1979

A Multimodal Approach for Counseling Rural Women: Models and Case Studies

Mary Vick Roth
Eastern Illinois University

PAPER CERTIFICATE #2

TO: Graduate Degree Candidates who have written formal theses.

SUBJECT: Permission to reproduce theses.

The University Library is receiving a number of requests from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow theses to be copied.

Please sign one of the following statements:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.

_____ _____

Date Author

I respectfully request Booth Library of Eastern Illinois University not allow my thesis be reproduced because the material includes case studies of clients.

August 16, 1979

Date

pdm

A MULTIMODAL APPROACH FOR COUNSELING RURAL WOMEN: MODELS AND CASE STUDIES

(TITLE)

BY

MARY VICK ROTH

B. S. in Ed., Eastern Illinois University, 1966

M. S. in Ed., Eastern Illinois University, 1974

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Specialist In Education

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1979
YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
THIS PART OF THE GRADUATE DEGREE CITED ABOVE

14 Aug 79
DATE

August 14, 1979
DATE

A MULTIMODAL APPROACH FOR COUNSELING RURAL WOMEN: MODELS AND CASE STUDIES

BY

MARY VICK ROTH

B. S. in Ed., Eastern Illinois University, 1966

M. S. in Ed., Eastern Illinois University, 1974

ABSTRACT OF A THESIS

Submitted in partial fulfillment of the requirements
for the degree of Specialist in Education at the
Graduate School of Eastern Illinois University

CHARLESTON, ILLINOIS
1979

THE PROBLEM

The purpose of this study was to develop a counseling model which would provide time-efficient and effective counseling services to meet the needs of rural women. Criteria were established for selected of a model and for evaluation of outcomes.

PROCEDURES

Research on previously-tested methods of counseling women as well as that on other counseling models was examined. Models were evaluated on the basis of established criteria. Discussion of use of the model selected was presented with three case studies illustrating its application. Evaluation of outcomes at the conclusion of therapy and on a follow-up basis concludes each case.

On the basis of evaluation of subject's counseling gains, the following conclusions may be drawn:

1. The Wholistic Model is a time-efficient and effective means of providing counseling services to rural women.

2. Clients met counseling goals in less than six months and reported maintenance of gains at follow-up intervals of six and twelve months.

RECOMMENDATIONS

This study is limited in scope to twenty rural women. However, the writer believes that the results warrant further investigation. Therefore, the following recommendations are offered:

1. Further study with a larger, randomly selected, sample with pre- and post-testing of counseling gains on bases other than client self-report and counselor judgment should be implemented.

2. The potential of the Wholistic Model for use with other populations and in group counseling should be examined.

3. Exploration of the use of the Wholistic Model by counselors, therapists, and other helping persons in self-assessment and self-renewal to avoid professional "burn-out" should be initiated.

4. Counselor educators should acquaint counselors and counselor trainees, through preservice and inservice experiences, with use of the Wholistic Model to structure their varied counseling techniques into a usable package.

ACKNOWLEDGMENTS

The author wishes to thank her advisor, Dr. Paul Overton, for his assistance with this study.

The support and encouragement of Merlin Roth, the writer's husband, is gratefully acknowledged.

Special thanks is hereby extended to the many women whose pain and dissatisfaction motivated us together to search for and find a satisfactory helping model. To those who permitted use of data from their experiences, the author is deeply indebted.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

APPENDICES

Figure Page

CHAPTER I

INTRODUCTION

Background

In the past three years as a counselor in a rural area, the writer's case load has included an ever-increasing proportion of women. Although their presenting problem has most frequently been a need for career information, it soon became apparent that they were actually seeking help with a variety of concerns. Tentatively at first, and then more quickly as acceptance encouraged them, they voiced other needs: for reassurance that their fledgling ideas, far from being "wrong," had merit; for self-confidence; for resolution of the conflicts between long-held beliefs and values and growing aspirations. They needed a safe place in which to explore ideas, to learn new coping skills, to try on new roles, to challenge old thinking.

According to many authors,[1] these needs were far from unique. Rather, they were typical of women today. However, a number of factors made meeting their needs appear to these women to be difficult if not impossible.

---

[1] Linda Brooks, "Supermoms Shift Gears: Re-entry Women," The Counseling Psychologist 6 (1976):33, Jean Holroyd, "Psychotherapy and Women's Liberation," The Counseling Psychologist 6 (1976):24; Esther Manning Westervelt, "A Tide in the Affairs of Women: The Psychological Impact of Feminism on Educated Women," The Counseling Psychologist 4 (1973):22.

All the women were isolated by distance, time, and family responsibilities from the women's centers and career planning services of universities and community colleges. These women, whose ages ranged up to fifty-six years, were isolated too by geographic and social factors, along with lack of paid job experience, from access to any but the lowest-paying, unskilled jobs. Lacking, for the most part, role models of women in professional, managerial, and other nontraditional careers, their aspirations were further limited by lack of knowledge of what careers actually might be possible and fulfilling for them.

Beyond even these limitations, however, were even narrower restrictions or an attitudinal nature. These were the personal biases which prevented their overcoming geographic and other difficulties and prevented their using what few sources of help were available to them closer to home.

An area mental health clinic offered developmental programs for women occasionally, but the service was unused. For example, even though a number of women mentioned to this writer a desire for assertiveness-training, when the mental health center offered such a workshop, no one attended. "I don't want people to think I'm crazy," and "I didn't know what people would think if I went," were typical responses when the writer asked women why they had not chosen to attend.

The second response reflects a primary reason that these women hesitated to seek help. They were unwilling to "go public" with their concerns. Knowing it was impossible to remain anonymous in their small rural communities and not yet convinced that their concerns were legitimate or respectable, they sought

privacy and support for their first ventures in self-exploration.

These women, with few exceptions, were fearful of being identified with the Women's Liberation Movement. They stereotyped the feminist as someone loudly aggressive, as someone who would demean and ridicule their more traditional life style. To emulate her attitudes and activities would be for them, they believed, social suicide, making them objects of scorn and alienation. They seldom confided even to their most trusted friends the troubled state of their lives. To do so seemed shameful, as if they would admit something was wrong with them. As a result, each woman was troubled that she alone in the community had such concerns and conflict. References to the real pain and confusion they felt were usually accompanied by disclaimers of nervous laughter or comments of, "Well, I guess that's the way it has to be."

The few women, all with college educations, who voiced whole-hearted approval of equality of opportunity for men and women, and who advocated less restrictive roles for women, were, nevertheless having difficultues integrating their voiced values into their thinking and living. They felt alienated from other, less vocal, women and were concerned that their conflicts were impossible to resolve.

The few women who had ventured to career planning centers associated with educational institutions reported that what was offered was not relevant to them. There was, apparently, too great a distance between where these women were in their personal needs and the services offered. This was not too surprising in view of the fact that most of the women did not know what

they wanted, being unable at that point to conceptualize their problems.

The other institution which might have assisted these women was the church, a powerful socializing influence in the area. Most of the churches were, however, of a more traditional outlook of men's and women's roles. In addition, most women were unwilling to voice their concerns to pastors or church friends. They felt their new ideas and questions would be viewed as wrong, not reflecting adherence to traditional Christian ideas of woman's place. One woman who did go to her pastor after her husband had severely beaten her because she had questioned his authority, was told that such beatings had scriptual precedent and that she should submit unquestioningly to her spouse's authority. Another client did find a more positive response when she sought help from her pastor; however, the generally authoritarian attitude of pastoral counseling in the area seemed to foster the very dependence upon external authorities that these clients were seeking to escape. A few of the less fundamental religious groups did encourage discussion of changing social roles, but women reported that they were not comfortable in speaking their minds in that setting, particularly since spouses were often present.

These women, though somewhat isolated, had not been living in a vacuum, of course. They had been bombarded by the mass media for several years. Television, newspapers, radio, so-called women's magazines, books, movies--all had spread the word that more options were available to women, that they were entitled to happy, fulfilling, meaningful lives. Thus their expectations rose; their dissatisfaction increased. But they lacked the skills

necessary to clarify their values, to plan for a future different from the one they had envisioned in their youths, to integrate all these changes into some meaningful identity. Most of them saw a career as a means for fulfilling their heightened expectations. Yet they had only a vague concept of what they truly wanted or how they might achieve their dreams.

Thus they came, seeking not revolution, but private help in the resolution of their inner and interpersonal conflicts. One fact was common to all these women: all had made a previous effort to obtain help. Without exception, these women reported negative outcomes from previous efforts. Many reported rapidly deteriorating functioning following their unsuccessful attempts to solve their problems. All were suffering from the physical manifestations of stress. But, being unfamiliar with the concept of the stress syndrome, they perceived their psychobiological deterioration as another failure. They were further discouraged by their inability to fulfill either their old or a new role with feelings of competence.

Purpose

This study grew out of the writer's attempts to meet the needs of the women in the setting previously described. The writer felt a need to find a model for helping her women clients in an effective manner. After examining past experiences of her clients, she concluded that traditional career and personal counseling methodologies seemed inadequate or inappropriate. Expressed needs were similar yet diverse. The most effective approach, therefore, would apparently be one which focused on the individual client rather than upon any particular counseling

methodology or technique. This necessitated the systematizing of a variety of diverse counseling techniques into a usable package.

With an increasing case load and the resulting time limitations, the counselor needed to be able to provide efficient service. To develop a model for assessing problems, planning and applying intervention strategies, and providing for on-going and follow-up evaluation seemed the necessary approach for meeting the counselor's and clients' needs within these limitations.

Given the clients' resistance to group counseling and the time limitations, it appeared that (1) individual counseling, at least in the initial stages, and (2) a strong self-help component with assignments for client-work between counseling sessions were needed. It was felt that this latter consideration would also be useful in helping the client become actively involved in her therapy and increase self - rather than external-dependence.

Since client concerns were complex, involving cognitive, behavioral, and affective systems along with interpersonal relationship and, since clients expressed negative outcomes from previous exposure to unimodal systems, a multi-modal model seemed most appropriate.

Given the manifestations of stress reactions which were apparent in all clients and which had such a direct bearing on feelings of general well-being, some attention to adaptations to stressors seemed indicated.

The purpose, then, of this study was to develop an effective model for the counseling of women. A model would be judged effective if, when utilized with a number of clients, the clients

felt their goals for counseling had been met, if the counselor judged that her time had been used efficiently, and if the clients maintained their gains through the end of the study.

Procedure

In order to accomplish this purpose, the writer selected the following procedure:

(1) Evaluate existing counseling models in terms of criteria selected

(2) Choose or develop a model which most closely met the needs expressed by clients and counselor

(3) Test the model with several subjects

(4) Evaluate counseling outcomes within the time-frame of the test and follow-up period

Definitions

Coping skills: those abilities necessary for personal and interpersonal functioning

Mode: component of therapeutic system or model dealing with one aspect of personality or environment

Model: system or pattern; guide

Multimodal therapy: a system of helping which is characterized by interventions in several modes of the client's personality and environment

Re-education: teaching new thinking and/or behavior patterns; training in new coping skills

Wholistic: an approach or orientation which recognizes that the individual aspects of an organism's personality are essentially interrelated and interdependent

Wholistic Therapy or Wholistic Counseling: an approach to helping which recognizes the essential interrelatedness of all systems or the individual and which intervenes in all systems

Organization of the Study

The remainder of this study will cite related research, present a model for counseling women, and demonstrate the use of the

model with three subjects. Conclusions and recommendations follow the case studies.

CHAPTER II

REVIEW OF RELATED RESEARCH

Criticisms of Traditional Psychotherapies and Career Counseling

Much has been written in the past decade about the inappropriateness of traditional methods of psychotherapy and career guidance for helping women. Critics range from the hostile to the hopeful. The former see traditional psychotherapies as a means of influencing women to continue to accept their "oppressed conditions in the traditional female role"[2] which is characterized in terms of "passivity, serving, submissiveness, and dependence."[3] The latter see traditional psychotherapies as merely well-meaning but ineffectual, no longer attuned to the needs of our society. They recommend that "counselors must take a giant step to increase their understanding...of what it means to be a woman in the"...present.[4]

Since an early study[5] documented the apparent biases of

---

[2]Carol J. Barrett et al., "Implications of Women's Liberation and the Future of Psychotherapy," Psychotherapy: Theory, Research and Practice 11 (Spring 1974):12-13.

[3]Rita M. Whiteley, "Women in Groups," The Counseling Psychologist 4 (1973):28.

[4]Jane B. Berry, "The New Womanhood: Counselor Alert," Personnel and Guidance Journal 51 (October 1972):106.

[5]Broverman et al., "Sex Role Stereotypes and Clinical Judgments of Mental Health," Journal of Consulting Psychology 34 (1970):1-7.

counselors in defining "mental health" differently in men and women, the profession has been criticized as perpetuating sex-role stereotypes and inhibiting the self-fulfillment of contemporary women.

Career counseling, too, has been criticized as encouraging women to consider too few career options.[6] Some critics charge that women find that "most counselors and tests aren't really relevant to our lives."[7]

Given that in 1976 women made up 40.5 per cent[8] of the labor force and that 47.3 per cent[9] of all women sixteen years of age and over were working in 1976, perhaps career counselors need to recognize that women are working, want or need to work, and therefore are entitled to objective, thoughtful and relevant career guidance. Vetter[10] recommends that information about women and work be included in preservice and inservice training of counselors.

Vetter[11] charges that counselors have too frequently seen women as insignificant in the labor market and a woman's career goals as secondary to her marital and parenting goals. Yocum[12]

---

[6]Helen S. Farmer, "Increasing the Career Options Considered by Girls and Women," I. G. P. A. Quarterly, no. 63 (Winter 1977), pp. 28-33.

[7]Laurine E. Fitgerald, "Women's Changing Expectations...New Insights, New Demands," The Counseling Psychologist 4 (1973):91.

[8]U. S. Department of Labor, Bureau of Labor Statistics, U. S. Working Women: A Databook, Bulletin 1977, p. 5.

[9]Ibid.

[10]Louise Vetter, "Career Counseling for Women," The Counseling Psychologist 4 (1973):54-67.

[11]Ibid., p. 55.

[12]Barbara E. Yocum, "Title IX: A Matter of Conscience and a Matter of Law," I. G. P. A. Quarterly, no. 63 (Winter 1977), pp. 9-19.

cites considerable research to support these charges.

Models for Counseling Women

The Consciousness-Raising Group

Some models for helping women have utilized the consciousness-raising group concept. Warren[13] defines "consciousness raising" as, "the process whereby women, meeting together in a supportive climate, examine their personal experience as women with particular emphasis on social conditioning and sexism in contemporary society."[14]

Not surprisingly, given the negative attitudes of many women toward traditional psychotherapies, these groups have had an anti-therapy orientation. Kirsch,[15] however, suggests that the consciousness-raising group is a viable alternative to more traditional methodologies. Although consciousness-raising groups originally were leaderless or led by women with more political activist than helping biases, modern groups are often led by women with some counseling training.[16]

Holroyd[17] cites gains for women through consciousness-raising group experiences. The concept of this type of group

---

[13]Linda W. Warren, "The Therapeutic Status of Consciousness-Raising Groups," Professional Psychology 7 (May 1976): 132-140.

[14]Ibid., p. 133.

[15]Barbara Kirsch, "Consciousness-Raising Groups as Therapy for Women," in Women in Therapy: New Psychotherapies of a Changing Society, eds. Violet Franks and Vasante Burtle (New York: Brunner and Mazel, 1974), pp. 326-354.

[16]Warren, p. 134.

[17]Jean Holroyd, "Psychotherapy and Women's Liberation," The Counseling Psychologist 6 (1976):22-28.

appears to be a viable one for helping women and the purpose of such groups appears to be increasingly therapeutic.[18]

Workshop-Type Experiences

One model for helping women is the workshop. This model is generally task-oriented in nature and focuses on one subject, such as career planning or assertiveness training. Activities used are frequently in the behavior or cognitive modes. For example, an assertiveness-training workshop[19] might define and assist the participant to identify assertive, non-assertive, and aggressive behaviors, provide guidance and feedback while the participant practices behaviors in the group setting, and then provide support as the participants integrate the target behaviors into interactions within their life settings.[20]

Certain skill-building workshops may teach such coping skills as decision-making techniques or job-hunting competencies. A few such workshops attend to the participant's need for "lifespan planning," providing activities designed to encourage self-exploration and behavior rehearsal of coping skills.[21]

The Information Center Model

One means of offering help to women has been through women's centers. "A women's center may be a community-based operation

---

[18]Warren, p. 138.

[19]John DeVolder et al., "Personal Renewal Through Assertive Training," workshop presented at Western Illinois University, Macomb, Illinois, 1976.

[20]Patricia Jakubowski-Spector, "Facilitating the Growth of Women Through Assertive Training," The Counseling Psychologist 4 (1973):75-86.

[21]Lifespan Planning Workshop, Parkland Community College, Champaign, Illinois, 1975.

or be located within a higher educational community. Typically, counseling and advisement re careers, training and placement are central functions. Rarely are these centers allied with a counseling center...."[22]

Recognizing that the typical university may not meet the needs of the non-traditional woman student, some institutions have established projects to assess her needs and to provide decentralized special services across the various departments of the university and coordinated by the women's center. The center offers information specific to that setting and provides interface between the institution and the returning women students.[23]

Cognitive Models

Many of the counseling models for women focus on the cognitive mode. Beck and Greenberg[24] recommend the cognitive approach to working with women.

Schlossberg[25] describes a two-stage cognitive model for helping women through the decision-making process. This model helps the client through what Schlossberg labels the stage of

---

[22] Fitgerald, p. 91.

[23] Barbara Joley, Final Report: Study On Recruitment of Adult Women Students, Eastern Illinois University, Charleston, Illinois, 1974.

[24] Aaron T. Beck and Ruth L. Greenberg, "Cognitive Therapy With Depressed Women," in Women in Therapy: New Psychotherapies of a Changing Society, eds. Violet Franks and Vasante Burtle (New York: Brunner and Mazel, 1974), pp. 113-131.

[25] Nancy K. Schlossberg, "A Framework for Counseling Women," Personnel and Guidance Journal 51 (October 1972):137-143.

Anticipation, during which the client should be helped to fantasize about different choices in the context of her life. When the client has expanded her awareness of the consequences of her choices, narrowed her interests and then settled on one option, the counselor guides her through the Implementation stage. Implementation involves preparing for and securing a career position with the continued guidance and support of the counselor. Since this model uses imagery, cognitive and behavioral re-education, it goes beyond the usual uni-modal workshop or program. This model would appear to facilitate self-awareness in the client.

Another cognitive model which helps the client conceptualize the decision-making process was developed by Eason.[26] The model uses a life style planning approach to help the client focus on her choices. The model is recommended for use with women who, according to Eason, "don't fit traditional theories of career development."[27] In this model,

> Life style is a term describing the concept of how behaviors relate to basic values and purposes. A life style is an overall way of looking at the world, at the physical environment, at concepts and ideas, at people and social interaction, and at oneself.... A life style springs from within the self rather than from roles defined by others.[28]

---

[26] Jean Eason, "Life Style Counseling for a Reluctant Leisure Class," Personnel and Guidance Journal 51 (October 1972), 127-132.

[27] Ibid., p. 127.

[28] Ibid., p. 128.

This model focuses on the person of the client and utilizes values clarification to help the client toward self-understanding, to aid her in recognizing her own personal orientation and in choosing activities appropriate to that orientation. The thesis of the developers of this model is:

> Vocational and educational counseling must become increasingly concerned with adults making choices about their broadest 'vocation,' the commitment and purpose of their whole person.[29]

Thus this model takes a wholistic approach to the problem of career counseling of women.

According to Sherman and Jones,[30]

> Not only counselors, but everyone who works with women today...need to become aware of the diverse, confusing forces impinging upon women and to help give them perspective without taking away their choices.[31]

The two models which follow attempt to increase counselor and client understanding of these "diverse, confusing forces" by conceptualizing the change process as it applies to reentry women.

The first model attempts to explain the internal and interpersonal change processes of the reentry woman by using Newcomb's balance theory.[32] The theory hypothesizes that change within the individual produces imbalance within the family and between

---

[29] Ibid., p. 132.

[30] Ruth G. Sherman and Jane H. Jones, "Career Choices for Women: The New Determinants," Journal of College Student Personnel 17 (July 1976):289-294.

[31] Ibid., p. 294.

[32] T. M. Newcomb, The Acquaintance Process, quoted in Rose Marie Roach, "Honey, Won't You Please Stay Home," Personnel and Guidance Journal 55 (October 1976), pp. 86-89.

the client and others. This imbalance involves a system of attractions among persons within the social framework. The imbalance follow predictable and recognizable patterns; therefore, it is possible to aid the client to predict changes in the attitudes and behaviors of significant others, to recognize these changes when they occur, and to prepare to deal positively with them. By these means it is possible to facilitate the client's continued growth by reducing internal and external pressures on the changing woman. Roach suggests teaching coping skills to help the woman in the reentry situation.[33] While this model applies balance theory specifically to the reentry woman, it appears applicable as well to women in other change situations.

The second model,[34] conceptualizes the reentry process as a series of stages. The model provides, "the counselor with a framework for both assessment and intervention."[35] The stages enumerated are (1) Vague Discontent, (2) Inner Preparation, (3) Intensive Family Involvement, (4) Assessment, (5) Generating Alternatives, (6) Narrowing Alternatives and Value Clarification, and (7) Implementation and Goal Setting.[36] Brook's thesis is that women entering college or work:

---

[33]Rose Marie Roach, "Honey, Won't You Please Stay Home," Personnel and Guidance Journal, 55 (October 1976):86-89.

[34]Linda Brooks, "Supermoms Shift Gears: Re-entry Women," The Counseling Psychologist 6 (1976):33-37.

[35]Ibid., p. 33.

[36]Ibid., pp. 33-34.

> ...are involved in a normal transitional state that is resolved through a series of stages. Counselors should be prepared to facilitate women who enter counseling at any stage....[37]

A cognitive model developed by Avery[38] attempts to help women conceptualize their own growth toward liberation. Describing the stages as (1) Before the dawn, (2) Epiphany, (3) Immersion, (4) Emergence, (5) Internalization, and (6) Action,[39] Avery does not give any guidelines to counselors for choosing intervention strategies to aid clients in each stage.

Avery hypothesizes that:

> To the degree that a woman is able to name, describe and delimit her experiences in growth toward personal liberation, she is also able to communicate more accurately and more effectively with herself and with the significant others in her life."[40]

A review of a final cognitive model focuses on efforts to adapt the cognitive-developmental theory to the counseling of women. The theory appears to offer particular insight into the stages through which cognitive development occurs, along with guidelines for use by the counselor may gain some understanding of the change process itself, particularly relating to the manner in which some change efforts may actually inhibit the client's growth.[41]

---

[37] Ibid., p. 36.

[38] Donna M. Avery, "The Psycho-Social Stages of Liberation," I. G. P. A. Quarterly, no. 63 (Winter 1977): pp. 36-42.

[39] Ibid., p. 36.

[40] Ibid.

[41] L. Lee Knefelkamp, Carole C. Widick and Barbara Stroad, "Cognitive -Developmental Theory: A Guide to Counseling Women," The Counseling Psychologist 6 (1976): 15-19.

According to the cognitive-developmental theory, persons develop in their thinking through nine stages; from the simpler to the more complex, from the more stereotypic and dogmatic, to the more open; from the more dependent upon external authority, to the more accepting of self-responsiblity.

The purpose of counseling, according to this theory is "fostering movement along the developmental hierarchy."[42] This theory hypothesizes that the movement must be at the client's own pace ad attempts to push the client too rapidly up the hierarchy result in too much disequilibrium and prevent development. The authors conclude that the greatest therapeutic gains occur when the counselor provides support and challenge.[43]

Incorporating the relevent tenets of this cognitive-developmental theory into a counseling model leads to the search for a model which permits the counselor to:

(1) Establish and maintain the core conditions essential to the therapeutic relationship

(2) Place the client rather than a counseling method at the center of the counselor's concern

(3) Avoid simplistic or political solutions to the client's problems.

(4) Attend to all aspects of the client's personality and environment

(5) Assess the degree of disequilibrium or stress level of the client

---

[42] Ibid., p. 17.

[43] Ibid., p. 16.

Multimodal Models

The following two models, although not designed specifically for use in counseling women, appear to be appropriate for such application and adhere to some of the criteria originally identified as bases for choice or a model for use in this study:

The Time-And-Place Model

Ponzo proposes an eclectic approach to counseling in which he advocates placing different strategies along a time continuum according to their efficacy in various stages of therapeutic intervention.[44] Ponzo's three-phase model incorporates philosophy and techniques from client-centered and gestalt therapies, transactional analysis, rational-emotive therapy, and behavioral counseling. The three phases are Awareness, Cognitive, Reorganization, and Behavior Change.

While Ponzo's model offers considerable help to the counselor in choosing intervention strategies, it offers no guidelines for diagnosis and evaluation. Nevertheless, the suggestions for sequencing of strategies appear to give help to the counselor seeking to systematize diverse activities. The sequential phase concept suggests that the greatest gains will be realized in therapy when interventions are in order from first through third phase.

---

[44] Zander, Ponzo, "Integrating Techniques From Five Counseling Theories," Personnel and Guidance Journal 54 (April 1976):415-419.

Multimodal Therapy

The multimodal therapy model developed by Arnold A. Lazarus is:

> ...predicated on the assumption that the durability of treatment outcomes will be in direct proportion to the extent to which problem identification (diagnosis) systematically explores each of the modalities, whereupon therapeutic intervention remedies whatever deficits and maladaptive patterns emerge.[45]

> We contend that even cursory attention paid to each modality in therapy will yield more durable results than treatments that ignore one or more modalities.[46]

Lazarus cites a study done by him and his associates to support this assumption:

> My trainees and I have consistently found that the multimodal orientation has enabled us to help individuals whose prognostic outlooks appeared to be anything but favorable. Our statistics over the past year show that twenty-two of twenty-six individuals in whom chronic depression had persisted for months and for years in some instances (despite traditional psychiatric intervention) responded to multimodal therapy by making significant gains in a mean of three months--usually consisting of one individual and one group meeting per week. Followup to date underscores the durability of our results.[47]

Lazarus uses the acronym "BASIC ID" to explain his model.[48] Each of the first five letters stands for an aspects of the client's personality. These aspects are behavior, affect, sensation, imagery, and cognition. The last two letters

---

[45] Arnold A. Lazarus, "Multimodal Behavioral Treatment of Depression, Behavior Therapy 5(July 1974): 553.

[46] Arnold A. Lazarus, Multimodal Behavior Therapy, Springer Series in Behavior Modification, vol. 1 (New York: Springer Publishing Co., 1976), p. 37.

[47] Arnold A. Lazarus, "Multimodal Behavioral Treatment of Depression," Behavior Therapy 5(July 1974): 553.

[48] Arnold A. Lazarus, 1976, p. 4.

represent factors in the client's environment, interpersonal relations and drugs, respectively. Lazarus expands the final term to encompass:

> ...the neurological and biochemical factors (which) obviously influence behavior, affective responses, sensations, images, cognitions, and interpersonal responses....We subsume these organic or physiological processes under the term 'Drugs,' as a generic symbol for this biological substrate....[49]

In using the model, Lazarus is concerned first with establishing the core conditions essential to therapeutic interaction. He then, after establishing rapport and eliciting some commitment from the client to enter therapy, begins to gather information in each modality. After two or three sessions, through questioning, guided imagery, and a "Life History Questionnaire,"[50] the therapist has a comprehensive picture of the client's problems, goals for treatment, and background. Using a systematic approach,[51] assessment, choice of therapeutic interventions and evaluation proceed.

Early in therapy the counselor works in the model, analyzing in depth each mode in turn. For example, working with the first mode, BEHAVIOR, the client is asked to identify those behaviors which he or she wishes to decrease or extinguish as well as those behaviors the client wishes to perform more frequently. The therapist may given the client an assignment to count the frequency useful in later evaluation. He would then choose intervention

---

[49]Arnold A. Lazarus, 1976, p. 6.

[50]See appendix B for the "Life History Questionnaire."

[51]See Table 1, following page.

TABLE 1[52]

FRAMEWORK OF THE LAZARUS MODEL

MODE	PROBLEM	INTERVENTION
BEHAVIOR: (Increase or Decrease)		
AFFECT (Feelings about behavior)		
SENSATIONS (Pleasant/ unpleasant)		
IMAGES (Precede or Follow Behaviors of Affects)		
COGNITION (Irrational Beliefs)		
INTERPERSONAL RELATIONS		
DRUGS (Appearance/ Physiological/ Complaints/ General Well-Being)		

[52]See Arnold A. Lazarus, 1976, p. 44.

strategies to assist the client to change the frequencies of target behaviors.

Similar strategies are followed with all aspects of the model. Throughout therapy the counselor uses the model to attend to all aspects of client personality and environment, paying particular attention to those which the client avoids or neglects in the counseling sessions.

Throughout therapy the counselor uses the model to attend to all modes. In each subsequent sessions the counselor arranges the material the client brings in within the structure of the model. Using the framework permits the therapist to provide on-going evaluation in each mode. Lack or growth along one parameter indicates to the therapist a need to reassess appropriateness of intervention strategies, investigate causes of client resistance, and change procedures. Finally, through such assessment, client and counselor may determine when the termination of therapy seems appropriate.

The model may appear cumbersome at first glance, requiring the counselor to diverge his attentions into too many areas. However, in practice, the model does systematize a counselor's work in evaluating and planning. Therefore, this multimodal approach appears to meet many of the criteria established in choosing a model for this study.

Research on Stress

Early Research on Stress

Hans Selye, pioneer stress researcher, first published his findings on a general adaptation syndrome (GAS), a reaction to stress, in 1936.[53] Twenty years later he again made public the results of his continued research.[54] Though earlier reports generated little attention in scientific circles and even less among the general public, in the ensuing twenty years, his wisdom has drawn much attention and resulted in a proliferation of stress research.

Selye defines stress as, "the sum total of wear and tear caused by any kind of vital reaction throughout the body at any one time."[55] A stressor is anything which produces this reaction. When an individual is under stress, he or she uses "adaptation energy"[56] in reacting to it. When an individual does not adequately respond or over-reacts to stressors, "diseases or adaptation"[57] may be produced.

Selye further notes that in dealing with stress the individual must find his or her (1) most successful methods of coping, and (2) optimum stress level. What is stressful to one person may not be to another. The level of stress which is stimulating

---

[53] Hans E. Selye, "A Syndrome Produced By Diverse Nocuous Agents," Nature, July 1936.

[54] Hans E. Selye, The Stress of Life (New York: McGraw-Hill, 1956).

[55] Ibid., p. 247.

[56] Ibid., p. 67.

[57] Ibid., p. 66.

to one person may be debilitating to another.

> "The average citizen would suffer just as much from the boredom of purposeless subsistence as from the inevitable fatigue created by the constant compulsive pursuit of perfection: in other words, the majority equally dislike a lack of stress and an excess of it. Hence each of us must carefully analyze himself and try to find the particular stess level at which he feels most comfortable....[58]

While individuals do develop their own coping patterns to stress, in general, persons deal with stress by avoidance, adaptation, or deviation. Each coping pattern takes its toll in an expenditure or adaptation energy. Learning to adapt to stress with the least damage to one's self and learning to eliminate or reduce stressors from one's life are tasks which are increasingly important to people in our society.[59]

Change itself is a stressor.[60] The more rapid the change, the more stressful its effects. As Knefelkamp noted, the task of the counselor is to assist the client in changing at a rate with which she can cope.[61]

Some research indicates that it is not the objective magnitude of a crisis that determines the degree of stress experienced by an individual, but rather whether he or she perceives that crisis as threatening self-esteem and ability to cope.[62]

---

[58] Hans E. Selye, Stress Without Distress (Philadelphia: J.B. Lippincott, 1974), p. 73.

[59] Ibid., p. 66.

[60] Alvin Tofler, Future Shock (New York: Random House, Bantam Books, 1970).

[61] Knefelkamp et al., p. 16.

[62] L. E. Hinkle and G. E. Wolf, quoted in Herbert Benson and Miriam Z. Klipper, The Relaxation Response (New York: Wm. Morrow, Avon, 1975), p. 61.

Women and Stress

Many writers suggest that women in our society are under particular stress as they seek to adjust to social changes. Roach cites the reentry woman who encounters stress in her family relationships and recommends that counselors recognize these "unique problems and interpersonal stresses."[63] Brooks suggests that counselors need to recognize that the confusion and depression that many reentry women experience are not neutrotic or deep-seated in nature. Rather, they may stem from situational stresses.[64] Knefelkamp et al., emphasize that pushing the client too rapidly through change generates excessive stress which blocks growth.[65] In relation the stress of change for women, they note:

> ...a relativistic view of one's role as a women may be accompanied by an enormous amount of disequilibrium. All the old rules and regulations suddenly disappear and the women is confronted with making her way in a world that offers a wide array of conflicting perspectives.[66]

Writing on the stresses that women race, Benson notes:

> Our rapidly changing world has necessitated many... adjustments. For example, before the women's liberation movement had filtered so far and deep, people were married under a set of unspoken agreements that society now questions and sometimes shatters. Today, women must reexamine their own roles and life-styles against conflicting expectations and suppositions. For the older

---

[63] Roach, pp. 86, 89.

[64] Brooks, p. 36.

[65] Knefelkamp et al., p. 16.

[66] Ibid., p. 17.

woman, the problems of reeducation and readjustment can be overwhelming.[67]

In a longitudinal study of how women cope with stress, one researcher found two coping patterns among women. One pattern, that of the self-defined woman, took an effective problem-solving approach to coping with stress; the socially-defined woman took an evasive or irrelevant approach. These patterns were consistent when the subjects were contacted after a fourteen-year period had elapsed.[68]

Methods of De-Stressing

Selye notes that the ways of reducing stress effects are a highly individual matter. Therefore, it is not surprising that highly diverse means of coping with the effects of stress have been suggested. Benson[69] reports that the physiological reactions to psychological stress can be overcome or diminished by the use of various relaxation techniques. Conversely, Harper[70] suggests that "jogging has implications for reducing tension for those who...operate under stressful situations, or who generate stress by the way they perceive experiences."[71]

Given the diversity of the clients' environmental stressors, internal and interpersonal stress-producers, and methods of reacting to stress, the counselor must be aware of the total

---

[67]Benson, p. 17.

[68]Abigail Stewart, unpublished study, reported in "Newsline," Psychology Today, June 1978, p. 116.

[69]Benson, pp. 26-27.

[70]Frederick D. Ha per, "Outcomes of Jogging: Implications for Counseling," Personnel and Guidance Journal 57(October 1978): 74-77.

[71]Ibid., p. 77.

life pattern of the client, including activities, methods of adapting, and the level of stress at which the client performs optimally.

The principle of "deviation" as defined by Selye is an important concept in understanding how people cope with stress. According to Selye, a second but different stress may produce more rapid recovery from the effects of a first stressor than would complete rest. Selye says the best guideline is to seek balance in activities. The person who has been under the pressure of intense mental effort might de-stress more rapidly by engaging in vigorous physical exercise than by sitting in front of the television set or trying to nap. On the other hand, when the individual is physically exhausted or exhausted by multiple stressors, rest is indicated.[72] Knowledge of this principle might help the counselor in guiding clients to de-stress.

---

[72]Selye, 1956, pp. 269-70.

CHAPTER III

THE PROGRAM

Selecting and Adapting the Model

Bases for Selection

Selection of the model was made on the basis of research findings on the counseling of women, criteria for selecting a model determined by client needs, and counselor needs.

According to the criteria thus determined, the model should:

1. Be applicable to the individual counseling situation
2. Be multimodal in nature
3. Permit attention to assessing and reducing client stress
4. Focus on the client rather than a method
5. Permit the counselor to systematically assess problems, choose interventions, and evaluate counseling outcomes
6. Permit systematizing of interventions
7. Accomodate a self-help component
8. Permit client to conceptualize growth through use of cognitive models
9. Permit teaching skills needed for continued client growth

Upon examination in the light of these criteria, the Multimodal Therapy Model appeared to come closest to meeting the criteria as well as being most amenable to adaptation to fit the remaining specifications. Adaptations of the

original model were made. The resulting model, because it permits and encourages the counselor to attend to the whole client, it called the "Wholistic Model." It may be represented by the acronym "BASIC IDS," with the final letter denoting the "Stress Factors."[73]

Adaptation of the model and the particular needs of the study necessitated the modification of the "Life History Questionnaire" used by Lazarus.[74] Expanded and reordered to facilitate information-gathering for the new model, this instrument became the "Self-Assessment Questionnaire."[75] The title reflects the counselor's emphasis on the client and her self-perceptions.

Using the Wholistic Model

Interrelatedness of all Modes

While using this model the counselor should remain aware that he or she is working with a whole person in whom the various modes are interrelated. This is evidenced by the fact that client gains in one modality may be accompanied by some degree of growth in other modes. This is also evidenced by fact that while attending to the various modes the counselor will become aware of similar responses across several modes. These patterns of similar responses facilitate problem identification. Following problem identification, the counselor may

---

[73]See Table 2, following page.

[74]See appendix A; also, Lazarus, 1976, pp. 219-231.

[75]See appendix B.

TABLE 2

THE WHOLISTIC MODEL

MODE	ASSESSMENT STRATEGIES	INTERVENTION STRATEGIES
BEHAVIOR	What behaviors to be Increased? Decreased? Correlates to? Quantify	Reinforce/nonreinforce Assertive training rehearsal techniques Graduated assignments Re-education
AFFECT	Perceived Pleasant? Unpleasant? Hidden? Correlates?	Role playing Relaxation training Desensitization Exaggeration
SENSATION	Pleasant? Unpleasant? Aware? Not aware? Hyperaware?	Relaxation Sensate focus Differential relaxation Physical activity
IMAGERY	Evokers of Pleasant? Unpleasant? Spontaneous? Guided?	Guided imagery Desensitization Empty chair technique Implosion (blow up) Eidetic, time-projection
COGNITION	Irrational beliefs: Shoulds? Perfectionism? External Attributions	Deliberate Rational Disputation Education-reading, disc. Corrective self-talk Reading assignments
INTERPER-SONAL RELATION-SHIPS	Which produce Satisfaction Dissatisfaction Express feelings? Receive feelings?	General relationship building Communication skills Exaggerated role-taking Analysis of transact.
DRUGS	Overall appearance Physiological com- plaints General fitness/ well-being	Nutrition, fitness info. Activity level changes Medical intervention Relaxation
STRESS FACTORS	Major past events Current stressors Reaction patterns Current Deviations	Reeducation Prioritize reductions Rehearsal of reactions Values clarification

decide to use the same intervention strategy to deal with problems identified in more than one mode, again because of the interrelatedness of symptoms.

The "Drugs" Mode

In general, the approach to using the Wholistic Model is similar to that of the Multimodal Therapy Model. There are, however, some differences.

Particular attention early in therapy to the last two modes may be particularly helpful with women clients. These modes are typically ignored by counselors who have been socialized to believe the mind/body dichotomy myth. However, since immediate gains may often be realized in these modes, thus increasing the client's sense of well-being, energy and motivation for effort in the other modes may often be the results. The following brief case history may serve to illustrate these points:

A client whose presenting problem was continued frigidity six months after a hysterectomy was found to be on a high dosage of Valium. The medication had been prescribed when the additional stresses of problems at work precipitated anxiety attacks and symptoms of depression. Discussion with her doctor about the possibility of reducing the dosage was recommended by the counselor because the high level of medication was apparently a factor in reduction of sex drive. A program of increased physical activities was advised along with elimination of one stress-producing factor in the client's environment, namely remediable conditions in the job setting. Immediately following these changes, the client's outlook began to improve. After only two

additional counseling sessions, during which work was done in all modes, the client had achieved the bulk of her counseling goals. Follow-up after six months showed gains were maintained.

Had the counselor hesitated to intervene in the "Drugs" modality, the positive outcomes for this client would doubtless have been delayed.

When working with a client in this mode, it is important to be aware of any clues that the client's neglect of her physical self reflects a subtle form of self-abuse motivated by fear, guilt, or feelings of lack of self-worth. Clues may be obtained from client statements and/or through guided fantasy in which the client visualizes her physical self. Under conditions in which the poor physical self-concept is generated by deep-seated fears of guilt, immediate change in this mode may not be possible. For example, obesity which results from deep-seated fears rather than simply lack of information about or inattention to proper nutrition may not yield quickly. In such cases, hypnotherapy or other long-term therapies may be necessary before a client approaches optimum physical fitness. Sometimes, however, the client may brush aside rather perfunctorily her concerns in this area, not because of resistance, but rather because she does not believe that the physical mode is an appropriate concern of counseling. The counselor's reassurance that everything that concerns the client is appropriate material in the counseling process will eliminate such reservations.

Concern on the part of the counselor that he or she lacks expertise in this mode may cause hesitation to intervene.

However, information is readily available and other professionals are usually ready to give assistance.

Needless to say, it is important for a counselor working in this mode to work closely with those in the medical profession. Most of the clients who came to this writer had recently had contact with a doctor for a checkup or treatment of some physical complaint. With the client's permission, the counselor could contact the doctor about the client. With emphasis that it is the doctor's patient under discussion, the counselor may report what activities he plans to introduce, elicit assurance that none of the planned activities are contraindicated by the client's medical history, and entertain any additional suggestions for treatment that the doctor wishes to make. The counselor will, of course, first obtain the client's permission to contact the doctor and will send a signed release form to the doctor, keeping one copy in the client's counseling file.[76]

All doctors whom this writer has contacted have been most cooperative and pleased to have another professional assist a patient in the adoption of a more healthful life-style. Insight into the patient's somatic condition have been generously given along with additional suggestions for interventions. Thus, while the counselor should not venture beyond his or her level of competence in this mode, assistance is readily available to augment expertise.

---

[76]See appendix C for sample forms

The Stress Factor

The stress factor represents the total pattern of stresses and adaptation patterns of the client. Working in this modality, the counselor first ascertains what stressors may have had a potent effect in the client's past. The counselor then investigates current sources of stress and the client's perceptions of them. It is important to elicit information about events which might usually be viewed as fortuitous as well as those of a negative nature. For example, a job promotion would appear to be a positive event. In reability, however, if the client views the event as a threat to ability to cope, the client may view the event as negative. The counselor must focus on what the event means to the client.

The counselor then examines the client's reaction patterns to stress. Whether the client typically responds to certain stressors in positive or self-defeating ways is important information to the counselor who is trying to understand the whole client.

Following this, the counselor examines the current stress level at which the client is functioning in relation to what the client considers to be her optimum stress level.

The final phase of working in this mode is to assist the client in finding appropriate ways of de-stressing herself. Client interest, personality, personal situation, and abilities must enter into the choice of activities to be investigated. In choosing activities, balance should be sought. The client whose daily life demands high levels of mental effort should explore physical activities or perhaps aesthetic experiences.

Examination of the client's total stress profile aids in the choice of appropriate activities.

Activities chosen by various subjects in this study have included yoga, jogging, dance, painting, different schools of meditation and relaxation, part-time employment, classroom or self-directed learning experiences, walking, and bicycling. Those who had been sedentary or were existing with high levels of physical tension were encouraged to seek a more active life-style. Those who lacked intellectual stimulation sought to upgrade their mental activities. A number found self-hypnosis helpful in producing relaxation and maintaining motivation.

Because these activities were carefully chosen for the individual client, they did not increase the stress level of the client as previous activities had done.

Core Conditions and Spontaneity

Lazarus[77] strongly emphasizes the need for establishing and maintaining the core conditions in the therapeutic relationship when utlizing the Multimodal Model. Ponzo[78] as well emphasizes that point. Perhaps, therefore, it is important to state emphatically that the framework of the Wholistic Model is only a guide to assist the counselor and should remain secondary to the client/counselor interactions.

---

[77] Lazarus, 1976, p. 54.

[78] Ponzo, pp. 415-516.

Using the model to plan work for the next session or to evaluate can be helpful. However, those plans and assessment should in no way be considered sacred, to be followed whatever the immediate needs, concerns, and self-assessments of the client. The model need not, and should not, inhibit spontaneity in counselor response.

Using the Self-Assessment Questionnaire

To assist the counselor using the Wholistic Model, the Life History Questionnaire[79] was modified. The new form, the "Self-Assessment Questionnaire,"[80] more closely follows the content of the Wholistic Model.

Lazarus usually gave his clients the questionnaire to take home and complete in order to say consultation time. However, believing that much important information--particularly from non-verbal cues--would thus be lost, the writer elects to administer the questionnaire in person. Care is taken to record verbatim and in detail all client verbal and non-verbal responses. Much information is thus obtained. Lazarus suggests that use of the questionnaire in initial sessions may inhibit spontaneity, and with this the writer concurs. Core conditions are established in the initial sessions and the questionnaire is administered at a later session. It thus provides new information including validation of previous clues and patterns of incongruence.

---

[79] See appendix A.

[80] See appendix B.

Case Studies Demonstrating Use of the Wholistic Counseling Model

Format of the Studies

Three case studies are presented in this study to demonstrate the use of the Wholistic Model in counseling Women. Discussion of the details of problems and intervention strategies in each mode will be accompanied by a table illustrating salient features of the processes. Evaluation or counseling outcomes will conclude each case history.

"Alice"[81]

Background

Alice presented herself to the counselor seeking relief of symptoms of acute anxiety. She fears she was regressing to a state of profound depression such as she had experienced previously. The first such episode had followed cancer surgery five years previously. The second occurence followed her daughter's suicide attempt. Alice was terrified that she could not prevent a relapse.

Alice's search for help had begun six months earlier. At that time she had awakened one morning and realized, she later reported, that there was no reason for her to get out of bed. However, obedient to her husband's commands and the counsel of her pastor, Alice had attempted to, as they said, "Shape up," and, "Get involved."

She had enrolled in a course at a local community college. The course, designed to assist adult women wishing to enter or

---

[81] In order to protect the privacy of subjects in this study, names were changed and descriptive data were, where possible, omitted.

re-enter the labor force, boosted Alice's confidence temporarily. Within three weeks she had sought and found employment. Elated, she had returned to class, only to be reprimanded by her teacher and told that she, "Wasn't ready to get a job yet." Alice's thin veneer of confidence crumbled under this criticism and she became increasingly anxious about her ability to perform at work.

In spite of her deteriorating emotional state, Alice had enrolled in two college classes in an effort to prepare herself for more satisfying and challenging employment.

Alice was very anxious and agitated at the beginning of the initial session. However, rapport was quickly established and a noticeable relaxation occurred. The client was highly motivated to cooperate with the counselor but was inclined to seek a dependent role in the relationship. Alice gradually became aware of this tendency to manipulate people to "take care of" her and was able to phase this behavior, along with others, out of her repertoire during the course of the counseling.[82]

Behavior

Although she was a woman of fity-six years, many of Alice's behaviors were childlike. She continually sought approval. Although timid and reticent, she sought verification of her every thought and idea in her relations with others. Criticism crushed her. When Alice began to become aware of these behaviors, their effect on others, and the payoffs she received from them,

---

[82]See Table 3, following page.

TABLE 3

THE WHOLISTIC MODEL USED IN THE

ASSESSMENT AND TREATMENT OF "ALICE"

MODE	PROBLEMS	TREATMENTS
BEHAVIOR	Excessive approval-seeking Manipulation, Disconnected speech, Withdrawal, Timidity, Reticence, Excessive sleeping	Nonreinforcement, Rehearsal techniques Assertive training, Assignment of social tasks
AFFECT	Worthlessness, "Bad girl," Guilt, Grief Shame	Role-playing, Positive self-imaging
SENSATION	Knot in stomach, Vertigo, Confusion, Numbness and pain in arm, Accelerated heartbeat	Relaxation, Self-hypnosis, Sensory awareness exercises, Arm exercises
IMAGERY	Stern father, Maimed and ugly self, punishing god	Positive imaging, Empty chair technique, Desensitization
COGNITION	"I am responsible for my daughter's problems," "I should perform perfectly," Everyone should approval of me."	Listing of accomplishments, Positive self-talk assignments, Disputing irrational
INTERPERSONAL RELATIONS	Submissive, Child-to-adult, No intimacy.	Analysis of transactions, Assertive traing, Role-playing, Relationship building assign., Communication ex.
DRUGS	Poor fitness level, No medication, Denture problem, Weight loss, Sleeplessness	Walking, Arm exercises, Positive imagery, Relaxation, Dental work
STRESS FACTORS	Mastectomy, Children leaving home, Daughter's problems, New job, classes, Loss of job she enjoyed	Talking with other mastectomy patients, New activities with husband, Positive self-statements

she was able to begin modification. Assertiveness training and practicing adult-to-adult communication were effective. Alice also enlisted her husband's help, explaining that she had to "learn to stand on her own two feet," and that she needed him to treat her as an adult. Lack of reinforcement of target behaviors by counselor and husband helped Alice decrease their frequency.

The behavior which most concerned Alice was her withdrawal. She frequently stayed in bed all day or returned there as soon as her husband had left for work. She went out socially very seldom. She had to force herself to attend classes at times and had little contact with other students in her classes. At church, which she attended with decreasing frequency, she avoided contacts with former friends. Alice was assigned daily activities which involved her making contact with others. She carried out the assignments faithfully, even when they became increasingly demanding. In the early period, Alice's high motivation to please authority even though she was reluctant to do so. After a time she was assigning herself tasks and later was spontaneously interacting with others without prior planning.

Affect

Alice reported few good feelings. She was aware, however, of strong feelings of worthlessness, of feeling that she was bad, or feeling ashamed, sad, and helpless. These, along with strong guilt feelings, often overwhelmed Alice. She retreated more and more into sleep. Noting her interest in some of the readings for a class she was taking, the counselor assigned

Alice the task of researching for the class whenever she wished to stay in bed or return to sleep. Alice soon became interested enough in the ideas presented to complete a paper which earned her praise from her teacher. Alice began to discuss more freely in class and to interact with other students. Later she seemed to take pleasure in learning for her own sake and seemed not to work solely for approval from teachers or other students.

Sensations

Alice was aware of not positive sensations but noticed numbness and sometimes pain in her arm, a "knot in her stomach," and heart palpitations, dizziness, and vertigo. She mentioned these sansations after considerable avoidance and seemed surprised that she felt these sensations. Relaxation training techniques were beneficial in reducing these symptoms. Alice learned to relax tense muscles and steady her breathing. The pain and numbness in her arm resulting in part from her radical mastectomy, decreased when Alice began doing the exercises her doctor had prescribed. Learning when these sensations occurred and what she was thinking or feeling at the time of their onset helped the client to eliminate or reduce the incidence of these unpleasant sensations. Sensory awareness activities helped Alice begin to become more in touch with her body.

Imagery

Alice was at first unable to recount any images. However, as the counseling progressed, she reported an image of herself as a bad little girl, maimed, ugly, and ashamed. She later added two images of her father: In the first, her father stood

with stern, frowning face and commanding finger, pointing while he intoned, "You be a good girl, Alice." Less often she imaged her father patting her on the head and smiling. Occasionally, the stern father image was of a Sistine God, in full beard and robes, threatening punishment for her sins.

Once Alice could face these images, talk to them, and replace the negative ones with more loving images, she began to progress rapidly. As she finally cut her long-dead parent down to life-size, Alice began to replace fear and depression with anger. For the first time in her memory, she began to admit and to express anger toward authority figures. When she was no longer fearful of receiving some horrible punishment, Alice, acting on her assertiveness training, began to take a less passive stance with others.

Cognition

The client had a number of irrational ideas about perfection. She was able to recognize them with some guidance, but had little success in dealing with them until she had laid to rest her ghostly images of authority figures.

At that point, disputation of irrational beliefs was effective in producing client gains. Alice began to change her belief system, accepting that she did not have to have everyone like her or approve of her. When she began to accept herself as fallible and to accept imperfect performances from herself, her feelings of being worthless began to recede. Her work for her classes became less compulsive and was motivated increasingly by an enjoyment of learning rather than fear of

appearing stupid or fear that others would not like her.

The idea that her cancer had been punishment for previous sins had haunted Alice. But as her disapproving images began to recede, the idea faded. Learning to identify her irrational thoughts and replace them with more rational cognitive responses was a significant step in her return to a high level of functioning.

Interpersonal Relations

Alice's interpersonal relations were the source of much of her discomfort. She related to her husband as a child. Her husband accepted, maintained, and preferred this authoritarian, fatherly role except when Alice's extreme dependence during a depressed episode made unusual demands upon him. Alice learned to analyze these transactions and to substitute more satisfying ones. As was previously noted, the husband cooperated when Alice sought a more adult-to-adult relationship with him and only infrequently attempted reversion to their previous parent-to-child patterns of interactions. As Alice became more assertive and more capable of observing their interactions objectively, she was able to disrupt his attempts to sabotage her growth and self-confidence.

Alice became increasingly adept at analyzing the interactions between herself and others as well. As a result she was able to change her way of relating to her manipulative younger daughter. Freed from the guilt she had been experiencing in the relationship, Alice was successful in encouraging the young woman to seek therapy.

Alice began to relate more and more to the people in her

classes. Her assertiveness training as well as communications skills gained through behavior rehearsal gave her confidence in her ability to do so.

Able to express her needs without whining, complaining or attacking, Alice began to build her relationship with her husband. She was relieved to learn, when they were finally able to communicate about things important to both of them, that he was not repulsed by her scarred body and cared very much for her. While they remained somewhat inhibited and reticent, there is more open and honest communication between them now than in the past.

Drugs

Alice's general physical well-being was poor. The sleeplessness, lack of appetite and activity during her periods of depression had taken their toll. A complete physical assured that there were no serious problems and that the cancer appeared not to have recurred. Alice's early conditioning about what was appropriate of "nice girls" and her negative feelings following her surgery had caused her to dissociate herself from her body. Initial attempts to elicit information in this mode at first produced nearly inaudible responses followed by efforts to change the subject. Once Alice was able to identify her irrational beliefs that the cancer had been a punishment for being bad, however, she was able to talk more freely about her physical self. She then began taking more interest in achieving a higher level of fitness.

The only exercise Alice considered seemly was walking. Daily evening walks with her husband aided communication as

well as physical well-being. Increased mobility and strength from exercising her damaged arm helped Alice to feel more kindly toward this part of her self. Relaxation techniques and encouragement to give greater attention to appropriate nutrition aided Alice in normalizing her food intake and sleep patterns. A trip to the dentist for replacement of ill-fitting dentures also boosted Alice's weight as well as her confidence in public. She had previously felt that she, "wasn't worth the money" new dentures would cost.

Stress Factors

Alice's general stress level had been high in earlier times. Alice liked her life that way. She had enjoyed running a household, teaching school, and being active in her church. She felt needed, wanted, and successful. However, after her children left home and she lost her job, her feelings of self-worth declined.

The deterioration of her relationship with her younger daughter, culminating in the daughter's suicide attempt, along with her cancer surgery, had further undermined her feelings of self-worth. It appeared to Alice that she had failed as a mother and as a wife. She could not make her daughter happy and could present only a maimed body for her husband's satisfaction.

She feared further failures in her job and in her classes. Thus, though Alice was existing in an environment with fewer stressors than before, her perception of how close she was to failing to cope with them was a self-fulfilling prophecy.

Left with a scarred body and mind and the conviction that she had nothing to offer anyone, Alice had gone to bed. Fortunately, therapy and the introduction of more meaningful activities helped her to recover.

Alice had apparently endured a time of high stress; major surgery, children leaving home, her younger daughter's problems. loss of a career. Yet it was not until she entered a period of too little activity that she had become unable to cope. But her first attempts failed. She lacked confidence to carry them through. The "ghosts" of past criticisms still haunted her. A single insensitive comment from her teacher had plunged her into depression. Her attempts to enrich her life, to add growth opportunities, were successful only when she began a balanced program of growth in all modes.

Evaluation

Alice began to glow, to joy in her learning and growing. She looked forward to each new day, convinced that it brought activities she enjoyed and was capable of handling. She was particularly pleased to report a deepening relationship with her husband which promised closeness and satisfaction in their maturing years.

Follow-up after fourteem months found Alice bubbling over with positive self-statements. "I am so happy," she spontaneously offered when encountering the counselor. Alice is currently well on the way to completion of a graduate degree program. Her relationship with her younger daughter is relatively tranquil and she enjoys an increasing number of

activities with her husband. Alice has coped capably with some stressful situations in recent months and has actively pursued a number of growth opportunities. Alice looks forward to a professional career, confident that she is capable of functioning in a more demanding situation.

"Gretchen"

Background

Gretchen had come to the counselor's office ostensibly to seek help for her son. She quickly admitted, however, that she was the one who needed help and was, "maybe going crazy."[83]

Speaking in thickly-accented English punctuated by much apparently purposeless non-verbal behavior, she revealed her concerns. Recently Gretchen had begun having "sells." The last had been so severe that she now feared a subsequent attack in public would result in fainting and embarrassment, even possibly death. The "spells" were characterized by heart palpitations, hyperventilation, dizziness, and a feeling of impending doom.

She had begun to withdraw more and more as the attacks increased in severity. Following the last episode, she had remained in her home for two weeks, afraid to go out and perhaps lose control.[84]

---

[83] See Table 4, following page.

[84] See Table 4, following page.

TABLE 4

THE WHOLISTIC MODEL USED IN THE

ASSESSMENT AND TREATMENT OF "GRETCHEN"

MODE	PROBLEMS	TREATMENTS
BEHAVIOR	Unclear, rapid speech, gestures, Hyperventilation, Fainting Withdrawing, Smoking to excess	Desensitization; Social contact assignments, with reward system; Positive imaging, Time projections
AFFECT	Fearful of death, losing control, drowning, Helplessness, Isolation, Hidden anger, Guilt	Exaggerated motions, Time projections and regressions
SENSATION	Palpitations, Vertigo Trembling, Breathlessness, Choking	Active relaxation, "NO" statements, Sensory awareness activities, Exercise -- dance
IMAGERY	Son on roof crying for her; Self drowning, Self Fainting, Dying	Time projection techniques, Implosion, Desensitization, Erase and replace with positive
COGNITION	Self-blame, I should have kept my children safe and happy, I should help myself	Rational statement practice, Positive statements
INTERPERSONAL RELATIONS	One friend, few acquaintances, Distance from husband, Controls and Manipulates son	Listening, communication skills training: Transaction analysis, Assertive Training, Relationship building
DRUGS	Sleeplessness, Tobacco use to excess, Tranquilizer prescribed, Muscular tension	Exercise, Tranquilizer
STRESS FACTORS	Son's problems, Emigration, War, Language and speech barriers, Perceives stress high; Desires moderate stress	Job, Class in oral comm., Time-projections, Rational disputings, Imaging Increased, Physical activity, Activities with spouse

Behavior

The problem behavior for Gretchen were withdrawal and her anxiety attacks. She also mentioned her chain smoking as a concern that she was "too nervous" to correct. Later Gretchen added that excessively rapid speech, enunciation difficulties, and erratic hand gestures were problems for her in communicating clearly.

Social contact assignments with a reward system helped Gretchen gradually emerge from her home. Establishing a hierarchy of situations from least to most threatening was the initial step of this intervention. Position imaging of herself coping with activities outside her home were added along with desensitization.

Affect

Gretchen was very much able to identify and communicate some of her feelings. She recognized that being fearful of death, especially by drowning or suffocating, and of losing control were old fears from long before her first "spell." She also expressed feelings of helplessness and isolation. One of her strongest feelings was guilt, particularly related to her belief that she was a failure as a mother. Although Gretchen had no trouble admitting these feelings, it was some time before she could own the anger she felt toward her older son and husband. Exaggeration of the motions with which she masked her anger helped Gretchen become aware of it.

Time-projection imaging of Gretchen as an older woman, still very much alive and undrowned, along with images of her

son as a successful, mature adult, helped ease her two primary fears.

Regression to early memories helped her recall a near-drowning incident in the surf. Knowing the origin of this previously unexplained fear seemed to given her some relief which was heightened by imaging herself swimming strongly to shore and striding away from the water

Sensations

Gretchen's sensations reinforced her fears. Feelings of breathlessness and suffocation heightened her belief that death or disaster was immenent. She had attempted to use passive relaxation and meditation to deal with these sensations. However, she reported that she was unsuccessful due to her inability to sit still long enough. Hypnosis could be used neither for relaxation nor for the regression activities mentioned previously because of the client's fear of losing control. Fortunately, active relaxation--alternately tensing and relaxing muscle groups--was beneficial as was exercise. When Gretchen expressed fear that exercise would precipitate a heart attack, she was, on the advise of her physician, given an exercise program which very gradually increased in level of demand and duration.

Gretchen was trained to become aware of the earliest sensations of increasing anxiety which she identified as stricture in the throat muscles with difficulty in swallowing. She was taught to short circuit this reaction by repeating the word "no" vigorously to herself while practicing active relaxation of other muscle groups.

Imagery

All of Gretchen's images were of disaster. Each time her older son caused her distress, the image of an actual event from his childhood flashed into her mind. The picture of the tiny boy trapped on the roof of a building appeared and was accompanied by feelings of guilt and thoughts of herself as a bad mother.

Gretchen was taught to visualize herself vigorously erasing this mental image and replacing it with one of her nearly-adult son as he now appeared.

The image of herself drowning had not been in her awareness until regression brought it into focus. Treatment of this image was previously described.

Gretchen's images of herself fainting or dying public were were treated with the implosion (blow-up) technique. Visualizing the events she feared carried to preposterously exaggerated conclusions appeared to help the original fantasies recede.

Cognitions

Gretchen's irrational beliefs were a tyranny of shoulds. "I should have been a perfect mother." "I should have made my children perfectly safe and happy." "I should be able to help myself."

In addition, she kept hypothesizing disaster and blaming herself for every unfortunate event that did occur to anyone in her family, even if the occurence was a result of another person's choices or actions.

A friend had tried to help her dispute these beliefs; but

while she could repeat the words, Gretchen did not really believe their content. The irrational beliefs returned strongly when the images reappeared.

Gretchen was given assignments requiring her to make positive self-statements and rational statements such as, "My children love me, even when I am not perfect," and "I am a good mother." The truth of these statements was fully accepted only after the images no longer appeared.

Interpersonal Relations

Communication barriers posed problems for Gretchen when she attempted to make friends in the small community to which they had moved. Her heavy accent and too rapid speech were difficult to comprehend. Her gestures were distracting. She was thought to be "different" and "odd" by the other women. Exercises to control rate and to clarify enunciation were initiated. Assignments to practice in social situations produced increased confidence. Later she chose to begin an oral communication class at an area community college and took a part-time job so that she might make contacts with other persons.

Her relationship with her older son was least satisfactory to Gretchen. Each used manipulation to control the other, and her son regularly fulfilled her predictions of disaster. Playing on his mother's guilt, he was able to evade responsibility for his actions. As Gretchen tried to maintain tight control over him, he grew increasingly evasive and this increased her worry. Letting her son out of her sight was fearful to Gretchen; he might fall off the roof.

Gretchen was taught to analyze the communications between her and her son. She eventually owned that she tried to control him by using threats of a heart attack. She also came to recognize how he evoked her guilt. The relationship improved slowly for a time as they began to communicate more honestly. As growth in other modes permitted Gretchen to let go of her control, their relationship became considerably less strained.

Gretchen had invested so much of her time and energies into her mother role that she had little left for her role as a wife. But when she was reminded that all of her children would soon have left the family home, leaving only her husband for companionship, she ought to rebuild the relationship.

Gretchen had for many years been the "good soldier" to whom her military husband gave orders. He was in total command of her life and was her interpretor and protector. Though he protected her from the outside world, he also prevented her growth. Only recently had she become aware of some resentment toward him and a desire to change her role. She was confused by ambiguous feelings; she wanted him to protect her but she wanted freedom to grow. She wished he would participate more in parenting, yet did not wish to lose her own control of the children.

As she came to recognize these feelings toward her husband, she began to voice her resentment and finally her anger at what she perceived as his lack of concern for their children and for her own needs. Likewise, she came to understand that her ways of coping with problems, with hysteria and tears drove him away.

Assertive training helped Gretchen learn to communicate her needs more honestly to her husband. She also learned to listen to him, as he began to voice his own resentments that she had time only for the children and never for him. Gretchen made an effort to set aside time just for him and found that the children survived without her when she left them to fend for themselves for an evening.

Gretchen and her husband began to talk to each other about themselves and their future together. Her assignments for this time were to avoid talking about the children, make no forecast of doom, and to listen with care to her husband's concerns.

Gretchen had satisfying relationship with her older daughter and one friend. Both had somewhat nontraditional lifestyles and value systems and were sounding boards on which Gretchen could try out her dreams of a new life for herself. Their continued support was valuable to her during her period of growth.

Drugs

Gretchen scheduled a physical exam after her severe anxiety attack. The doctor said she had no heart trouble but probably had an overactive thyroid. A tranquilizer was prescribed and lab tests were scheduled for a later date. As she left, Gretchen expressed fears that she was going crazy. The doctor assured her that she had physical, not emotional problems.

When the results of the lab tests revealed no physical cause of her symptoms, Gretchen experienced shame and embarrassment. She could not even control her own body, she thought.

Gretchen at first refused to take the tranquilizer and insisted that she would learn to control her body without putting

any chemicals into it. She expressed fears of becoming dependent upon medication. However, after further consultation with her doctor, she agreed to take the drug for a brief time, but only until she could cope on her own. After use of the drug as needed for three weeks, she was able to cope with sufficient ease to discontinue its use.

Her problems with sleeplessness disappeared with an increase in activity and discontinuation of her afternoon rest periods. As her frightening images and fears of death receded, so did her physiological symptoms.

Stress Factors

Gretchen was by far her own most powerful stressor. Terrified by her old fears and lacking activities to occupy her, she constantly hypothesized disaster. It was not the actual events but her perceptions of what had happened or might happen that she reacted to.

Gretchen's early years had been full of reall stress. She had survived a war in her homeland. She had survived transplantation to a new country as a young bride. Isolated by lack of knowledge of language and customs, by her husband's absences, and frequent moves, she had coped. Her husband's expectations were those which she had been raised expecting to fulfill. She knew her place and functioned well as the mother of two children until her momentary absence gave her son the opportunity to explore the rooftop of the hotel where they vacationing. Gretchen returned to see the tiny figure of her son clinging desperately to the edge of the roof and calling for

her. She hadn't forgiven herself. For the ensuing thirteen years she had tried to be the perfect mother, protecting him from all harm.

Now as her son approached adulthood, Gretchen could no longer protect him. When the problems common to an immature adolescent befell him, she panicked. Her son, like her body and her mind, was out of control.

Gretchen benefited from learning problem-solving skills and transactional analysis. She became able to analyze a situation and to attack it productively, particularly after she had been freed of her terrifying images. In one session, freed of her old fear of drowning, and feeling a growing ability to cope, she remarked that she "finally had her head above water."

Gretchen operated optimally at a moderate stress level. She like to be active but no overwhelmed. Some of the activities which she had chosen to diminish stress, such as meditation and afternoon rest/reading periods had actually increased her stress level. As Gretchen learned that she had a need for considerable physical activity and that such activity actually benefited rather than endangered her, she learned to control her stress level.

When Gretchen began to set aside some time in the afternoons just for herself, to read and rest and listen to her beloved classical music, she began to suffer from an increase in tension and sleeplessness. She was encouraged to make this an active time. A book on dance guided Gretchen in the active enjoyment of her music while reducing her tension level, improving physical well-being, and permitting normal sleep patterns.

A balance of varied activities chosen with her own needs in mind enabled Gretchen to achieve the level of stress at which she functioned optimally.

Evaluation

Follow-up after six months found Gretchen enjoying her life. She was comfortable in her part-time job, having made new friends. She was looking forward to the up-coming vacation she and her husband were taking alone together. Asked about her son, she shrugged and remarked that he was learning to solve his own problems. Noting that her older daughter had just been accepted into medical training at Harvard, Gretchen commented that she had done pretty well as a mother.

The trembling, erratic gestures, and rapid speech were gone. The new Gretchen looked confident and comfortable. There had been no recurrence of her anxiety attacks. She reported that she still smoked but had cut her consumption in half.

"Bella"

Background

Bella came to the counselor's office because she was contemplating a mid-life career change. A strikingly attractive and perfectly groomed woman, she attempted to project an image of relaxed competence. Had it not been for frequent inappropriate laughter and a certain rigidity, she would have succeeded.

Bella related that she hoped her skills, graduate degree, and job experiences would help her to find a more challenging job than the one she now held.

Aside from help with a resume and information about careers which might interest her, she needed no assistance, she said.

Nevertheless, Bella made another appointment and reported that she had made progress in job hunting and had an upcoming interview. She was looking forward as well to attending a national convention at which she was to speak. She loved travel and hoped to find a job which would permit her to do so. Bella's restlessness and nervous laughter increased as she talked. Finally, when confronted, she admitted that she was deeply troubled but had difficulty asking for help. The smile which had remained fixed on her face during both sessions faded and she began to weep.[84]

Behavior

The only behavior Bella wished to change, she said, was the weeping. It had started recently and happened at inconvenient times. Later Bella admitted that she didn't like her laugh. After a pause she noted that she often smiled or laughed when she wasn't feeling happy.

Bella said she was bothered by impulsive behavior; sometimes she did things that she later regreted. For example, she noted that she often became involved in organizations in which she had no real interest in order to avoid boredom or painful or disliked tasks. After talking in this vague way for some time, she mentioned that her two younger sons were results of such impulses. She had acted impulsively as her older sons began to leave the family and she perceived that she was no longer needed.

---

[84]See Table 5, following page.

TABLE 5

THE WHOLISTIC MODEL USED IN THE

ASSESSMENT AND TREATMENT OF "BELLA"

MODE	PROBLEMS	TREATMENTS
BEHAVIOR	Weeping, Avoidance, Nervous Laughter, Impulsiveness	Establish priorities, Problem-solving techniques, Desensitization, Reward system, Hypothesizing, Implosion
AFFECT	Emptiness, Being cheated, Fear of Failure, Anger, Fear of being Dumb, Loneliness, Guilt	Dialogue among selves, Empty chair, Reality-testing
SENSATION	Headaches, Restlessness, Dissociation, Rigidity	Exercise, Sensory awareness exercises, Guided Imagery
IMAGERY	White-gloved lady, Glamorous career-woman, Slovenly, dumb housewife	Regression, Dialogue among selves, Value-seeking
COGNITION	Absolutisms, I should be happy, He should value me, I should perform perfectly	Values clarification, Rational disputation, Time projections, Reading assignments
INTERPERSONAL RELATIONS	Frigid toward husband Sexually active outside marriage	Fair-fight training Communication training, Reinforcement, Contract, Non-demand pleasuring
DRUGS	Too little physical activity, Alcohol, Self-medication, Sleeplessness	Increased physical activity--jogging, exercise and diet course; Regulation of schedule, Relaxation
STRESS FACTORS	Too little challenge, Lack of decision-making skills, Role conflicts	Job change, Caribbean cruise, Training in decision-making skills, Conflict resolution

Although Bella tended toward vagueness about some of her concerns, she was taught to establish priorities in her activities. As a result, she dropped out of two organizations which no longer held any real interest for her.

Establishing a baseline of the frequency of the occurence of inappropriate laughter made Bella aware of how frequently this behavior occurred. She had almost eliminated it entirely by the time the first week was up.

Establishing a reward system and breaking unpleasant tasks up into smaller components helped Bella deal with her avoidance behaviors and to complete disliked tasks. For example, she disliked clerical tasks and would delay performing them until their sneer numbers required a full day's work. Breaking them into smaller units of work to perform more frequently and rewarding herself for the completion of each unit was effective. However, Bella soon dropped the reward system, stating that she was an adult and didn't "need bribes."

Bella for the most part, presented what appeared to be rather superficial behaviors as concerns and seemed to continue to need to convince the counselor that she was capable of correcting these few minor flaws herself.

Affect

Bella talked at length about her anger with her husband. He was insensitive and his expectations of her were ridiculous. Bella mentioned that she sometimes felt lonely because there were few other women with similar interest in her community. Bella was afraid of failing. She needed to prove that she was

intelligent and free to use her talents. She was angry when her husband did not commend her for her achievements. When an article she had authored appeared in a professional journal, she was proud but furious with her husband's lack of praise.

Bella feared growing old before she had proved herself in a career. She feared being old and ugly and no longer attractive to men. Above all, Bella feared being dumb and dull. Her attention to her dress and appearance consumed much time and effort. Each trip or event required days of shopping for a new wardrobe. She was concerned that her daytime image be chic and professional, her nighttime image glamorous and seductive.

Talking to an imaginary husband in the empty chair in the counselor's office helped Bella learn to express the anger she felt toward him. Time projection techniques were used to help her face the fear of aging. Seeing herself as still attractive and competent in her advanced years enabled her to realize that her mature years could be pleasant.

She began to dare to express feelings honestly after she learned to hypothesize outcomes of doing so. She built a hierarchy from least to most threatening until she had become desensitized to most of the threatening situations. Implosion reduced the threatening nature of the final items and she was able to complete all tasks. The mask which had prevented her making friends began to give way to honest expression.

Counseling had progressed for some time before Bella owned the hidden affect of guilt. Though she professed to

be "liberated" and a "feminist," in reality she was still very much enslaved to the guilt engendered by her failure to live up to her husband's ideal, the role for which she had been prepared as a young woman and which she now so vehemently denied.

Sensations

Bella related to her body as an object. She posed, rather than moved. Her body was a mannequin from which she dissociated. Bella lived in her head, behind her smiling mask. She was not a "sex object" to be desired for her body; she was an intelligent woman who wished to be admired for her intelligence, she said. Yet at the same time she dressed provocatively or dramatically.

Bella did report frequent incapacitating headaches at rather frequent intervals. The tension which produced them was evident in the rigidity of her body as she posed publicly.

Relaxation and simple exercises helped Bella reduce the incidence of headaches to some extent. Sensory awareness exercises helped her to regain awareness of the rest of herself.

Imagery

Bella's images were of extremes. One was of a glamorous career woman presiding in the sumptuous board room of an unknown corporation then dashing away to fly across the country to an important meeting. This image of the nationally-renowned managerial woman represented the kind of success she said and thought she wanted.

Another image was of an overweight woman in soiled robe and slippers, hair disheveled and face bare, sitting in front of a television set and eating candy. This was the undisciplined,

stupid wretch Bella feared she would become if she acceded to her husband's wishes and stayed home to be "just a housewife." This was the image that so repulsed Bella that she had avoided all women who did not work outside the home, believing that deep down they were as repulsive as her image.

The third and most significant image Bella evoked was of a prim, conservatively-dressed woman in white gloves smiling vacuously and submissively as her husband chastised her. Bella's inappropriate laughter returned when she described this image. Bella was regressed to her first encounter with this figure. After a long pause she described a young woman she had known in college who had smiled and submitted in just that manner as her sorority sisters had every so politely criticised her every aspect. Bella realized that the white-gloved image was the one she had sought to attain when she had attended a women's college and prepared for a traditional woman's career which she had at that time hoped would be temporary and definitely secondary to her real career as wife and mother.

Bella saw three women, the one she had once hoped to become, the one she still consciously hoped to become, and the one she was terrified of becoming. It was a long painful process before Bella began to integrate aspects of these three selves. Many diaglogues ensued before she learned to respect and to like some qualities in each of these personages. Dialogues among her young traditional self, her desired self, and the self she feared to become helped Bella reduce the guilt which had deeply troubled her.

Bella's loneliness had been a result of fear generated by these images. She had stated that there were no women in her community who were "liberated" as she was. She had despised women who were "just housewives," judging them harshly for their intellectual laziness and willing submission to what she felt was a demaining role. But as she integrated the images, she came to admit that she had been afraid to become friends with such women lest their lives appear so attractive to her that she would give up her ambitions and succumb to laziness.

Cognition

Bella believed anything could be solved by an intelligent person. Therefore, she was reluctant to admit her difficulty in solving her problems. She disliked what she thought of as stupid, emotional women who couldn't think for themselves.

Bella's thinking was in absolutes. One role was all wrong, unthinkable; another should be perfect. Unfortunately, reality did not seem to fit this model. Her role did not make her happy. Therefore, there must be something wrong with her. She feared that deep down she was as stupid and slovenly as the women who repulsed her. Maybe her husband was right; maybe her accomplishments were a meaningless waste of time.

At this point Bella was introduced to some readings about so-called mid-life crises. She recognized herself and her husband in some of the examples and gained some understanding of his viewpoint.

Bella's irrational beliefs were that she should perform her role perfectly, that only one role was right, that she had been deceived in her early years into believing that the

traditional role was the only right one, that her husband should be sensitive, that she should be happy. Rational disputings helped Bella deal with the irrational beliefs. Values clarification helped her begin to sort out what was really important for her happiness.

Bella was shocked to discover, on reading about cognitive development, that her absolutist adherence to the feminist viewpoint contained biases and stereotypical attitudes as narrow as those of persons whom she criticized for their narrow viewpoint. As Bella's three women began to merge into a cherished image of many viewpoints, she was freed to accept a more moderate stance.

Interpersonal Relations

Bella was contemplating a divorce when she first came for counseling. She no longer wished to endure her husband's "crudeness, insensitivity and lack of warmth." She consulted with a lawyer about how to procede to ensure adequate financial support for herself and her minor children. Bella felt that she had invested many years of being a good wife and she meant to protect her investment. She talked to her sons about her plans. Their attempts to dissuade her from such a course caused her some consternation and she lost her resolve. She could not uproot the two young boys, the products of her panicky and impulsive behavior years earlier when her three much older sons began to leave their home and who perceived that she was no longer needed. Her older sons were saddened and disapproving. She couldn't leave them to face their father's tempers and insensitivity without her presence to heal the hurts. She stayed.

She and her husband no longer shared a bedroom, and she rebuffed any attempts at intimacy, but she stayed. To all outward appearances, she was still a good wife.

She thoroughly enjoyed the attentions of her two current lovers, however, and they, for a time, reassured her that she was attractive. They were sensitive; they listened to and applauded her successes. They showered upon her the attention she craved. Through one lover she vicariously experienced the exciting life in the executive suite that she thought she wanted for herself. The other was kind and thoughtful, helping her to feel wanted, loved and needed.

Her executive lover stopped calling. She made excuses that he was out of the country, that he was busy. Finally she admitted that neither had made any real commitment to the relationship. She finally admitted, too, her fears that she had not been interesting enough to him.

Bella felt a blow to her self-esteem when she discovered that her husband had an intimate relationship with his secretary. She was furious. She hastened to explain that she was not angry that he was having an affair but that he had chosen someone so "uninteresting, unattractive, and dull."

Bella began "negotiating" with her husband. If he would give up his extra-marital relationship, she would do the same. The shouting lasted all night.

Bella began to undergo fair fight training. She managed to communicate some of the principles to her husband. They talked and listened with gradually diminishing hostility. She learned that he was proud of her accomplishments but still

preferred warmth to brilliance. He learned that she appreciated the secure financial situation he had built for his family through his genious and years of hard work.

They expressed their needs, negotiated, and signed a contract. Each carried out the terms of the uneasy truce, including positive reinforcement of desired behaviors. Gradually their physical relationship was rebuilt through non-demand, pleasuring techniques. Bella wanted her husband to travel with her; he wanted her to stay home with him. Each was satisfied that the terms were met. Each is too proud to go back on the promises, although they occasionally regress until gentle reminders re-establish the desired effect.

Drugs

Bella's fitness level was poor. Her only exercise had been occasional dancing. She drank heavily at times and took sleeping pills during periods of greatest stress.

When Bella quit her job she began a diet and exercise course in a distant town. She began to regain a sense of well-being such as she had not experienced for many years.

The rigidity and headaches were no longer problems and her restlessness was assuaged by adequate exercise.

Moderating her schedule along with gains in other modes made pills and alcohol unnecessary and unattractive. The weeping which had initiated her therapy was no longer a problem.

Stress Factors

Bella wanted a demanding pace and a challenging lifestyle. She felt trapped in a dull marriage, a dull job, and a dull town. She was terrified that she herself was growing old and dull.

She performed well in stressful situations involving deadlines, public speaking, politics, and public relations. The most stressful situations for her were those involving decision-making. The conflict among value systems prevented Bella's being decisive in her own problem solutions. She generalized the anxiety response to other contexts. She made impulsive decisions or sought to rationalize or avoid decisions. Training in decision-making skills and values clarification helped in this area.

Bella quit her undemanding job and eventually secured a part-time job in an urban area to which she could commute occasionally. Although not the dream job she had sought, it did provide opportunities to use her skills at the state level and exposure to intellectually stimulating colleagues.

Bella made friends with a neighbor with whom she now regularly jogs. The woman, "just a housewife," is now more real than Bella's stereotyped images.

Evaluation

Follow-up after six-month and one-year intervals found Bella fucntioning well. She and her husband had taken a Caribbean cruise and were communicating fairly openly and honestly. Bella dropped by the counselor's office in paint-spattered causal clothes between errands. She sat relaxed and comfortable as she related her recent experiences. They had made friends on the cruise and were expecting to receive them as houseguests shortly. There was no smiling mask, just a comfortable, mature woman who was accepting the compromises that she had made of her many conflicting expectations.

CHAPTER IV

SUMMARY OF THE STUDY

Conclusions

Problem

The problem was to develop a counseling model which would provide time-efficient and effective counseling services to meet the needs of rural women. Criteria were established for selection of a model and for evaluation of outcomes.

Procedures

Research on previously-tested methods of counseling women as well as that on other counseling models was examined. Models were evaluated on the basis of established criteria. Discussion of use of the model was presented with three case studies illustrating its application. Evaluation of outcomes at the conclusion of therapy and on a follow-up basis concludes each case.

On the basis of evaluation of subject's counseling gains, the following conclusions may be drawn:

1. The Wholistic Model is a time-efficient and effective means of providing counseling services to rural women.

2. Clients met counseling goals in less than six months and reported maintenance of gains at follow-up intervals of six and twelve months.

Recommendations

This study is limited in scope to twenty rural women.

However, the writer believes that the results warrant further investigation. Therefore, the following recommendations are offered:

1. Further study with a larger, randomly selected, sample with pre- and post-testing of counseling gains on bases other than client self-report and counselor judgment should be implemented.

2. The potential of the Wholistic Model for use with other populations and in group counseling should be examined.

3. Exploration of the use of the Wholistic Model by counselors, therapists, and other helping persons in self-assessment and self-renewal to avoid professional "burn-out" should be initiated.

4. Counselor educators should acquaint counselors and counselor trainees, through preservice and inservice experiences, with use of the Wholistic Model to structure their varied counseling techniques into a usable package.

APPENDIX A

LIFE HISTORY QUESTIONNAIRE

Purpose of this questionnaire:

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In scientific work, records are necessary, since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time.

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. *No outsider is permitted to see your case record without your permission.*

If you do not desire to answer any questions, merely write "Do not care to answer."

* * * * * * * * * *

Date _____

1. *General*

Name: _____

Address: _____

_____

Telephone numbers: (day) _____ (evenings) _____

Age: _____ Occupation: _____

By whom were you referred? _____

With whom are you now living? (list people) _____

_____

Do you live in a house, hotel, room, apartment, etc.? _____

Marital status: (circle answer)

Single; engaged; married; remarried; separated; divorced; widowed.

If married, husband's (or wife's) name, age, occupation?

_____

Religion and Activity:

a) In childhood _____

b) As an adult _____

2. *Clinical*

a) State in your own words the nature of your main problems and their duration:

b) Give a brief account of the history and development of your complaints (from onset to present):

c) On the scale below please estimate the severity of your problem(s):

mildly upsetting _____

moderately severe _____

very severe _____

extremely severe _____

totally incapacitating _____

d) Whom have you previously consulted about your present problem(s)? _____

e) Are you taking any medication? If "yes," what, how much, and with what results? _____

_____

3. *Personal Data*

a) Date of birth: _____ Place of birth: _____

b) Mother's condition during pregnancy (as far as you know): _____

_____

c) Underline any of the following that applied during your childhood:

Night terrors	Bedwetting	Sleepwalking
Thumb sucking	Nail biting	Stammering
Fears	Happy childhood	Unhappy childhood

Any others:

d) Health during childhood?

List illnesses:

e) Health during adolescence?

List illnesses:

f) What is your height? _____ Your weight? _____

g) Any surgical operations? (Please list them and give age at the time)

h) Any accidents?

i) List your five main fears:

1.

2.

3.

4.

5.

Page 74

j) Underline any of the following that apply to you:

headaches	dizziness	fainting spells
palpitations	stomach trouble	anxiety
bowel disturbances	fatigue	no appetite
anger	take sedatives	insomnia
nightmares	feel panicky	alcoholism
feel tense	conflict	tremors
depressed	suicidal ideas	take drugs
unable to relax	sexual problems	allergies
don't like week-ends and vacations	overambitious	shy with people
can't make friends	inferiority feelings	can't make decisions
can't keep a job	memory problems	home conditions bad
financial problems	lonely	unable to have a good time
excessive sweating	often use aspirin or painkillers	concentration difficulties

Others: Please list additional problems or difficulties here.

k) Underline any of the following words which apply to you:

Worthless, useless, a "nobody," "life is empty"

Inadequate, stupid, incompetent, naive, "can't do anything right"

Guilty, evil, morally wrong, horrible thoughts, hostile, full of hate

Anxious, agitated, cowardly, unassertive, panicky,

k) (cont.)

Ugly, deformed, unattractive, repulsive

Depressed, lonely, unloved, misunderstood, bored, restless

Confused, unconfident, in conflict, full of regrets

Worthwhile, sympathetic, intelligent, attractive, confident, considerate

Others:

l) Present interests, hobbies, and activities: _____

_____

m) How is most of your free time occupied? _____

_____

n) What is the last grade of school that you completed? _____

o) Scholastic abilities; strengths and weaknesses: _____

_____

p) Were you ever bullied or severely teased? _____

q) Do you make friends easily? _____

Do you keep them? _____

4. *Occupational Data*

a) What sort of work are you doing now?

b) Kinds of jobs held in the past?

c) Does your present work satisfy you? (If not, in what ways are you dissatisfied?)

d) What do you earn?_____

How much does it cost you to live?_____

e) Ambitions _____

Past: _____

_____

Present: _____

_____

5. *Sex Information*

a) Parental attitudes toward sex (e.g., was there sex instruction or discussion in the home?)

b) When and how did you derive your first knowledge of sex?

c) When did you first become aware of your own sexual impulses?

d) Did you ever experience any anxieties or guilt feelings arising out of sex or masturbation? If "yes" please explain:

e) Any relevant details regarding your first or subsequent sexual experience:

f) Is your present sex life satisfactory? (if not, please explain)

g) Provide information about any significant heterosexual (and/or homosexual) reactions:

h) Are you sexually inhibited in any way? _____

6. *Menstrual History*

Age at first period? _____

Were you informed or did it come as a shock? _____

Are you regular? _____ Duration: _____

Do you have pain? _____ Date of last period: _____

Do your periods affect your moods? _____

7. *Marital History*

How long did you know your marriage partner before engagement?

How long have you been married? _____

Husband's/Wife's age _____

Occupation of husband or wife: _____

a) Personality of husband or wife (in your own words):

b) In what areas is there compatibility?

c) In what areas is there incompatibility?

d) How do you get along with your in-laws? (This includes brothers and sisters-in-law)

Page 76

How many children have you? _____

Please list their sex and age(s). _____

_____

e) Do any of your children present special problems?

f) Any relevant details regarding miscarriages or abortions?

g) Comments about any previous marriage(s) and brief details.

8. *Family Data*

a) Father:

Living or deceased? _____

If deceased, your age at the time of his death? _____

Cause of death? _____

If alive, father's present age? _____

Occupation: _____

Health: _____

b) Mother:

Living or deceased? _____

If deceased, your age at the time of her death? _____

Cause of death? _____

If alive, mother's present age? _____

Occupation: _____

Health: _____

c) Siblings:

Number of brothers: _____ Brothers' ages: _____

Number of sisters: _____ Sisters' ages: _____

d) Relationship with brothers and sisters:

1) past: _____

_____

2) present: _____

_____

e) Give a description of your father's personality and his attitude toward you (past and present):

f) Give a description of your mother's personality and her attitude toward you (past and present):

g) In what ways were you punished by your parents as a child?

h) Give an impression of your home atmosphere (i.e., the home in which you grew up. Mention state of compatibility between parents and between parents and children).

i) Were you able to confide in your parents? _____

j) Did your parents understand you?_____

k) Basically, did you feel loved and respected by your parents?_____

If you have a step-parent, give your age when parent remarried:_____

l) Give an outline of your religious training:

m) If you were not brought up by your parents, who did bring you up, and between what years?

n) Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?

o) Who are the most important people in your life?

p) Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"?

q) Are there any other members of the family about whom information regarding illness, etc., is relevant?

r) Recount any fearful or distressing experiences not previously mentioned:

s) List the benefits you hope to derive from therapy.

t) List any situations which make you feel calm or relaxed.

u) Have you ever lost control (e.g., temper or crying or aggression)? If so, please describe.

v) Please add any information not tapped by this questionnaire that may aid your therapist in understanding and helping you.

9. *Self-Description* (Please complete the following):

a. I am a person who _____

b. All my life _____

c. Ever since I was a child _____

d. One of the things I feel proud of is _____

e. It's hard for me to admit _____

f. One of the things I can't forgive is _____

g. One of the things I feel guilty about is _____

h. If I didn't have to worry about my image _____

i. One of the ways people hurt me is _____

j. Mother was always _____

k. What I needed from mother and didn't get was _____

l. Father was always _____

m. What I wanted from my father and didn't get was _____

n. If I weren't afraid to be myself, I might _____

o. One of the things I'm angry about is _____

p. What I need and have never received from a woman (man) is _____

q. The bad thing about growing up is _____

r. One of the ways I could help myself but don't is _____

10. a) What is there about your present <u>behavior</u> that you would like to change?

b) What <u>feelings</u> do you wish to alter (e.g., increase or decrease)?

c) What sensations are especially:

1) pleasant for you?

2) unpleasant for you?

d) Describe a very pleasant image of fantasy.

e) Describe a very unpleasant image of fantasy.

f) What do you consider your most irrational thought or idea?

g) Describe any interpersonal relationships that give you:

1) joy

2) grief

h) What personal characteristics do you think the ideal therapist should possess?

i) How would you describe an ideal therapist's interactions with his clients?

j) What do you think therapy will do for you and how long do you think your therapy should last?

k) In a few words, what do you think therapy is all about?

11. With the remaining space and blank sides of these pages, give a word-picture of yourself as would be described:

a) By yourself

b) By your spouse (if married).

c) By your best friend

d) By someone who dislikes you

APPENDIX B

SELF-ASSESSMENT QUESTIONNAIRE

General Information

Name:_____ Date:_____

Address:_____ Telephone:_____

Occupation:_____ Age:_____ Birthdate:_____

Birthplace:_____ Referred by:_____

Patient's Story

What have you come for help with?_____

_____

_____

_____

How long have you had this problem?_____

Give me a brief history of this problem:_____

_____

_____

How upsetting is this problem:

___Mildly? ___Moderately severe? ___Very severe? ___Extremely?

What have you previously done for this problem?_____

_____

What were the results?_____

_____

What could you do without the problem that you can't do now?_____

_____

Behavior

What are some of the things you do that you would like to stop doing?

_____

_____

What are some things you would like to be able to do that you can't do now?_____

_____

How do you feel when you do these things you don't want to do?_____

_____

How do you feel when you can't do the things you would like to?_____

_____

Affect

Which of these feelings apply to you?

___Anger	___Depression	___Panic
___Conflict	___Inferiority	___Happy
___Inferiority	___Loneliness	___Anxious

What feelings do you not feel that you would like to feel?_____

_____

What are your five main fears?

1._____ 2._____

3._____ 4._____

5._____

Sensations

Which of these apply to you:

___Headaches	___Palpitations	___Tension
___Unable to relax	___Excessive sweating	___Dizziness
___Stomach trouble	___Fatigue	___Nausea
___Bowel disturbances	___Tremors	___Others

What is the most pleasant sight you have ever seen?_____

_____

What is the most unpleasant sight you ever saw?_____

_____

What sensations are especially pleasant for you?_____

_____

What sensations are especially unpleasant for you?_____

_____

Imagery

Describe a very pleasant image of fantasy_____

_____

Describe an unpleasant image of fantasy_____

_____

Tell me about a scene from your childhood:_____

_____

Tell me one of your fantasies about the future:_____

_____

_____

Give a word picture of yourself as you see you:_____

_____

_____

Give a word picture of yourself as seen by your spouse:_____

_____

_____

Give a word picture of youself as seen by your best friend:_____

_____

_____

Give a word picture of yourself as seen by someone who dislikes you:

_____

_____

Cognition

What do you consider your most irrational thought or idea?_____

_____

When you are feeling unhappy, what do you say to youself?_____

_____

_____

When you are feeling happy, what do you say to yourself?_____

_____

_____

What thoughts have you had that frightened you?_____

_____

_____

Interpersonal Relationships

What is your marital status? _____S _____E _____D _____W

If married, how long?_____What is your spouse's name?

_____ Age?_____ Occupation?_____

With whom are you now living?_____

On a scale of 0 to 10, with 0 being very unhappy and 10 being very happy, where would you rate your marriage?_____

What sort of work do you do now?_____

_____

What kind of work have you done in the past?_____

_____

What do you like about your present work?_____

_____

What would you like changed about it?_____

_____

How do you get along with your coworkers?_____

_____

Tell me about your childhood home:_____

_____

How did your father treat you?_____

_____

How did your mother treat you?_____

_____

Were you ever bullied or severely teased?_____

_____

Do you make friends easily?_____

Do you keep them?_____

What were parental attitudes toward sex?_____

_____

When and how did you derive your first information about sex?_____

_____

_____

Did you ever experience any anxiety or guilt feelings arising out of sex or masturbation?_____

_____

Is there anything important about your first or later sexual experiences that you should tell me?_____

_____

Is your present sex life satisfactory?_____

_____

Are you sexually inhibited in any way?_____

Describe your spouse's personality:_____

_____

In what ways are you compatible:_____

_____

In what areas is there incompatibility:_____

_____

How many children do you have?_____Names and ages:_____

_____

Do any of your children present special problems? _____

_____

Is there anything else I should know about your family?_____

_____

What would you like to tell your spouse that you have hidden?_____

_____

When someone hurts you, how do you react?_____

_____

When someone pleases you, how do you respond?_____

_____

What relationships give you pleasure?_____

_____

What relationships give you pain?_____

_____

How would you like to change any of these relationships?_____

_____

Drugs

What was the condition of your mother's health during her pregnancy with you?_____

How was your health during childhood?_____

Any operations?_____ Age?____ Any accidents?_____

_____ Age?____ Any illnesses?_____

How was your health during adolescence?_____

Any operations?_____ Age?____ Any accidents?_____

_____ Age?____ Any illnesses?_____

How is your health today?_____

Height?_____ Weight?_____ Any surgery recently?____

_____ Age?____ Accidents?_____

Age?____ Is there anything else I should know about your health?

_____

Stress Factors

What is the worst thing that ever happened to you?_____

_____

What are some other bad things that happened to you?_____

_____

How old were you when they occurred?_____

What is the best thing that ever happened to you?_____

_____

What other good things have happened to you?_____

_____

Describe the situations in which you feel most comfortable:_____

_____

In what situations do you feel least comfortable:_____

_____

When something bad happens to you, what do you do?_____

_____

When something good happens to you, what do you do?_____

_____

What other things have you not yet told me about that I need to know in order to help you?_____

_____

Self-Description

I am a person who_____

All my life_____

Ever since I was a child_____

One of the things I feel proud of is_____

It's hard for me to admit_____

One of the things I feel guilty about is_____

If I didn't worry about my image_____

Mother was always_____

What I needed from mother and didn't get was_____

Father was always_____

What I wanted from my father and didn't get was_____

One of the ways people hurt me is_____

If I weren't afraid to by myself, I might_____

One of the things I'm angry about is_____

What I need and have never received from a woman(man) is_____

_____

One of the ways I could help myself but don't is_____

_____

If I knew I'd never be caught, I'd_____

Something I've never told anyone is_____

Expectations of Counseling

What do you think counseling can do for your?_____

How long do you think you will need counseling?_____

What reservations do you have about counseling?_____

_____

What final things would you like to tell me?_____

_____

APPENDIX C

LETTER TO MEDICAL PROFESSIONAL

Dear Dr._____:

Your patient, _____, has sought my
(client's name)
professional help in dealing with _____.
(problems)

I am recommending the activities listed below to assist her in improving her condition. If any of these activities are contra-indicated by anything in your patient's medical history and/or present condition, please so advise.

You may be assured that any information sent to me will be kept in strictest confidence. A medical release form signed by your patient is enclosed for your protection.

Activities:_____

_____

Should you wish to recommend additional procedures or give additional information, I will be happy to accept your assistance. Together we can provide the best care for your patient.

Thank you very much.

_____
(counselor's signature)

MEDICAL INFORMATION RELEASE FORM

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I hereby give permission for release of any pertinent medical information to _____ by _____
counselor's name doctor's name.

I understand that this information will be shared for treatment purposes only and will be dealt with in a confidential manner.

_____
signature of patient

_____
date

NOTE: Patient should sign two copies.

BIBLIOGRAPHY

Avery, Donna M. "The Psycho-Social Stages of Liberation." I.G.P.A. Quarterly No. 63(Winter 1977): 36-42.

Barrett, Carol J.; Berg, Pamela I.; Eaton, Elaine M.; and Pomeroy, E. Lisa. "Implications of Women's Liberation and the Future of Psychotherapy." Psychotherapy: Theory, Research and Practice 11(Spring 1977): 11-15.

Beck, Aaron T. and Greenberg, Ruth L. "Cognitive Therapy With Depressed Women." In Women in Therapy: New Psychotherapies of a Changing Society, pp. 113-131. Edited by Violet Franks and Vasante Burtle. New York: Brunner and Mazel, 1974.

Berry, Jane B. "The New Womanhood: Counselor Alert." Personnel and Guidance Journal 51(October 1972): 105-9.

Brooks, Linda. "Supermoms Shift Gears: Re-entry Women." The Counseling Psychologist 6(1976): 33-37.

Broverman, I. K.; Broverman, D. M.; Clarkson, F. E.; Rosenkranz, P. S.; and Vogel, S. R. "Sex-role Stereotypes and Clinical Judgments of Mental Health." Journal of Consulting and Clinical Psychology 34(1970): 1-7.

DeVolder, John; Storey, John; Sheets, Carl; and Hummers, Jo An.. "Personal Renewal through Assertive Training." Macomb, Illinois, 1976. (Mimeographed.)

Eason, Jean. "Life Style Counseling for a Reluctant Leisure Class." Personnel and Guidance Journal 51(October 1972): 127-32.

Farmer, Helen S. "Increasing the Career Options Considered by Girls and Women." I.G.P.A. Quarterly no. 63 (Winter 1977): 28-33.

Fitgerald, Larine E. "Women's Changing Expectations...New Insights, New Demands." The Counseling Psychologist 4(1973): 90-95.

Harper, Frederick D. "Outcomes of Jogging: Implications for Counseling." Personnel and Guidance Journal 57 (October 1978): 74-77.

Holrody, Jean. "Psychotherapy and Women's Liberation." The Counseling Psychologist 6(1976): 22-28.

Jakubowski-Spector, Patricia. "Facilitating the Growth of Women Through Assertive Training." The Counseling Psychologist 4(1973): 75-86.

Joley, Barbara. "Final Report: Study of Recruitment of Adult Women Students. Charleston, Illinois, 1974. (mimeographed.)

Kirsch, Barbara. "Consciousness-raising Groups as Therapy for Women." In Women in Therapy: New Psychotherapies of a Changing Society, pp. 326-54. Edited by Violet Franks and Vasante Burtle. New York: Brunner and Mazel, 1974.

Knefelkamp, L. Lee; Widick, Carole C.; and Stroad, Barbara. "Cognitive-developmental Theory: A Guide to Counseling Women." The Counseling Psychologist 6(1976): 15-19.

Lazarus, Arnold A. "Multimodal Behavioral Treatment of Depression." Behavior Therapy 5(July 1974): 549-554.

Lazarus, Arnold A. Multimodal Behavior Therapy. Springer Series in Behavior Modification, no. 1. New York: Springer Publishing Co., 1976.

Newcomb, T. M. The Acquaintance Process. New York: Holt, Rinehart and Winston, 1961.

"Newsline." Psychology Today, June 1978, p. 116.

Ponzo, Zander. "Integrating Techniques from Five Counseling Theories." Personnel and Guidance Journal 54(April 1976): 415-19.

Roach, Rose Marie. "Honey, Won't You Please Stay Home." Personnel and Guidance Journal 55(October 1976): 86-9.

Schlossberg, Nancy K. "A Framework for Counseling Women." Personnel and Guidance Journal 51(October 1972): 137-43.

Selye, Hans E. "A Syndrome Produced by Diverse Nocuous Agents." Nature (July 1936).

Selye, Hans E. The Stress of Life. New York: McGraw-Hill, 1956.

Selye, Hans E. Stress Without Distress. Philadelphia: J. B. Lippincott, 1974.

Sherman, Ruth G. and Jones, Jane H. "Career Choices for Women: The New Determinants." Journal of College Student Personnel 17(July 1976): 289-94.

Tofler, Alvin. Future Shock. New York: Random House; Bantam Books, 1970.

U. S. Department of Labor. Bureau of Labor Statistics. U. S. Working Women: A Databook. Bulletin, 1977.

Vetter, Louise. "Career Counseling for Women." The Counseling Psychologist 4 (1973): 54-67.

Warren, Linda W. "The Therapeutic Status of Women's Consciousness-raising Groups." Professional Psychology 7(May 1976): 132-140.

Westervelt, Esther Manning. "A Tide in the Affairs of Women: The Psychological Impact of Feminism on Educated Women." The Counseling Psychologist 4(1973): 19-26.

Whiteley, Rita M. "Women in Groups." The Counseling Psychologist 4(1973): 27-43.