The Alabama Counseling Association Journal, Volume 35, Number 2

The Alabama Counseling Association

J O U R N A L

ALABAMA COUNSELING ASSOCIATION

Enhancing human development throughout the life span

Promoting public confidence and trust in the counseling profession

Caring for self and others

Acquiring and using knowledge
Respecting diversity
Empowering leadership

Encouraging positive change

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Letter From the Editor

I am pleased to announce a new initiative, approved by the ALCA Publications Committee. ALCA will publish its Special Edition Journal in the summer of 2011. This Special Edition Journal will focus on the issue of suicide. This edition will feature articles on the areas of suicide prevention, intervention, and postvention. To assist with the editing of this edition, I have asked Dr. Judith Harrington to be "Co-Editor." Dr. Harrington has extensive experience in this field. Dr. Judith Harrington teaches *Suicide: Prevention, Intervention, and Postvention* at UAB. She is a member of the National Suicide Prevention Lifeline Standards, Training, and Practices Committee, is trained in suicide intervention and is an approved trainer by the American Association of Suicidology and the Suicide Prevention Resource Center, and is an AFSP-trained Suicide Bereavement Facilitator. She has served as the Suicide Prevention Coordinator, which entailed serving as state suicide prevention coordinator for the Alabama Suicide Prevention Task Force through a joint partnership with The Birmingham Crisis Center, an agency with whom she has had a 27 year affiliation.

Dr. Harrington and I want to provide ALCA members with a scholarly resource and also a product for clinical application that will assist in ALCA members' efforts to reduce the number of deaths in Alabama. We will collaborate to invite and select experts in this field as well as topics to beaddressed. (explored.) When identified, these experts will be invited to submit their manuscript to be included in this special edition, following a prospectus process. This process is different from how manuscripts are usually submitted to *The Journal.* Typically, potential authors submit manuscripts to the Review Board who then evaluate the manuscript in terms of relevancy, significance of research/content, quality of presentation, and adherence to the American Psychological Association (APA) writing style. After feedback is presented to the author and if the manuscript is deemed relevant, the author resubmits the manuscript for further scrutiny and possible editorial changes before published in either the fall or spring edition.

For this special edition, invited authors who agree to submit a manuscript on an agreed upon topic will submit their manuscripts directly to Dr. Harrington and myself for editing. Dr. Harrington and I have agreed on the following process for submissions for this edition:

* We will select, contact and secure authors and topics for this edition by the end of July, 2010.
* Authors will submit a prospectus outlining the contents of their article for final approval (date to be determined).
* Once the prospectus is approved, authors will submit manuscripts for inclusion during the spring, 2011 (date to be determined).
* Editing will occur during the spring, 2011.
* Special edition published during the summer, 2011 (Date to be announced).

Dr. Harrington and I are extremely excited to begin this work. We wish to thank the Publications Committee and Executive Director Dr. Chip Wood for their counsel. We view this initiative as a convergence of scholarly effort, clinical best practices, and a service to the mental health and public health of all Alabamians through the generosity of ALCA's decision to devote its resources to this special edition. In 2007, suicide, considered a preventable death through systemic initiatives, we lost over 580 Alabamians to suicide in all age ranges, SES and demographic categories, and georgraphic (rural and urban) settings, leaving thousands in a state of complicated bereavement and higher risk for suicide themselves.

Lawrence Tyson, PhD, Editor

Spring 2010
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Productive and Nonproductive Counselor Supervision: Best and Worst Experiences of Supervisees

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Abstract

This study examines reported best and worst supervisee experiences of participants. Most supervision research emphasizes productive and effective aspects of supervision. Some efforts, however, have emphasized nonproductive or lousy aspects of supervision (Worthington, 1987). A factor analysis of participants' reported best supervisee experience revealed a one-factor solution, a finding consistent with qualitative research efforts suggesting integration of roles and expectations is key for effective supervision. By contrast, a factor analysis for participants' reported worst experiences as a supervisee revealed a two-factor solution, suggesting a lack of integration as well as problems in two distinct areas of supervision practice. Conclusions and suggestions for further research are offered.

Supervision in the helping disciplines is a critical component of professional development (Ronnestad & Skovholt, 1993). Supervision provides the experiential foundation for integrating, with increased competence, theoretical principles into practice (Bernard & Goodyear, 1998; Falender & Shafranske, 2005; Ronnestad & Skovholt). Some authors have emphasized aspects of the supervisory process associated with exemplary supervisory behaviors as well as strategies characteristic of effective supervision (Borders, Cashwell, & Rotter, 1995; Ronnestad & Skovholt). The most prominent elements of supervision emphasize: (a) structure (e.g., clarifying role expectations, intentionality, and deliberate planning) (Bradley & Ladany, 2001; Ladany, Friedlander, & Nelson, 2005; Nelson & Friedlander, 2001; Ronnestad & Skovholt; Vespia, Heckman-Stone, & Delworth, 2002), (b) strategy (e.g., compromise, tolerance, and scrutiny emphasizing both support and challenge) (Falender & Shafranske), or (c) relationships (e.g., empathic understanding, genuineness, respect, and concreteness) (Blocher, 1983; Carifio & Hess, 1987; Veach, 2001; Worthen & McNeill, 1996).

Nonproductive aspects of supervision have received far less attention in the literature. As Worthington (1987) observed, "a good theory of lousy supervisor behaviors is missing" (p. 203). Worthington alluded to the potential value of examining supervisor behaviors indicative of nonproductive or even detrimental supervision. Similarly, Ladany, Friedlander, and Nelson (2005) observed that problematic behavior of supervisees has elicited intense scrutiny, yet supervisor incompetence has been virtually ignored in the literature.

An initial theoretical framework to conceptualize lousy supervision emerged out of a qualitative study conducted by Magnuson, Wilcoxon, and Norem (2000). These investigators sought to identify nonproductive supervisory behaviors and to develop a schema for categorizing such behaviors. Magnuson et al. identified three primary domains of ineffective supervisory behaviors: (a) administrative/organizational, (b) cognitive/technical, and (c) relational/affective. Indicators of inadequate supervision in the administrative/organizational domain primarily reflect the supervisor's level of adeptness in structuring the supervisory process, clarifying expectations and objectives, and managing the ongoing procedures associated with supervision. In the cognitive/technical domain, professional competence as a practitioner and as a supervisor is the focal point for perceived supervisor inadequacy. Further, deficits in professionalism accompanied by vague and abstract feedback from supervisors, supervisor reliance on a single theoretical orientation, or un-

willingness to incorporate supervisee theoretical ideas tend to amplify perceptions of supervisor inadequacy. Examples of inadequate supervision in the affective/relational domain include limited interpersonal sensitivity, compromised confidentiality, and failure to create a safe environment.

Magnuson et al. (2000) cautioned that lousy supervision may not be easily defined. They concluded that "lousy supervision is more complex than either the presence of ineffective practices or the absence of effective practices" (p. 200). Instead, they suggested that "lousy supervision seems to result from a combination of both factors, with lousy supervision anchoring one extreme of a continuum that ranges to an opposite and equally complex construct of excellent supervision" (p. 200). Such an observation is consistent with the efforts of Allen, Szollos, and Williams (1986), who concluded that nonproductive supervision is difficult to clarify based on the presence of specific characteristics because no single characteristic is a critical determinant of poor supervision. Essentially, poor supervision appears to be described best by what supervisors fail to provide, rather than what they provide. Watkins (1997) expressed a similar belief that ineffective supervision may not be the exact opposite of effective supervision.

Various demographic variables have received attention concerning their influence on supervisee-supervisor interactions and their contributions to the formation of supervisory relationships. These variables include gender, race/ethnicity, supervisee-only status versus supervisor-supervisee status, and academic affiliation (Borders, 2001; Cook, 1994; Helms, 1990). The impact of these and related variables on the supervisory relationship is likely to be "subtle and highly complex" (Nelson & Holloway, 1990, p. 478). Some researchers have argued that designations of gender and racial/ethnic identity are overly simplistic and insufficient in cultivating a deep understanding and appreciation of an individual's cultural formation and its impact upon the supervisory process (Ellis & Ladany, 1997; Fong & Lease, 1997; Nelson, Gray, Friedlander, Ladany, and Walker, 2001). However, some categorical variables appear to be relevant in relation to lousy or nonproductive supervision. Specifically, two such variables are (a) supervisor experience (i.e., supervisee-only or supervisee and supervisor status), and (b) supervision context (i.e., an academic experience as a component of graduate study or post-graduate supervision in an applied setting).

Skovholt and Jennings (2004) observed "To be an expert, one must accumulate experiences that deepen, improve, and extend one's vision of a given field or discipline" (p. 4). In terms of supervisory experience, Fong, Borders, Ethington, and Pitts (1997) and Granello (2002) suggested that the most compelling gains in higher-order counseling expertise emerge when supervisees experience the role of supervisor. Peace and Sprinthall (1998) asserted that understanding the complexity of both a counselor and a supervisor role promotes maturity and greater appreciation for the tasks and demands of supervision. Thus, familiarity with the roles of supervisee and supervisor could inform one's appraisals of their supervised experiences as being beneficial or nonproductive.

Investigating problematic supervision would appear to be of value insofar as such findings might increase understanding about what not to do in clinical supervision. Given the inherent complexity involving the constructs of good supervision and lousy supervision, attempts to examine commonalities as well as differences at both ends of the spectrum of clinical supervision could prove beneficial in understanding more fully the supervision process. Moreover, given the increasing emphasis placed on the quality control aspect of clinical supervision by licensure and credentialing agencies along with training program accrediting bodies (Bernard & Goodyear, 1998), that only one study could be found in the professional literature investigating best and worst supervision experiences suggests the timeliness of such an effort. Additional study juxtaposing best and worst supervision experiences may contribute to greater clarity and understanding of factors that distinguish effective from ineffective supervision.

Magnuson and Wilcoxon (1998) observed that supervision in graduate school differs from supervision in post-graduate practice. For example, counselors-in-training are enrolled in an academic program with built-in structure, well-defined curricula, and typically have multiple supervisors at any point in time. Supervisors of prelicensed counselors, however, assume sole responsibility for the supervisee without the benefit of academi-

cally defined evaluation criteria or any prior unbiased assessments of the supervisee's strengths and weaknesses. Furthermore, academic supervisors are able to closely monitor the work of the student supervisee, whereas the supervisor of a prelicensed counselor may have limited contact and limited opportunities to observe a supervisee's work. Additionally, while student supervisees pay tuition, in post-academic supervision there is a direct fee-for-service transaction that takes place between supervisors and supervisees. Finally, prelicensed supervisees are free to choose their supervisor. Each of these aspects of the supervisory relationship has implications for the process and outcome of the supervisory experience and the nature of the supervisory relationship, both in terms of exemplary and nonproductive supervisory practices.

Results and discussion will be offered concerning distinctions in factor patterns distinguishing between productive and nonproductive supervisory practices with respondents. The initial purpose of this study was to develop and validate an instrument to determine whether the domains of lousy supervision identified by Magnuson et al. (2000) could be validated quantitatively. A second purpose was to determine if the three domains of supervision reflect similar factor patterns for participants rating their best supervision experience and their worst supervision experience. A third purpose was to examine the influence of selected demographic variables on the participants' ratings. Specifically, the variables examined in this element of the study concerned supervisor experience and the contextual setting of supervision (i.e., graduate/academic or postgraduate).

Method

Participants

The population for this study was professional members of the American Counseling Association (ACA) who had completed a minimum of 5 years of postgraduate practice as a counselor and who had participated in face-to-face supervision at some point in their graduate or postgraduate careers. The professional membership level represents the highest level of membership, distinguished from associate or student status in the ACA. A national random sample of 1,000 participants was selected. No other screening criteria were used, although the hope was that random selection would yield a sample reflecting an array of practice settings, professional experience as a counselor, and supervisor experience.

Of the 1,000 questionnaire packets distributed, 290 questionnaires were returned, for a response rate of 29%. However, 12 of the questionnaires could not be used because they were either incomplete or were completed by a participant who did not meet the eligibility criteria for inclusion. A total of 278 usable questionnaires yielded a 27.8% response rate.

Instrumentation

A survey instrument was designed to elicit information regarding various aspects of supervisor behaviors. Items were designed to reflect supervisory behaviors that typically occur in one of the three domains of lousy supervision (administrative/organizational, cognitive/technical, and relational/affective) identified by Magnuson et al. (2000). The survey was a Likert-type scale consisting of 19 items.

To establish construct validity prior to data collection for the study, the instrument was distributed to five counseling professionals who agreed to serve as expert raters (four counselor educators and one student affairs administrator). All raters possessed a doctorate in counselor education, and each held a credential for clinical supervision in counseling. As a group, the number of years involved in the practice, teaching, or research of counselor supervision ranged from 5 to 30. The raters reported that during their careers the number of practitioners/students they supervised ranged from 15 to over 300. The raters also reported having had between two and six clinical supervisors each during their professional lives.

The expert raters were asked to consider each item of supervisory behavior in the instrument and to determine which of the three domains of supervision (i.e., administrative/organizational, technical/cognitive, and relational/affective) each item best fit. A tally of the rater responses revealed that on 11 of the 19 items of super-

visory behaviors, rater agreement was 100%. Rater response on two items revealed little agreement among the raters, thus these two items were discarded. Based on expert feedback, two items ("Gave too much or too little corrective feedback") and ("Gave too much or too little affirming feedback") were amended so that each item reflected a single inquiry (e.g., Gave too much corrective feedback," "Gave too little corrective feedback," etc.). This final revision, designated as the Supervisory Behavioral Profile (SBP), yielded an instrument with a total of 19 items.

Procedure

Survey packets were distributed by postal mail to the preferred mailing addresses indicated on participants' ACA membership profile. No distinction was made concerning home or work designations for survey packets. Each packet contained an introductory letter explaining the purpose of the research along with a statement of confidentiality and informed consent, a form for reporting demographic data, two versions of the SBP, and a self-addressed stamped envelope for return.

Participants were asked to complete two versions of the SBP. The first version (SBP-Best) inquires about "my best supervisory experience," and the second version (SBP-Worst) inquires about "my worst supervisory experience." Responses to items on both versions range from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). Specifically for the SBP-Best, each item represents a response to the sentence stem, "*As a description of my best supervisor. . . ."* Lower scores on the SBP-Best represent supervisee perceptions of productive supervisor behavior. For the SBP-Worst, each item represents a response to the sentence stem, *"As a description of my worst supervisor . . . ."* Higher scores represent supervisee perceptions of nonproductive supervisor behavior. Factor analyses were conducted to compare group data for participants rating their best and worst supervisory experiences.

A short demographic data form was included with the survey questionnaires to gather descriptive data about the participants and about their supervisors. These data included age, gender of participant, race/ethnicity of participant, gender of best and worst supervisor, and race/ethnicity of best and worst supervisor. Two additional variables of interest were also included on the demographic form. First, participants were asked to indicate their experience in a supervisory role. Specifically, participants were queried as to whether they had served in the role of *supervisee only* or in the role of *both supervisee and supervisor*. Secondly, participants were asked whether their best and worst experiences as a supervisee occurred as a graduate student or in their post-graduate status. A series of ANOVA's were conducted to determine the impact of selected demographic variables on nonproductive supervision.

All procedures were reviewed and approved by the Institutional Research Board (IRB) of The University of Alabama. No follow-up reminders or subsequent contact was made with participants to encourage higher rates of participation.

Results

Participants

Participant ages ranged from 30 to 79 years with a mean age of 52 and a median age of 53. Of the 267 participants who provided information regarding gender, 57 were male and 213 were female. Two hundred forty-eight were Caucasian, 10 were African American, 7 were Hispanic American, 5 selected "other," and 5 did not respond to this inquiry. Seventy-one participants reported having a doctoral degree in counseling and 193 reported having a master's degree in counseling.

The mean number of years of counseling experience among the participants was 17.1. When asked about certification status, 256 participants indicated they were certified, licensed, or both, while 18 reported no such credential.

The participants were asked to indicate their experience in a supervisory role. Specifically, participants were queried as to whether they had served in the role of *supervisee only* or in the role of *both supervisee and supervisor*. Seventy-seven participants indicated they had only served in the role of a supervisee, while 194 reported they had served as both supervisee and supervisor. Of the participants, 128 stated they had not taken had taken a graduate supervision course, while 142 indicated that they had taken such a course.

Another variable of inquiry was whether the participants' best and worst experiences as a supervisee occurred as a graduate student or in a post-graduate status. One hundred twenty-seven reported their best supervisory experience occurred during graduate study, while 144 reported their best experience occurred in a post-graduate context. By contrast, 125 indicated their worst supervisory experience occurred during graduate study, and 136 indicated their worst supervisory experience occurred in a post-graduate context.

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Data Analysis

Factor analyses were conducted to identify factor patterns related to participants' ratings of their best supervision experience and their worst supervision experience. Data were derived from participant responses on the SBP-Best and SBP-Worst. The results of these factor analyses are displayed in Tables 1 and 2.

For the SBP-Best, principal components factor analysis yielded three factors with a Kaiser-Guttmen criterion of eigenvalue greater than 1.00. Because the criterion of eigenvalue greater than 1.00 may misjudge the most appropriate number of factors (Gorsuch, 1983), the scree plot was carefully examined. The scree plot indicated the total variance was best explained by a single-factor solution for the SBP-Best factor analysis.

The principal component factor analysis conducted on the SBP-Worst yielded a five-factor solution based on the Kaiser-Buttmen criterion of eigenvalue greater than 1.00. Examination of the scree plot indicated a two-factor solution was the most appropriate solution. Therefore, a varimax rotation was conducted using a two- and three-factor model. The two-factor solution was adopted because it provided the most distinct structure for ease of interpretability. Factor 1 was designated as "Relational" because the majority of the items and factor loadings reflected some aspect of the interpersonal relationship between supervisee and supervisor. Factor 2 was designated as "Technical/Cognitive" because the majority of the items reflected aspects of the supervisory process that were cognitively based or technical in nature. Table 2 presents the two factors with their respective items and factor loadings. Factor 1 consists of 11 items, accounting for 26.6% of the total variance. Factor 2 consists of 8 items, accounting for 19.43% of the total variance. Data generated from participant responses to the SBP-Best and SBP-Worst analyses reflected distinctly different factor patterns between participants rating their best supervisory experience when compared to their worst supervisory experience. The reliability of both instruments was also assessed. The alpha coefficient for the SBP-Best was .92, and the alpha coefficient for the SPB-Worst was .87.

Because the emphasis of this study was on lousy supervision, ANOVAs were conducted to determine the influence of supervision context on SBP-Worst scores. The first ANOVA compared total scores, which could range from 19 to 76. Respondents who had been both a supervisor and supervisee had more negative perceptions of their worst supervision experience (M = 49.82, SD = 9.75) than those who had only been a supervisee (M = 46.53, SD = 11.36), $F(1,243) = 4.92$, $p < .05$. Comparisons were also made by Relational and Technical/

Cognitive subscores. The possible range of Relational scores was from 10 to 44. A significant difference was found on the Relational subscale when comparing counselors whose worst supervision experience was as after completing graduate school ($M = 29.76$, $SD = 6.94$) with those whose worst supervision experience occurred while in graduate school ($M = 27.53$, $SD = 7.07$), $F(1,246) = 5.69$, $p < .05$. The counselors whose worst supervision experience occurred after completing graduate school had more negative perceptions of their supervisors.

The possible range of Cognitive/Technical scores was from 9 to 36. A significant difference was found when comparing the Cognitive/Technical scores of participants who had both a supervisee and a supervisor ($M = 17.26$, $SD = 3.95$) with those who had been only a supervisee ($M = 18.54$, $SD = 4.11$), $F(1,249) = 4.98$, $p < .05$. The counselors who had been only a supervisee had more negative perceptions of their worst supervision experience than those who had been both a supervisee and a supervisor.

Table 1

Factor Analysis Results for Supervisory Behavioral Profile - Best

Item	Factor 1
Showed insensitivity to my developmental needs	.787
Showed insensitivity to my professional development needs (e.g., lack of professional role modeling, lack of commitment to my professional growth)	.745
Failed to appreciate my theoretical model or orientation	.718
Gave too little affirming feedback	.715
Provided vague feedback	.715
Was an unskilled supervisor	.712
Avoided issues that arose between the two of us	.710
Was an unreliable professional resource (e.g., used supervision time to provide therapy, confidential information disclosed)	.691
Gave too little corrective feedback	.690
Imposed his or her personal agenda	.687
Gave too much corrective feedback	.668
Failed to provide standards for accountability (e.g., expectations not clarified, evaluative criteria not articulated)	.628
Was an unskilled practitioner	.591
Gave too much affirming feedback	.587
Focused primarily on microskills and techniques	.580
Was intrusive (e.g., micromanaging, controlling)	.570
Failed to clarify expectations for supervision	.566
Relied on a single primary theoretical model of counseling	.537
Failed to provide a safe environment during supervision	.503

Table 2
Factor Analysis Results for Supervisory Behavioral Profile - Worst

Item	Factor 1	Factor 2
Gave too much corrective feedback	.790	-.073
Was intrusive (e.g., micromanaging, controlling)	.764	.010
Failed to appreciate my theoretical model or orientation	.724	.134
Imposed his or her personal agenda	.695	.303
Showed insensitivity to my developmental needs	.681	.411
Gave too little affirming feedback	.678	-.034
Focused primarily on microskills and techniques	.644	.027
Relied on a single primary theoretical model of counseling	.568	.074
Showed insensitivity to my professional development needs (e.g., lack of professional role modeling, lack of commitment to my professional growth)	.543	.481
Failed to provide a safe environment during supervision	.492	.284
Avoided issues that arose between the two of us	.399	.391
Failed to provide standards for accountability (e.g., Expectations not clarified, evaluative criteria not articulated)	.075	.743
Gave too little corrective feedback	-.280	.688
Failed to clarify expectations for supervision	.174	.638
Was an unskilled supervisor	.312	.644
Provided vague feedback	.075	.635
Was an unskilled practitioner	.291	.509
Was an unreliable professional resource (e.g., used supervision time to provide therapy, confidential information disclosed)	.364	.503
Gave too much affirming feedback	-.219	.415

Discussion

The initial purpose of the study was to develop and validate an instrument to determine whether the domains of lousy supervision identified by Magnuson, Wilcoxon, and Norem (2000) could be validated quantitatively. The findings did not provide validation of the three domains of lousy supervision identified by Magnuson et al. (2000). One possible explanation could be that the instrument used in the present study lacked a sufficient number of items to represent each domain of lousy supervision. Additionally, Magnuson et al.'s findings may not have been confirmed because the respondents participating in their study were exclusively classified as experienced supervisors, while a portion of the participants in the present study (27.8%) had never served as supervisors. The data did, however, identify two domains of nonproductive supervision that appear to correspond to the relational/affective domain and the technical/cognitive domain as described by Magnuson et al. Further, the data were consistent with previous findings reported by Gray, Ladany, Walker, and Ancis (2001) and Ellis (2001), who noted multiple and multifaceted aspects of nonproductive supervision in their outcome measures with student supervisees.

A second purpose of this study was to determine if these three domains of supervision reflect similar factor patterns for participants rating their best supervision experience as well as their worst supervision experience. The findings suggest that good supervision is different from poor supervision. Magnuson et al.'s (2000) speculation that lousy supervision may not be straightforward and easily defined corresponds to the evidence found in this study based on different factor patterns for "best" versus "worst" supervisors. In this regard, the

complexity involved in defining the constructs of good supervision versus lousy supervision underscores Watkins' (1997) observation that ineffective supervision may not be the exact opposite of effective supervision.

A recurring theme in the supervision literature suggests that productive supervision is associated with effectively managing multiple tasks that are administrative and relational in nature (Bordin, 1983; Cohen & DeBetz, 1977; Holloway, 1995). One context for examining this theme emerges from the discrimination model of supervision (Bernard, 1979). This model depicts three possible supervision foci (i.e., intervention skills, conceptualization skills, and personalization skills) used in conjunction with three possible supervisory roles (i.e., teacher, counselor, and consultant). From this context, a one-factor solution as the preferred representation of data from participants describing their best supervisor suggests that effective supervisors can navigate smoothly among the differing roles and functions of supervision relative to administrative and relational elements of supervision. By contrast, the two-factor solution to represent the profile of participants' worst supervisors could be viewed as a failure of supervisors to integrate and manage the multiple functions and foci of supervision to yield productive outcomes. The findings from the current study appear to suggest that failure to effectively manage these aspects of supervision could be a critical aspect of nonproductive supervision.

A third purpose of the study was to examine the influence of selected demographic variables on the factor patterns for participants' ratings. Statistically significant differences emerged in the categories of supervision setting and supervisor experience. On the Relational subscale, data revealed that participants describing their worst supervisory experiences occurred following their graduate study. Although this finding is somewhat challenging to interpret due to the scarcity of professional literature addressing the issue of academic versus postgraduate supervision, a qualitative study conducted by Magnuson and Wilcoxon (1998) provided a possible link. Magnuson and Wilcoxon's study investigated needs and practices associated with clinical supervision of prelicensed (i.e., postgraduate) counselors. Supervisor ambiguity emerged as a prominent theme reflecting uncertainty among participants related to their expectations of supervisor competence. Perhaps the findings of this study related to postgraduate supervision may reflect the ambiguity among participants similar to that noted by Magnuson and Wilcoxon.

Two statistically significant findings emerged in the category of supervision status. When compared by overall SBP-Worst scores, the participants who had served in the roles of both supervisee and supervisor held more negative views of their worst supervision experience than participants who had only served in the role of supervisee. This difference was also found when comparing the participants on the Cognitive/Technical subscale of the SBP-Worst. A possible contributor to this outcome may be that participants with experience as both supervisee and supervisor possessed a broader range of experience to draw on when rating their worst supervision experience and are therefore able to examine more critically the differences in those supervision experiences. Such a conclusion would be consistent with the research conducted by Fong et al. (1997) and Granello (2002) that suggests that the most compelling gains in high order counseling skills are brought about by the supervisee's supervised experience, a key component of enhancing cognitive complexity. This view is also corroborated by Peace and Sprinthall (1998) in their conclusion that cognitive development should assume a more critical role in the training of future psychotherapists and should be represented as a specific goal of clinical supervision.

The results of this study should be interpreted with caution and due consideration of its limitations. As an initial limitation, the sample was not representative of the population. It was primarily female (77%) and Caucasian (90%). Due to the unequal representation of participants in this study, the results may not be generalizable to other organizations, ethnicities, or even across genders. As a second limitation, the design of the instrument required participants to respond negatively to negatively phrased items. Such a design may have encouraged a test-taking mindset among participants and influenced the nature of their responses, thereby compromising the integrity of results. However, despite these limitations, unique elements of the study were that participants were recruited via their professional membership status in ACA and that they were professionals working in a variety of practice settings from across the US. Additionally, the study represented an attempt to examine quantitatively some of the findings previously noted in more qualitative methodologies focused on nonproductive supervision.

The findings from this study were projected to have implications concerning (a) early identification of supervisors with less than adequate performance, (b) early intervention to remediate supervisor, and (c) early intervention to mitigate potential negative effects to supervisee (Watkins, 1997). Additionally, the results of this study were projected as a possible contribution to greater understanding regarding the distinguishing features of effective and ineffective supervision as a matter of supervisor training in counselor education programs. Similarly, quantitative validation of a model of detrimental supervisory behavior offered potential assistance for (a) counselor educators involved in preparing counselors to supervise, (b) practitioners who may be supervising pre-licensed counselors, and (c) practitioners receiving supervision.

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College Student Stress: A Predictor of Eating Disoder Precursor Behaviors

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Abstract

Eating disorders are compulsive behaviors that can consume a person's life to the point of becoming life threatening. Previous research found stress associated with eating disorders. College can be a stressful time. If stress predicted precursor behaviors to eating disorders, then counselors would have a better chance to help students sooner. This study focused on stress and three precursors of eating disorders, *Drive for Thinness, Body Dissatisfaction, and Bulimia symptoms.* Regression analysis of 362 college students' responses to a 96 item compiled, electronic survey found that age, gender, and stress did predict the precursor variables. Implications for college counselors are discussed.

An eating disorder (ED) is a compulsive behavior that consumes all aspects of a person's life (Johnstone & Rickard, 2006). According to the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), eating disorders are separated into three categories: anorexia nervosa (AN), bulimia nervosa (BN), and a binge eating disorder (BED). The National Eating Disorder Association (NEDA, 2006) describes anorexia as a self starvation technique to lose weight due to an individual's distorted perception of his/her body image. Individuals with anorexia have an obsessive desire to be severely thin, regardless of their current image (Halvorsen & Heyerdahl, 2006). Bulimia involves consuming large amounts of foods in a short amount of time, then getting rid of the calories by purging or using laxatives (NEDA, 2006). Individuals with bulimia struggle to maintain their weight and fail to control their eating habits, allowing food to overpower their own self-control (Zalta & Keel, 2006). Binge eating is characterized as secretive cycles of overeating without purging (Stein et al., 2007). All eating disorders are serious and can be considered in the extremes as life threatening diseases that are more common in society than most people realize (NEDA, 2006). In the following sections, prevalence rates, associated health problems and predictors that may contribute to the development of an ED are discussed.

Prevalence

Research suggests that the incidence of eating disorders have increased over the last 30 years (Ackard, Fulkerson, & Sztainer, 2007). Based on a review of research, NEDA (2006) concluded that approximately 10 million females and 1 million males currently struggle with anorexia or bulimia with millions more of Americans dealing with a binge eating disorder and these findings have been supported by others (e.g., Ackard et al., 2007; Kugu, Akyuz, Orhan, Ersan, & Izgic, 2006). The statistical evidence for men experiencing eating disorders is lower than women but health professionals report that 10% of all individuals seeking treatment tend to be men (Hudson, Hiripi, Pope, & Kessler, 2007).

Research also suggests that adolescents are at a much higher risk for developing eating disorders. In a recent study Hewitt and Gray (1993) observed the prevalence rate among adolescents in a sample of 4,746

from BN or BED. Corning, Krumm, & Smitherman (2006) found similar results: Out of 203 participants (23%) qualified for the diagnoses of anorexia, 169 participants (19.2%) reported bulimic symptoms, and 493 participants, and more than half of the sample (56%) was binge eaters. It is evident that eating disorders affect people of all ages but data from studies report that college students are at an alarmingly high risk for developing an eating disorder.

An estimated 10 % of female college students suffer from clinical or borderline eating disorders. Of which over half suffer from bulimia nervosa (Ackard et al., 2007). Furthermore, one out of every 100 American college students appears to binge and to purge to lose weight (Hewitt & Gray, 1993). Elgin and Pritchard (2006) found that by their first year of college 18% of women and less than 1% of men have a history of an eating disorder and that 19 % of college age women in America is thought to be bulimic and 10 % to 25% battle anorexia. These results suggest that teachers, counselors, parents, and other personnel who come into contact with the college population need to be aware that eating disorders are prevalent, widespread and problematic behaviors.

Physical and Psychological Problems Associated with ED's

Given the widespread prevalence of all three eating disorders, it is essential to understand the associated problems these individuals will encounter. Each eating disorder has psychological, behavioral and physical complications. The NEDA research (2006) suggests that though a person may experience one of these disorders, he/she may also exhibit characteristics related to the other disorders. If not treated, these physical and emotional complications can become very serious and may result in death.

Physical problems. The most common physical aspects of anorexia are brittle nails, loss of hair, irregular menstruation, and excessive weight loss (Arnold et al., 2002). Anorectic individuals fail to provide their bodies with essential nutrients needed to maintain proper function which forces the body to slow down (Walsh & Devlin, 1998). As the heart rate decreases and the blood pressure declines the chances for cardiac complications increases. Individuals with bulimic symptoms often have swollen cheeks, bruised fingers, dental problems, and tearing of the esophagus due to continuous vomiting (Desai, Miller, Staples, & Bravender, 2008). The recurring binge and purge cycles can affect the entire digestive system resulting with a chemical imbalance. The imbalance can affect the heart as well as other vital organs (Desai et al.). Physical aspects of BED are less noticeable but can be just as severe, including high blood pressure, high cholesterol, kidney disease, bone detoriation and possibly cardiac complications, including heart attacks (Desai et al.). Individuals with BED are at a much higher risk for obesity which increases the triglyceride levels also associated with cardiac complications.

Psychological problems. Eating disorders are the result of an obsessed preoccupation with food and weight but research suggest that these dangerous diseases are much more than simply unhealthy eating habits they also arise from underlying psychological problems (Whiteside et al., 2007). Some individuals have reported that, "the bulimia was not the problem but a side effect to the unstable environment and emotional feelings" (Whiteside et al., 2007, p 23). Thus, eating disorders may arise from a combination of behavioral, emotional, and psychological factors (Whiteside et al., 2007).

Ironically individuals who develop eating disorders often begin with a diet, believing as a result that the weight loss will improve self esteem. However, the reality is the opposite reaction occurs initiating more feelings of helplessness and self doubt (Swineburne & Touyz, 2007). For all of the disorders, psychological problems consist of negative body image, low self esteem, and the need for perfectionism (Romano, Halmi, Sarkar, Koke, & Lee, 2002). Dieting, bingeing, and purging begin as a way to cope with emotions and a way to control life, but these behaviors damage the emotional well being of individuals (Whiteside et al., 2007).

Predictors Associated with Eating Disorders

Stress. Stress is a psychological factor that surrounds many aspects of life such as family stress, work stress, social stress, and major life events (Troop, Holbrey, & Treasure, 2006). Maladaptive responses to stress and anxiety can leave an individual more vulnerable to everyday pressures. The reaction to stress is referred to as stress response and when the body is functioning properly this allows a person to perform well, but when the stress is overwhelming the body overreacts (Corcoran & Franklin, 2002) and a prolonged process will affect individuals by increasing the risk for heart disease, depression, even throwing the digestive system off balance (Daley, Jimerson, Heatherton, Metzger, & Wolfe, 2008). If chronic stress continues individuals begin to see no escape and as a result psychological problems may develop. McLean, Miller, & Hope (2007) reported that stress is associated with anorexia nervosa, bulimia, and binge eating. Swinbourne & Touyz (2007) observed anorectic patients and found that 25% to 75% of their participants suffered from chronic stress. Cooley and Toray (2001) found that 63% AN participants and 57% BN participants reported having experienced high levels of stress before they were diagnosed with an eating disorder. In their study participants acknowledged in personal interviews that the ED was a response to the high levels of stress (Cooley & Toray, 2001). Stress has been reported to increase during life changes, such as moving to college. If research found that college students did report stress, given the correlates found in past research, this population could be susceptible for developing eating disorders.

College life is often stereotyped as a time for freedom and fun. The majority of students look forward to new adventures, challenges, and breaking away from parental control. Yet not all students feel as comfortable making this transition (Vohs, Heatherton, & Herrin, 2001). Students who are unable to adapt to the new vibrant and demanding atmosphere can become vulnerable for developing an eating disorder (Cooley & Toray, 2001). How students handle the transition and social demands differs according to the individual and can increase the possibility that one or more behaviors can develop into an eating disorder may develop (Trautman, Worthy, & Lokken, 2007).

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Depression and self-esteem. Depression can be defined as a set of symptoms ranging from mild to severe, implicating feelings of sadness that deprive individuals of fulfillment on a daily basis (Sawdon, Cooper, & Seabrook, 2007). Additionally, dysthymia can also increase people's feelings of desperation and hopelessness (Schumaker, Warren, Carr, Schreiber, & Jackson, 2005). Depression and self esteem are correlated issues. For example, the inability to interact in social situations may lead to low self esteem and if left unchecked, may result in depression. Then, depression can then lead to a further inability to relate with others which lowers self esteem (Schumaker et al. 2005).

Research suggests that for many depressed individuals, eating disorders provide a temporary escape as the unhealthy eating episodes allow the individual to feel in control (Troop et al., 2006). For example, Avalos & Tylka (2006) and Arclus & Button (2007) found that anorexics and bulimics feel helpless in all situations except over the food they consumed because they controlled the amount or the nutrients which gives them temporary satisfaction. Depression, low self esteem, and stress are correlated to eating disorders with serious consequences for the general population.

The Challenge. When eating disorders reach the prognosis of a full blown stage, they become severe and can result in life threatening situations (Barker, Williams, & Galambos, 2006). When eating disorders are at the full blown stage, they become challenging for both the person with the issue and the professionals who help them (Barker et al., 2006). Treating anorexia is challenging. If a patient is very ill and weighs below the average weight, inpatient hospitalization may be necessary (Arnold et al., 2002). This may take months before the patient is stable enough to be moved to outpatient therapy. All three disorders are treated with psychotherapy and medicine. Both can involve a significant amount of time as well as a financial commitment (Taylor et al., 2006). All individuals who suffer from eating disorders must learn how to eat again and this can be a slow long process (Pendelton, Williams and Swank, 2001). Some individuals never fully recover and those who do

overcome this battle still have daily challenges involving food. If precursors could be clearly identified then counselors, particularly colleges counselors, could identify and begin treatment helping students to prevent fully developing an ED, treatment challenges associated with full-blown eating disorders could be avoided.

The focus of this study examined stress in association with precursors of eating disorders, such as *Drive for Thinness (DT), Body Dissatisfaction (BD), and Bulimia symptoms (BS)* (Stein et al., 2007*)*. Results from earlier work indicate that all three variables influence the onset of eating disorders. Precursors to eating disorders are much easier to treat than full blown eating disorders (Arnold et al., 2002). If stress can be identified as a precursor for *DT*, *BD*, and *BS* in a college population, by addressing stressors related to college life counselors would have a better chance to help students from developing a full-blown diagnostic eating disorder. Earlier intervention could promote a more successful recovery. Understanding the antecedents of eating disorders would help students avoid the destructive path.

Method

Participants. The participants in this study consisted of female and male college students, ($N = 385$), enrolled in a four-year university located in the southeastern region of the United States. Twenty-three students were removed from the data analysis due to incomplete data or not being the age of consent (19 years old), which resulted in a total of 362 participants for purpose of analysis (270 females, 92 males). The mean age of the students was 22 years old ($SD = 5.46$). The sample was diverse, 67% (248) Euro-American, 17% (69) African American, 5% (22) Asian American, 3% (11) American Indian, .08% (3) Hispanic, and .08% (3) Pacific Rim and reflects the general university population. No incentives were offered for participation, but some students may have received extra credit for participation, but that was negotiated between student and professor.

Procedure. Upon receiving approval from the institutional review board, all registered students received an email introducing the purpose of the study and a hot-link that would take them to the electronic survey created using Survey Monkey. They were invited to read the introduction/consent sheet and their decision to participate was noted by their choice to proceed to the survey. The 96 item survey was completely anonymous with no tracking to the original computer allowed. On average, completion time ranged from 20 to 45 minutes. Due to the sensitive nature of the questions, a research design was created which allowed students to leave the questions unanswered or to withdraw from the survey at anytime without receiving penalty. Contact information for the university counseling services was provided so that students who may be feeling depressed or suicidal could reach out for help.

Measures. The survey consisted of 96 items concerning demographics, self-esteem, depressive symptoms, stress levels, and at- risk for eating disorder behaviors. Demographics included gender, age, ethnicity, living arrangements, and status in school. The survey consisted of questions assessing the independent variables (gender, self-esteem, depression, stress) with the dependent variables (drive for thinness, body dissatisfaction, and bulimia).

Clinical Scales

Self-Esteem. Self-Esteem as reported by the participants was measured using the Coopersmith Self Esteem Inventory (CSEI) (Coopersmith, 1981). The CSEI is a 25-item instrument with two responses: Like me or unlike me. This instrument assessed a variety of factors such as personal issues, parental aspects, and ambition within themselves. For example, one question asked, “Things usually don’t bother.” Another question asked, “My family expects too much of me.” There are also questions relating to social aspects such as, “Most people are better liked than me.” The scores were calculated according to the original scoring manual. Scores ranged from 0 to 100. Scores less than 49 represent very low self esteem and scores less than 63 represent moderately low self esteem. The reliability was originally reported by Coopersmith (1967) who reported a reliability coefficient of .86. This scale was used for a clinical description describing the population but was not used in the regression analysis.

Depression. Depressive symptoms reported by the respondents were measured using the Beck Depression Inventory II (BDI-II) (Beck, Steer, & Brown, 1996) which is a 21 item self report. Each item of the BDI-II requires participants to select one of four options based on the severity of the depressive symptom (Beck, Steer, & Brown, 1996). Statements about topics such as sadness were made with the possible responses being, "I do not feel sad, I feel sad much of the time, I feel sad all of the time, and I am so sad I can't stand it." Another topic was worthlessness with responses such as, "I do not feel worthless, I do not consider myself as worthless as I used to, I used to feel more worthless, and I feel utterly worthless." The BDI-II is scored by summing the answers for all 21 items, with higher scores indicating higher levels of depression. The scores range from 0-63 with < 9 = not depressed, 10-15 = mild depression, 16-19 = mild to moderate depression, 20-29 = moderate to severe depression, and 30-63 = severe depression. Prior research has provided support for a test-retest reliability of the BDI-II with a coefficient of .96 (Spoor et al., 2006).

Inferential Scale

Stress and anxiety. Stress and anxiety levels were measured using the State Trait Anxiety Inventory (STAI) (Speilberger, Gorsuch, & Lushene, 1977), which measured stress related behaviors in adults, such as nervousness, tension, apprehension and worry. The participants read each question and responded one of the four options: not at all true, somewhat true, moderately true or very true. Questions asked about personal feelings concerning calmness, timidness and feelings of confusion. The STAI scales have been used with male and female college students. The test-retest reliability for the STAI has a coefficient .86 (Freeman & Gil, 2004). For this study, the reliability coefficient was .93.

Dependent Variables. At risk eating behaviors were measured using Garner, Olmstead, and Polivy's (1983) Eating Disorder Inventory-II (EDI-II). This inventory has 8 subscales. For the purpose of this study three subscales were used as the dependent variables. They measured variables of *Drive for Thinness (DT), Body Dissatisfaction (BD),* and *Bulimic symptoms (BS)*. Each question required responses to a Likert-type scale, for example: Often, somewhat, rarely or never. The *DT* subscale refers to the constant desire to lose weight or constant worry about gaining weight. For example, "I am preoccupied with the desire to be thinner." The *BD* subscale concerns negative image questions, for example, "I feel my stomach is too big." The *BS* subscale contains questions about binges, for example, "I have gone on binges where I felt I could not stop." Scores were calculated according to the Garner's original scoring key. Earlier research found the three subscales had reliable coefficients of .79 to .95 (Sassaroli & Ruggiero, 2005). In this study, the *BS* subscale had a standardized alpha of .85, the *BD* subscale had a standardized alpha of .86, and the *DT* subscale had a standardized alpha of .77 all within social science standards.

Results

The findings in this study are consistent with previous studies. In the first section, the clinical results are discussed. The second section addressed the inferential results. The regression results suggest there is a relation between the inferential measure, stress, and the dependent variables of *DT, BD, and BS.*

Clinical Results

Beck Depression Inventory. Following the scoring key, the results of the BDI suggest that 92 (26%) students reported mild depression, 31(.08%) students reported mild to moderate depression, 54 (15%) students reported moderate to severe depression and 14 (.04%) students reported severe depressive symptoms. The total number of responses for this section of the survey was 334 with 28 unanswered. This indicates that 191 (53%) of this sample report feelings of depression and that 68 students were at-risk depressed students. Eighty-six students reported feeling sad much of the time and 4% reported feeling sad all of the time. A large number of students,

43 (12%) reported having suicidal thoughts but would not follow through with suicide and three (.8) students stated they would kill themselves. Responses to the BDI-II suggest that depression can effect eating patterns as 77 (21%) of students reported having an appetite less than usual and 83 (23%) of students experienced an increase in appetite. The evidence suggests that this non-clinical sample includes a large number of at-risk depressed individuals who may be susceptible to eating disorders among other sequelae.

Coopersmith Self-Esteem Inventory. All 362 participants responded to this section of the survey and the reports of 174 (50%) suggest that many of these participants have self-esteem issues. Using the scoring key, results suggest that 95 (26%) students had severely low self esteem and 79 (23%) students had moderate to low self esteem. A large number of students 153 (42%) wanted to change things about themselves, 81 (22%) had low opinions of themselves, 101 (28%) felt they were not as nice looking as other people, and 58 (16%) wished they were someone else. These results from this non-clinical sample suggest that a large number of participants had self esteem issues, which increases their chances of developing an eating disorder among other disorders.

Inferential Results

Bivariate results. Zero-sum bivariate correlations were conducted with the variables of interest: age, gender, stress, *BD, DT, and BS*. Multiple significant correlations were found (Table 1). Of interest to this study was the fact that gender was dummy coded for analysis (0 females, 1 males) and results suggest that males were more likely to experience "drive for thinness."

Table 1

Zero-Order Correlations for Gender, Age, STAI, EDI –DT, EDI – B, EDI – BD

VARIABLE	1	2	3	4	5	6
Gender	-	.01	.03	.27**	.07	.10
Age	-	-	.03	-.01	-.001	-.05
STAI			-	.20**	.26**	-.14**
EDI-DT				-	.53**	-.27**
EDI-B					-	-.21**
EDI-BD						-

Note. ** $p < .01$; $N = 362$

Regression analysis results. A two-step linear regression was conducted with each of the three dependent variables: *Drive for Thinness, Body Dissatisfaction, and Bulimia Symptoms.* In the first step of each regression, age and gender were entered. At the second step, the STAI stress index was entered.

Dependent variable: Drive for thinness (DT). *DT* was examined (Table 2). In the first step, age and gender were entered as predictors and the model was significant at $F(2, 347 = 14.20, p < .001)$. The R^2 was .07 and gender was a significant predictor ($\beta = .27, p < .001$). After the stress measure was entered in Step 2, the model remained significant $F(3, 346 = 14.67, p < .001)$. Gender was a significant predictor in the regression ($\beta = .27$, p< .001) meaning males were more obsessed with thinness. Additionally, stress also predicted *DT* ($\beta = .19$, p< .001). In this step the total variance explained for *DT* was 11% (adjusted $R^2 = .11$) indicating a large effect size (Cohen, 1988).

Dependent variable: Body dissatisfaction (BD). The second model predicting the outcome variable, *BD*, was assessed (Table 3). In Step 1, age and gender were entered as the demographic variables and the model was significant $F(2, 347) = 5.68, p < .01$). The R^2 was .03 and age was a significant predictor of body dissatisfaction ($\beta = 17.80, p < .02$). In step 2, stress was entered and the model remained significant $F (3, 346) = 3.80, p < .02$). Thus, participant's age remained a significant predictor of body dissatisfaction ($\beta = .17, p = .001$) while stress was also a predictor ($\beta = .10, p = .05$), the contribution to the $R^2 \Delta$ was little. The total variance accounted for was 03% (adjusted $R^2 = .03$) indicating a small effect size (Cohen, 1988).

Dependent variable: Bulimia symptoms (BS). The model predicting the outcome variable, *BS*, was then examined (Table 4). After entering the demographic variable of age and gender in Step 1, the model was not significant $F (2, 347) = .49, p = .62$). When the stress variable was entered in Step 2, the model was significant $F (3, 346) = 78.31, p < .001$ with a $R^2 \Delta$ of .19. The stress index was a significant predictor of bulimia ($\beta = .44, p < .001$). Thus, the total variance accounted for was and adjusted R^2 of 19%, which indicates a large effect size (Cohen, 1988).

Table 2

LINEAR REGRESSION PREDICTING EDI – DRIVE FOR THINNESS

	Grade		
Predictor Variables	B	SE B	β
Step 1			
Gender	.45	.09	.27**
Age	-2.16	.01	-.00
Step 2			
Gender	.44	.09	.27**
Age	-2.40	.01	-.02
STAI	.47	.12	.19**

Notes. Adjusted $R^2 = .07, p < .001$ for Step 1; $R^2 \Delta = .04$,
Adjusted $R^2 = .11, p < .001$ for Step 2
** $p < .001$; $N = 362$

Table 3

LINEAR REGRESSION PREDICTING EDI – BODY DISSATISFACTION

	Grade		
Predictor Variables	B	SE B	β
Step 1			
Gender	4.18	.04	.05
Age	1.09	.00	.17**
Step 2			
Gender	3.98	.04	.50
Age	1.09	.00	.17**
STAI	.12	.63	.10*

Notes. Adjusted R^2 = .026, p = .01 for Step 1; R^2 Δ = .01,
Adjusted R^2 = .03, p < .05 for Step 2.
** p < .001; *p <.05; N = 362

TABLE 4

LINEAR REGRESSION PREDICTING EDI – BULIMIA SYMPTOMS

	Grade		
Predictor Variables	B	SE B	β
Step 1			
Gender	-5.2	.05	-.54
Age	8.97	.00	.12
Step 2			
Gender	-5.90	.05	-.06
Age	2.64	.00	.34
STAI	.31	.04	.44**

Note. Adjusted R^2 = .003, p = .62 for Step 1; R^2 Δ = .19,
Adjusted R^2 = .19, p < .001 for Step 2.
** p < .001; N = 362

Discussion

A review of literature suggests that college students are at risk for developing eating disorders (Cooley & Toray, 2001; Johnstone & Rickard, 2006; Trautman et al., 2007). Responses from a non-clinical sample of university students were collected. This work examined the relation between pre-existent stress and the development of behaviors often reported to precede the development of eating disorders, specifically *Drive for Thinness*, *Body Dissatisfaction*, and *Bulimic Symptoms*. Correlations between gender and stress were found. Further, a "clinical picture" of the self-esteem and depression issues would be captured by responses. After assessing participants' self esteem and depressive symptoms, we see a population that is at-risk clinically, and begin to see the relation between stress and behaviors thought to precede eating disorders. Based on these results there are implications that college counselors and other mental health personnel may find useful.

Clinical Discussion. While the focus of this research was the inferential relation between stress and the precursor behaviors, we were curious how non-clinical college students would report their self-esteem and depressive symptoms given that review of literature (Vohs et al., 2001) suggests that the transition to college can affect a student's mental health. The Coopersmith Self Esteem Inventory and the Beck Depression Inventory were used qualitatively to "put a face" on the problem. The large numbers of participants reporting depressive feelings and low self-esteem in this study do suggest that students may find transition to college most difficult and are struggling.

College counselors need to be aware that more students may be depressed experiencing challenges to self-esteem, than those who request counseling services. Without intervention these eating changes may further increase eating disorder behaviors which may result in a severe case of an eating disorder. While this study did not ask who had sought counseling services, it has been reported that college students hesitate to seek services for a variety of reasons, including the stigma they associate with the need to seek help (Vogel, Wade, & Hackler, 2006; 2007). Counselors may need to increase out-reach efforts to make students aware of the insidious nature of depression and poor self-esteem. Further, these results further suggest that counselors should always query students' eating patterns as part of the depression discussion they have with their clients. These findings could suggest to the counselors and to administrators the need to integrate depression and self-esteem awareness issues into the campus orientation curriculum.

Inferential Discussion. The results from the regression found stress as a predictive factor for the *BS* behaviors associated with bulimia confirming previous findings (Troop et al., 2006). Students who have trouble coping with elevated levels of stress may binge as a form of coping. However, this coping method does not alleviate stress and the individual will still have to learn how to manage stress appropriately. When working with students who demonstrate high levels of stress counselors should explore the students eating habits in depth. If students are unable to cope with stress or eat to counter stress they may be susceptible for developing a full blown eating disorders.

The EDI-II *BD,* scale measures an individual's dissatisfaction with the shape of his or her body and measures image disturbance as well. The regression assessing body dissatisfaction found that age was an associated factor predicting body dissatisfaction, and once again these results support previous findings (Trautmann, Worthy, & Lokken, 2007) that age was a correlate of body dissatisfaction. However, unexpectedly, older students reported more body dissatisfaction. While it was expected that younger students would have been more attuned to their physical image, the current study's finding suggests a different challenge for counselors. Older students, such as seniors or adults returning to school to further their education often have more responsibilities and possibly less time to take care of their physical health and meet academic demands (Tiggemann, 2004). Older students may also feel increased competitive pressure to be attractive when they are constantly in the presence of younger students. When counselors are working with older students, they will need to be aware that if their clients report increased stress they may want to further explore the students' perception of image and satisfaction levels in relation to their eating patterns.

The EDI-II *DT,* scale identifies individuals who have a morbid fear of gaining weight and the scale captures patterns of excessive dieting, excessive thoughts about weight, and constant fear of weight gain. Stress was a significant predictor of DT, which supports the relation between stress and drive for thinness found in other research (Pendelton et al., 2001). Gender was found to be significant predictor for DT with males more likely to be driven to attain thinness. Of note, in this study only one fourth of the participants were male, meaning even though small in number, males were the primary variable explaining drive for thinness. The current results support previous studies suggesting the increase of eating disorders among the male population (Heinberg & Kraft, 2007). These findings remind all who clinically engage with college students that gender does not offer protection and that eating disorders can affect anyone.

Eating disorders among the male population represents an understudied area that is in need of more research (Hudson et al., 2007). In recent work, the concept of a self-referencing physically oriented male, namely the *metrosexual male* has surfaced (Heinberg & Kraft, 2007). The metrosexual male places great emphasis and importance on appearance much like their female counterparts. In this study, males were not asked to identify themselves as metrosexual. Whether they are or not these findings suggest male respondents were at-risk for the demonstration of the excessive patterns measured by the drive for thinness variable. The literature on the metrosexual is developing (Heinberg et al., 2007) and counselors will need to be aware of this growing risk and they will need to consider the possibility that males who report stress may also be experiencing eating disorder symptoms.

Limitations and Future Work

The current study did have some minor limitations. Although the population represents a nonclinical population, the survey did not consider asking the participants about previous diagnoses or previous treatments, which could have clarify existing problems with which students entered college. Further research exploring the construct of metrosexual male would shed more light on the finding that males in this study were more obsessed with thinness and future work will address this growing research construct.

Conclusion

The current study has strength as it does contribute to the previous knowledge of eating disorders and it offers insight. This study observed a nonclinical population and found factors that predict disturbed eating behaviors and attitudes. Stress was related to all three eating disorder precursor. The results confirmed findings of previous studies, which report the increase of disturbed eating behaviors within the male population. The more counselors know about psychological associations triggering unhealthy eating patterns the more chance they will have to intervene, possibly preventing the onset of a severe, full-blown eating disorder. Results can increase counselors' awareness that eating disorders affect both genders. University administrators and counselors may need to provide more outreach programs for students to help them understand that the demands of college may challenge self-esteem and increase the chances for depression and that increases stress may make them more vulnerable for psychological problems.

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Legal and Ethical Implications of Working with Minors in Alabama: Consent and Confidentiality

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Abstract

Until recently, there has been little guidance in the professional literature with respect to counseling minors outside of the school setting. Although most authors suggest referring to state statutes for legal limits of counseling practice, little research exists describing these requirements in Alabama. The purpose of this literature and statutory review is to increase school and mental health counselors' awareness of accepted practice and the possible legal limitations of working with minors in the State of Alabama.

Ethics refers to decisions of a moral nature about people and their interaction in society (Kitchener, 1986). Needs to be added to the references. Law refers to legal standards for behavior developed by legislators and interpreted by judges (Remley, Hermann, & Huey, 2003). Needs to be added to the references As most counselors know, sometimes the distinctions between these two, as well as their relationship to each other, are ambiguous. Until recently, there has been little guidance in the professional literature with respect to counseling minors outside of the school setting. Lawrence and Kurpius (2000) found little research or professional literature concerning appropriate legal and ethical procedures for service provision to minors in the community agency setting. In fact, their exploration of the *Journal of Counseling and Development* between 1995 and 2000 failed to discover any articles on this subject. A subsequent search of available databases for relevant articles from 2000 to 2008 produced similar results. The purpose of this literature and statutory review is to increase school and mental health counselors' awareness of accepted practice within the profession and the possible legal limitations of working with minors in the State of Alabama.

Models for Ethical Practice

A number of authors have provided general guidelines that are useful in understanding the issues of counselor competence, confidentiality, parental rights, record keeping, collaboration, touch, and multicultural approaches in working with this population (Bergin, Hatch, & Hermann, 2004; Lawrence & Kurpius, 2000; Sori & Hecker, 2006; Stone, 2005). Specifically, Lawrence and Kurpius (2000) propose the following seven best practices in working with minors: (1) practice within the educational, training, and supervisory limits of your abilities; (2) be familiar with state statutes; (3) a written statement of policies concerning confidentiality should be discussed with both parents and child at the outset of the counseling relationship; (4) acquire written informed assent from minor clients if choosing not to gain parental consent for treatment; (5) keep precise records of all counseling sessions; (6) maintain adequate liability insurance; and (7) collaborate with colleagues or obtain legal counsel if uncertain as to the proper course of action.

Similarly, Stone (2005) describes the STEPS model for ethical decision making for school counselors that includes the following: (1) Define the problem emotionally and intellectually; (2) Review pertinent codes and laws; (3) Consider client's chronological and developmental levels; (3) Consider setting, and rights of both parents and minors; (4) Apply moral principles; (5) Identify possible actions and their consequences; (6) Evaluate the possibilities: (7) Consult with knowledgeable colleagues; (8) Implement plan and evaluate outcomes.

Models for ethical practice such as these two provide some guidance for counselors who are uncertain about what course of action to take when working with minors. Following such guidelines is consistent with what Reamer (2005) refers to as procedural standard of care – the way an ordinary, reasonable, and prudent professional would act under the same or similar circumstances. Failure to maintain accepted standards of care may represent unethical behavior and establish liability for malpractice. In addition to the practices mentioned by Lawrence and Kurpius (2000) and Stone (2005), Reamer (2003) suggests that professionals should document their decision-making steps. In the following sections, specific ethical and legal issues will be presented along with guidance from the field about how to respond. We encourage you to think through the issues presented using the suggestions of one or more of the authors above as a framework to guide your own decision- making.

Common Dilemmas

Consent and Assent

In the State of Alabama, the age of majority is designated as 19 years (Alabama Code § 26-1-1, 1975). However, in working with minors in a clinical setting, Alabama Code, Section 22-8-6 (1971) states

> "Any minor may give effective consent for any legally authorized medical, health or mental health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease, and the consent of no other person shall be deemed necessary." (p. 3681)

Furthermore, Section 22-8-7 (1971) protects mental health professionals who act in good faith to assist a minor client "who professes to be, but is not, a minor whose consent alone is effective to medical, dental, health or mental health services…" and as such, the mental health counselor "shall not be liable for not having consent" (p. 3681).

The *ACA 2005 Code of Ethics* (Code), in relation to confidentiality, states in Section A.2.d that counselors acknowledge "the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf." (p.?) The Code further states in Section B.5.b that "Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship" and to be "sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/ guardians over the welfare of their children/charges according to law." (p. ?) As such, counselors should work to establish collaborative relationships with parents or guardians when possible.

Relying on ACA, the American School Counselor Association (ASCA), and the Association of Specialists in Group Work (ASGW) ethical standards as well as legal precedent, Bergin et al. (2004) discuss the issue of informed consent as it relates to minors within the school setting. They suggest that at the beginning of the academic year, schools should notify parents as to the existence of school counseling services provided to their children. Parents should then be instructed to contact the school in writing if they do not wish for their child to participate in counseling sessions. However, before counseling groups are initiated concerning sensitive topics (e.g., divorce, substance abuse, risky sexual behaviors, etc.); the counselor must gain permission from the parents or guardians. If there is joint custody in the case of divorce, both parents must be notified. The counselor should then directly contact each parent by phone, inform them that their child is enrolled in a counseling group, and gain both verbal and later written approval for the child's participation (Bergin et al.).

Salo and Shumate (1993) found that few states have passed laws requiring parental or guardian consent prior to initiating a counseling relationship with a minor in either the school or community agency setting. However, the counselor must be aware of the expected community standards of behavior or applicable school board policies (Ledyard, 1998). If the minor client is unable to give consent, the counselor should clarify the therapeutic process and attempt to protect his or her best interest (Ledyard, 1998).

Furthermore, it is the counselor's ethical responsibility to include the client in the decision to release information, or informed assent, whenever possible (Herlihy & Corey, 1996). Presenting feedback on a child's progress in therapy is expected but may be performed without divulging specific content of sessions (Corey, Corey, & Callanan, 2007). Lawrence and Kurpius (2000) state that "minors over the age of 7 years can give informed assent to be involved in counseling or research. Although this is not legally recognized, it demonstrates respect for the minor and signals that the minor has agreed to participate" (p. 134). Likewise, the Association of Specialists in Group Work (ASGW) *Best Practices Guidelines* (1998), Section A.7.c., requests that group workers "obtain the appropriate consent/assent forms with minors and other dependent group members."

Confidentiality

Confidentiality is another issue that lacks clarity when counseling with minors. Salo and Shumate (1993) state that courts have generally ruled that the privacy rights of minors are an extension of parental privacy rights and therefore counselors have legal obligations to the parent or guardian. Additionally, most legal jurisdictions do not consider minors to have the ability to give informed consent (Ledyard, 1998) and as such, the issue of gaining children's consent prior to treatment is seldom considered (Hall & Lin, 1995). Therefore, Lawrence and Kurpius (2000) suggest inclusion of the parents during the first meeting to clarify boundaries concerning the sharing of information and to build trust with all parties. Stein (as cited in Lawrence and Kurpius, 2000) also suggests that in instances of divorce, failure to obtain consent from the custodial parent may be grounds for malpractice. The Code of Ethics of the American Mental Health Counselors Association (AMHCA) (AMHCA, 2005) defines and describes the limits of confidentiality in Principle 3. In working with minors, a counselor is obligated to report cases of child abuse but otherwise may include the parent or guardian in the counseling process as appropriate while taking "measures to safeguard the client's confidentiality" (p. ?). Additionally, Section J states that recording sessions with minors may only occur "with their written permission or the written permission of a responsible guardian" (p.?) and "[e]ven with a guardian's written consent, one should not record a session against the expressed wishes of a client." (p. ?)

The limits of confidentiality were largely defined in the context of a landmark legal case, *Tarasoff v Regents of the University of California* (1976). Needs to be added to the references. During a counseling session, a graduate student at the University of California at Berkeley disclosed to his therapist his intent to kill his girlfriend upon her return to campus. Although the therapist contacted the campus police and his supervisor, he did not attempt to notify the girlfriend, Tatiana Tarasoff, as to the threat. As a result of her subsequent death, the court ruled in *Tarasoff* that failure to warn or protect a third party of a specific threat with intent may be grounds for liability. As a result, counselors must explain the limits of confidentiality during the initial session and that confidentiality will be breached if clients threaten to harm others, themselves, or property (Lawrence & Kurpius, 2000).

In their discussion of parental demands for confidential information exchanged during counseling with minor clients, Mitchell, Disque, and Robertson (2002) state that the law and ethical codes concur in that confidentiality should be broken in suspected cases of child abuse, attempted suicide, and where danger to others is imminent. Professionals who work with minors (i.e., teachers, administrators, social workers, school psychologists, and counselors) are required by law to report instances of abuse in order to protect the safety of children. When information that leads one to suspect abuse is disclosed during a counseling session, counselors who are uncertain about their obligations to report should consult with colleagues and attain legal advice when such instances occur (Lawrence & Kurpius, 2000). If another professional's behavior places a child at risk for harm or exploitation, breaking confidentiality may be necessary to prevent further injury (Pomerantz, Santanello, & Kirn, 2006).

In addition to abuse and other types of harm, sexual harassment is a form of discrimination from which minors are entitled to equal protection. The decision in *Oona R. S. v. McCaffery* (1997) Needs to be added to the references. held school officials, including school counselors, liable for failure to act in instances of sexual harassment (Linn & Fua, 1999). As all schools are required by federal law to appoint an official to

attend to sex equity issues under Title IX of the of the Education Amendments of 1972, now known as the Patsy T. Mink Equal Opportunity in Education Act, consultation with the coordinator may help to clarify questionable instances.

According to the National Institute of Mental Health (NIMH, n. d.) suicide was the third leading cause of death of children ages 10 to 14 and adolescents ages 15 to 19 in 2004. Using data from the National Longitudinal Study of Adolescent Health, Pirkis et al. (2003) found that less than one third (28%) of adolescents who report suicidal ideation receive counseling, however, and that those who did were most likely to be treated by private doctors (37%) and schools (34%). However, the risk of suicide can be reduced when therapists focus on adolescents' level of hopelessness, hostility, negative self-concept, and isolation (Rutter & Behrendt, 2004).

In recent years, an increase in incidents of self-injurious behaviors among youth have led to counselor reassessment of "harm-to-self" which had most often been interpreted as threats of suicide or the presence of suicidal ideation. Determining disclosure of confidential information concerning a minor client who self-mutilates may be difficult, as the counselor risks further alienating the child by violating his or her trust (Froeschle & Moyer, 2004). Encouraging clients to share critical information with parents presents an opportunity to teach appropriate communication between the client and parents in a collaborative approach to therapy. If the client refuses to disclose or poses a risk to self, such as presenting with psychotic forms of mutilation (cutting of the arms, legs, or other area as a means of coping with stress, as opposed to body piercings of the ear, nose, brow, navel, etc.), counselor disclosure may be appropriate (Froeschle & Moyer, 2004) or mandated by law in certain states.

Additionally, instances of substance abuse and risky sexual behavior may represent a threat for short - or long-term self-harm. The 2003 National Youth Risk Surveillance Survey (YRSS) of the Centers for Disease Control (as cited in Bartlett, Holditch-Davis, and Belyea, 2007) reported 28% of adolescents age 10-24 participated in heavy episodic drinking in the previous month while 4% reported sniffing or inhaling an intoxicating substance. The CDC also found that 31% of sexually active males did not use a condom and 79% of females did not use birth control pills prior to intercourse. These findings support a previous 1997 study by the National Institute for Alcohol Abuse and Alcoholism, that alcohol abuse places adolescents at risk for school problems, risky sexual behaviors, and criminal behavior (as cited in Bartlett et al.). As a minor may be hesitant to discuss sexual issues if there is the possibility of disclosure to parents or guardians, the counselor should set clear boundaries, cover informed consent, limits of confidentiality, and consult with other professionals as needed (Herring, 2001). Houston-Vega and Neuhring (as cited in Herring, 2001) note that commonly as the courts have not applied duty-to-warn standards in the case of risk of HIV transmittal to partners, the counselor may employ one of several approaches, including discussion of confidentiality-related HIV policies prior to treatment; the transmittal risks involved with specific sexual or drug practices; discussion of specific issues relating to HIV as they arise; offering to speak with the client's partner(s); and awareness of current legal statutes.In the school setting,

Stone (2002) suggests that counselors consider the age and maturity of the student and the student's decision-making ability when discussing sensitive subjects such as pregnancy. For example, if there are no specific policies forbidding the discussion of abortion, counselors must make use their professional judgment about doing so based on their knowledge of the client. In relation to this subject, the Alabama Statutes, Section 26-21-3 (1987), state that "Except as otherwise provided…no person shall perform an abortion upon an unemancipated minor unless he or his agent first obtains the written consent of either parent or the legal guardian of the minor" (p. 397). However, the statue further holds that if either or both parents or legal guardian is unavailable or refuses consent, a minor may "petition, on her own behalf, the juvenile court, or court of equal standing, in the county in which the minor resides or in the county in which the abortion is to be performed for a waiver of the consent requirement" following the procedures outlined in Section 26-21-4 (1987, p. 397). Therefore, informing a minor client of her rights to seek treatment or diagnosis of pregnancy as outlined above in Section 22-8-6 (1971) and her right to petition as outlined in Sections 26-21-3 (1987) and 26-21-4 (1987) might be discussed in counseling.

HIPAA and FERPA Requirements

Case Notes

As noted by Reamer (2005), Health Insurance Portability and Accountability Act (HIPAA) regulations define psychotherapy notes as any recorded medium by which a mental health professional documents "the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record" (p. 117), excluding session duration, symptoms, client summary of diagnosis, prognosis, treatment modalities and plans, prescriptions, and progress.

In order to define the rights of parents and students regarding educational records, in 1974 Congress passed the Family Education Rights and Privacy Act (FERPA), also referred to as the Buckley Amendment. Needs to be in references. However, Fischer and Sorenson noted, (as cited in Merlone, 2005), counselors' personal files are not considered to be part of the student record if they are not made available to others and are not stored with the students' permanent records. Sorenson and Chapman (as cited in Merlone, 2005) caution that once personal notes are shared with anyone, however, they are no longer considered private and must be disclosed to parents if requested.

The U. S. Department of Education further clarified this issue in a manual entitled *Protecting the Privacy of Student Records* Needs to be in records. which states that handwritten notes by a counselor, teacher, or administrator concerning a student are not considered to be educational records under FERPA and are not bound by the rules of disclosure (Cheung, Clements, & Pechman, as cited in Merlone, 2005). Swanson (as cited in Merlone, 2005), cautions that although counseling notes are not educational records, they are open to subpoena and as such should include only necessary information and should be written in behavioral terms. Merlone further cites the American School Counseling Association (ASCA, year
?), Myrick, and Swanson that counselors have successfully protected student confidentiality by testifying that the record is hearsay, that there is no proof supporting the testimony and, therefore, the testimony has no legal validity.

Conclusions

Entering into counseling relationships with minor clients presents counselors with unique challenges, particularly in relation to consent, assent, and confidentiality. The minor's legal right to participate in counseling is not always clear, particularly outside of the school setting, and counselors are advised to seek parental or guardian consent as well as the assent of the minor client. Because the very act of gaining consent from parents or guardians means that the counseling relationship is not confidential, issues of confidentiality become paramount. Minor clients should be advised in advance of counseling the limits placed on their privacy. Parental requests for information, suspicions of abuse or neglect, intention to harm self or others, and other types of risky behavior may result in the sharing of information by the counselor to others who are charged with protecting the minor client's welfare.

In many instances, the counselors of minor clients must make decisions about disclosing client information to others. Some circumstances are clear and demand decisive and immediate action (e.g. mandatory reporting of suspicion of child abuse). Others are less clear (e.g. risky sexual behavior) and require that counselors make judgments about what constitutes risk to a minor client. In the absence of clear guidelines, counselors are encouraged to use a model such as the ones proposed by Lawrence and Kurpius (2000) or Stone (2005) to guide them in making decisions and taking actions that would be viewed by other reasonable, well-trained counselors as the appropriate thing to do.

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Left Behind But Not Forgotten: School Counselors' Ability to Help Improve Reading Achievement

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Abstract

Examined is an outlook of the achievement gap among African-American and White students in school settings. Statistics and other pertinent information are evaluated to demonstrate how this is a growing problem in schools. An exploration of how school counselors can meet the demands and recognize the effects the achievement gap has on African-American students and interventions that should be put into place to help with this rising problem are essential in helping to close the achievement gap crisis, as a result of this movement there have been numerous accomplishments; nevertheless major challenges continue to linger.

School improvement has been a main concern for presidents, governors, and other state policymakers for the past twenty years. As a result of this movement there have been numerous accomplishments, nevertheless major challenges continue to linger. One such challenge is the reading achievement gap between African American students and their European American counterparts (National Center for Education Statistics, 2007). This article provides a definition of the achievement gap, instructional efforts classroom teachers can utilize to help close the achievement gap, and how school guidance counselors can help African American students increase reading performance, thus helping to close the achievement gap.

Accountability and improving student achievement has also been a main focus of the school counseling profession. There has been a shift in the way that school counselor accountability is being measured. In the past, school counselor accountability was measured by answering the question, "What do counselors do?" Now school counselor accountability is measured by answering the questions, "How are students different as a result of what school counselors do?" This shift is mainly due to the passing of the No Child Left Behind Act (U.S. Department of Education, 2001).

What is This Achievement Gap?

The "achievement gap" speaks to the observed disproportion of scores on a number of educational measures among groups of students, particularly defined by race/ethnicity, gender academic performance, and socioeconomic status. The achievement gap can be measured in several ways, such as standardized test results, dropout rates, grade point average, etc. This article addresses the achievement gap African American students face based on national and State of Alabama reading assessment results.

Assessing the Achievement Gap

Multiple sources of reading achievement data clearly indicate the existence of a reading achievement gap based on socioeconomic status and ethnicity between African American students and their European American counterparts. The Nation's Report Card State Reading Snapshot Report 2005 - 2007 for students in Alabama indicates that eighth graders scored on an average of five points below the nation's average (Alabama State Department of Education, 2007). The gap has decreased by three points since the 2003 Snapshot when the gap in

scores was eight points. When 8th grade scores in Reading are disaggregated by race/ethnicity between the state and the nation, the gap in scores is 6 points for White students and 7 points for Black students when compared with students of the same race. Within the state White and Black students scored 263 and 235, respectively. The 2005 scores indicate an alarming 28-point gap in achievement within the state between Black and White students. This gap has increased by 3 points since the 2003 Snapshot report where the gap is scores was a significant 25 points. National scores in 8th grade Reading are 247 for students eligible to receive free/reduced lunch and 270 for those ineligible to receive free/reduced lunch; indicating a 23-point difference in scores. Within the state of Alabama, students eligible to receive free/reduced lunch scored 239, which is 8 points lower than the national average. Eighth grade students in Alabama ineligible to receive free/reduced lunch scored 265, only 5 points lower than the national average in Reading. The 2003 Snapshot indicated 8th grade students eligible to receive free/reduced lunch within the state scored 23 points lower than those ineligible to receive free/reduced lunch in reading. The 2005 Snapshot indicates a 26-point difference in scores within the state, indicating a three-point decrease; though not statistically significant, this decline in performance still needs to be addressed.

School Counselors Closing the Reading Achievement Gap

Numerous researchers have reported how the implementation of school counselor activities positively impacted students' reading performance. This research includes using peer counseling to improve reading performance of high school students (James, Charlton, Leo, & Indoe, 1991), registered therapy dogs to improve student reading performance of elementary students (Paradise, 2007), dance to improve reading skills of first-grade students (McMahon, Rose, & Parks, 2003), and relaxation as a reading remediation tool for elementary students (Culbertson & Wille, 1978). Although these programs successfully increased reading performances of the participating students, none of these studies focused on increasing the reading performances of middle school aged African-American students.

One program has proven effective in improving the academic performance of African-American students in middle school. The Student Skills Success Program (SSS; Brigman, Campbell, & Webb, 2004; Brigman & Webb, 2004) is an intervention used to close the academic achievement gap for low achieving students. The SSS program is an intervention delivered in a structured format, by trained school counselors. School counselors deliver the program during classroom guidance and group sessions. The program focuses on three skill sets which consist of a) cognitive and meta-cognitive skills, b) social skills, and c) self-management skills. Cognitive and meta-cognitive skills include goal-setting, progress monitoring, and memory skills. Social skills include interpersonal, social problem solving, listening, and teamwork skills. Self-management skills include managing attention, motivation, and anger. Researchers suggest that this program increases reading scores of African-American students, as well as other ethnicities (Miranda, Webb, Brigman, & Peluso, 2007). A statewide, standardized assessment, the Florida Comprehensive Assessment Test (FCAT) was used to measure academic achievement gains. The FCAT scores from two consecutive years were used as pretests and posttests in this study. The mean score for African-American students in the treatment group increased from 642.5 on the pretest to 651.9 on the posttest, while the mean score for African-American students in the comparison group only increased from 650.9 on the pretest to 655.5 on the posttest. The results show that when school counselors implement programs like the SSS, it helps increase academic achievement and close the reading achievement gap.

School counselors should also implement a comprehensive school counseling program to help close the reading achievement gap. The American School Counselor Association National Model (ASCA, 2005) was developed to provide the framework for developing, implementing, and evaluating comprehensive school guidance and counseling programs that included the national standards. School counseling programs are comprehensive, preventive, developmental, integral in the total educational program, and driven by data. The ASCA National Model is now being used by most professional school counselors (Sink, Akos, Turnbull, & Mvududu, 2008), but some school counselors are not highly implementing comprehensive school counseling programs. Research has shown how students' academics, behavior, attitude and self-esteem have positively impacted by highly implemented comprehensive school counseling programs (Lapan, Gysbers, & Petroski, 2001 & 2003;

Lapan, Gysbers, & Sun, 1997; Sink & Stroh, 2003). One study compared the reading achievement of students who attended schools with highly implemented comprehensive school counseling programs to the reading achievement of middle school aged students who attended schools where a comprehensive school guidance program was not highly implemented.

Sink, Akos, Turnbull, and Mvududu (2008) conducted a study in Washington State middle schools with 6th and 7th grade students. The researchers used scores from the Iowa Test of Basic Skills (ITBS) for 6th graders and the Washington Assessment of Student Learning (WASL) for the 7th graders. The results indicated that students in schools with highly implemented comprehensive school counseling programs significantly outperformed students in schools without comprehensive school counseling programs implemented. The 6th grade students in schools with highly implemented comprehensive school counseling programs did better on the ITBS language scores and the 7th grade students did better on the WASL reading scores. Although this is just one study with middle school students, this provides evidence that a fully implemented comprehensive school counseling program does have a positive impact on reading achievement.

Implications for School Counselors

School counselors are urged to fully implement comprehensive school counseling programs at the elementary, middle, and high school levels. To fully implement a comprehensive school counseling program, school counselors are encouraged to give up some of their non-guidance duties to focus on actual guidance duties. This also means increasing communication with administrators to allow school counselors to stop "pushing papers" and devote more time to guidance and counseling duties (Dollarhide, Smith, & Lemberger, 2007).

School counselors are encouraged to show how their programs and activities contribute to an increase in student achievement (Trusty, Mellin, & Herbert, 2008). Counselors can collaborate with teachers and administrators to help disaggregate data and close the reading achievement gap (Sink, 2008). School counselors can offer their skills of collaboration, consultation, leadership and advocacy to help in the process of increasing student achievement.

School teachers are constantly in contact with students and are the first to notice concerns with academics. School counselors are encouraged work with teachers and administrators on school improvement plans to make sure that counseling programs are included as interventions. School counselors can also take on a leadership role as a part of the school's leadership team. This gives school counselors an opportunity to advocate for student needs and assist with identifying programs that are scientifically based, such as the SSS.

The National Reading Panel (2000) suggests that teachers' use of high-interest, easy reading text with controlled vocabulary, can assist students reading below grade level especially in the middle grades. Such an academic intervention might address multiple student needs through combination with bibliotherapy. For example, school counselors could collaborate with teachers to incorporate bibliotherapy into the curriculum. Bibliotherapy can promote social development and a love for literature and reading (Gladding & Gladding, 1991).

School counselors and counselor educators are compelled to focus on conducting more research to identify techniques, strategies, and programs that school counselors are using to help close the reading achievement gap. More research should also be conducted on the effectiveness of fully implemented comprehensive school counseling programs in the elementary, middle, and high schools.

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