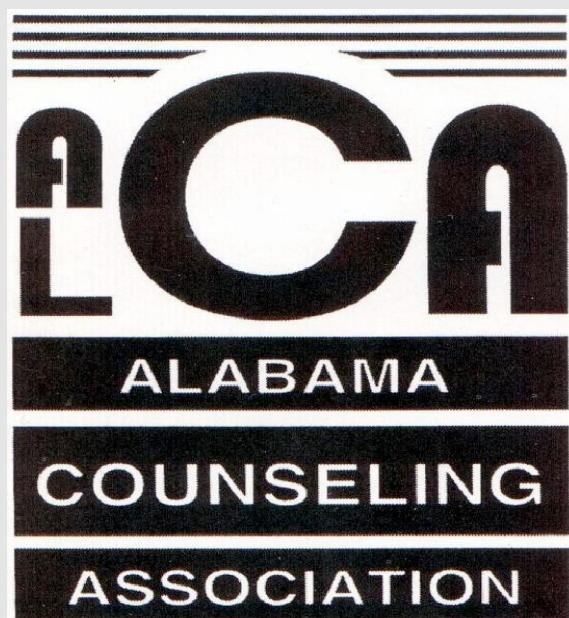


# The Alabama Counseling Association Journal



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***Letter from the Editor***

I am excited and happy to be working for all of you as the new Editor. Usually, new editors start out with a vision and goal for their term. My goal is to make this journal inviting, interesting and inclusive for *all* members. We have a wonderful variety of dedicated professionals in our association ranging from clinical practitioners to school counselors to counselor educators and as the editor, I want to make sure that all of our divisions, chapters and members have a voice in our journal.

How can we make that happen? Well, of course, I want to make sure that we maintain the integrity and quality of our publication. Next, I also want to make sure that we include relevant and timely articles that include not only research but voices of our practitioners. Every year at our annual conference we have so many wonderful information sessions that include practical interventions and techniques and I want to encourage you all to share some of your expertise through our journal. If you are reluctant to get back into the whole APA formatting/writing habit... never fear. One of my goals is to help aspiring writers! So, if you have an idea that you want to share with your ALCA colleagues, please let me know.

Lastly, we would like to thank our previous editor, Dr. Larry Tyson for his service to our association. And thank you to the authors and editorial board members who have contributed to this journal in the past and to those that will contribute in the coming years.

I look forward to hearing from you.

***Linda***

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\*Accepted by previous editor, Lawrence Tyson.

# Developing 21<sup>st</sup> Century Multicultural Counseling Skills: Implications for Addictions Counselors

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## Abstract

Multicultural counseling has been emphasized in the counseling profession for many decades. However, contemporary issues such as projected changes and incidence of substance use dictate a renewed focus on multicultural counseling skills. Population projections for 2050 indicate that the nation's population will be comprised of 50% minorities. The prevalence of substance abuse is a major problem in this country. Substance use disorders are the most commonly occurring mental health disorder. This article will review multicultural implications for addictions counselors.

Addictions counseling in the 21<sup>st</sup> century demands that counselors adapt their paradigm of treatment to include consideration of the client's social context in addition to addressing maladaptive behaviors. Gladwell (2000) indicates "when it comes to interpreting other people's behaviors, human beings invariably make the mistake of overestimating the importance of fundamental character traits and underestimating the importance of the situation and context" (p. 160). For this reason, it is not uncommon for counselors to focus solely on the client's negative intrapersonal characteristics rather than also considering "social, cultural, political, and economic factors that impacts the client's daily life" (Lewis, Dana, & Blevins, 2011, p. 13). Practicing multicultural counseling will allow the counselor to consider the variables that impact the client's life. Although multicultural counseling has been emphasized within the counseling profession for many decades, contemporary issues (e.g., changing population demographics, and increased occurrence of substance use disorders) demands a renewed focus on multicultural counseling skills in all counseling specialties.

## 21<sup>st</sup> Century Addictions Counseling

Providing addictions counseling with a multicultural perspective is central to competent practice in the 21<sup>st</sup> century for two reasons (a) predicted changes in cultural diversity of population of the United States (Diller, 2011; Grieco, 2009) and (b) the prevalence of substance use in society (Lewis et al., 2011). Census data indicates that minorities make up one-third of the U.S. population and are predicted to become the majority in 2042, with the population projected to be 54 percent minority in 2050 (U.S. Census Bureau, 2008). Moreover, between 2000 and 2010 more than half the growth in the total United States population was due to increase in the Hispanic population (Grieco, 2009). Population projections for other minorities indicate increases as well. Specifically, the African American population is projected to increase from 41.1 million to 65.7 million in 2050; whereas, the Asian American population is projected to climb from 15.5 million to 40.6 million (U.S. Census Bureau, 2008). As evidenced by the aforementioned population projections, providing addictions counseling with a multicultural perspective is an essential skill in the 21<sup>st</sup> century.

Parallel to changes in demographics of this nation's population is the prevalence of substance use disorders. Substance use disorders are the most commonly occurring mental health issue in this country (Vuchinich, 2002). Evidence of the prevalence of substance use is corroborated by statistical data which indicates 25% of patients who visited a primary care physician had a substance use problem. Likewise, it is estimated between 20% to 50% of hospital admissions resulted from substance abuse. Moreover, substance abuse is the primary cause of preventable death in this country (Doweiko, 2009).

Substance abuse is a major problem in the U.S. overall; however, ethnic-minority groups may be at particular risk. Data indicates that ethnic-minority substance abusers are disproportionately underserved by treatment providers and could suffer higher incidence of adverse health consequences (Blume, Morera, & De La Cruz, 2005). Clients from minority groups are potentially at higher risk of developing substance abuse issues as compared to clients from majority group. Members of ethnic minority populations could be at risk for substance abuse issues due to the socioeconomic disparities among racial and ethnic minority populations compounded by the strong relationship between substance abuse and low socioeconomic status (Lassiter & Chang, 2006). For these reasons, Lassiter & Chang cautioned that addictions counselors will likely encounter clients from diverse cultural backgrounds and therefore should be sufficiently trained and proficient in working with diverse clients.

Sexual minorities are at higher risk of alcohol and drug abuse (Stevens & Smith, 2001). "Studies indicate that, when compared with the general population, LGBT people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009, p. xiii).

Routine use of marijuana, cocaine, stimulants, sedatives, and tranquilizers, and nicotine are common in society. However, the mere use of drugs is not necessarily problematic. Those substance users who experience life problems and health risks as a result of their drug use might seek counseling. A client's problem is identified as being related to substance abuse "if a client's use of alcohol or other mood-altering drugs has undesired effects on his or her life or on the lives of others (Lewis et al., 2011, p. 4). It is increasingly likely that clients seeking counseling for substance use related issues will be a member of a minority group; accordingly, the counselor should recognize individual differences among clients and aim to address substance use in the context of the client's sum life function. Regardless of counseling specialty, counselors working in any setting will inevitably encounter clients from diverse cultures affected by drugs.

Ultimately, the formula for effective counseling in the 21<sup>st</sup> century should be comprehensive and must consider the client's intrapersonal cultural characteristics that may contribute to substance abuse. Counseling with a multicultural perspective accomplishes the tasks of considering extrinsic factors such as social, culture, political, and economic factors that impact clients' daily lives. The purpose of this article is to emphasize the importance of practicing within a multicultural perspective thus outlining the required knowledge needed to provide substance abuse services to an increasingly diverse client population. This article will define multicultural counseling, address multicultural counseling from an ethical viewpoint, and outline what counselors should know when working with specific populations – African Americans, Hispanics, and lesbian, gay, bisexual, and transgender individuals (LGBT).

### **Multicultural Counseling Defined**

There are numerous definitions of multicultural counseling. However, two definitions are examined in this article. Hays and Erford (2010) defined multicultural counseling as the integration of cultural identities within the counseling relationship, whereas West-Olatunji (2001) offered a more complex definition of multicultural counsel-

ing, “multiple perspectives or multiple cultural viewpoints within the counseling relationship in which none are dominant or considered more ‘normal’ than others” (p. 418).

These definitions suggest the underlying principles of multicultural counseling are equality, collaboration, and mutuality. Equality is fundamental to multicultural counseling given that neither the culture of the client or counselor is seen as dominant. Counseling from a multicultural perspective requires collaboration as the counselor relies on the client to provide input on issues that are culturally relevant. Moreover, multicultural counseling is characterized by mutuality in that the counselor adapts and adjusts to the client's culture and the client gains awareness of counselor's culture by entering into the counseling relationship (Diller, 2011). Both the client and counselor acquire some awareness of the other's worldview.

The underlying principles of equality, collaboration, and mutuality are not stagnant principles; in fact, they are manifested in the counselor's beliefs and actions. Effective multicultural counseling requires the counselor to have certain skills which necessitate that the counselor "(a) modify his or her technique to reflect the cultural differences of the client; (b) be prepared to deal with difficulties that may arise because of the cultural differences between the client and the counselor; and (c) know how a problem is conceptualized and how the problem is solved within the boundaries of cultural patterns" (Torres-Rivera, Phan, Maddux, Wilbur, & Garrett, 2001, p. 28). Contemporary realities of the 21st century indicate that counselors must practice multicultural counseling. Multicultural counseling is not simply a matter of choice; it is an ethical mandate.

### **Multicultural Counseling: An Ethical Mandate**

The American Counseling Association (ACA) Code of Ethics (2005) mandates ethical practice and emphasizes multicultural counseling. Diversity and multicultural issues are intertwined in almost all sections of the ACA 2005 Code of Ethics. In particular, the introduction to Section A is relevant to the purposes of this article, which states, “Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also should explore their own cultural identities and how these affect their values and beliefs about the counseling process” (Developing competent practice necessitates focusing on the client and the counselor's worldview, culture, and, beliefs. Along the same lines, Section E.5.b addresses the importance of the counselor's awareness of the affect the clients' culture has on the etiology of problems. In addition, counselors should consider the clients' socioeconomic and cultural experiences when diagnosing mental disorders. Based on ethical mandates, case con-

ceptualization requires counselors to “actively” attempt to recognize the influence clients’ culture has on the development of substance use issues.

In general, addictions counselors should display cultural sensitivity and cultural competence when working with clients from diverse backgrounds. A counselor who displays cultural sensitivity is aware of the cultural variables that could impact the client’s substance use and the cultural variables that impact the counseling process, therefore, a culturally competent counselor is one whose behavior has been transformed as a result of his or her awareness. The culturally competent counselor displays behaviors that result in effective delivery of services (Paniagua, 2005). Counselors should be aware of the cultural factors that influence substance abuse and those factors that could impact treatment.

### **Specific Populations: Addictions Counselors Awareness**

Awareness of factors that impact substance use behavior, diagnosis, and treatment of clients from diverse populations is crucial to providing the best possible services in the 21st century. The risks factors, consequences of substance abuse, and appropriate treatment vary by race, ethnicity, sexual orientation, age, gender, and other demographics. Consequently, addictions counselors working with diverse populations should possess specific knowledge in regards to the population they serve. The following sections will address what counselors should know when working with African Americans, Hispanics, and LGBT populations.

#### **African Americans**

African Americans have been extensively studied relative to drug use and dependence. According to Stolberg (2009), gender differences remain the most common analysis in identifying drug prevalence and risk factors. Studies have consistently shown that drug use among African American adolescents is far less than those of their Caucasian counterparts. However, with the progression of age, African Americans began to surpass their Caucasian counterparts in drug experimentation and addiction. Although crack cocaine has been stereotypically identified as the drug of choice among African Americans, multiple studies consistently report that alcohol and marijuana are most commonly associated with African Americans who enter treatment. The contributing factors for the



rise in drug use among African American youth have been attributed to inner-city youth growing up in disadvantaged neighborhoods, being labeled as antisocial, and access to alcohol, street gang activity, poor self-esteem, and family history of addiction (Kogan, Luo, Brody, & Murry, 2005).

Addictions counselors who work with African American clients should be aware of socioeconomic factors that impact substance use and that wide gaps exist between African Americans and general population. For example, the median annual income of African American households in 2010 was \$32,068 as compared to \$37,759 for Hispanics and \$51,846 for Whites. African American households experienced the largest household income percentage decline in 2010 (a decline of 3.2 percent from 2009). Additionally, the poverty rate for African Americans is about 3 times higher (27.4% vs 9.9%, respectively) than that of Whites (DeNavas-Walt, Proctor, & Smith, 2011). The impact of socioeconomic factors is significant given there is a correlation between lower socioeconomic status and increased incidence of substance abuse.

According to SAMHSA (2011), as these disparities relates to prevalence of drug use, the rate of illicit drug use is higher in this population (9.5%) as compared to national average of 7.9%. Correspondingly, 1 in 7 (14.2%) of adult African Americans who needed alcohol treatment during the past year received treatment at a facility. The percentage of African American adults in need of treatment for illicit drug use during the past year received treatment at a facility was even higher at 24.2%. These percentages are higher than the national averages for adults (SAMHSA). Substance abuse in the African American community is a serious issue that requires counselors to be attuned to the cultural factors that contribute to substance abuse.

Culturally competent counselors should recognize that African American clients are often distrustful of counselors of other races and of counselors whose values differ from their own. "Counselors should not be surprised or defensive when clients who are members of oppressed groups exhibit distrust toward the counselor and the counseling process" (Lewis et al., 2011, p. 100). When one considers the cultural experiences of African Americans, in particular slavery and racism, this distrust is healthy (Paniagua, 2005). It should also be noted that for many clients their first experience with counseling is court-ordered and/or mandatory rather than voluntary. In these cases counseling is less about personal growth and development and more directed at remediating behaviors and/or punishment (Lewis et al.). Conse-

quently, the counseling process is viewed by some African Americans as a method of control exerted by the dominant culture to regulate their lives (Coombs & Howatt, 2005).

Accordingly, the African American church, as opposed to community mental health agencies, has been instrumental in developing avenues to address the serious drug problems within the African American community. Greater than 90% of African American churches provide varying social support (Whiters, Santibanez, Dennison, & Clark, 2010). This is of grave importance due to African Americans' hesitancy to seek assistance from mainstream counseling venues. Counselors should be aware of the client's relationship with the church and how the church could be a great community resource. The counselor should also be attuned to client's other personal resources including the nuclear family, extended family, and community resources. The family unit is complex consisting of blood related and nonrelated individuals such as friends, church members, and clergy. The African American family structure is more fluent than family structures of other cultures due to role flexibility. For instance, siblings might be called upon to raise other siblings and the father is not always the head of household (Diller, 2011; Paniagua, 2005).

### **Hispanics**

According to U.S. Census Bureau (2008), one of the major contributing factors in the changing racial and ethnic composition of the U.S. population is migration from Latin America; resulting in rapid growth in the Hispanic population. The term "Hispanic" refers to individuals of Spanish or Latin American descent living in the U.S. (Paniagua, 2005). Individuals of Hispanic origin comprise the largest ethnic minority group in the United States. Although, collectively, they share a common language (Spanish), religion (Catholicism), and an array of cultural values, there are differences within this population. In particular, Hispanics migrate to the United States from many countries. Sixty-four percent of the Hispanic population migrates from Mexico. Hispanics from Puerto Rico and Central and South Americas account for 10% of the population, respectively; whereas, Hispanics of Cuban descent comprise 4% of Hispanic population (Dillers, 2011). Because Hispanics are the largest ethnic minority group in this country, counselors should be aware of the factors that impact substance abuse in this population.

Substance use and abuse within the Hispanic population is of serious concern because members of minority groups may be more at risk for substance abuse issues than the dominant culture because of socioeconomic disparities (Lassiter & Chang, 2006). Risk factors associated with substance abuse within Hispanic population are low

socioeconomic status, lack of access to healthcare, unemployment, low educational attainment, acculturation stresses, economic marginalization, and other environmental issues (Torres-Rivera, Wilbur, Phan, Maddux, & Roberts-Wilbur, 2004).

Demographic trends also point to potential risk of substance abuse concerns among Hispanics. When compared to non-Hispanic White population, the Hispanic population is younger with one-third of the population being under the age of 18. According to Amaro, Cortes, and Cacari-Stone (2005), the Hispanic population is primarily "young and disproportionately affected by stress, poverty, discrimination, and lack of access to preventive services" (p. 1). To provide effective counseling services targeted at those who are most at risk, addictions counselors should be cognizant of the fact that one-third of the Hispanic population is under the age of 18 and that this demographic trend is critical given the fact that development of substance abuse problems usually occurs between the age of ten and twenty. A recent report by SAMHSA (2009) revealed that nearly 8.3 percent of Hispanics ages 12 or older were categorized as needing treatment in the past year for alcohol disorders, and another 3.4 percent were in need of illicit drug treatment. Of the 8.3 percent in need of alcohol treatment, only 7.7 percent received the help they needed at a specialty treatment facility. On the other hand, 15.1 percent of those in need of illicit drug use treatment received treatment in a specialty facility.

Equally important in understanding addictions among the youth of the Hispanic population is the correlation between substance abuse patterns of those Hispanics native in the U.S. and those who immigrate. Immigrant Hispanics have lower incidence of substance abuse than Hispanics born in the United States. Accordingly, counselors working with young immigrants should engage in prevention strategies in order to maintain the lower incidence of substance use in this segment of the population (Amaro et al., 2005).

Differences in substance abuse patterns persist in terms of the substance of choice and risk factors across different ethnic groups within the Hispanic population. A study (SAMHSA, 2009) revealed significant substance use patterns and treatment needs within Hispanic population. To illustrate, Hispanics of Mexican origin had a higher (9.2%) incidence of alcohol treatment needs as compared to Puerto Rican (7.7 percent), Central or South American (6.8 percent), or Cuban origin (5.2 percent). In contrast, Hispanics of Puerto Rican descent had a higher

incidence of illicit drug use treatment (6.1 percent) than Hispanics with Cuban (3.6 percent), Mexican (3.3 percent), or Central and South American origins (2.2 percent).

Given these realities, it is imperative that addictions counselors have an increased understanding of cultural factors that contribute to substance abuse; know how demographic trends and substance use patterns should impact treatment practices; and be aware of how effective treatment approaches that can provide a positive therapeutic relationship with Hispanic clients (Stevens & Smith, 2001). It is important for counselors working with Hispanic clients to know that traditional Euro American approaches to counseling often do not reflect minority cultures. Additionally, these approaches tend to diminish the impact of individual differences, experiences, behaviors, and choices to change oneself or one's life conditions. Therefore, counselors must use counseling approaches that reflect the culture of the client. Although research findings on working with Hispanics suggest that no one counseling approach proves to be more effective than others, counseling approaches that are culturally sensitive seem to be more effective; for example, family, bilingual, bicultural, and group-oriented approaches (Torres-Rivera et al., 2004).

## **LGBT**

Substance abuse among LGBT individuals is influenced by multiple factors. Illicit drug use, alcohol, marijuana, and other readily available street drugs use among this group has been well documented (Bonell et al., 2008). However, more recently researchers have identified several risk factors that may contribute to the increased use of methamphetamine among LGBT individuals including poor family relationships, unemployment, stressful community and health care accommodations as well as interpersonal and social environments (Padilla, Crisp, & Rew, 2010). Addictions counselors should be attuned to the unique needs of LGBT individuals experimenting with methamphetamine by allowing them the opportunity to address their sexual orientation and intimate relationships (Mathews, Selvidge, & Fisher, 2005). Although current research relative to multicultural counseling indicates that this population has unique needs that should be addressed in treatment, the ACA Code of Ethics (2005) mandates the importance of an affirmative approach to working with LGBT individuals. There remains serious concerns as to the extent addictions counselors are addressing the unique needs LGBT clients.

Mathews et al, (2005) reported that a growing number of treatment facilities are not open to culturally specific concerns particularly LGBT issues. Agencies with this narrow view of addressing the cultural needs of their

clientele cultivate negative behavior in the counselors they employ. In contrast, agencies that are open to addressing the cultural needs of their clients can significantly influence positive counselor behaviors. Counselors need be aware of their attitudes and behaviors with respect to how both addiction and sexual orientation impact treatment outcomes. Counselors should work to expand their worldview to better understand the cultural values and belief of those individuals they serve (Riser, Timpson, McCurdy, Ross, & Williams, 2006). Addictions counselors should be aware of the possible impact they may have and be conscious of their responses to LGBT clients' needs. In some cases, the counselor is the only person with whom the client has communicated his or her concern (Mathews, Lora, & Fenton, 2006).

Mathews et al. (2006) indicates that gay and lesbian clients believe that feeling safe facilitates honesty which is crucial to recovery. Both honesty and safety were critical elements of being able to talk openly about their sexual orientation in treatment. While it is not necessary for clients to focus on their sexual orientation in treatment, it is very important for counselors to be empathic in their exploration of client concerns; therefore, the client does not have to focus on hiding his or her sexual orientation. Another relevant point corroborated by this research relates to the theoretical orientation of the counselor. Counselors who respond to the cultural concerns of clients with a theoretical orientation that takes into account the client's cultural concerns were most effective and most appreciated.

### Conclusions

Projected demographic changes in the U.S. population and the prevalence of substance abuse issues among ethnic and sexual minorities have significant implications for addictions counselors. First, a significant change in the demographic composition of client base will dictate greater emphasis on multicultural counseling skills (Diller, 2011). According to Robinson-Wood (2009), effective counselors recognize differences among people and take action to improve their multicultural competence with diverse populations. Second, in order for counselors to be effective in the 21<sup>st</sup> century, it is imperative that they develop awareness, skills, and knowledge necessary to work effectively with diverse populations (Gladding & Newsome, 2010). Third, counselors acquire respect for the quality of counseling relationship. While the counseling profession remains predominantly White, the diversity of the potential client pool is changing. Considering these facts, there is a possibility of cultural schism developing in the

counseling relationship; specifically when considering a counselor's practice maybe based on theories, ideologies, and techniques that are not always compatible with the client's worldview (Hays & Erford, 2010).

Furthermore, "Insensitivity to the actual experiences of clients from different cultural backgrounds can lead to discrimination as well as to ethical misconduct" (Gladding & Newsome, 2010, p. 71). Likewise, counselors should develop data driven programs with measurable outcomes. Data related to addictions suggests that there is a propensity for ethnic and sexual minorities to use particular substances; therefore, counselors should use that data to enhance prevention, treatment, and recovery programs that are culturally and client specific.

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# Examining Cognitive Behavioral Approaches to Combating Substance Dependence

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## Abstract

The high rate of substance abuse and crimes associated with it has become a national, and in some instances, international concern. Some societies choose to treat the disease of addiction as a crime while others have begun to focus more on effective ways to provide rehabilitation to those dealing with this issue. Although cognitive-behavioral therapy is evidence based and seemingly effective, it has not been proven to provide long-term results for intravenous users of heroin.

Substance abuse remains a major issue, not only in the United States of America, but all over the world and with significant research surrounding effective treatment for people diagnosed with substance addiction in the United States, Asia (Sharma & Chatterjee, 2012), Australia (Teeson, Baillie, Lynskey, Manor, & Degenhardt, 2006), and Europe (Schaub et al., 2011). Cognitive-behavioral therapy, an evidence based practice, has shown over multiple studies to be a very effective form of treatment for substance abuse and dependence (Bahr, Masters, & Taylor, 2012). CBT and many substance abuse treatments assume that clients' thought patterns need to change. CBT also focuses on restructuring and the development and building of interpersonal skills (Lowenkamp, Hubbard, Makrios, & Latessa, 2009). By heightening the individuals' awareness and cues associated with their substance abuse, the individual learns to implement strategies to avoid and therefore not participate in activities that lead to substance abuse. Clients learn to engage new and different coping mechanisms, and apply those in settings in their daily life (Lowenkamp et al., 2009).

Opioid addiction is uniquely different from addiction to other controlled substances in a number of areas including, lethality, addiction progression, and treatment prognosis. There is an abundance of information on the

length that heroin addicts and those addicted to other drugs have gone to in order to get their drug of choice including lying, stealing, prostitution, and even murder (Morrison, 2006). Addiction to opioids are often accompanied by an intense physical need for said drugs coupled with drug seeking despite the logical consequences associated with the behavior. Effective treatment programs require a combination of different treatment approaches in an attempt to assist the client with discontinuing drug use, preventing relapse, and establishing a therapeutic environment for themselves including a positive support system.

With the ability to gain access to many opiate drugs legally and the extreme addictive nature of these substances, there is an increasing need for treatment providers to develop and utilize new and innovative techniques in order to combat this issue. While no single treatment is appropriate for all addicts (National Institute on Drug Abuse (NIDA), 2012), there are indications that cognitive behavioral approaches may provide a strong foundation for treating this challenging addiction. The purpose of this paper is to examine the use of cognitive-behavioral therapy techniques, counseling styles, and other proven methods, including pharmacological interventions associated with this disorder and the interventions' helpfulness when engaging an individual that fits in this category in a counseling relationship.

### Aspects of Presenting Issue

According to the National Survey on Drug Use Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2007, 23.2 million people ages 12 or older reported a need for treatment at that time for a drug or alcohol problem (SAMHSA, 2008). Only 2.4 million of those reported that they received treatment at agencies/facilities designed to provide some sort of treatment; leaving 20.8 million who needed addictions treatment but did not receive it (NIDA, 2012). One concerning variable when looking at these numbers is the increasing use of heroin.

There has been a steady increase in heroin related deaths throughout the nation. The last available report for heroin related deaths is for 2009 completed by United States Center for Disease Control (CDC). In 2009, the total of those deaths was 3278. In Jefferson County alone, the total in 2009 was 18, 12 in 2010, and 30 in 2011. As of May 2012, the total of heroin related deaths is 23 in Jefferson County Alabama alone (as cited in Robinson,

2012). In 2008, drug related deaths became the leading cause of injury death in the United States. 40 percent of those deaths were due to opioids (Warner, Chen, Mahuc, Anderson, and Miniño, 2011).

### **Diagnostic Criteria**

Substance Dependence is currently defined in the Diagnostic and Statistical Manual of Mental Disorders 4<sup>th</sup> ed., Text Revision (American Psychiatric Association [APA], 2000) as “A maladaptive pattern of substance use, leading to clinically significant impairment or distress” (p. 197). Within a 12 month period the user must also present with one or more of the following criteria: a developed tolerance, physical withdrawal, desire or unsuccessful efforts to discontinue usage of the substance, spending markedly long amounts of time completing activities necessary to obtain the drug. Other criteria include missing the majority of non-drug related activities including employment obligations and social activities, and continuing substance use despite knowledge of repeated physiological and psychological issues that have occurred as a direct effect of the substance (APA, 2000).

Opioid Dependence, (DSM-IV-TR diagnostic code 304.00) (4th ed., text rev.; *DSM-IV-TR*; APA, 2000), is often times the result of opioid use during the course of medical treatment. Physicians may prescribe opioid pain medication after surgery or for patients with chronic pain. Heroin, an opiate drug, is drastically more powerful than morphine and is commonly used intravenously. The effects of the drug include feelings of euphoria and drowsiness. Tolerance develops quickly, producing a need for more of the substance in order for the drug user to develop the desired effects (Morrison, 2006).

### **Outpatient and Medication Assisted Treatment**

The main goal of cognitive-behavioral therapy in outpatient addictions treatment would be to help clients recognize and successfully avoid triggers and situations where they might engage in substance use and other risky behaviors (Beck, 2011). Cognitive-behavioral therapy helps the client engage in treatment and hopefully change their attitudes and behaviors while learning skills that will promote a healthy existence. Clients are commonly provided with treatment plans that detail their presenting problems, goals for addressing these problems, and ways to measure success. Clients participate in a number of scheduled individual sessions throughout the duration of their treatment and specified group sessions that address individual and specific issues faced by the addict.

Medication assisted therapies are increasingly more popular. Medications that have been approved by the Federal Drug Administration (FDA) for treatment of heroin and other opioid addiction are methadone and buprenorphine, also known as suboxone. Some have found that naltrexone may also be helpful. This drug works by blocking the effects of heroin and other opioids; however many patients are not compliant when using naltrexone and it is therefore not as popular as methadone and buprenorphine (NIDA, 2012). Medications such as methadone and buprenorphine, can serve as a substitute for an opiate drug of choice because they work on the same parts of the brain that opioid drugs target. Medical doctors are able to prescribe these medications in outpatient clinics at a medically safe dose after assessing each client's individual need for a specified dose. Assessment for dosage necessary includes a collection of information on the client's history of drug usage, current daily amount used, and withdrawal severity (NIDA, 2012).

Medication can assist with weakening the craving for a drug and protecting the client from experiencing withdrawal while working on underlying factors that may contribute to drug usage, such as past trauma, grief, and other life stressors. Once normal brain functioning has been reestablished, addicts can safely detox slowly from the medication while still under a physician's supervision (NIDA, 2012). In addition, since clients are able to legally obtain methadone or buprenorphine while admitting and working through an addiction, harm reduction occurs. Clients may perhaps be less likely to commit a crime in order to obtain opioids or engage in intravenous drug usage or other risky behaviors.

A recent study has also shown that the use of Oxcarbazepine, an anticonvulsant used to prevent seizures, may be helpful in reducing self-aggressive behaviors in clients with heroin dependence specifically. Self-aggressive behaviors include repeated overdoses, suicide attempts, and self-mutilation. The cognitive-behavioral therapy was focused on coping strategies and cognitive restructuring and occurred in an outpatient setting twice weekly. Overall, the combined medication assisted with CBT significantly decreased self-aggressive behaviors and mildly decreased severity of the dependence (Passetti et al., 2011).

### **Substance Dependence Treatment with Adolescents**

Research has been conducted on the effectiveness of cognitive- behavioral therapy for adolescents with substance abuse and dependence diagnosis. Because of academic obligations and the ability of many adolescents

to be supervised by parental figures, much of adolescent substance abuse treatment is done as outpatient treatment. With this population, cognitive-behavioral therapy is often coupled with Multidimensional Family Therapy (MDFT) which was originally developed for adolescents and their families (Latimer, Winters, D'Zurilla, & Nichols, 2003). This integrative approach is designed to treat not only the primary client, but the family as a whole unit.

Research of CBT and MDFT indicate that each of these therapies prove to be effective when used separate from each other or in an integrative format when working with adolescents up to 6 months after treatment begins (Latimer et al., 2003); however, research has indicated that adolescent substance users who did not participate in MDFT, combined with CBT had a higher rate of relapse when follow up was done 12 months after intake (Latimer et al., 2003). Overall for long term success in treatment of adolescent substance abuse and dependence, the use of Multidimensional Family Therapy is a better predictor for long-term success (Liddle, Dakop, Turner, Henderson & Greenbaum, 2008).

### **Cognitive Behavioral Treatment in a Residential Setting**

Residential treatment can be effective for those with more progressed and long-term addiction. These are highly structured programs that not only include individual and group therapy, but also include educational classes and substance related and non-substance related therapeutic groups. Residential programs are commonly referred to as treatment communities because clients reside in a facility run by a substance abuse agency. A collection of different approaches are combined to meet residents' needs. (Passetti et al., 2011).

A previous study by Passetti et al (2011) examined the use of cognitive-behavioral approaches in the treatment of opiate dependent clients. The study focused on comparing individuals who were receiving treatment in an outpatient setting versus those receiving treatment in a residential setting. The clients in the outpatient setting were also receiving methadone or buprenorphine as a part of their treatment. The residential clients participated in physician assisted detox programs that included psychotherapy for close to a month before transitioning to residential rehabilitation. The findings of the study suggested that cognitive-behavioral treatment planning could benefit from placement matching, meaning that assessment of the individual's need for a specific drug treatment would help to drive proper placement and treatment planning (Passetti et al., 2011).

Although many outpatient and residential programs utilize cognitive-behavioral techniques that provide structure and set outcomes for treatment, residential treatment is for clients who have repeatedly failed in outpatient treatment due to inability to make decisions that keep them clean and sober. Residential treatment is also for those whose collective treatment issues cannot be safely and well managed in an outpatient treatment (Gossop, Browne, Stewart, & Marsden, 2003). The sample in residential treatment was more likely to have quit school, participate in intravenous drug usage and have concurrent addictions (Passetti et al., 2011).

Ultimately, the clients in the outpatient/community setting had significantly higher scores for decision making and abstinence at follow up. They researches suggest that this may be due more to the complexity of the issues presented by the clients that were in residential treatment, than by the setting itself. The researchers as noted that those in the outpatient/community setting were able to detox much slower than the clients in residential treatment who completed month long detox programs. The researchers did note that opiate dependent individuals with significant decision-making impairment at the beginning of the study did not succeed in outpatient treatment (Passetti et al., 2011).

### **Cognitive Behavioral Treatment of Substance Dependence in Prisons**

The Alabama Department of Corrections reported in 2008 that drug offenders accounted for close to 34 percent of the 11,729 inmates who served time in the Alabama prison system (as cited in Robinson, 2012). Drug related offenses include sale of, distribution of, intoxication by, and possession of drugs or drug paraphernalia. This thirty-four percent did not account for addicted individuals who were in incarcerated for robbery, prostitution, and other crimes that were committed to support their addiction. In 2005, seventy-three percent of inmates in United States prison systems reported that they used drugs regularly before being incarcerated. It is also recorded that at that time, fifty percent of the inmates arrested in that year were intoxicated during the time that they committed their crime (Petersilia, 2005).

In order to cut down on the number of drug offenders in Alabama's prisons, drug courts have been established to get these offenders into drug rehabilitation programs. The more willing and non-violent offenders also go through a program that includes supervision by a case manager and regular drug testing. If the offenders remain

drug free for at least a year, their charges are dropped. There are currently 60 drug courts in 57 counties in Alabama (Alabama Judicial System, 2009).

Due to the rise in people with addictions in the prison system, programs have and are being placed in prison to provide addiction education and rehabilitation for prisoners while they serve their time. There are specialized Alcoholics Anonymous meetings in prisons, but prison systems are beginning to move more towards individualized treatment and utilization of evidence based practices in corrections institutions. Cognitive behavioral therapy is being used to enhance the therapeutic community (Pelissier et al., 2001).

An examination of 760 people from 20 prisons who received CBT during their sentence was completed. It was concluded that six months after release, those who received CBT were less likely to use drugs or be incarcerated when compared to persons who had not received CBT (Pelissier et al., 2001). The Forever Free program is a substance abuse program that was designed for women prisoners. In this study, 101 women voluntarily participated in CBT, while 79 elected not to. In the follow up a year later, the group of women who had received CBT had significantly fewer arrest and significantly less drug usage than the group who had not participated (Hall, Pendergast, Wellisch, Patten, & Cao, 2004). Taken as a whole, it has been found that mandated treatment is effective. Prison and jail time appear to be a decent motivator for substance dependent individuals to get and stay clean and sober.

### **Treatment for Co-occurring Disorders**

Clients that are considered to have co-occurring disorders are those who are typically diagnosed with alcohol or drug dependence and with a serious mental illness such as bipolar disorder, major depressive disorder, or schizophrenia. The biggest barrier to treatment for this population is mainly that their addictive behavior can interfere with mental health treatment and the mental illness may interfere with what is offered at some addiction treatment programs (Hides, Samet, & Lubman, 2012). A cycle of institutionalism commonly plays out for this population in hospitals, jails, shelters, prisons, and a variety of treatment centers.

Their behavior can lead to these places, but often, any therapeutic response is limited to addiction treatment or mental health treatment, rather than an integrated plan to address the whole person. The goal of treatment centers that provided services for co-occurring disorders should be to empower this population to live as inde-

pendently as possible, with freedom from reliance on institutions. Clients with co-occurring disorders have a higher rate of relapse, greater social impairment, and a higher rate of suicidal behavior. Researchers debate whether or not much of the non-substance related diagnoses are substance induced or if many clients with mental illnesses commonly attempt to self-medicate (Hide et al., 2012).

There is a great amount of research on the usage of CBT with substance abuse and the usage of CBT with some other mental illnesses, but little research on the use of CBT with those who have co-occurring disorders. In the separate studies of CBT with clients with depression and CBT for clients with substance addiction, it has been determined that there is significant improvement with both groups, that the effects of CBT are durable, and that the clients continue to improve over time (Hides et al., 2012).

In studies comparing the use of cognitive-behavior therapy with antidepressants with clients diagnosed with depression and substance use, the majority of the participants improved greatly. These results differed for clients who participated in intravenous drug use though. For intravenous drug users, there was a decrease in depressive symptoms, but no significant decrease in substance usage. The improvement in depression was also not maintained by the 6 and 9 month follow-ups (Stein et al., 2005).

There is evidence that when comorbid, non-intravenous using patients are given proper psychotropic medication in conjunction with CBT, that there is improvement. This has been studied with not only selective serotonin reuptake inhibitors (SSRIs), but other psychiatric medications also. In studies with CBT paired with fluoxetine in comparison with CBT paired with placebos, there was little to no improvement in the group that received the placebo (Riggs, Mikulich, Coffman, & Crowley, 2009). Fluoxetine, also known as Prozac, is used to treat depression, obsessive-compulsive disorder, some eating disorders, panic attacks, and premenstrual dysphoric disorder.

### **Limitations**

There is only limited research on co-occurring disorders and the use of cognitive-behavioral therapy. The majority of any researched completed has focused only on any substance dependence paired with depressions. More research should be done on substance dependence when paired with other serious mental illnesses such as schizophrenia and anxiety disorders.



Ultimately, although cognitive- behavioral therapy appears to be useful for most substance addition, including opioid addiction, the effectiveness declines when utilized with those who have progressed to the point of ingesting heroin intravenously. Hides et al (2010) also write that there is a need for research trials that examine the use of anti-depressants and other psychiatric medication in conjunction with substance use pharmacotherapies. They also write that there is a need to enhance the effectiveness of CBT and develop a more in-depth understanding of what makes CBT work.

### Conclusion

Research shows that drug courts, therapeutic communities, multi-dimensional family therapy, medication assisted therapy, and cognitive behavioral therapy are all effective in treating opiate and other substance addicted individuals. Overall though, the most effective treatments tend to use a combination or effective treatments to meet each client's individual needs (Bahr et al., 2012). Cognitive-behavioral therapy has not been found to be grander than other psychotherapies by comparison although CBT is the most empirically supported. None of the other psychotherapies were found to be superior either. In sticking with using a combination of treatment strategies, substance addiction agencies and facilities may want to aspire to not only address the drug usage associated with addiction, but also aid the individual in the personal, social, and vocational adjustment necessary for the maintenance of a truly sober and productive life.

Treatment that seems to be the most effective with those who have opioid addiction is methadone maintenance and buprenorphine. Opioid replacement is by far the most effective when working with clients who participate in intravenous heroine usage. However, some critics of the treatment state that methadone is just another drug, that the users are never truly drug free, and that legalizing methadone and buprenorphine for usage by opioid addicts only increases drug usage (Spence, 2007). Many addicts who have gotten to the point of intravenous drug usage usually have a long history of drug usage. As previously mentioned though, residential treatment is the treatment commonly given to people with substance dependence that have long-term use. Supporters of opioid replacement feel that the potential for harm reduction when using methadone and buprenorphine, outweigh the negative effects of replacing one addiction with another (Smye, Browne, Varcoe, & Josewski, 2011).

Many residential treatment facilities, because they are abstinence based, do not allow mood altering medication including drug replacement medications or benzodiazepines that are used to treat anxiety disorders. Just as in the Passetti (2011) study, client may instead engage in a short-term detox program before entering a residential treatment facility. These programs often utilize and incorporate the Big Book of Alcoholics Anonymous, AA meetings, and sponsorship, as well as cognitive-behavioral therapy and other evidence based practices. Other aspects of residential treatment include educational groups and lectures to teach the clients about the scientific nature of the disease of addiction and other social aspects of the disease. Facilities equipped to handle clients with co-occurring disorders will also teach about their mental illnesses, assist clients with getting psychiatric medication, and provide other services related to the unique combination of mental illnesses.

Based on the recent spike in heroin related deaths in Jefferson County, Alabama alone, on drug replacement being most successful with intravenous heroin users and drug replacement not being in most residential settings, we may understand better why intravenous heroin users are not as successful in residential treatment that relies mostly on CBT techniques. There may be a need for a more integrative approach to treating this specific substance dependent group and it may be useful to introduce drug replacement into a residential setting where intravenous drug users can have less physical symptoms of withdrawal in a safe and drug free environment. They can then benefit from CBT and other treatment options while slowly detoxing from methadone or buprenorphine and possibly have a better long-term success rate. There may be residential facilities in which this is taking place, but there is no research available on using this approach. I propose that residential agencies begin to form partnerships with agencies that provide methadone maintenance and buprenorphine treatment. Both types of treatment agencies may benefit from learning more about what services each has to offer and through collaborative interventions.

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# Men Choosing Nontraditional Careers: Implications for Counseling and Pedagogy

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## Abstract

Gender role socialization, stereotypes, and workplace discrimination limit men in their career choices. These issues create challenges for men choosing nontraditional careers. While the research on men in non-traditional careers is limited, this article reviews the literature on men's gender roles and the effects on career choice; and men's experiences in nontraditional careers. Considerations for changing career counseling constructs and best practices for counseling males considering and working in non-traditional careers are discussed. Implications for further research are presented. Counselor educators and counselors who understand how men's gender roles, career knowledge, and experiences affect their careers may provide men and boys with quality career counseling.

“Men who would like to work in an area that is numerically dominated by the other gender may perceive this gender segregation as a hindrance for their personal and professional development” (Wolfram, Mohr, & Borchert, 2009, p. 114). While at the same time they bring the benefits of their male privilege with them (Lupton, 2006, Evans, 1997). Yet few researchers have studied men choosing traditionally female careers, their reasons for these choices, and their experiences in these occupations (Dodson & Borders, 2006; Heppner & Heppner, 2009, Simpson, 2005). “In order to understand more fully the existing sex composition of occupations, it is important to study not just what encourages men to work in particular occupations but also what discourages them from working in others” (Cognard-Black, 2004, p. 115).

Much of the research on men in nontraditional careers was from the 1980s and 1990s, with teaching as the main occupation researched (Addi-Raccah, 2005). The Department of Labor Statistics (DLS) defined nontraditional careers as those with 25% or less of the worker's gender in that workforce (Heppner & Heppner, 2009). The research on nontraditional careers for men had methodological flaws, with small samples, use of tests with little validity, and narrow research questions (Cognard-Black, 2004). Researchers have studied women's choices to enter careers where the majority of workers were male (Auster & Auster, 1981; Chusmir, 1990; Flores, Navarro, Smith, & Plosza, 2006; Reskin & Roos, 1990). They found that women, many of whom are single parents or co-breadwinners in their families, were attracted to the higher status and better pay in male dominated fields and increased opportunities for advancement (Chusmir, 1990; New York State Occupational Equity Center [NYSOEC], 1994). Men in female dominated careers were viewed as settling for a low-prestige, lower-paying job with poor mobility prospects (Addi-Raccah, 2005, Chusmir, 1990; Cognard-Black, 2004, Galbraith, 1992). While social disapproval and discrimination may be affect people entering gender segregated careers, more men are choosing to enter female dominated occupations (Jackson, Wright, & Perrone-McGovern, 2010). Researchers expect this trend to continue as women increase their percentage in the workforce, careers become more gendered balanced (Jackson et al., 2010), more men in nontraditional careers increase salaries and status (Cushmir, 1990), new role models emerge, and men pay more attention to their health, physically and emotionally (Chusmir, 1990).

Social scientists have studied the gender prevalence in career categories beginning in the 19th century (Kimmel & Messner, 2004), stereotyping them as either feminine, nurturing and service oriented, or masculine, requiring physical strength or analytical ability, for occupational success (Wolfram et al., 2009). The actual requirements of most jobs are generally no longer related to gender (Clark, 2000b). While careers are becoming more gender-balanced and there are almost equal numbers of men and women in the work force, both sexes continue to enter gender based occupations (Jome & Tokar, 1998). Non-traditional careers for men include social work, nursing, elementary education, and secretarial/office work, which employ 57% of all women. Other female dominated careers are librarians, flight attendants, hairdressers, and other service workers (Heppner & Heppner, 2009).

Gender role socialization, negative society perceptions, and stereotypes all affect men's career selection (Chusmir, 1990; Hayes, 1986). Flores et al. (2006) suggest these same factors may affect researchers' "devaluing the importance of investigating factors that influence the nontraditionality of men's career choices" (p. 215). This

paper reviews the literature on men who chose nontraditional careers, their challenges in those careers, their characteristics, and implications for best practice and further research in school and career counseling for males. Considerations for counselor education and research will be discussed. School and career counselors will require the knowledge, awareness, and skills to work with this changing career demographic.

#### Men's Nontraditional Career Choice and Characteristics

Men's gender roles are central to occupation choice according to the career choice circumscription and compromise theory (Gottfredson, 2002, Simpson, 2004). Research showed children judge occupations based on their self-concepts, with gender role being considered first (Gottfredson, 2002). Children 6 to 8 years old eliminated occupations incompatible with developing self-concepts - circumscription. Boys were more unwilling to violate their gender role self-concept than girls (Simpson, 2004), and were less likely to cross gender role stereotypes as they aged (Gottfredson, 2002, Rochlen, Good, & Carver, 2009). As boys matured they eliminated, or compromised, career options based on inaccessibility, for example those dominated by women (Simpson, 2004). Traditionally, men have been dissuaded from entering "feminine" fields due to lower status and money, and a greater likelihood of being devalued and ridiculed for entering a gender inappropriate career (Chung & Harmon, 1994; Jome & Tokar, 1998).

While we are assigned a sex at birth, our gender role self-concepts, identified typical gender traits, and internalized gender roles, are learned through socialization (Franklin & Fear-Fenn, 1993; Sayman, 2007; Wolfram et al., 2009). While biological differences do exist between men and women, Bem (1993) believed "gender polarization, the ubiquitous organization of social life around the distinction between male and female" (p.80) limited both sexes. Feminist theory and therapy also proposed that adhering to traditional gender roles has not only stifled women's life choices, but men's choices as well (Brown, 1994). Gender polarization prescribes specific scripts for being male and being female. People internalize the rules about gender as their own by the time they are adults. Many men are socialized to be competitive, independent, financially solvent, and autonomous, which are rewarded at work, but may fail in family life (Franklin & Fear-Fenn, 1993), where the affective domain and harmonious relationships are important. Research has shown masculine gender roles correlate with measures of well-being, higher self-efficacy, and lower depression (Wolfram et al., 2009). Theorists believed this is due to masculinity being highly valued



Gender-role conflict occurs when a person's attributes and society gender rules are not consistent (Wolfram et al., 2009). Bem (1993) stated "Any person or behavior deviating from the scripts may be viewed as problematic - as unnatural or immoral" (p.81). If one's preferences or temperament do not match society's expectations, the person may reject that characteristic or behavior, creating a negative self-image (Bem, 1993). Gender role conflict occurs when men's "adherence to the masculine mystique (i.e., a socially constructed set of values and beliefs that defines optimal masculinity) and their fear of femininity . . . prevent men from obtaining their full human potential and also restrict others from obtaining their full human potential" (Moradi, Tokar, Schaub, Jome, & Serna, 2000, p. 62). This conflict is correlated with lower well-being, personality traits, psychological symptoms, intimacy, relationship satisfaction, sense of entitlement, aggression toward women, vocational interest and career choice, a higher likelihood of leaving a job, and lower professional commitment in managers (Moradi et al., 2000; Wolfram et al., 2009).

Education plays a vital role in gender role socialization (Gottfredson, 2002; Rochlen et al., 2009; Sax & Bryant, 2006), with teachers starting to show gender specific career examples in pre-kindergarten (Sayman, 2007) and providing experiences that reinforce sex roles in the curriculum and teacher expectations. During adolescence male gender role socialization and traditional career interest and choices are habituated in high school classes, athletics, participating in extracurricular activities, and working to explore academic and career options (Flores et al., 2006, Sayman, 2007). In vocational education, research showed students were placed in sex-role stereotypical careers (Sayman, 2007). Female students were the majority in vocational education fields of health-services, dental/medical technology, and business and legal assistant, while male students were in the higher paying programs of trade and industry, computers, data processing, and engineering/science technologies.

By college, men with greater confidence in their leadership skills, greater desire for achievement, and more traditional views of gender roles tended to choose traditionally male fields, while those with more egalitarian views of men and women chose nontraditional fields (Sax & Bryant, 2006). There was an association between students perceiving high levels of faculty advice, respect and encouragement, with an interest in "feminine" careers. However, time spent talking with faculty outside of class predicted a shift toward traditional career choices. Sax and Bryant (2006) asserted that while higher education has the opportunity to nurture students to freely explore and grow, campuses may be reinforcing perceptions students already have. The researchers advised that greater atten-

tion should be paid to the intentional and unintentional messages delivered to students by faculty, peers and the curriculum.

Other factors that affect men's choice of nontraditional careers include personal, family and societal influences (Chusmir, 1990). Nontraditional careers provide men with more freedom to choose less stressful and less aggressive jobs, an opportunity to pursue self-fulfillment not available in "masculine" jobs, increased stability and mobility, and increased interaction with the opposite gender (Hayes, 1986). Socioeconomic levels were a factor in English men's career choice, with men in lower socioeconomic levels choosing female dominated careers because of less opportunity for advancement in traditional workplaces than men in higher socioeconomic levels (Lupton, 2006). This was true even when education attainment was the same. In a survey of English men in nontraditional jobs, Bagilhole and Cross (2006) found the changes in the workplace, nontraditional work role models, differing gender roles, and career goals influenced nontraditional career choice.

Researchers have also tried to determine if sexual orientation influenced career interest (Chung & Harmon, 1994). Gay men scored lower on the realistic and investigative scales of the Self-Directed Search (SDS), but higher on the artistic and social scales. Even though their career profiles were nontraditional, Chung and Harmon (1994) believed gay men were guided into traditional careers based on gender because of counselors' heterosexist views and lack of attention to clients' relationship skills. English gay men in nontraditional careers (Simpson, 2004) reported their sexual orientation influenced their career choice and the nontraditional career "fitted well with their sense of self" (p. 374).

Chusmir (1990) developed a model of nontraditional career choice for men which focused on the influence of personal, family, and societal factors. Lease (2003) found partial support for this theory in college men who entered nontraditional careers and those that entered male-dominated fields. Men who were socially liberal chose nontraditional careers, while men who had higher education goals, academic ability, and socioeconomic status chose traditional careers. Lease (2003) concluded that therapists should be aware of gender issues and values clarification for men, including family goals and parenting roles.

Lent, Brown, and Hackett's career choice model, social cognitive career theory (SCCT) has also been applied to the complex factors that influence nontraditional career development (as cited in Flores et al., 2006). SCCT translates Bandura's social cognitive theory to career development by identifying how personal variables,

environmental factors, and cognitions interact to affect career interests, choice, performance, and development. SCCT's focus on sociopolitical and cultural contexts may be specifically important to understanding gender and other cultural issues in career development. From SCCT, Flores et al. (2006) predicted that nontraditional career self-efficacy would predict nontraditional career interest, and that nontraditional career self-efficacy and nontraditional career interest would predict nontraditional career choice. Background context like acculturation level, parental support, and perceived occupational gender barriers predicted nontraditional career self-efficacy. In addition, if a father's career was nontraditional, this directly predicted the selection of a nontraditional career choice by his son.

There continues to be a need for researchers to identify the decision-making process for men entering nontraditional fields, including personal characteristics, multicultural issues, and societal influences, and for counselor educators to include gender socialization and nontraditional career choice in career counseling curriculum. There is specific need for research on men in minority populations since they are an increasing population, career theories have not demonstrated multicultural validity, and multicultural clients have "distinct values, beliefs, practices, and traditions that may influence the process of career development" (Flores et al., 2006, p. 216).

Researchers have tried to determine if there are personality, value, or other differences between men in traditional and nontraditional careers (Galbraith, 1992; Jome & Tokar, 1998). The research on characteristics of men in elementary education and nursing careers compared to women and men in traditional careers found more career satisfaction, more married men, an increased sense of reward and comfort, and the importance of relationship in (Galbraith, 1992). While research on men in traditional and nontraditional careers found men in traditional careers endorsed more masculine values, more homophobic attitudes, and reported greater gender role conflict (Jome & Tokar, 1998). Specifically, these men endorsed anti-femininity and toughness norms and reported difficulty with emotional behavior between men.

When researchers studied men's gender role attitudes and interests in men in nontraditional, gender neutral and gender traditional careers, they found distinct differences in views of

masculinity, sexual orientation, and social interest (Jome, Surething, & Taylor, 2005). Traditionally employed men scored much higher on the Index of Homophobia and lower on social interests; while there was no significant difference on these two scales between the gender non-traditional and neutral. Specifically, the regression analysis found men with homophobic feelings, less social interest, and less difficulty with intimate and emotional expression with other men, the more they tended to be traditionally employed.

Jome et al. (2005) speculated the results reflect traditional employed men's lack of contact with homosexual co-workers, who tend to choose female dominated careers. Meanwhile, gay men may choose female dominated careers to escape heterosexist attitudes in male traditional fields. Jome et al. (2005) also believed men with stronger interpersonal skills chose nontraditional occupations that are service oriented. Finally, the researchers proposed the emotional expression finding was because traditionally employed men prefer to interact with other males in the workplace, particularly presumed heterosexuals.

#### Men's Experience in Nontraditional Careers

Although theorists proposed men experience discrimination in nontraditional careers (Kanter, 1977; Cognard-Black, 2004), there are few studies of men's experience. Researchers have found that men have better wages and wage increases than women across nontraditional (Snyder & Green, 2008) and traditional occupations, although men in nontraditional careers make less than men in traditional workplaces (Cognard-Black, 2004; Lupton, 2006). Additionally, Canadian male nurses were disproportionately represented in administrative and prestigious specialty positions (Evans, 1997). One of the first theorists, Kanter (1977), believed that when workers were in an extreme minority, less than 15% of a total organization, on an important characteristic like culture or gender, they would experience discrimination, called tokenism. Kanter (1977) proposed token workers were marginalized, and subjected to more scrutiny, criticism, and performance pressure. Token workers were expected to be more dissatisfied and leave their employment. Kanter (1977) acknowledged that those token workers who are valued more in a culture may not have the same experiences, experiencing advantages that outweigh the token worker disad-

vantages. Later theorists (Taylor, 2010; Zimmer, 1988) argued that the effects of sexism supersede the impact of tokenism in the case of men in non-traditional careers. Evan's (1997) research with Canadian male nurses supported this theory, since the men gained promotion and coveted specialties by distancing themselves from the feminine image of nursing and female colleagues. Women colleagues nurtured the male nurses' careers.

A recent theorist identified internal factors that may characterize men's experiences in nontraditional careers (Simpson, 2005). Simpson (2005) proposed that role strain, the conflict between separate roles, may affect men trying to maintain the male role in an occupation identified as female. English men in nontraditional careers reported others assumed that they were homosexual or sexually perverse (Simpson, 2004). Male elementary school teachers identified problems with gender role conflicts, since nurturing and physical contact with small children were required, and role encapsulation when men were expected to be responsible for discipline (Cognard-Black, 2004).

Men in nontraditional careers also reported economic and social status consequences (Addi-Raccah, 2005; Cognard-Black, 2004) "Men tend to pay a higher economic price than women do for working in female-dominated occupations, as they experience a devaluation in their economic and social status compared to men in male-dominated or balanced occupations" (Addi-Raccah, 2005, p. 741). In teaching, men face social consequences, including fear of being accused of sexual harassment, women's resentment of male privilege in hiring, not being taken seriously by female teachers, and questions about masculinity and sexual orientation (Addi-Raccah, 2005, Cognard-Black, 2004).

### Coping Strategies

To understand how men working in non-traditional careers cope, researchers have identified direct action and palliative coping strategies (Gonzalez-Morales, Rodriguez, & Peiro, 2010). Direct action coping was problem focused, controlling, and active to eliminate a perceived threat, while palliative was emotion focused, passive, and avoiding to lessen emotional discomfort (Gonzalez-Morales et al., 2010). Researchers have also investigated social support, which was considered a resource, not a coping strategy (Gonzales-Morales et al., 2010). Since the masculine gender role is considered to include technical competence, competitiveness, aggressiveness, and rationality, it was associated with the direct action coping category. Direct action coping was positively correlated with well-being, but palliative coping had inconsistent results.

While workers expected less stress when using coping skills, this depended on the effectiveness of the coping skill and the response of the work environment (Gonzalez-Morales et al., 2010). The coping-gender match hypothesis stated that people use coping strategies that match their socialized gender role most effectively. Also, those using coping skills associated with the other gender may experience negative responses in male dominated work settings due to the role congruity theory, which proposes men who do not demonstrate stereotypical attributes trigger prejudiced perceptions and expectation.

When researchers focused on how men compensate for sexism and challenges to masculinity in nontraditional workplaces, they found men focused on the career aspect of their work, dissociated from work when outside the workplace, and focused on leisure activities that match their view of masculinity (Lupton, 2006). Men who focused on the career aspect chose more masculine identified specialties (Simpson, 2004; Snyder & Green, 2008), identified with the male groups in power, attempted to attain leadership positions, or represented or reclassified the work to appear more masculine (Bagilhole & Cross, 2006; Lupton, 2006; Simpson, 2004). Men who were unable to find adequate coping strategies reported seeking alternative employment.

#### Career Counseling Considerations

The movement toward a gender-balanced work force means intentional career selections for both sexes (Jome & Tokar, 1998). When counselors and educators view clients and students from a strength-based perspective, and do not circumscribe according to gender, clients and students have the opportunity to explore, risk, and flourish according to their own individual strengths, needs, talents and interests. Adopting the focus and principles of feminist theory into career counseling education and practice has been proposed to increase males' acceptance of their gender role, understanding of role conflicts with social constructs of gender, knowledge of nontraditional careers, and attainment of coping skills for nontraditional workplaces (Sayman, 2007; Szymanski, 2003).

In education, changing the gendering of occupations would start with teacher education (Sayman, 2007). Teachers would not only learn to expect gender neutral career interests and provide nontraditional role models, but would be taught critical theory for implementation in the classroom. Critical theory identified how issues of power, oppression, and domination work in the culture and encouraged awareness and social action. Critical pedagogy would help students recognize and challenge existing gender roles and other constructs that affect career interest, exploration, choice, and experiences (Sayman, 2007).

School counselors would support teachers by providing information on student gender role self-concept and personal constructs that predict interest and ability in different occupations (Flores et al., 2006). School counselors would also assist teachers in understanding how boys and girls are often treated differently in the classroom and provide alternative teaching strategies (Levine & Orenstein, 1994). School counselors would provide students with career information and role models based on these constructs, encouraging career exploration in academics and extracurricular activities (Flores et al.; 2006, Jackson et al., 2010; NYSOEC, 1994). Further, school counselors would be instrumental in identifying students that would benefit from nontraditional careers and providing mentoring and role models (Clark, 2000a)

Career counselors would apply the four dimensions of feminist therapy (Szymanski, 2003). The first dimension of a collaborative relationship (Szymanski, 2003) would focus on helping males trust their own experiences in nontraditional workplaces, encourage the identification and expression of gender self-concept, and resolve gender role conflicts. The second dimension of analyzing power (Szymanski, 2003) would require clarification of boundaries and roles in the workplace identify how gender contributes to client safety and power abuses, identify the client's coping style, and support effective coping styles for the nontraditional workplace. The dimension of emphasis on diversity (Szymanski, 2003) would focus on the gender factors that affect the client's mental health, including all those identified for men in nontraditional careers. The final dimension of social context and feminist advocacy and activism (Szymanski, 2003) would promote and support males in nontraditional careers. Career counselors would advocate for gender role self-concepts based on the person's identified gender characteristics regardless of sex, work to provide role models and information on nontraditional careers, inform the education system on gender role self-concept and career choice, identify gender inequities in educational and extracurricular opportunities, and educate workplaces on the values, process, and practices that would support all workers in a nontraditional workplace.

Across education and counseling professionals, there would be a focus on changing the use of gender specific language to describe occupations. Teachers and counselors would replace feminine and masculine adjectives with gender neutral descriptors, such as analytical or relational. Counselors and teachers would also need to be aware of their own gender prejudices and stereotypes and how they express them, even unintentionally.

Finally, counselor educators would need to introduce career counseling students to these constructs and provide supervision for these issues in practice. Further, counselor educators and researchers would need to support further research into the many gaps identified in nontraditional career choice, experience, coping, and counseling.

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# Challenge Course Activities in Counselor Education as a Means to Enhance Student Participation in Experiential Counseling Groups

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## Abstract

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) in counselor education endorse utilizing experiential counseling groups as a means of providing students the opportunity to simultaneously experience and observe counseling group development. In this context, students may learn a great deal from being able to experience the depth of all stages of group development. This article describes one counselor education program's inclusion of a preliminary day of challenge course activities as a primer to engaging in a semester-long (10 sessions) experiential counseling group. The authors discuss a theoretical framework and model; multi-semester observations of benefits and challenges of the approach; perceived outcomes among students; and conclusions and recommendations.

Requiring student participation in an experiential counseling group experience is typically included in counselor education program curriculum as a means of providing students a first-hand opportunity to observe the dynamics of a counseling group while personally experiencing the benefits of a group and is supported by professional and accrediting organizations (Wilson, Rapin, & Haley-Banez, 2000; Connolly, Carns & Carns, 2005; CACREP, 2001). Challenge course activities that involve physical, mental and emotional engagement among team members working collaboratively toward individual and group goals have often been cited for developing cooperation and communication while fostering caring, trust, and tolerance among group members (Alexander & Carlson, 1999; Fischesser (1991); Fletcher & Hinkle, 2002; Forgan & Jones, 2002; Glass & Benshoff, 2002; Glass

& Shoffner, 2001; Hatch & McCarthy, 2003). The authors describe how engaging students in a series of challenge course activities prior to their participation in an experiential counseling group may facilitate productive process, dynamics and movement through the stages of group development for students in a counselor education program.

### **Experiential Counseling Groups in Counselor Education Programs**

Experiential counseling groups are a form of group work that can be both beneficial in terms of personal problem-solving and psycho-educational in their propensity to facilitate an understanding of group dynamics of developmental properties (Fletcher & Hinkle, 2002; Gass & Gillis 1995; Glass & Shoffner, 2001; Hatch & McCarthy, 2003; Raiola, 2003). Students may benefit from participating in an experiential counseling group as a means for better understanding the perspective of group members and their experiences associated with navigating the developmental stages that occur within groups (Corey & Corey, 2001; Hensley, 2002). For these and other reasons, many counselor education programs, in particular those who are CACREP accredited, incorporate some form of experiential group counseling as a means of providing students the opportunity to experience and observe counseling group development (CACREP, 2001).

Due to many factors, such as the length of class periods, number of students per class, and the number of class sessions during a semester, the goal of having students experience each of the group stages (initial, transition, working, termination) is challenging at best and prohibitive at worst. Factors known to negatively affect group developmental are lack of trust, group cohesion, and willingness to take risk (Corey & Corey, 2001). Providing students with an outdoor experience prior to beginning the personal growth group may allow the group to acquire the ability to cooperate and communicate with each other more effectively, trust each other to a greater degree and bond together. Also, participating in this type of outdoor experience may also provide the group members with a more meaningful personal growth group within the classroom (Marotta, Peters, & Paliokas, 2000).

### **Challenge Course Activities**

Challenge course activities are often defined as low or high courses (Attarian, 2001; Fletcher & Hinkle, 2002; Gillis & Speelman, 2008; Hatch & McCarthy, 2003). This counselor education program chose to utilize a low ropes course as part of its curriculum. Usually, low course elements are utilized to promote teamwork among participating group members. High elements are intended to encourage individual risk taking, taking advantage on the group presence to provide emotional and physical support (Hatch & McCarthy). Low course activities often

focus on group problem solving, communication, cooperation and team building skills (Fletcher & Hinkle, 2002; Gas & Gillis, 1995; Gillis & Speelman, 2008; Priest & Gass, 1997) and activities commonly associated with building trust (Forgan & Jones, 2002; Harris, Mealy, Matthews, Lucas, & Moczygemba, 1993; Long, 2001). Challenge courses typically include a wide range of activities, each designed to achieve specific group goals, not the least of which is group cohesion (Fletcher & Hinkle, 2002). Challenge course activities typically engage members in structured experiences designed for develop group cohesion by requiring group members to communicate and work together to accomplish specified goals (Glass & Benshoff, 2002; Glass & Shoffner, 2001).

The level of challenge (emotional, mental, and physical), risk (physical and emotional; perceived and real), and trust required varies depending upon the activity chosen. Because low challenge course programs use the group modality as the primary method of delivery there are several benefits that are theoretically consistent with the goals associated with experiential counseling groups used in counselor education programs. According to Luckner & Nadler (1992), some of the dynamics that may be examined within challenge course activities are: (a) goal ambiguity, (b) diffusing anxiety, (c) members' search for position, (d) focus on affect and confrontation, (e) leadership, (f) defensiveness, (g) experimentation, (h) group viability, and (i) termination. Beginning to work through each of these dynamics prior to the actual counseling group experiences helps to facilitate a more rapid movement toward the working stage.

Cashwell and Nassar-McMillan (1997), stated challenge course groups parallel those of small counseling groups in that they undergo initial, transition, working, and final stages of development. Challenge course activities are often designed to help participants problem-solve based on group members engagement in cooperation, trust, communication, encouragement, respect for the rights of one another, and productive confrontation (Glass & Shoffner, 2001).

When participants are placed in new situations, they usually exhibit familiar coping strategies such as leading or following, listening or monopolizing, cooperating or manipulating, or other such skills that contribute for better or worse to the overall group process (Cashwell & Nassar-McMillan, 1997). Associated feedback, self-awareness and insight generate an opportunity for members to adapt in order for the group to be able to meet the established goals. According to Fletcher and Hinkle (2002), individuals who participate on a low ropes course

may observe and practice skills and interactions associated with leadership development, verbal and nonverbal communication, problem solving, trust, and decision-making.

Marotta et al., (2000) supported this belief. They contended participating in outdoor experiential exercises along with other teaching modalities may result in an increased knowledge of personal growth and group interactions for students studying group dynamics.

Challenge course activities have been shown to be a mechanism for the accelerated development of cohesion among group members (Glass & Benshoff, 2002; Hatch & McCarthy, 2003). According to Hatch & McCarthy, “if undertaken at the beginning of an experiential training group experience, the challenge course may serve as a valuable tool for setting the stage for individual and group growth” (p. 205). In an effort to expedite group development and accentuate the benefits of interaction in the working stage the authors sought to bolster specific group characteristics via the addition of a series of challenge course activities or “elements” as a precursor to the 10-week experiential counseling group. A particular effort was made to design challenge course experiences that would contribute to successful group stage development. The characteristics emphasized were: open and honest communication, group identification, cohesion, trust, and willingness to risk.

#### **A Model for Enhancing Experiential Counseling Groups with Challenge Course Activities**

The authors are both experienced in facilitating groups and teaching courses in group development within counselor education programs. One author has the added experience of leading challenge course activities. Once their paths crossed as faculty in the counselor education program at the University of Alabama at Birmingham (UAB), they began to engage in discussions regarding their passion for teaching group counseling and various strategies for doing so. Out of those discussions emerged the idea of incorporating a full day of challenge course activities as a means for facilitating and perhaps accelerating student participation and growth within the required group course experiential group. The initial concept continued to evolve over a period of several semesters leading to a more deliberate approach or the model inclusive of the documentation of perceived outcomes of the model.

The purpose of implementing a low ropes challenge course activity as a precursor to the students participating in their 10-week “personal growth group” is to enhance group cohesion, communication, and trust. Combining constructs from both group and ropes course literature led the authors to hypothesize that group cohesion,

communication, and trust would be enhanced and then transferred into the group's 10-week experiential activity, thereby contributing to a group atmosphere conducive to moving more quickly to the working stage.

### **Preparation for Challenge Course Activities**

The group counseling course "personal growth group experience" typically begins during the third week of a 14-week semester. Students are introduced to the course schedule within the syllabus during the initial class meeting and general expectations are discussed and questions addressed. During the second week of the course, prior to the Saturday in which the challenge course activities are conducted the challenge facilitator, in the presence of the course instructor, addresses the class regarding the logistics and nature of activities. Location, preparation, and expectations are discussed and questions addressed. Although students only participate on "low rope" challenge elements, the facilitator discusses the liability waiver, medial release, and informed consent documents that must be signed prior to participating on the challenge course. The facilitator also explains dress requirements, eating and hydration precautions, and directions to the challenge course. Students are told the day on the course requires them to participate from approximately 9:00 a.m. – 4:00 p.m.

### **Challenge Course Activities**

On the designated Saturday, the facilitator meets the students at the challenge course site and collects consent documents from each student. The facilitator privately discusses medical release forms with each student, asking questions and clarifying responses to answered items. The students are brought together to receive an introduction and an overview of challenge course terminology and what the group can expect of the facilitator. Components of the introduction include a discussion of the following: (a) stretch, comfort, danger zone; (b) define/share personal and group goal(s) for the day; (c) disequilibrium / equilibrium; (d) real/perceived risk; (e) safety: responsible for one's safety first, then others; (f) role of facilitator; and (g) how the facilitator will interact with group.

Activity course events and sequencing is divided into: a) games (designed to stimulate cognitive, physical, emotional domains); b) portable initiatives (to force students into making decisions, goal setting, etc.); c) elements (sequenced with increasing complexity and difficulty); d) processing of each activity (including a discussion of intra- and inter-personal responses, issues, and interest); and e) comprehensive processing of the day's activities (including personal learning experiences, observations of group behavior, and what may be taken from the day's experiences into the counseling group).



### Challenges and Benefits of the Model

The initial expectations of the authors were the peer-group challenge course model would enhance group cohesion, communication, and trust. Furthermore, these dynamics would be transferred by each participant into the group's 10-week experiential activity, thereby contributing to a group atmosphere conducive to moving more quickly to the working stage.

The authors observed the following behaviors of participants:

- There seemed to be an increased closeness derived from interacting with each other in a “non-academic” setting;
- There seemed to be an opportunity for examination of personal behaviors by participants without feeling “judged”;
- There seemed to be an ability for participants to become closer with classmates in a manner that normal class attendance does not allow;
- There seemed to be a belief that the experience would aid them in the experiential growth group; and
- There seemed to be an increased level of enthusiasm and hope related to the benefits of participating in the experiential counseling group.

Following the day of participation on the challenge course, the leader facilitates a brief summary discussion of personal feelings, thoughts, and experience about the overall activity. The following are some typical student's responses that encapsulate their challenge course experience:

- “I didn't know much about my classmates and wasn't sure I could ‘open-up’ prior to participating in these activities.”
- “After today, I feel closer to my classmates than I did before.”
- “I have more trust in my classmates than before I participated in these activities.”

The authors have observed that over several semesters students tend to transition from the Saturday challenge course experience to the experiential counseling group energized in one of two ways that facilitates movement into the working stage: (a) they have developed a high level of trust and cohesion; or (b) they have begun to identify conflict within the group that needs to be addressed.

As noted above, there are many potential benefits to this model. The authors have observed very few downsides to this approach. The two primary liabilities have been: a) the inconvenience of setting aside Saturday for the challenge course activities; and b) the physical risk associated with prescribed physically challenging activities. While it is true that initially a small number of students may voice displeasure regarding the necessity of meeting on a Saturday; ultimately students tend to “get it,” and express their understanding of the benefits of such an experience. Indeed, over the course of 4 semesters, only one student has been unable to participate in the Saturday experience. No serious, and few minor injuries have occurred during the time in which this approach was carried out. Additionally, it should be mentioned that alternate plans need to be readied in the event that inclement weather precludes the ability to participate in outdoor activities. Such a problem has only presented itself once during the course of this project. Overall, the authors feel strongly that the benefits far surpass the liabilities of this approach.

### **Conclusions / Recommendations**

Our preliminary overall conclusions support the findings of Hatch and McCarthy (2003). Preliminary data suggests the utilization of a pre experiential counseling group challenge course model has numerous benefits and a small number of challenges. Some of the more apparent benefits include: (a) early high levels of a sense of cohesion and trust; (b) development of a strong sense of collaboration, (c) becoming comfortable with sharing emotions within the group, and (d) getting to the working stage more quickly.

Observable challenges include the following: (a) obtaining 100% participation from students on a designated weekend; (b) safety issues associated with conducting physically challenging activities; and (c) implementing alternative plans in the event of inclement weather. Anticipating medical emergencies (though not likely) is essential, and providing information beyond the typical informed consent is necessary.

To the degree possible, the inclusion of a pre challenge group course model such as this, or variations of such a model should be considered within counselor education programs as a means of facilitating and accelerating

stage development within experiential counseling groups. The authors would like to encourage other counselor education programs to explore variations of this model in their own program and do so with the plan of documenting outcomes for analysis and publication as a means of further understanding the benefits and challenges of such models.

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# The Relationship between Standardized Test Scores and Bullying in Middle School

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## Abstract

The objective of this research was to determine what effects bullying in middle school has on standardized testing scores. A convenience sample of 64 ( $n=64$ ) seventh grade, middle school students, of whom 15 reported being bullied at least three times a week, was tested utilizing the Alabama Reading and Math Test (ARMT) (Alabama State Department of Education, 2010) and the Stanford Achievement Test (SAT) (Pearson Education, 2010), and the PRIDE (International Survey Associates, 2006) survey was administered to use the direct responses from students about the school climate regarding bullying. The same convenience sample of middle school students ( $n=57$ ), were tested again as eighth graders, with 16 reporting being bullied at least three times a week; the ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010) were the only tests utilized because the school did not administer the PRIDE (International Survey Associates, 2006) survey during this school year. Results indicated significance in lower test scores among students who were bullied than their non-bullied peers.

*Keywords:* bullying, standardized tests, ARMT, SAT, middle school

Bullying in school is an omnipresent educational challenge. The purpose of this study is to measure the impact bullying has on middle school student's standardized test scores. Performance on the Alabama Reading and Math Test (ARMT) (Alabama State Department of Education, 2010) and Stanford Achievement Test (SAT) (Pearson Education, 2010) is explored. This study will serve as an initial investigation into the understanding of bullying and how it affects the educational outcome of students.

According to Olweus (1995), bullying is typically defined as repeated relational or physical aggression directed to one or more peers. Schools are working diligently to help the victims and aggressors of bullying, yet bullying has not completely gone away. Students still suffer daily from some form of bullying while they attend school. Bullying can take on several different forms: physical, verbal, emotional, and most recently, cyberbullying. Cyberbullying is defined as willful and repeated harm inflicted through the medium of electronic communication tools (Beran & Li, 2005). The consequences of repeated bullying occurrences not only include the ultimate consequence of suicide, but may also include dropping out of school. Literature shows a correlation between school attendance and grades; many students miss school often out of fear of being bullied (Sbarbaro & Smith, 2011). Standardized tests are indicators that state departments of education and the federal government can use to assure students across the country are meeting national standards of education. However, the standardized tests do not take into account any outside factors, including bullying, that might hinder the learning process for students.

A cohort of 64 students was tracked during their seventh and eighth grade years of middle school. 15 of 64 seventh grade students were bullied at least three times per week and 16 of 57 eighth grade students were bullied at least three times per week. The bullied students did re-

ceive administration and counseling intervention that included weekly counseling and monthly meetings with parents for the bullying; yet, while these students report that bullying decreased it never stopped completely. The continued bullying was usually done through cyberbullying, and the aid of social networking sites and cell phones, during after school hours.

The current study utilized surveys and standardized test scores in order to explore how a cohort of students tracked during their seventh and eighth grades performed on the ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010). The following research questions were posed: (a) How often were students bullied at school?; and (b) Was there a significant difference in the bullied students test scores compared to their non-bullied peers; thus, does bullying affect the overall cognitive skills of students?

Schools must be held accountable for the education of students it services; therefore, State and Federal government are able to hold schools and school systems liable through standardized testing. High-stakes, standardized testing was reformed by the No Child Left Behind (No Child Left Behind [NCLB], 2001) legislation to hold lower achieving schools and personnel accountable for the curriculum delivered within the school. Unfortunately, the legislation did not make guidelines for schools and administrators to prevent manipulation of the system by teaching to the test, withholding the lowest performing students from test taking, and even fraudulent score reporting like in the case of the “Texas Miracle” (Rose, 2011).

As Wiliam questioned (2010), “to what extent do differences in test scores represent differences in the quality of schooling provided (construct relevant variance) rather than other factors, such as the amount of parental support, differences in the prior achievement of students on entering the school system, and so on (construct-irrelevant variance)?” (p. 110). While standardized testing is used to report varying statistics to stake holders at the state and Federal levels,

concerns still remain regarding outside factors that might attribute to low scores: socioeconomic status, level of intellectual disabilities, and like this report is piloting, bullying. Studies have shown that bullying does affect a student's self-esteem, emotions, and academics (Jones, Masten, & Livingstone, 2009; Olweus, 1995). Therefore, does bullying affect scores on standardized testing?

Schools and school systems have some flexibility to identify what bullying is or what bullying constitutes. The majority of schools, school systems and even state boards of education agree with Voors (2000) identification of bullying. According to Voors, certain criteria must be met for conflicts and confrontational behavior to be considered bullying: consistent and negative actions, imbalance of power between the child and bully, contrasting feelings due to the bullying episode, and bullying can manifest itself physically, verbally, and/or relationally. Consequently, how are these conflicts addressed or accounted for on standardized tests?

The reason students are bullied varies widely. However, Frisén, Jonsson, and Persson (2007) report:

Of the adolescents who reported, 39% indicated that they had been bullied at some time during their school years and 28% said that they had bullied others; 13% reported being both victims and bullies. The ages during which most students had been bullied at school were between 7 and 9 years. Bullies reported that most of the bullying took place when they were 10 to 12 years old. The most common reason as to why individuals are bullied was that they have a different appearance. (p. 749)

Some studies have indicated bullying among school aged children and standardized test scores do have some correlation. School related outcomes such as pressure added by bullying,



standardized testing, and community pressures regarding school safety due to bullying can add to tragedies such as suicides and school violence like the school shootings at Columbine (Forrest, 2011; Speltz, 2011; Hazel, 2010). According to Child Health Alert (2006), 22% of students in elementary school are involved in bullying either as the bully, the victim, or both. It was also found in the same study that children who are bullying victims performed lower on achievement tests and had higher rates of absences from school.

The purpose of this study is to measure the impact bullying has on middle school student's standardized test scores; in particular, the Alabama Reading and Math Test (ARMT) (Alabama State Department of Education, 2010) and Stanford Achievement Test (SAT) (Pearson Education, 2010). This study will serve as an initial investigation into the understanding of bullying and how it affects the educational outcome of students.

## **Method**

### **Subjects**

Sixty-four students at a rural Alabama high school, which houses grades seven through twelve, served as the sample for this study. Consent was given by the principal of the school and approved by the superintendent of the school system to use the ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010) testing data. The signed consent form indicated that (1) the study was to use testing data to identify empirical data that might correlate bullying and standard achievement testing scores, (2) the students were not required to participate, and (3) no student names or student identifiers would be used in this study.

In order to maintain confidentiality, the school counselor identified students who were bullied more than three times a week and marked the testing score sheets. The counselor then completely deleted any names or identifiers from each set of scores. Once the data was collected all paperwork was shredded.

A convenience sample consisting of 64 in seventh grade and 57 students in eighth grade, all enrolled as students at a rural Alabama high school were used as subjects in this study. The inconsistencies in student samples, seventh grade  $n=64$  and eighth grade  $n=57$  come from the transfer of students to other schools and/or absence during the testing. The subjects made up the cohort for the grades from which assessments were used in this study.

The final convenience sample for the first set of statistics consisted of 34 males and 30 females. The mean age for all participants during the first year assessments was  $M=13.5$ ; all of the students were in the seventh grade. The ethnic and racial self-identifications were as follows: 96% (61) White, European, or European American; 1% (1) Black/African American; 3% (2) Latino(a).

The final convenience sample for the second set of statistics consisted of 30 males and 27 females. The mean age for all participants during the second year assessments was  $M=14.5$ ; all of the students were in the eighth grade. The ethnic and racial self-identifications were as follows: 92% (52) White, European, or European American; 3% (1) Black/African American; 5% (3) as Latino(a).

Extreme caution should be made when generalizing populations because a sample of convenience was used for this study. Generalizability of the results is restricted because of the population studied.

## Measures

Two separate assessments, Stanford Achievement Test-10 (SAT-10) (Pearson Education, 2010) and Alabama Reading and Math Test (ARMT) (Alabama State Department of Education, 2010), were given to students in the spring of their seventh grade year of school to measure achievement. The same group of students was again given the SAT-10 (Pearson Education, 2010) and ARMT (Alabama State Department of Education, 2010), in the spring of their eighth grade year of school to measure achievement.

These same students were given a PRIDE (International Survey Associates, 2006) assessment, which measured areas in which students felt they might need help. A Likert scale was used on the assessment when asking questions regarding bullying, sexual activeness, and alcohol and drug use. The PRIDE (International Survey Associates, 2006) survey is used by the state of Alabama to help show that schools are meeting Continuous Improvement benchmarks (CIP) set by the state and Federal government. The Learning Environment Section (LES) within the school demographic information portion of the PRIDE (International Survey Associates, 2006) survey asked the direct questions “To what degree do the following interfere with your classwork: 31 bullying (verbal, physical, and emotional) and 32 cyber bullying (International Survey Associates, 2006). On the PRIDE (International Survey Associates, 2006) survey, Questions 35-39 of section III of the LES also asks questions regarding the frequency of particular acts of bullying including: exclusion, name calling, teasing, rumor spreading, threatening, and cyberbullying. The PRIDE (International Survey Associates, 2006) survey helped in the process of identifying what percentage of students said bullying was happening in the school environment and what percentage actually reported to school personnel; there was a 5:1 ratio of stu-

dents anonymously reporting that bullying was a major problem within the school setting and those students that were actually coming forward about the bullying.

The SAT-10 (Pearson Education, 2010) and ARMT (Alabama State Department of Education, 2010) were chosen because the assessments help to measure a student's achievement and compare the student's scores to other students, in the same grade, across the nation. The SAT-10 (Pearson Education, 2010) provides individual score types for subtest and domain totals; score types are number correct, scaled score, percentile rank, stanine, grade equivalent, normal curve equivalent, achievement/ability comparison, and school ability index. The SAT-10 (Pearson Education, 2010) also provides individual score types for battery totals and composites, group score types on test items, group score types on tests and totals, and norms. For the purposes of this study the individual scaled score (SS) was the score used to compare students who were bullied at least three or more times a week to students who were not bullied. The scores were used from the seventh and eighth grades. According to SAT (Pearson Education, 2010) the definition of scaled score (SS) is, "A standard score derived from the number correct (raw score) that indicates performance on all forms and levels of a given Stanford 10 subtest along a single, comparable scale. The scaled score facilitates conversions to other score types and the study of changes in performance from grade to grade".

The ARMT (Alabama State Department of Education, 2010) provides individual achievement levels for reading and math. Achievement levels are as follows: I- Does not meet standards, II- Partially meets standards, III- Meets standards, IV- Exceeds standards. Followed by the level of achievement, students total points earned out of points possible and scaled score are provided. For the purposes of this study the scaled score was used from seventh and eighth grade assessments and compared to SAT-10 scores (Alabama State, 2008).

According to Feuer, Towne, & Shavlelson (2002), student achievement was measured using SAT-10 ( $\alpha = .87$ ). Panels, known as the Alabama Accountability System, were constructed from 131 city and county districts from the state of Alabama and established validity for the ARMT (Morton, 2005). Reliability was not proved when the “Alabama State Department of Special Education (2004) hired Harcourt to test the [Alabama Reading and Math Test] in grades four, six, and eight” (Hurstons, 2011).

### Results

The first research question posed the frequency of students being bullied at school. Utilizing the PRIDE (International Survey Associates, 2006) survey results it was found that 75% of students who bully, are bullied, or witness bullying did not report the incidences to school personnel. 25% of students at this school did report; thus, aiding in identifying the number of bullied students to compare to the overall number of students tested.

To examine the second research question, ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010) standardized tests scores were correlated with amount of times a student claimed to be bullied and the affect it had on student’s cognitive skills. The difference scores were then examined using analysis of variance (ANOVA). Table 1 shows the means, standard deviation, F test, and significance for the ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010) for students in the seventh grade. This ANOVA revealed a significant difference between scores of students who were bullied at least three times per week and students who were not bullied or bullied less than three times per week.

Table 1

*Analysis of Variance on Reading and Mathematics for Seventh Grade*

	N	Mean	Std. Deviation	F	Sig.
<b>ARMTread7</b>				7.648	.007
<i>Bullied</i>	49	677.69	23.836		
<i>Not Bullied</i>	15	659.07	18.960		
<i>Total</i>	64	673.33	24.001		
<b>ARMTmath7</b>				7.736	.007
<i>Bullied</i>	48	672.42	31.640		
<i>Not Bullied</i>	15	647.53	24.997		
<i>Total</i>	63	666.49	31.845		
<b>SATread7</b>				6.408	.014
<i>Bullied</i>	49	685.06	28.224		
<i>Not Bullied</i>	15	664.40	25.631		
<i>Total</i>	64	680.22	28.823		
<b>SATmath7</b>				9.310	.003
<i>Bullied</i>	49	674.71	32.084		
<i>Not Bullied</i>	15	647.13	25.025		
<i>Total</i>	64	668.25	32.590		

Table 2 presents the means, standard deviation, F test, and significance for the ARMT (Alabama State Department of Education, 2010) and SAT (Pearson Education, 2010) for students in the eighth grade. As in Table 1, a statistically significant difference was found between scores of students who were bullied at least three times per week and students who were not bullied or bullied less than three times per week.

Table 2

*Analysis of Variance on Reading and Mathematics for Eighth Grade*

	N	Mean	Std. Deviation	F	Sig.
<b>ARMTread8</b>				7.566	.008
<i>Bullied</i>	41	676.46	26.110		
<i>Not Bullied</i>	16	657.00	17.174		
<i>Total</i>	57	671.00	25.374		
<b>ARMTmath8</b>				4.660	.035
<i>Bullied</i>	41	690.39	34.204		
<i>Not Bullied</i>	16	669.94	25.849		
<i>Total</i>	57	684.65	33.175		
<b>SATread8</b>				6.845	.011
<i>Bullied</i>	41	679.51	27.941		
<i>Not Bullied</i>	16	658.19	26.858		
<i>Total</i>	57	673.53	29.057		
<b>SATmath8</b>				9.653	.003
<i>Bullied</i>	41	687.56	35.563		
<i>Not Bullied</i>	16	657.88	21.912		
<i>Total</i>	57	679.23	34.829		

## Discussion

### Summary

The primary purpose of the present research was to identify students who were bullied at least three times per week and distinguish if the bullying affected standardized test scores. Overall, several of the findings were consistent with prior research. First, students who were bullied tend to have lower academic scores than their non-bullied peers. Second, any form of bullying will have multiple effects on a student victim of bullying; including academics because the victims focus is no longer on success within academics but survival while at school (Jones, Manstead, & Livingstone, 2009; Olweus, 1995).

### Limitations

Although this study contributes preliminary insight to assist schools when creating prevention, intervention, and post-vention anti-bullying programs, it is not without its limitations. The most obvious of which is the limited subject sample. This research also does not account for other outside factors that might attribute to lower achieving test results.

Thus, while schools have policies in place to help victims of bullies and the bully, other forms of prevention, intervention and post-vention are needed to better deal with bullying and the cognitive, emotional, and physical devastation it creates.

### **Directions for Future Research**

The applications of this research should be further examined by including a larger and more diverse sample population. If the results obtained are proven on a larger population of students then further research examining appropriate and effective intervention, prevention, and post-vention strategies are needed.

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# Balancing Work and Family in the 21st Century: Implications for Sexual Satisfaction among Dual- earning Partners

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## Abstract

Previous research has indicated that work-family conflict can lead to significant psychological distress, including anxiety, depression, substance abuse, and psychosomatic symptoms. It has also indicated that sexual satisfaction is often considered a critical dimension of love in a relationship, and when an individual's self-perception is negatively altered, sexual attitude can also be altered. This article will explore the relationship between work-family conflict and dual-earning partners' sexual satisfaction in their relationship. A discussion of the implications for counselors with regard to helping clients address and develop individualized interventions to reduce the stress associated with work-family conflict, helping clients regain intimacy and sexual satisfaction in their relationship, and advocating for workforces to become more aware of family unity and its roles in the 21st century are included.

In the 19th century a dogma originated from the English upper middle classes which held that a woman's proper place was in the home and that the man's was in the world of commerce (Barnett & Hyde, 2001). Since the 1970s, this belief has been challenged in the United States, as more and more women enter the workforce, redefining gender roles and signifying the most dramatic social change for both men and women in the late 20th and early 21st centuries (Barnett & Hyde, 2001; Hansen, 2000; Saveri & Falcon, 2000). The amount of time spent on child care continues to decrease for employed women and increase for employed men (Barnett & Hyde, 2001), and cur-

rent trends in the workforce illustrate more dual-earning partners, with 72% of mothers with children under the age of 18 employed outside the home in 2002 (Halpern, 2004).

Despite these significant changes in demographics of the United States, society is still designed for the waning family model depicting a stay-at-home caregiver (Halpern, 2004) thus giving rise to higher incidences of work-family conflict (Perrone, Wright, & Jackson, 2009). Researchers have focused on work-family conflict as well as work-family enrichment for the past thirty years (Allen, Herst, Bruck, & Sutton, 2000; Aryee, Srinivas, & Tan, 2005; Barnet & Hyde, 2001; Behson, 2002; Frone, Russell, & Cooper, 1997; Frone 2000; Greenhaus & Powell, 2006; Hansen, 2000; van Steenbergen, Ellemers, & Mooijaart, 2007). However, little if any, research has been conducted to determine the relationship between work-family conflict and sexual satisfaction among dual-earning partners.

### Identity Theory

Identity theory explains how we as individuals choose different roles to express our identities, and how we assign a certain level of importance to each role. Identity theory views the self “not as an autonomous psychological entity but as a multifaceted social construct that emerges from people’s roles in society” (Hogg, Terry, & White, 1995, p. 256). Accordingly, identities are internalized role expectations attached to the multitude of roles in which an individual may participate, one for each distinct relationship in which a position might be occupied (Stryker & Burke, 2000).

*Role Identity.* Each role position that an individual occupies in society is referred to as a role identity and functions as a distinct component of the greater self (Hogg et al., 1995). For example, an individual’s role identities may include wife, mother, student, counselor, etc., or husband, father, network engineer, martial artist, etc. Role identities provide meaning for self, via the process of labeling oneself as having an affiliation within a social membership (Hogg et al., 1995). Role identities play an integral part in the perceptions of our own self-worth, depending on adequate or inadequate fulfillment of these roles. To illustrate, if an individual is satisfied with the enactment of a particular role, self-esteem and positive emotions are enhanced. Conversely, if an individual is dissatisfied, negative emotions such as doubting self-worth occur, and can lead to symptoms of psychological stress (Hogg et al., 1995; Stets, 2005).

*Role Behavior.* Role behavior, or identity salience, is defined as “the probability that an identity will be invoked across a variety of situations, or alternatively across persons in a given situation” (Stryker & Burke, 2000, p. 284). Identity roles are organized hierarchically based on their importance or self-relevance to each individual. Therefore, roles that are the most self-defining are placed at the top of this hierarchy, and are more likely to be related to the individual’s behavior (Hogg et al., 1995). Because this salience of identity roles differs from individual to individual, different behaviors may arise in a particular context when comparing two people who share the same role. For example, although two people may share the same *student* and *parent* role identities, one might prefer to spend time with their children on the weekend, while the other spends more time studying. The salience of a particular identity role increases as commitment to the role increases (Hoelter, 1983). In the example above, it is clear that the first individual has a higher salience to their parent identity role, and the second to their student identity role, most likely due to their individual levels of commitment to each role.

*Commitment.* Within identity theory, commitment can be defined as the degree to which “one’s relationships to specific others depend on one’s being a particular kind of person” (Hoelter, 1983, p. 141). Both interactional commitment (the number of roles associated with an identity) and affective commitment (the importance of the relationships associated with an identity) are conversely related to an individual’s identity salience (Hogg et al., 1995).

### Work-Family Conflict

Work-family conflict most commonly occurs when pressures to fulfill the work and family roles are incompatible with one another (Allen et al., 2000; Aryee et al., 2005), or in other words, this emotional dissonance may occur when an individual’s pursuit of fulfilling the work role interferes with their ability to meet demands in the family role and vice versa (Frone, 2000). Identity theory was formed on the understanding that individuals desired agency in constructing and maintaining identities to which they could devote time and energy. When these self-images are challenged by obligations the individual perceives a threat (Frone, 2000, p. 888). Applying this theory to work-family conflict, a work-to-family conflict signifies a barrier to an individual’s ability to meet family-related demands and responsibilities, which threaten their family-related self-image. A common illustration of a work-to-family conflict experience is missing an important dinner with one’s partner/family because of working late (Elliot, 2008; Grzywacz & Bass, 2003). Conversely, a family-to-work conflict signifies a barrier to an individ-

ual's ability to meet work-related demands and responsibilities, which threatens their work-related self-image such as feeling physically drained at work after staying up all night with a sick child (Grzywacz & Bass, 2003). Because work and family roles are both core components of an adult identity, work-to-family and family-to-work conflicts can be very stressful (Frone, 2000).

Scarcity theory (Marks, 1977; Greenhaus & Beutell, 1985) posits that one's personal resources, such as time, energy, and attention are finite. As a result, devotion of attention to one role implies that fewer resources can be spent on another role (van Steenbergen et al., 2007). Thus, individuals who perceive their resources to be finite make trade-offs to reduce role strain (Aryee et al., 2005). When an individual feels their resources are finite in a work-family conflict, the outcomes can lead to job dissatisfaction, job burnout, turnover, depression, life dissatisfaction, and marital dissatisfaction (Allen et al., 2000).

*Conflict Subtypes.* Four distinct subtypes of work-family conflict that individuals frequently experience have been identified (van Steenbergen et al., 2007) Strain-based conflict occurs when the strain resulting from one role makes it difficult for an individual to meet the requirements of achieving the fulfillment of another role. An illustration of a family-to-work strain-based conflict might be the physical exhaustion experienced by a new parent while at work resultant from the sleep debt they incur secondary to having a newborn infant. Second, time-based conflict occurs when the time an individual devotes to the fulfillment of one role makes it difficult to meet the requirements of achieving the fulfillment of another role. As an example, a parent may be unable to attend his or her child's athletic games because their work schedule overlaps with the game times. The third type of conflict, behavioral conflict, occurs when the behavior necessary for an individual to fulfill one role makes it difficult to meet the requirements of achieving the fulfillment of another role. To illustrate, a mother's nurturing behavior in her family role interferes with her ability to behave as an assertive manager in her corporate professional role. The final subtype of conflict, psychological conflict, occurs when the psychological preoccupation with one role becomes pervasive and interferes with the requirements of achieving the fulfillment of another role. An example of a work-to-family psychological conflict might be a father's inability to remain fully present (mentally) with his children on the weekend, because he is constantly thinking of work-related issues.

*Gender Differences in Work-Family Conflict.* Work-family conflict has been linked to various negative outcomes in two distinct areas of an individual's life, including non work-related and mental health. As work-

family conflict increases, life satisfaction, marital adjustment, and family satisfaction all decreased (Allen et al., 2000). Some suggest that this is because “as people have come to expect more balance, they may experience more dissatisfaction with their life when that sense of balance is violated” (p. 293). Further, researchers have indicated that as work-family conflict increases, psychological strain increases, including anxiety, irritability, hostility, frustration, depression, substance dependence/abuse, and other mood disorders (Allen et al., 2000; Frone et al., 1997; Frone, 2000). Increased work-family conflict increases physical psychosomatic symptoms, such as poor appetite, fatigue, nervousness, tension, and higher blood pressure (Allen et al., 2000; Frone et al., 1997).

Gender differences have also been noted with work-family conflict. Women tend to have more negative mood and anxiety outcomes in relation to work-family conflict, while men are more likely to experience a higher rate of job burnout as well as substance dependence/abuse (Frone, 2000). Interestingly, the directional attributes of the conflict seem to be connected to the symptomatic expression. For example, family-to-work conflict has a higher association with depression and poor physical health and work-to-family conflict has a higher association with heavy alcohol use (Frone et al., 1997). Because employed mothers still provide the majority of child care in their family role, females often experience higher levels of family-to-work conflict as compared to males (Behson, 2002). In addition, researchers have found that women experience higher levels of work-to-family strain-based conflict, and work-to-family psychological conflict as compared to men (van Steenbergen et al., 2007) yet men evidence unique social support needs that often go unnoticed (Steiner, Bigatti, Hernandez, Lydon-Lam and Johnston, 2010).

Aryee et al. (2005) indicated that this discrepancy is a matter of internalizing gender role ideology. It has been posited that men tend to work over family, and women tend to prioritize family over work (Arrington, Cofrancesco, & Wu, 2004).

#### Role Expansion Theory and Work-Family Enrichment/Facilitation

In contrast to work-family conflict, work-family enrichment/facilitation can be viewed as a complementary relationship, for which the experiences, skills and opportunities gained in the work role can help an individual fulfill their family role, and vice versa (Aryee et al., 2005). In this perception of balancing work and family, workers bring with them family experiences that help enrich their contributions to work and organizations.

Role expansion theory for work-family facilitation was proposed by Marks (1977) as an alternative to the work-family conflict. Instead of an individual's resources being perceived as finite, this perspective considers human energy to be unlimited, allowing participation in one role to have positive effects on other role performances (van Steenbergen et al., 2007; Greenhaus & Powell, 2006). Primarily, work and family experiences can have a positive effect on an individual's well-being, including physical and psychological well-being, especially when each role is perceived as high quality. As a second benefit of role expansion, there is a buffering effect of participating in one role reducing distress or strain from another role. Research has shown that when workers have satisfying, high-quality work experiences, this buffers the negative effects of family stressors in their family role (Greenhaus & Powell, 2006). A final benefit suggests that positive experiences from one role can be transferred into the other, creating energy that can be used to enhance experiences in the second role. An example of this might be the patience a mother has for her children being carried over to her management position, where she treats her employees with patience and allows them to develop at their own pace.

*Enrichment Subtypes.* Greenhaus and Powell (2006) conceptualized two distinct subtypes of enrichment, including instrumental enrichment, and affective enrichment. Instrumental enrichment occurs when the skills, abilities, and values acquired from one role can be effectively used in another role. As an illustration, family-to-work instrumental enrichment might occur when multi-tasking skills used when attending to children are applied to work situations. An example of work-to-family instrumental enrichment might be time management skills learned in the work place that can be applied to family situations. The second type of enrichment, affective enrichment, occurs when positive affect or emotion resulting from one role is carried over to another role and contributes to the fulfillment of that role. For example, family-to-work affective enrichment might occur when the satisfaction and pride of the family role carries over to the work role and increases productivity. An illustration of work-to-family affective enrichment might occur when patience with work challenges carries over to the family role and reduces frustration.

*Gender Differences Work-Family Enrichment/Facilitation.* Current studies show that men tend to have more work-to-family affective enrichment, while women tend to have more family-to-work affective enrichment (Aryee et al., 2005; Greenhaus & Powell, 2006; van Steenbergen et al., 2007). This gender difference implies that meaningful experiences at work have a positive effect on men's family role, while meaningful experiences with family have a positive effect on women's work role. Aryee et al. (2005) indicated that, in general, men assume a



more work-related responsibility and therefore experience more work overload than women. Conversely, women assume a more family-related responsibility, and therefore experience more family overload than men in general. Taking this into consideration, the gender differences in work-family enrichment/facilitation can be explained as the use of role expansion to positively enhance the less dominant role of that gender.

*Work-Family Enrichment/Facilitation and Outcomes.* Just as work-family conflict can have negative outcomes in non work-related and mental health areas of an individual's life, work-family enrichment/facilitation can help create positive outcomes in these same areas. Job satisfaction also has a positive relation to family satisfaction, especially for women, where positive experiences at work can act as a buffer towards challenges in the family role (Barnett & Hyde, 2001) and income derived from work has a positive relation to marital quality and well-being (Greenhaus & Powell, 2006). Grzywacz and Bass (2003) have found that family-to-work enrichment significantly reduces the risks of depression and alcohol dependence/abuse. Barnett and Hyde (2001) found this to be especially true for women, who report less symptoms of depression when they are working and raising a family, as opposed to just staying at home with the family. Similarly, men who are engaged in both the work and family role tend to report fewer symptoms of distress than men who aren't fathers. In addition, psychological engagement at work is seen to have a positive relation to men's psychological engagement in family life, and vice versa for women (Greenhaus & Powell, 2006).

#### Sexual Satisfaction

"Sex is a basic human function and a fundamental part of life. Sex involves physical, psychological and emotional factors and affects general well-being and overall quality of life (Arrington, Cofrancesco, & Wu, 2004, p. 1643). Sexual satisfaction is often considered a critical dimension of love in a relationship, and researchers have found various associations between it and the reported quality of a relationship and quality of life in general (Byers, 2005; McCabe, 1999; Tower & Krasner, 2006; Trudel, 2002; Yeh, Lorenz, Wickrama & Conger, 2006; Young, Denny, Young & Luquis, 2000). For example, Byers (2005) has shown a strong positive association between sexual satisfaction and relationship satisfaction, and Litzinger and Gordon (2005) have found that many couples rate sexual satisfaction as a significant component of their relational happiness and functioning. By contrast, sexual dysfunction is linked to impaired quality of life (Arrington et al., 2004), depleting a relationship of intimacy (Litzinger & Gordon, 2005), emotional distance between partners (Byers, 2005), frustration, distress, anx-

iety, and depression (Arrington et al., 2004), and overall difficulties within a relationship (Trudel, 2002). Consequently, continued sexual activity and sexual interest are important factors of maintaining a healthy relationship (Tower & Krasner, 2006).

Identity theory encapsulates the significance of each role identity in an individual's life, such as wife, mother, student, etc. These fragments of self, as a whole, contribute to perceptions of self-worth – negatively during inadequate role fulfillment, and positively when adequately fulfilled. If an individual's self-perception is altered in a negative way, sexual attitude can also be altered and may include the inability to become aroused or achieve orgasm (Arrington et al., 2004). This sexual dysfunction as a result of conflicting self identity may impact self-esteem, quality of life, interpersonal relationships, as well as various aforementioned aspects of sexual satisfaction. Interactional commitment and affective commitment define the number of roles and the importance of the relationship associated with an identity, respectively (Hoelter, 1983; Hogg et al., 1995; Stets, 2005; Stryker & Burke, 2000). Role behavior, or identity salience, explains how these identity roles are assigned to a hierarchy of importance, where the individual is most likely to behave according to the role they perceive as the most self-defining, in any given situation.

There are gender differences with regard to sexual satisfaction. McCabe (1999) has indicated that males tend to place a greater emphasis on sexual activities in a relationship than females, as well as report higher levels of sexual satisfaction. Interestingly, they also assign a higher level of sexual dysfunction to their partners as compared to females. This may be due to the fact that males tend to have a stronger sexual motivation than females, and therefore possess a greater interest in sexual activity (Byers, 2005). On the other hand, Young et al. (2000) have shown that females tend to associate sexual satisfaction more with the emotional closeness of the relationship. For example, if intimacy within a relationship is impaired in even the slightest way, females are more likely to experience sexual dysfunction and low sexual satisfaction, whereas the levels of intimacy would need to be severely impaired before males experienced similar results (McCabe, 1999).

#### Practice Implications

Based on the existing research and literature pertaining to identity theory, work-family conflict, work-family enrichment/facilitation, and sexual satisfaction, mental health and couple and family counselors have an opportunity to address the relationship between role strain and sexual satisfaction among dual-earning partners. As

the number of dual-earning partners in the workforce continues to increase, these interventions would need to tailor to the needs of employed men and women stuck in a society designed around the obsolete family model depicting one stay-at-home caregiver and one employed partner.

Professional counselors can include problem-focused coping techniques in their work with clients experiencing work-family conflict. Of the two major methods of coping with stress discussed, problem-focused coping is supported in the literature as a significant moderator to work-family conflict, via its ability to allow an individual to take a more proactive approach towards altering their underlying environmental stressors (Behson, 2002; Lapierre & Allen, 2006).

Acknowledging the need for change within society's perception of the family unit and their roles in the work force would allow for positive results in the business environment, home environment, and intimacy between dual-earning partners. Accordingly, counselors can help clients learn to advocate for themselves through educating about formal work accommodations to family (FWAF) and informal work accommodations to family (IWAF), which are considered forms of problem-focused coping which employees can use to balance their work and family domains (Behson, 2002). The FWAF is usually focused on company or organization policies which create permanent or semi-permanent separations between the work and family roles (Behson, 2002). Examples of these policies can include job sharing, flextime, and parental leave, and are usually only available for specific instances of work-family conflict. FWAF are also more likely to involve major changes in an individual's work schedule (Behson, 2002). IWAF, on the other hand, can be defined as "a set of behaviors in which employees temporarily and informally adjust their usual work patterns in an attempt to balance their work and family responsibilities" (Behson, 2002). In contrast to FWAF, IWAF may modify how, when, or where work gets done. However, these adjustments usually involve minor changes in the end result of an individual's work schedule, allowing them to maintain their regular amount of hours worked per week (Behson, 2002). Examples of IWAF can include, but are not limited to, coming into work early in order to leave early (perhaps to attend a child's sports game, or pick them up from school); receiving family-related phone calls at work; working through lunch to leave early or using one's lunch break for family-related tasks; working weekends in anticipation of or to make up for time spent during the week on family-related matters (Behson, 2002). IWAFs such as these acts as a buffer against the stresses of work-family conflict, and help individuals achieve a greater balance in their work and family lives.

Counselors can also help clients to identify the instrumental and affective enrichment between their work and family roles, altering their perception of work-family conflict, and promoting the enrichment/facilitation model. To this end, the professional counselor could develop an activity for the client to make a list of all the skills/values and behaviors/emotions they are most satisfied with in both their work and family domains. Then, the counselor and client can reflect on this list and think of ways in which each item from a particular domain can be positively applied to the other. In this way, the counselor can help the client move away from perceiving the balance of work and family as a conflict, and towards viewing the relationship as more of enrichment. This could improve mental health by reducing the amount of stress a client experiences when struggling with their roles.

Once the underlying stressors are addressed, counselors could then focus on the clients' sexuality. This focus seems especially important for males, who tend to place a greater emphasis on sexual activities in a relationship than females (McCabe, 1999). For males experiencing sexual dysfunction, counselors should address physiological, psychological, relational, psychosexual skills and situational factors with the client and their partner in order to improve and maintain sexual satisfaction (McCarthy & Fucito, 2005). With females, sexual satisfaction has more of a link to emotionality and intimacy, which can often become disrupted when disappointed or angry with her partner. Interventions should be designed on an individual basis, and should assess the "degree of intimacy and her emotional conditions to facilitate desire" (McCarthy, 2004, p. 26). Similar to males, psychological, relational, medical, sexual skills, erotic scenarios, and situational factors should all be evaluated by the mental health professional to develop a treatment plan.

### Conclusion

Balancing work and family in the 21st century is not an easy task for dual-earning partners, especially as much of the work arena is still designed around one stay-at-home caregiver and one working head of the household. The work and family identity roles have become two of the most salient in everyday life, and when one role prevents success in another, this can lead to role strain and psychological distress. Accordingly, work-family conflict could have a significant effect on dual-earning partners' sexual satisfaction, which could in turn negatively impact the overall reported satisfaction in the relationship. Counselors can assist clients experiencing this role strain through emphasizing problem-focused coping techniques such as becoming more aware of FWAF and IWAF in the client's workplace, by assisting with the identification of the instrumental and affective enrichment

between their work and family roles, and, once the underlying role strain is addressed, through helping clients regain the intimacy and sexual satisfaction in their relationship by evaluating physiological, psychological, relational, psychosexual skills, and situational factors in order to develop a unique treatment plan tailored to the needs of each individual or couple.

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## The Alabama Counseling Association Journal

An official publication of the Alabama Counseling Association, The Alabama Counseling Association Journal is an electronic journal published twice a year. A primary purpose is to communicate ideas and information which can help counselors in a variety of work settings implement their roles and develop the profession of counseling. The Journal may include thought-provoking articles, theoretical summaries, reports of research, and discussions of professional issues, summaries of presentations, reader reactions, and reviews of books or media. The ALCA Journal is located on the ALCA website ([www.alabamacounseling.org](http://www.alabamacounseling.org)).

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