to mean spiritual or spirituality. For the purposes of this article, however, the terms will be distinguished according to The *Thesaurus of Psychological Index Terms* (Walker, 1991). It states that religiosity "is associated with religious organizations and religious personnel" (p. 184) whereas spirituality refers to the "degree of involvement or state of awareness or devotion to a higher being or life philosophy. Not always related to conventional religious beliefs" (p. 208). This distinction is relevant to the counseling endeavor as it allows us to take a closer look at the deeper nature of counseling—perhaps even the soul of counseling.

If it is true that clients do not really get well, as Jung said, until they have touched the hem of the garment he called *numinous*, then perhaps counselors should seek to know how to provide assessment and treatment, which addresses the constituent spiritual element of counseling. In increasing cultural competencies and competencies for addressing religious/spiritual issues, counselors are called upon to understand various religions, which are fundamental to given cultures. Further, in this day in which so many call themselves "spiritual but not religious," understanding the spiritual component of wellness, and of the therapeutic endeavor, would, if Jung's statement is true, be even more essential to effective counseling.

Changing the Definition of Wellness

Abraham Maslow (1971) studied the optimally functioning person in which transcendent self-actualizers were at the top of his hierarchy. These were people who reached above the merely-healthy self-actualizer, demonstrating certain characteristics that can easily be characterized as fitting into such descriptors as the totality or wholeness described by Jung. In an article entitled *Counseling for Spiritual Wellness: Theory and Practice*, in the *Journal of Counseling and Development,* the authors, Chandler, Holder and Kolander (1992), synthesized the characteristics of the transcendent self-actualizer thusly:

> …a more holistic perspective about the world, a natural tendency toward synergy (cooperative action)—intrapsychic, interpersonal, intracultural, and international; much more consciously and deliberately metamotivated behavior (i.e., by truth, goodness, unity); more responsiveness to beauty; a greater appreciation for peak experiences; non-power-seeking attitude over others; the ability to speak naturally and easily—the language of "Being"; the ability not only to be aware of their self-identity but the capability of going beyond the ego self; attitudes that were more lovable and awe-inspiring; and more cognizance of the sacredness of every person and every living thing (p. 168).

Generally speaking, this is a person who understands the magnitude of life from a more holistic, joyful, soulful, integrated and transcendent perspective. In order to attain to this level of functioning, a person must be able to take care of the other hierarchical needs addressed by Maslow. Perhaps s/he even relies upon this transcendent perspective to take care of those other needs.

Should this definition for wellness apply to all clients? Certainly, counselors cannot create expectations for clients. Ideas, theories and ideals about wholeness, notwithstanding, clients are going to function at the level of their capacities and choices. If, however, counselors are going to be willing to invite a more spiritual approach into the counseling endeavor, a

consideration may need to be made for adding the spiritual dimension to the old bio-psycho-social model of assessment and treatment.

A Case for Wholeness as a Positive Outcome of Counseling

A student of the Bible, the Hindu Upanishads, the ancient Gnostic texts as well as cultures and religions around the world, Carl Jung researched the variant cultural influences on the human psyche as well as the deeper relationship between self and culture, both of which ultimately fall down to the deeper relationship between the consciousness and unconsciousness of a given individual. Jung clarifies the relationship between consciousness and unconsciousness thusly:

> Consciousness and the unconscious do not make a whole when either is suppressed or damaged by the other. If they must contend, let it be a fair fight with equal right on both sides. Both are aspects of life. Let consciousness defend its reason and its self-protective ways, and let the chaotic life of the unconscious be given a fair chance to have its own way, as much of it as we can stand. This means at once open conflict and open collaboration. Yet, paradoxically, this is presumably what human life should be. It is the old play of hammer and anvil: the suffering iron between them will in the end be shaped into an unbreakable whole, the individual. This experience is what is called…the process of individuation (1939, p. 13).

What this means, then, is that even when things become symptomatic or diagnostic, the psyche could be trying to find and integrate the self. Indeed, Grof (2000), one of the founders of Transpersonal Psychology, has this to say about even some of the worst symptoms counselors may encounter:

> …many of the conditions, which are currently diagnosed as psychotic and indiscriminately treated by suppressive medication, are actually difficult stages of a radical personality transformation and of spiritual opening. If they are correctly understood and supported, these psychospiritual crises can result in emotional and psychosomatic healing, remarkable psychological transformation, and consciousness evolution (p. 137).

If this is true of such devastating disorders, how much more so could it be true of depression, anxiety, PTSD and other like disorders, or even issues, such as divorce, job change, and other like life crises?

In fact, though much more research is needed in this area, some significant results of including spirituality into counseling practice have already been revealed. A 2010 small pilot study on the efficacy of a pluralistic spirituality-based intervention (SBI) in treating generalized anxiety disorder, found that it "had greater efficacy than a rigorous control in improving symptoms of GAD and enhancing spiritual well-being" (Koszycki, Bilodeau, Raab-Mayo, and Bradwejn, 2013, p. 489). Research also demonstrates that cognitive behavioral therapy (CBT) that includes spirituality increased positive psychological outcomes for individuals in drug and alcohol treatment. Further, a meta-analysis conducted in 2007, on the effectiveness of spiritually oriented psychotherapy showed positive outcomes for anxiety, depression, stress and eating disorders (Hodge, 2011).

Murray Stein (1998) explains the process of becoming conscious through the eruption of affect:

> The way into the unconscious, Jung points out, lies initially through emotion and affect. An active complex makes itself known through disrupting the ego with affect. This is a compensation from the unconscious and offers potential for growth. Eventually, he goes on, these affective disturbances can be traced to primordial roots in instinct, but they can also lead to images that anticipate the future. Jung posits a finalistic point of view, a movement toward a goal. In order to approach wholeness, the conscious/unconscious systems must be brought into relationship with one another (p. 188).

This disruption of emotion potentially allows the client to bring, into conscious awareness, aspects of the self previously unknown to him/her, thus bringing the client closer to wholeness. Counselors who are developing the core competencies for addressing spiritual/religious problems

can utilize this disruption of emotion that typically comes about as a result of a psychological crisis of some sort, to facilitate a process toward wholeness, which begins, as stated above, with the touching of the hem of the garment Jung called *numinous*.

Case Study

The following case is fabricated but made of true-to-life material. John has recently learned that his wife of seven years is having an affair. He is devastated by this fact, especially since he has also learned that she is pregnant with the other man's child. John and his wife have spent an enormous amount of money on various approaches to fertility to no avail. It was John, much more than his wife, who wanted children. Not only is he broken-hearted about his wife but he is furious with life, for as he put it, "there is just no way to make this even look like fair." During the assessment process the counselor learns that he was raised by a Baptist pastor who taught him of a "good God who blesses good people." In his agony and tears of frustration he repeats several times, throughout several sessions, that he just does not know what he has done to deserve this.

Is John having a spiritual problem? On the surface, it might be assumed that his statements are the common protestations of grief. In this case the counselor might help him to get in touch with the feelings of grief, while simultaneously facilitating his awareness of some self-soothing skills he might put into place. The counselor might provide support for his efforts to get a divorce and move on with his life taking with him some of the lessons of love and loss. All of these are helpful, and they may facilitate his ability to put his life back together with some new coping skills in hand.

But if the counselor is listening for the spiritual issues, it might also be possible to hear that John is having an existential crisis in which the foundation of his spiritual identity is being

rocked. Who is he now, if his goodness cannot get his God to bless him? What mysterious and terrifying forces have arisen to bring him to this precipice, on which he has now the opportunity to discover a deeper aspect of soulful living.

How can the counselor facilitate his creative response to this spiritual crisis? Joining him in his questioning is one way to open up the conversation toward greater awareness. If the counselor allows his soul-wrenching questions to pass as put protestations of grief, then an opportunity might be missed. Rather, the counselor might say something like, "Okay, let's go with that question, if you have understood your God correctly then what *have* you done to deserve this?" What that question first has the capacity to do is to surprise the client so that he gives himself permission to really ask the question. Following that might be a litany of all of the good and kind things he has done, followed by the protestation that when "I have sinned, I have always asked for forgiveness and I try really hard not to sin!" So, then, why is this happening?

The "Why?" questions are always on the tip of the tongue when it comes to these tragic issues of living that seem to come out of nowhere for no reason humans can grasp. It is not uncommon for people to forestall the settling into acceptance until they have answered those questions. Indeed, they commonly hold acceptance hostage to these questions. So, if it is common for humans to ask these questions, why not really ask them? If the question is asked then, dare we consider an answer? This puts the terrifying element into the equation, for so many have also been taught not to question any authority, much less that of their particular image of the Divine.

If the answer to the question is that John does not believe that he has done anything to deserve this devastating situation, then what are the other possibilities? Is it possible that what his father taught him is not really true? And if that is possible, is it also possible that at least

some aspect of his *imago Dei*—his deepest, most authentic image of the Divine, which Jung related to the self or soul—must now be located and appreciated? It is often at these junctures, in which people are faced with this type of conundrum about the seeming absolutes in life that they must either revise or throw out entirely their projections.

Therefore, some might say that if the Divine does not exist this way, than the Divine does not exist at all. Is that a stand John could genuinely tolerate, given that he had previously felt a deep and warm connection to his God? If so, what would this mean about his foundation for life? Where does he find meaning and an essential life-affirming philosophy now? How does this change his experience of the self?

Another option is that he might find that his *imago Dei* must change to take in a new perspective. This is a place of containment in which there is an allowance for the Divine to be the Divine, separate and distinct from human expectations. Since he is letting go of old agendas, John may now allow himself to be contained by this new version of the Divine and to contain that new version within a deeper understanding of self. From this place he may have the courage to revise all kinds of belief-based structures about life to come more in line with reality. What does this, then, mean about the foundation of his life and experience? How will he look at his history and his future differently? How does this change his experience of the self?

From this questioning process it is possible to learn that John now has the opportunity to find and begin to live from a deeper, more meaningful perspective—perhaps one that could even offer the possibility of deeper personal responsibility and the reception of life in all of its glory and its pain. If this were to be the outcome of counseling, John has not only felt and dealt with his grief, learned how to self-soothe and how to move on with life, but he has found deeper more

potent aspects of himself and of life—perhaps even attaining to a greater, more transcendent level of wellness.

In this process the counselor need not verbalize reference to any particular Divine image but the one that the client has imaged. The counselor need not put forth any other religious value than that held by the client. The exploration of the client's questions can utilize the language and motifs of the client. The counselor's job here is not to bring the client to any particular religious or spiritual understanding, but rather to facilitate the client's awareness of the client's questions and the client's answers. In this way whether the client referenced the Judeo-Christian God, the Muslim Allah, the Buddhist philosophy of Buddha nature, or any other *imago Dei*, the client is the one doing the work of exploration. The therapist is joining the client, supporting the client and being willing to facilitate the inner journey necessary to finding a genuine answer to the client's questions.

It is apparent that this exploration implies not only the questioning of previous religious training, but also the questioning of the client's identity and his spiritual connection to the Divine. Therefore, he is addressing both a religious and a spiritual problem, according to the definitions referenced in the DSM IV and V above. What is also apparent is that the counselor is able to allow the client to come from and be in his own religious or spiritual experience, without counselor bias, as is required by "Core Competencies for Addressing Religious of Spiritual Issues." This is but one example of the many ways counselors can be open to exploring the spiritual and/or religious aspects of client's lives in ways that could be life-altering.

The Inspiration of the Counseling Endeavor

If counselors believe that only the mention of the name "God" in a counseling session is relative to a religious or spiritual problem, perhaps they miss the point. If, however, the

wholeness or wellness mentioned above is a possibility for clients, then perhaps a longer and deeper view of the nature of human psychology is called for. Leaving the spiritual element out of assessment and counseling endeavors may mean that we are not treating the whole individual, couple, or family.

If counselors are inspired toward personal wholeness, they are much more likely to be inspired to potentiate the facilitation of wholeness with clients. Indeed, counselors are required by the Core Competencies to attend to self-awareness in a way that evaluates his/her own values and how they might impact the client—a process that lends itself toward wholeness. If such wholeness or wellness as described by Maslow and Chandler, Holder and Kolander above is possible through the counseling endeavor, perhaps then counselors should consider how it might look to facilitate such wellness or wholeness in a counseling session.

Maslow (1971) researched a special set of "B-Values" which "behave like needs" and which he called "metaneeds." Of these he said:

> Their deprivation breeds certain kinds of pathologies which have not yet been adequately described but which I call *metapathologies*—the sicknesses of the soul which come, for example, from living among liars all the time and not trusting anyone. Just as we need counselors to help people with the simpler problems, so we may need *metacounselors* to help with the soul-sicknesses that grow from unfulfilled metaneeds…. In fact I would go so far as to say that these B-Values are the meaning of life for most people, but many don't even recognize that they have these metaneeds. Part of the counselor's job may be to make them aware of these needs in themselves…. (p. 44).

Can counselors truly say that they treat the whole person, if they are not addressing these metaneeds?

Conclusion

When we consider the concepts of optimal wellness and wholeness, the old bio-psycho-social model of assessment and treatment of the client might need to be revised to add the

spiritual dimension. Adding the spiritual element to the counseling process does not mean counselors become Priests, Imams, Rabbis, Pastors or Gurus. But it does mean that they can make room for the natural longing in the human psyche to become whole. Further, "One does not have to belong to any particular theoretic orientation to attend to the spiritual component of wellness with clients; one does need, however, an understanding, appropriate training, and, of course, a willingness to work with the spiritual dimension" (Chandler, Holden and Kolander, 1992, p. 174).

The willingness to be open to the spiritual element of the counseling process is central to building the competencies relative to addressing religious and spiritual issues in counseling. If client wholeness or wellness is a potential outcome of such willingness, then the question that remains is this: Are counselors practicing ethically and responsibly if they forego the very things that might facilitate a client's wholeness?

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Using Art-Based Strategies in Group-Based Counselor Supervision

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Using Art-Based Strategies in Group-Based Counselor Supervision

In addition to course work and experiential learning experiences, a vital aspect to counselor training is clinical supervision. Supervision acts as a mediator bridging the gap between theory and practice. Supervision models are continually expanding to incorporate more creative and effective techniques. Utilizing creative interventions has been increasing in clinical work and may be beneficial to be utilized more in training counseling students. One way to incorporate creative and expressive techniques into a counseling program is to integrate art-based strategies into clinical group supervision.

Literature Review

There is an abundance of literature on the subject of clinical supervision in counseling. For the purposes of this article, the literature was divided into three sections following a general overview of clinical supervision in counseling. These sections are school counselor supervision, group supervision, and art-based techniques.

Clinical supervision

Clinical supervision is a fundamental aspect of preparing mental health professionals for competent practice (Bernard & Goodyear, 2009). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) mandates participation in counselor supervision as part of education and training procedures (CACREP, 2009). Although course work in psychotherapy theories, group therapy techniques, research, and so forth are crucial in equipping students for clinical practice, it is through supervised experience with clients, in the internship or post-graduation, that deep learning about clinical work occurs. (Deaver & Shiflett, 2011)

A variety of definitions for clinical supervision exist. Differences typically reflect aspects of the author's academic discipline and training focus (Deaver & Shiflett, 2011). Bernard and Goodyear (1998) conceptualize clinical supervision as an intervention that is provided by a more senior member of a profession to a junior member of that same profession. The authors conceptualize clinical supervision in the same way and will use the same definition for this article. The relationship is understood to be evaluative and serves to enhance the skills of the junior member, as well as insuring supervisee client welfare. Supervision is provided in an individual or group format with the location being negotiable. The primary goals of clinical

supervision are to facilitate supervisee development and oversee the quality of services the supervisee provides. (Bernard & Goodyear, 2004; Overholser, 2004)

School Counseling

In the school counseling setting, experienced school counselors provide supervision to school counseling students during their practicum and internship experiences (CACREP, 2009), but little is known about the use of clinical supervision after graduation. Unfortunately, clinical supervision after graduation is inconsistent across the school counseling profession. School counseling, like all school services, is managed by the building principal, who may not have any training in mental health. Given the lack of consistency of supervision across the profession and lack of research on the topic, school counselor supervision is not well understood (Granello, 2002). Current literature suggests that professional school counselors are rarely prepared for the site supervision of counselors-in-training (Page, Pietrzak, & Sutton, 2001), nor are they equipped to initiate interns into the various roles required of a school counselor according to ASCA's National Model (Studer & Oberman, 2006). These deficits in supervision training may result in inadequate supervision, poor modeling on the part of the supervisor, frustration, and substandard initiation into the profession. (Magnuson, Wilcoxon, & Norem, 2000)

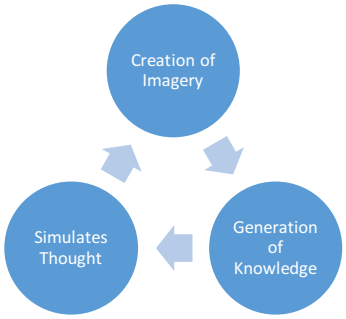
Group supervision

The use of group formats for clinical supervision of students and counselors is a growing trend across the country. Group leaders are continuously searching for ways to improve their supervision to address multiple learning styles. Yalom and Leszcz (2005) recognized the importance of group supervision in the development of effective group leaders and counselors. It also has been observed that despite the small but growing empirical literature on group

supervision (Linton & Hedstrom, 2006; Riva & Cornish, 2008), little has been written about the best practice processes, interventions, or applications within the supervision of group leaders (DeLucia-Waack & Riva, 2010).

Art-based techniques

The literature suggests that art practice—that is, focused and mindful art-making—is itself a constructivist, meaning-making endeavor (Grushka, 2005; Marshall, 2007; Serig, 2006; Sullivan, 2006; Walker, 2004). Art practice is similar to the research process, in that art-making leads to the creation of imagery, generation of knowledge, and the stimulation of new thought. This is demonstrated below in a model based on Deaver & Shiflett (2011):



Art-based supervision is based on experiential learning. There is a connection between first manipulating materials to create an art piece and then making sense of it (Arnheim, 1980; Hickman, 2007; Marshall, 2007). Art-making ‘‘allows information to be seen differently, in a fresh, more meaningful, personal, and experiential way (as in art, symbolism, and metaphor). This transformation of concepts through imaging produces new insights and learning’’ (Marshall, 2007, p. 23). Art-making in and of itself may not be sufficient for knowledge construction. The act of critical reflection is necessary in art-making in order for art practice to be an opportunity for construction of meaning (Sullivan, 2006; Walker, 2004). In a way, art-

making and critical reflection circularly reinforces one another making both components necessary for meaning making. Additionally, the use of art and reflection assists the students to see the situation from multiple perspectives, some of which cannot be seen without the use of art.

Case study. Curtis Sullivan*, an intern in a masters of mental health counseling program, created a visual case presentation of one of his clients from his internship site. Curtis chose a client who challenged him as a clinician. He wanted to get input of the case from his clinical supervisor and fellow peers. One concern he had about the therapeutic relationship is that he didn't think he was helping the client because he wasn't seeing immediate results. He created a collage that grouped the client's issues into categories. As he was explaining his visual case presentation to the supervision group, and through questions from the supervisor and peers, Curtis realized that as a clinician, he was teaching his client to compartmentalize and process big issues in smaller chunks because of his structured therapeutic style. Curtis admitted that the process of creating the visual case presentation and sharing with the class, he gained more inspire about the therapeutic relationship, the counseling process, and himself as a clinician.

Considerations

Based upon the literature of clinical supervision and art-based techniques, the authors have developed the following considerations based upon their combined supervision experience with art-based techniques in clinical supervision. The considerations have been divided into focus, logistics, resistance, multicultural considerations, and types of art-based supervision techniques.

Focus. Art-based group clinical supervision can be conducted in varying formats, interpersonal versus intrapersonal, depending on the setting and needs of the supervisees and the

training and knowledge of the group supervisor. The two basic settings for this type of supervision are academic program based and post-graduate based. While these two settings have a lot in common as far as materials and techniques, the complexity of the supervision should be adjusted to fit the developmental needs of the supervisees. For example, beginning counseling students may benefit from activities based upon recognizing what a client is feeling or even what he or she is feeling as a clinician, while more advanced supervisees may find this too elementary. More advanced clinicians may benefit in using art techniques to assist in conceptualizing difficult cases or to understand group and interpersonal dynamics. In contrast, certain supervision activities, such as separating a client's feelings from your own, may benefit supervisees of many levels. Art techniques may also reveal transference or countertransference issues or areas of concern in a tangible, recognizable medium.

Academic programs may benefit from using art-based supervision throughout the course of a student's studies. Clinical supervisors in academic programs have the benefit of being able to incorporate alternative supervision methods throughout multiple courses. The use of emerging supervision techniques, such as art-based supervision, can help students conceptualize their clients in different ways. These supervision sessions could also help the student supervisee as he/she is struggling to learn how to effectively treat clients for the first time.

Logistics. There are practical considerations to keep in mind when engaging in art-based group supervision. These logistical considerations include materials, location, and complexity of exercises.

Materials. The materials offered for the supervision should be carefully considered. The commonly used materials for art-based supervision are similar to those utilized for art therapy.

Drawing materials can include pens, pencils, crayons, markers, paint, and colored pencils. (Johnson & Sullivan-Marx, 2006) It is important to consider what drawing materials would be the most suitable for the activity chosen. Different materials elicit varying degrees of emotions; for example colored pencils elicit less emotions than pastels due to the nature of the medium. The greater ability to manipulate the material, the more emotions the material can elicit. The time required to perform activities is also important to consider. While some activities may be compatible with a slow-drying materials like paint, other activities may require immediate displaying in the group. Another important consideration with drawing materials is the physical abilities of the supervisees. Limitations to fine or gross motor skills should be evaluated and the appropriate accommodations made. (Johnson & Sullivan-Marx, 2006)

While many supervisors may immediately think of drawing and coloring as the only feasible method of art-based supervision, non-drawing mediums should also be considered. Non-drawing mediums include collage, clay, model magic, and play-dough. These mediums provide supervisees with an alternative method of self-expression. Magazines can be utilized to make a collage or for supervisees to find a specific picture that represents the purpose of the activity. To cut down on time, the supervisor may have pre-cutout words and images from magazines that the counseling students may utilize. Moldable mediums, such as clay and play-dough, provide supervisees with the opportunity to work with their hands and create a three-dimensional representation for the provided activity. Model Magic is similar to clay or playdough, however, it dried to become a sculpture the student may color and keep.

Based on the student's ability, personality, learning style, and preferred methods of expression, other creative based art forms may be used such as music (songs and/or lyrics),

expressive writing, videos, photography, or dance. The self-reflection piece is still vital to meaning making when using these methods.

Location. Another significant consideration in art-based group supervision is location. A prepared clinical supervisor, in both academic and practice settings, should consider the physical location in which the supervision will take place. When planning a location, it is important to consider what kind of surface will be needed for the art project. While sitting around a table is not always conducive to group supervision, it is important to provide a stable surface for the art project. Supervisors should consider if clipboards would be sufficient or if an actual table is needed.

Another location-based consideration is whether the supervision sessions will be conducted face-to-face or in an alternative format. While art making is primarily done in individual supervision, it is important to note the possible use in group supervision. Time in a huge consideration when utilizing art in group supervision. Supervisors need to factor in the time it will take to execute the intervention and also the time allotted to share it with the group. Depending on the processing questions, meaningful discussions may take the whole supervision session. While face-to-face supervision is the norm for most counselors, alternatives are sometimes needed for extenuating circumstances. For example, in remote regions it may not be possible for counselors to attend a weekly supervision meeting, particularly in a group format requiring multiple members. For these supervisees, alternative supervision formats are important. Art-based supervision can be very effective for these types of situations. Through the use of video-conferencing technology, such as Web-Ex and Skype, it is now possible to meet together across great distances without losing the body language competent.

In academic settings, distance supervision can also be useful. One example is with members of the military and their partners. It is not unusual for military members or their partners to engage in academic programs thanks to the financial assistance the military provides. (Department of Defense, 2013). For these individuals, deployment and station transfers are a significant concern (Newby, et al, 2005). Distance supervision for these individuals provides a way to help counseling students complete their academic programs despite transfers in location. Special accommodations should be provided for military members and their partners. The inclusion of these options in program handbooks could also help in the recruitment and retention of military-affiliated individuals. Students living far away from the campus, have long internship/work hours, or have complicated schedules may also benefit from distance supervision.

Complexity. The last important factor in logistics is complexity. It is important for supervisors to consider the complexity of the art-based projects utilized. Complexity should be conceptualized as not only the difficulty level of the project, but also the size of the medium provided. While slowly increasing the difficulty of a project is not foreign to most supervisors with a background in education or medicine, titrating the size of the medium can be strange to consider.

Case Study. For example, when the first author first started using art-based techniques in my group supervision, I provided my supervisees with a whole sheet of paper for their project. The supervisees looked very apprehensive and verbalized concerns that they would not be able to fill up such a large amount of space. I quickly learned, both through a literature review and practice, that it is important to titrate the sizes of the medium up. I frequently use the concept of how psychiatric patients are titrated up on a medication until they reach a therapeutic level.

Much like medication, it is important to slowly increase the amount of space provided so as to not overwhelm the supervisee. It is suggested that a supervisor start out with an index card sized space before increasing slowly to the desired space. Following the same idea, it is also important to provide the option of different sizes of materials to your group supervisees as some individuals may be able to handle the increased space.

Case study. I (Agbisit)I started providing art based supervision with basic paper and crayons or colored pencils, however the more I was trained in using art in therapy and supervision, the more I started incorporating other methods of expression and allowed my students to choose which method they are most comfortable with. Because of the time and location of class and the size of one student's project, a person-sized structure, the student took pictures of the sculpture and submitted it with her case conceptualization write up. Since then, I require students to provide a digital form of the artwork in addition to the actual art piece. This assists with having a simple way to turn in projects that are too big to physically carry. Some digital forms include: PDF versions, pictures, power points, and MP3s. An addition benefit of having a digital form is that usually in the beginning of an art project, many counseling students want to "complete the assignment," but by the end, they are proud of their creation and the meaning behind it. A digital copy is one way students may document their work and use it as a reminder of some sort, motivation, or sense of accomplishment as a clinician.

Resistance. While some counselors may be resistant to using art-based strategies because of their perceived lack of skill in art, no certification is necessary to utilize art in supervision. Counselors should, however, obtain training through coursework, art making in supervision, workshops, special trainings, or obtain supervision with an art therapist. The strategies used in art-based counselor supervision are adaptable to persons of varying artistic abilities. The art

supplies discussed in this experiential presentation are accessible to supervisors in all geographic areas (including virtually) and can be utilized by persons with varying physical abilities.

Multicultural and Ethical Considerations. A major consideration when engaging in art based supervision is supervisor competence. Like using any unfamiliar technique, obtaining supervision of supervisor or consultation with an art therapist or a therapist who is an expert in using art in therapy and supervision is important for supervisors offering art making for the first time. As with all treatment methods we use with clients, culturally competent supervisors should consider the needs of diverse supervisees. Diversity can come in a multitude of forms, so it is important to quantify some of the specific considerations that should be attended to in art-based counselor supervision. Multicultural considerations should include attention to differing socioeconomic status, access to supplies, race, ethnicity, sexual orientation, and physical abilities. Consideration should also include students' openness to using art in supervision and confidence in ability. The same standard of confidentiality used in written case conceptualization and supervision interventions should also be used also in art-based techniques. Additionally, art-based materials should be treated with the same level of care as case notes.

Types

There are many different ways art may be utilized in supervision. Art-based strategies may assist in understanding the therapeutic dynamic or even in understanding how interpersonal factors affect the counseling process. Art-interventions may also track progress in the counseling relationship or counselor growth. Below are some general common types of ways supervisors can utilize art in supervision.

Case conceptualization. Case conceptualization, also known as visual case processing, is the first type of art-based supervision that will be discussed. This type of art-based supervision is the most commonly used by the first author in his professional work. This type of supervision can be very useful in helping access the multiple learning styles of supervisees. Through the integration of visual, auditory, and participatory learning styles, the supervision session can be enhanced for both individual and group formats.

According to Ishiyama (1998), the visual case conceptualization method involves four main steps; (1) reflection on a case and responding with words to a series of prompts, (2) generating imagery and metaphors, (3) drawing the case, and (4) presenting the case in group supervision. The first step, reflection on the case, involves the supervisee self- reflecting on the client case silently. This can be done in a variety of ways depending on the needs of the supervisees. Supervisees in the past have chosen to silently think about the case, review session notes, or to write down a few key words or phrases from the case. This reflection time gives the supervisee time to focus just on that specific client case.

During the second step, generating imagery and metaphors, the supervisee is instructed to think of an image or metaphor that would accurately describe the client case. This image can be of the case overall, in the past week, or even how they view their relationship with the client. Examples of previous case drawings are often very helpful as they provide guidance about what is expected. This step is where supervisees in the past have become apprehensive. Concerns about artistic ability and the "perfect" picture to symbolize an entire case frequently have come up. It is important to assure the supervisee that this is a safe environment to take risks in. The picture does not have be advanced, nor the picture the "perfect" one.

The third step, drawing the case, is much more complex than one would think. As discussed above, it is very important to put forethought into this step. To effectively empower a supervisee to draw the case, appropriate supplies and mediums must be presented. Failure to provide varying sizes and mediums could stifle the creative process in a supervisee. During this time, it has been found to be conducive for the supervisor to also draw a case conceptualization image. The shared creative process has served to ease supervisee anxiety over artistic ability and ideal picture.

The last step, presenting the case, is where supervisees often achieve the most learning. During this step, supervisees, if in a group, take turns presenting their cases based upon the pictures. The supervisee provides the group, or supervisor if individual, with basic information about the case before presenting the picture to the group. Through presentation of the picture and the ensuing questions and discussion, information about the case is provided. Often supervisees have realized aspects about the case, particularly surrounding their relationship with the client that they did not recognize previously. The visual case presentation method serves to provide both supervisees and supervisors with another lens through which to view a case. Sometimes the altered method of viewing the case can provide significant information or themes that are not present during a traditional case presentation.

In order to incorporate different learning styles and to solidify and strengthen the student's ability to conceptualize cases, the second author expanded the visual case presentation to utilize any expressive technique and also added an additional written component to Ishiyama's model. She requires her students to do a creative case conceptualization with a written piece. Some creative conceptualization examples include visual drawings, videos, model clay, sculptures, and music. The student is then required to explain in paper form the creative piece in

as much detail as possible about how it relates to the client and therapeutic relationship and process. The paper also includes ethical and multicultural considerations and self-awareness. The paper is due prior to the presentation. Adding the written piece not only adds depth in the presentation, it also adds depth to the group discussion after the presentation.

Counselor self-reflection. There are four methods of counselor self-reflection that can be used in art-based supervision; 1) developing empathy with the client, 2) clarifying the therapist's feelings, 3) differentiating the therapist's feelings from the client's, 4) and exploring the therapeutic relationship (Kielo, 1991). The four methods move from a more rudimentary understanding of the impact of emotions in the therapeutic relationship to a more complex one. Through the use of self-reflection on emotions, supervisees can gain a better understanding of both themselves and their clients. (Kielo, 1991)

In the first method, developing empathy with the client, the supervisee draws a picture of how s/he imagines the client feels. This activity helps the supervisee better understand how s/he perceives the client was feeling during the session. An inaccurate perception by the supervisee can then be challenged and corrected by the supervisor. In the same way, an accurate perception of the client's feelings can also be a starting point for a discussion of how the supervisee reacted in session.

In the second method, clarifying the therapist's feelings, the supervisee self-reflects on their own emotions either currently or during session via art. This activity helps the supervisee gain a better understanding of their own emotional state both in session and during supervision. At times, a counselor's emotional state can interfere with their ability to practice effectively.

Therefore, it is important for supervisees to gain a better understanding of their own emotions both in and out of sessions.

The next method of counselor self-reflection is differentiating the therapist's feelings from the client's feelings via art. In this method the supervisee reflects on both the feelings of their client and their own. This activity is important in that it allows supervisees to differentiate between their own emotions and their clients. Sometimes, it is difficult for counselors to separate themselves from the intense emotions of their clients. This activity is important in developing the skills to separate the counselor and client emotions.

Tracking counselor growth. Another use of art-based techniques in supervision is to track supervisee growth. The first author has had success with using art-based techniques for this purpose with counseling students. In this application, art can be used in two ways; 1) periodic check-ins or 2) reflective review. In the first use of art in tracking counselor growth, the supervisee produces art, such as a picture, at pre-determined points during the supervisory relationship. The art can cover any number of topics, including the supervisee's view of their skills or expertise. While a number of topics can be used when creating the art, it is important to retain the same theme throughout the entire supervisory relationship. For example, I have frequently had students create a picture at the beginning, mid-term, and final weeks of both practicum and internship courses. The students were instructed to create a picture that demonstrates how they perceive their skills at that moment in time. This same instruction was given during all three art creation events. The use of art creation on the same topic over a period

of time allows both the supervisee and supervisor to see growth in the supervisee. In the past, supervisees have seen how their perception of their skills has changed during the 16-week semester.

The second use of tracking supervisee growth, reflective review is similar to the first but is conducted in a different manner. During reflective review, the art creation is limited to a one-time event. The supervisee is given instruction to create an art piece on a particular subject, just like in the periodic check-in method. Instead of creating just one picture, however, the supervisee creates two-three pieces depicting their perceptions over the course of time, depending on supervisor directions. In the first author's practice, the supervisees perform the reflective review during the final weeks of the respective course. Supervisees are directed to reflect upon how they remember their skills at the beginning of the semester, middle of the semester, and then how they feel about their skills at the current time. While reflecting upon one's previous perception of skill could be seen as less authentic than an in-the-moment reflection, the realization of personal growth is still present. It is believed by the authors that accurate rating of growth in skills is not as important as the supervisee's growth in self-confidence because of the exercise.

Modeling therapy techniques

Since the use of art in therapy is experiential, supervision time may be used to model art-based techniques that supervisees can use with clients. The process of explaining an art intervention and making the art is an intervention in itself. When a supervisor models an intervention, the supervisor is modeling a way for the supervisee to administer the intervention to his or her clients. As the supervisee is following the intervention instructions, he or she is

experiencing the thoughts and emotions that the intervention brings up. These emotions may include confusion, anger, mixed emotions, happiness, and uncertainty. Having the supervisee experience the process of the intervention will help increase empathy and understanding when working with clients. Furthermore, the supervisee will be better able to assist a client if the client gets stuck or has difficulty with a particular part of the intervention.

The added bonus of doing the intervention during supervision is the ability to process what is happening with both the supervisee and the supervisor. During the processing, the supervisor and supervisee can talk about the intrapersonal dynamics going on with the supervisee. The supervisor, similar to a counseling session, may assist supervisee in discovering projection and transference issues, blocks, and resistance to improve self-awareness. Additionally, the supervisor can discuss dynamics involved in administering the intervention, something that may be taboo in a regular client session because it may be seen as gross self-disclosure. Not all interventions, especially if the counselor is not confident in using the intervention, are straightforward and there is an element of problem-solving and decision making involved. It is important to normalize the process for counselors in training so they do not get disheartened.

Another way role modeling is important is because the supervisor can assist the supervisee in incorporating the intervention into the supervisee's counseling style and personality by processing the timing, the clarity of explanation, developmental level needed to execute it effectively. Assessing the difficulty level, openness, and skill level of the client are also important topics to discuss. Speaking of the appropriate population, risk factors to watch out for, and appropriate setting and supplies needed to administer the intervention are also important factors to consider.

Perspective-taking. Supervision can be used to provide a chance for supervisees to reflect on how they view themselves and how they perceive others view them. Art interventions may be used to expose internal processes in a way that words cannot. The process of creating and self-interpreting art can illuminate the position one sees him or herself in relation to others, whether that is equal, elevated, inferior, distant, etc. This can directly correlate to the therapeutic counseling dynamic and may have a negative impact on the therapeutic relationship if that dynamic does not mesh with the client. When a counselor has insight of interpersonal dynamics, he or she is better able to utilize interventions intentionally and effectively.

Another way utilizing art interventions to increase perspective taking is that the supervisee is able to look that the art from different distances, angles, and lighting. The supervisee can also rotate and touch the art, and may even manipulate its properties, such as cutting, restructuring, burning, etc. This gives visual and kinesthetic learners a different perspective on viewing, handling, and interpreting the art, hence giving the supervisee more authority to handle the art in different ways. This may translate to the supervisee to being able to see his or her life as well as his or her client's life with new perspectives and meanings.

Termination. Termination is a natural process within the supervision and therapeutic relationship. Prior to termination, counselors should mentally prepare themselves for termination (King, 2001). Supervisors can assist students by preparing them during supervision though interventions, discussion, and assignments. One method utilized as a tracking tool and a termination activity is to do a weekly check-in of the supervisee's experience and feelings about their clinical training experience. Each week the picture is processed with the supervisee and supervisor and at the end of the semester, the pictures are lined in order from start to finish and is processed by the student and supervisor. This may also be done with a blank madala. The

student and supervisor processes the growth, areas of improvement, and development of the student throughout the semester and discuss ways to grow as a counselor. Another termination activity for counseling interns is guided-imagery. The supervisor reads a prompt specifically developed for termination with counseling interns. The intern is then asked to draw the image seen during the guided imagery prompt and then process it with the group. This specific intervention is designed to assist interns in terminating from internship and planning the next steps in the transition between being a counseling student and a clinician.

Conclusion

Using art-based strategies in counseling and supervision allows counselors to go deeper within themselves and their clients. Art-based strategies incorporate both right and left brain functioning and the process of creating and processing art allows students to process cases from a perspective words alone may not be able to access (Caoacchione, 1996). Because it incorporates the student's learning style and creativity, art based strategies may accelerate learning and understanding of the counseling process, inter and intrapersonal dynamics, and personal growth. Using art in supervision may also assist the student in creating creative interventions during client sessions.

There are unlimited ways art may be utilized in supervision. Because it may not be a common technique used, it is always encouraged that supervisors seek consultation and training when utilizing new supervisory techniques. Starting with less manipulative material such as crayon and colored pencils may be beneficial for supervisors with limited experience and comfort with using art. The same ethical standards and care should be utilized with art-based interventions. With intentional and proper use of art-based strategies in supervision, students

and clinicians in counseling training programs and post-graduation supervision may benefit counseling skills, understanding, personal growth, and client growth.

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