# COUNSELING AIDS



### **COUNSELING AIDS**

GLENN V. RAMSEY

©, 1970 THE HOGG FOUNDATION FOR MENTAL HEALTH



THE UNIVERSITY OF TEXAS, AUSTIN, TEXAS 78712

#### **PREFACE**

The four articles included in this publication, "Counseling Aids," were originally developed as a set of lectures which were presented at a series of seminars on counseling organized for chaplains of the United States Air Force by The Hogg Foundation for Mental Health at The University of Texas between 1956 and 1966. The general aim of the presentations was to translate some of the current theories and principles of counseling into language and procedures which would be more easily useful for lay counselors than those given in the technical-professional publications. Eventually three of the four lectures were published in journals. A widespread demand for the articles was subsequently made by other counselors such as clergymen, psychiatric nurses, social workers, and occupational therapists. The continuing request for the reprints led to their combined presentation in this publication, "Counseling Aids." It is hoped that this publication will serve as a helpful guide to the ever-increasing number of counselors who are attempting to meet man's pressing needs and alleviate some of the vexing problems which confront him.

The articles are in one sense "dated" as they were written between 1956–1966 and reflect the interest of the period in person-to-person counseling. Since then professional attention, including that of the writer, has been turned toward a greater focus on group counseling and psychotherapy. However, these articles do have a relevancy to current counseling practice, as the predominant pattern is still a one-to-one relationship. Many counselors first engage in individual counseling and then proceed to group work. This is understandable, as many of the same basic concepts and principles inherent in the one-to-one setting are often a part of the more complex group therapy process.

The writer is grateful to the Hogg Foundation for the professional opportunity to participate in the Chaplain Seminars and to develop the four lectures presented in this publication. A special word of thanks is due Dr. Bernice Milburn Moore, who gave personal and professional support to my work with the project and contributed many thoughtful and helpful suggestions along the way. The writer alone, however, is responsible for material presented herein. He recognizes that many of the viewpoints and interpretations reflect his own beliefs and biases in the emerging field of counseling and psychotherapy.

The Hogg Foundation for Mental Health of The University of Texas was requested in the summer of 1955 by the then Chief of Chaplains, Major General Charles I. Carpenter, the United States Air Force, to develop a seminar on counseling for Protestant chaplains from all Air Force Commands within the nation. Catholic chaplains attended a similar course at Catholic University in Washington, D.C. This seminar was finally designated Counseling on Human Factors for Air Force Personnel. One full year was utilized for the development of the curriculum and for the recruitment of faculty from the various branches of The University of Texas System. Each of the teaching staff was a member of the Graduate Faculty of The University of Texas at Austin or the equivalent in stature.

A planning and administrative committee for the seminars was developed with membership of Dr. Robert L. Sutherland, director, the Hogg Foundation; Dr. Henry A. Bowman and the late Dr. Harry Estill Moore, professors, Department of Sociology, The University of Texas at Austin. Dr. Bernice Milburn Moore served as director of the seminars. Dr. Glenn V. Ramsey, consulting psychologist and the author of this pamphlet was associate director. During the ten years of the cooperative relationship, over 500 chaplains, ranking from fledgling first lieutenants to full colonels of many years of service, spent thirty days each on the University campus and received a 120-hour intensive course within this time schedule. At the close of the eighth year, Dr. Henry A. Bowman became director of these seminars when Dr. Moore moved into the position of associate director, Philanthropy in the Southwest, a program funded by a \$550,000.00 grant from the Ford Foundation to the Hogg Foundation. However, she continued to teach until the close of the contract with the Air Force in 1966.

During the years of these seminars, with two sessions each year, Chaplain, Colonel, Ormonde Stanley Brown, Commandant of the Chaplain School, Lackland Air Force Base, served as liaison between the Office of the Chief of Chaplains and the Hogg Foundation. After his departure for Europe in June 1963, Chaplain, Colonel, Delvin Ressell became liaison when he assumed the duties of Chaplain Brown at Lackland. The Chaplain School has since been moved to the Air University at Maxwell Air Force Base in Alabama.

In 1966, the Office of the Chief of Chaplains decided on another course of instruction in counseling for chaplains through theological seminaries. Though the actual seminars at The University of Texas in Austin are no longer in existence, the relationship of the Foundation to former seminar members and the Office of the Chief of Chaplains remains close.

This pamphlet of essays by Dr. Glenn V. Ramsey stands as a living reminder of these seminars to all who studied or taught in them. Moreover, it offers recognition to a man who gave of his time, energy, and talents with great generosity for some ten years that others working with younger men and their families in the military might be given personal and group support through counseling procedures. To Dr. Ramsey, the Hogg Foundation expresses its sincere gratitude.

Following his retirement from the United States Air Force in 1968, Chaplain, Colonel, Ormonde Stanley Brown joined the staff of The Hogg Foundation for Mental Health as Assistant for Administration. From him, comments are added from the point of view of the chaplains with reference to these

seminars and the contribution to them by Dr. Ramsey.

Bernice Milburn Moore
Executive Associate
The Hogg Foundation for Mental Health

2

The content of these published lectures was forged in the crucible of raw experience and is of enduring quality. Fads and fashions pass or perish. The insights of these lectures will long inspire and inform chaplains whose ancient role remains the "cure of souls." They, more than any others, are the counselors of men—men engaged in the ultimate tests of life, whose "givens" encompass the entire gamut of poignant experience in crisis, combat, loneliness, despair and often death.

Of those efforts that constituted training for chaplains during the period covered by these lectures, the Chaplain Seminars will be remembered as an outstanding and unique experience. Nothing else that was attempted ever evoked so consistently generous a response from its benefactors as did this ten-year innovative Hogg Foundation undertaking. This fact shall remain as an imperishable tribute to the great spirit of its early director, Dr. Bernice

Milburn Moore, and the practical wisdom, inspired leadership and "know-how" of Dr. Glenn V. Ramsey, associate director.

Ormonde Stanley Brown
Executive Associate
The Hogg Foundation for Mental Health

### CONTENTS

Preface

Introduction

The Initial Counseling Interview 9

Aids for the Counselor in Detecting Early Maladjustment 20

Role Relationships in Counseling 35

The Referral Task in Counseling 54

#### \*THE INITIAL COUNSELING INTERVIEW

\*Reprinted, with permission, from Pastoral Psychology, November, 1966

Many counselors have asked themselves at times what should be the primary goal of the initial counseling session. This issue has been debated by specialists for many years. Today two rather divergent viewpoints exist regarding the purpose of the first counselor-counselee interview. One group sees the general objective of the initial interview as serving primarily a diagnostic purpose.\* Counselors with this orientation use the period for gathering facts on which they can formulate some type of diagnostic opinion regarding the counselee's problem. On the other hand, another group of counselors perceives the primary goal of the initial interview as a time in which a helping relationship is to be established. It is this latter viewpoint which serves as the primary focus for this paper. First, attention is given to the general characteristics of the two approaches in order to distinguish one from the other. This

<sup>&</sup>lt;sup>o</sup> Diagnosis as used herein means an assessment of a human situation through critical perception and not its medical usage meaning the recognition of disease by its symptoms.

is followed by a presentation of a set of guiding principles which appear to support movement of the counseling process toward the relationship goal.

The two different goals for the initial interview as cited previously, while not mutually exclusive, do have some rather basic differences. Those who endorse the diagnostic viewpoint fundamentally believe that a diagnostic opinion must be rendered before any truly effective helping or therapeutic effort can be initiated. Therefore, a counselor's principal duty in the initial interview is to collect the necessary data on which he can render an evaluative opinion. This belief places the initiative and responsibility for conducting the interview squarely in the hands of the counselor. He is viewed as an expert who, with his special knowledge and skills, is invested with the authority for conducting the interview and procuring the needed data. Often such counselors have a more or less pre-set diagnostic plan to guide the interview. To obtain the requisite data they make use of such techniques as the question-answer method, administration of tests, examination of records and reports, gathering of a case history, and interviewing. The role of such a counselor therefore, is a very active one; the role of the counselee a very passive one in which he answers, submits to, and complies with the wishes of his counselor. In all such efforts the main objective of these counselors is to secure the necessary data on which to render at least a tentative, if not a definitive, diagnostic opinion.

Counselors who see the goal of the initial interview as one in which a helping relationship is to be established hold to a somewhat different set of assumptions and principles. They do not believe that a diagnosis is a necessary prerequisite to the giving of help, support, and other therapeutic acts. This latter group assumes it is possible and advisable to initiate a helping relationship beginning with the first contact with the counselee. In order to work toward this goal of establishing a helping relationship, these counselors believe the initiative and responsibility for conducting the interview is more or less equally shared by both parties. Counseling to them is essentially a collaborative, cooperative, jointly determined enterprise. The expert role of the diagnostically oriented counselor is therefore replaced by a "co-equal" model

of interpersonal relationship.

As a consequence of the assumptions held by the relationship counselor, the very nature of the counseling process takes on different characteristics.

In general, it becomes a more open, spontaneous, dynamic type of interaction. Since no pre-set plan determines the topics or areas to be covered, the counseling agenda arises more or less spontaneously from the interaction which evolves between counselee and counselor. The counselor plays a listening and supporting role in contrast to the active and directive role inherent in the diagnostic type of interview. The counselee's role, on the other hand, becomes a more active and creative endeavor than the passive and dependent stance required in the other setting. The counselee at the end of the initial interview in a helping relationship should feel that he has had the opportunity to develop the session around issues and problems he has chosen, and that the counselor has accepted him as a person, problems and all. This, in turn, tends to give the counselee a heightened sense of his own personal worth, dignity and competence.

Several well-known counselors have taken the position that the primary goal of the initial interview is the establishment of a relationship with the counselee. Wolberg (1954) states his views on this point when he writes, "The beginning stage of therapy has for its principal objective the establishing of a working relationship with the patient. This is the crucible in which personality is changed. Without such mutuality, there will be no therapeutic progress. Because the working relationship is so vital to success in therapy,

all tasks must be subordinated to the objective of its achievement."

Gill, Newman, and Redlick (1954) also make several comments which are congruent with the relationship goal for the initial interview. They write, "In the psychiatric interview the interpersonal relationship is focal. The psychiatrist must deal adequately with this relationship to insure that the desired communication between therapist and patient shall take place." In the same publication, these authors conclude, after making a survey of the literature concerning the initial interview, ". . . there is a strong move in the direction of changing the initial interview from a diagnostic fact gathering, to a diagnostic evaluation of interpersonal relationships."

The goal of establishing a counseling relationship with a counselee is certainly not perceived as universally needed by all persons calling upon counselors for help. Persons may have other needs or problems in which the counselor may render a service. For example, the individual may simply want information about how to seek a job, how to enroll in a university, how to find a lawyer, and so on. Others may ask for a counselor's help but the coun-

selor recognizes that such persons really require the services of some other professional such as a minister, physician, welfare worker, psychiatrist, or teacher. In such cases the counselor has certain evaluative duties and referral responsibilities, but a discussion of these activities is beyond the scope of this paper. Assuming, however, that the counselee is in need of, and seeks, a counseling relationship, then the question arises of how this goal may be effectively achieved.

CUDING PRINCIPLES. If the goal of the initial interview is seen as the establishment of a helping or therapeutic relationship, then the following principles might serve well as guides for the counselor seeking the attainment of such a goal:

1. The counselor must recognize that his relationship with the counselee was to some degree structured or determined long before the two of them actually came face-to-face.

Among such determinants are cultural stereotypes, role concepts, and technique expectancies. Most counselors are familiar with existing stereotypes associated with clergymen, psychologists, psychiatrists, social workers, and other professionals. Sometimes such stereotypes may act as blocks to effective counseling, other times they may be helpful. Also influencing counseling structure are the preconceived beliefs concerning the counselor's role in the helping process. Counselees may perceive his function in many ways. He may be seen as an expert answer giver, a "problem solver," a "father confessor," or an arbitrator. Another set of preconceptions involves the expectancies a counselee holds concerning techniques he will encounter once he enters counseling. He may anticipate the use of tests, question-answer procedures, free association, dream analysis, confessionals, and so on. Such ideas held by counselees are often not wholly consistent with those of the counselor concerning his role and function. Therefore, one of the first responsibilities of a counselor is to recognize any incompatible ideas between counselor and counselee and to work toward more congruent aims. A common understanding concerning goals, roles, and functions is imperative if a collaborative effort is to be achieved in the counseling process. This is a necessary structuring job which falls primarily upon the counselor.

2. The counselor recognizes that the social reception of the counselee and

the physical atmosphere of the office setting have a recognizable influence

on the counseling relationship.

In general, the counselee should be given about the same reception as any stranger would receive when invited into a home. He should be given a welcome, recognized by name, told he is expected, invited to be seated, asked to smoke if he desires, and recognition made of his appointment. The reception should be genuine, courteous, and dignified. These receiving responsibilities often fall upon the outer office staff, and it is the counselor's responsibility to train his staff to meet acceptable standards. The counselor is also obligated to extend the same personal and courteous reception to the counselee when they first come face-to-face in the office. This usually consists of an appropriate introduction, and such statements as "Come in," "Please be seated here," "You may smoke if you wish," and so on.

The physical arrangements and furnishings of the room also spell out certain types of counselee-counselor relationships. For example, does the counselor sit behind a desk or across a coffee table? Are there on display numerous diplomas, licenses, professional books, pictures of the "great," and other furnishings which give the counseling setting an authoritarian atmosphere? Counselors primarily interested in helping relationships attempt to minimize the use of authority symbols to define roles and to depend more upon their abilities and professional skills to clarify competencies and relationships. The social reception by staff and counselor, the office furnishings and arrangements, the physical comfort of the counselee, and other such factors do have a definite influence upon a counselee's perception of the counselor and play a definite part in establishing the nature of the counseling relationship.

3. The counselor recognizes that the counselee is likely to experience some

degree of anxiety when he first comes face-to-face with the counselor.

Such anxiety may arise from several sources. In the first place, the counselee is likely to be disturbed over his personal problems and difficulties or he would not be seeking help. Some apprehension is likely to arise if he is coming face-to-face with the professional counselor for the first time. The situation is largely unknown and possibly perceived as threatening to him. Another source of worry may be the possibility that he will be given a negative evaluation or diagnosis regarding his condition. Finally, he may fear encountering social stigma if his friends and community learn that he has sought counseling assistance. The counselor should recognize the possibility, or actual

signs, of anxiety at the outset of an interview and take whatever steps he can to reduce these stress factors. Often openly recognizing and talking about the counselee's situational anxiety will do much to alleviate his discomfort. If more deep-seated types of anxiety are apparent, they must be met by more intensive counseling methods which are likely to extend far beyond the initial interview.

4. The counselor attempts to give the counselee ample encouragement and opportunity to express his thoughts and feelings during the initial interview.

The troubled person comes to "tell his problem" to the counselor. So, let him. Often a counselee is blocked or discouraged from presenting his difficulties because the counselor prolongs the social reception, interjects irrelevant conversation, attempts to establish "rapport" with set procedures, reveals immediately some evaluative opinions, reviews his professional qualifications, or frequently interrupts the counselee. Usually the counselee is more than willing to talk about his difficulties if invited to do so and then given the opportunity. Often all that is needed to start a counseling session is the assurance of the confidence of the record and a simple opening statement such as, "What would you like to talk about?"

In those few cases where the counselee has difficulty starting to talk about his problems, the counselor can often help him over the impasse by focusing attention and discussion on his communicative difficulties. Usually in such cases there is a history of inability to talk about oneself. Often the counselee welcomes a chance to talk about his verbal blocks even though it may not be the main problem which brought him to counseling. In most cases, after a counselee has been able to express himself on one issue, it is easier for him to discuss others.

The relationship counselor will usually find that he plays primarily a listening role during the initial interview. He attempts to "tune in" on what the counselee is saying, both cognitively and emotionally. If the counselee's first interview experience is one in which he feels he has been given ample time to express himself, then he usually feels it was a good session and some progress has been made.

5. A counselor tries during the initial interview to avoid imposing a too narrow structure, or a too directive influence upon the counseling relationship. A basic belief here is that the counselee is best able to lead or direct the

interview to the most important and relevant issues concerning his problems or difficulties. Therefore, the counselor tries to structure the relationship so the counselee has maximum latitude for discussion of any topic, to express any opinion, and to release any feeling he wishes. In order to achieve this breadth of structure, relationship counselors often make use of "broad" or "open" questions. Such questions are largely non-restrictive in nature and allow a broad spectrum of responses. Examples of such questions are: "Would you like to tell me what brought you here?" "Do you wish to tell me about your problems?" "Can you tell me about how you feel?" "Are there other things you wish to discuss?" Too often the inexperienced counselor asks the opposite type of question which limits the counselee's responses to some specific fact. Examples of such "narrow" or restrictive types of questions include: "Where were you born?" "Do you go to church?" "What is your wife's name?" "Where do you work?" "What college did you attend?" These are more or less "data hunting" questions which usually call for short answers. After such data are collected they often turn out to have little relevance to the real issues and problems a counselee faces. The counselee usually feels, after answering a barrage of such specific questions, that he has been interrogated, processed, or examined, and often wonders how all this procedure will really help him.

The open or broad type question allows the counselee to move into those issues and topics which he feels are important. Such interactions also allow him to control the extent and depth of involvement he feels capable of handling at any given time. The data which do emerge from these broad questions usually seem more dynamic, meaningful, and relevant than those obtained from direct inquiries. In general, most counselees who have been given the latitude of directing the interview into channels of their own choosing report

the outcome of the initial interview as meaningful and helpful.

6. The counselor is urged, especially during the initial interview, to keep an open hypothesis and to avoid a premature evaluation or diagnosis of the

counselee's problem.

Often it is hazardous to the helping process to make a quick diagnosis or evaluation. Once the counselor feels he knows "the problem," he may tend to freeze to it and *make* it the problem. Seldom does a troubled counselee face only one specific problem. Usually there is a constellation of difficulties of which the problem is only the one most visible. Also, the first problem per-

ceived may be a more or less surface one. A counselee usually needs more time than is provided by the first interview to develop the psychological strength and confidence to look at deeper or more basic difficulties.

The counselor who jumps into the diagnosis or evaluation often becomes trapped into looking only for data to support his opinion. He then becomes blind to other data which, if noted, spell out other problems. A counselor also gets a false sense of doing something for the counselee by making an evaluation or diagnosis, when in reality he has done little to help. The counselor who is driven by his own anxiety to get a sense of closure by forming an evaluation opinion often traps himself. This act may reduce his own personal discomfort, but it does little to aid the counselee. The skilled counselor is seen as a person who isa ble to tolerate an ill-defined and ambiguous situation especially during the initial interview so that he can keep himself open to the wide range of psychological data which unfolds during the counseling interaction.

7. The counselor tries to avoid making condemning and evaluative judgments of the counselee's behavior.

Usually the person in trouble is all too aware that much is wrong with his way of life and his relationships to others. Often he is sorely burdened with a sense of guilt and wrong-doing. The counselor who indulges himself in making moral judgments of the counselee does little to help him and may, by such an act, actually intensify his problems. A counselee is always quick to sense if a judgmental attitude is held toward him and usually interprets such a set as a rejection of him as a person. Once this occurs, a block usually arises which impedes or destroys any helpful assistance the counselor may have been able to give. What a counselee wants and needs is simple acceptance of himself as a person—a person who is burdened with life's problems and difficulties. A counselor's role is to try to understand rather than judge the counselee's dilemma, and to give whatever assistance he can to help the person reorganize his life along more constructive and rewarding patterns.

The counselor who tries to hold to a non-judgmental attitude certainly does not have to take the position of condoning any of the harmful acts which the person has committed. Neither does he need to feel he should absolve the erring person from the responsibility he should rightfully bear for his own conduct. A counselee is usually aware that much of his behavior may not be acceptable to the counselor when judged on his personal value system. Yet

the counselee sees embodied in the professional counselor a different set of values which are associated with his professional role as a helper, and not those which guide the counselor's own private life.

8. The counselor tries to develop the counseling agenda around issues and feelings released by the counselee.

The assumption here is that the counselee is best able to judge what are his most significant and relevant problems and what he is best able to handle psychologically. The counselor, by closely following the data given by the counselee, seems to be pursuing the best leads for uncovering and dealing with significant problems. This principle seems to facilitate the counseling process and move it into desirable directions and outcomes. The counselor's role is one of tuning in and responding to the data which a counselee presents.

At times, a counselor may possess information about the counselee derived from outside sources. Interjecting such knowledge into the counseling session can often be disruptive because it may turn out to be misinformation; concern issues the counselee does not want to face at the time; raise questions concerning the confidence of the record; turn the counseling into a less productive direction; or introduce irrelevant issues. Basically, such a maneuver takes the initiative and responsibility away from the counselee and forces him to deal with issues which the counselor feels are important rather than those the counselee wishes to develop. There are times, however, when outside administrative actions are a part of the total counseling problem. The situation may warrant introduction of public facts or problems which are known by the counselor. Also, the counselor may introduce matters of fact or general information which appear relevant to the needs of the counselee. In general, however, the counseling process seems to move most effectively when the agenda more or less arises from the counselee's thoughts and feelings, and the counselor follows and develops the issues so evolved.

9. A counselor tries to adjust the tempo of the counseling session to the psychological-emotional response pattern set by the counselee.

Each counselee moves at any given time at a pace characteristic for him and in accordance with the nature of the problem with which he is coping. Sometimes he may move rapidly; other times very slowly. Too often the counselor, because of pressures on him, wants to speed things up in order to get more done. By putting pressure on the counselee to move rapidly, the coun-

selor often impedes rather than facilitates the counseling process. There are no shortcuts or "forced draft" gimmicks to get quickly to so-called basic or core problems. Good counseling takes time. The counselor can best facilitate goal attainment by adhering to recognized counseling principles. Regardless of the amount of time the counselor has to give to a counselee, he recognizes that the tempo of the process is best set by the counselee, and that this in turn provides the most expeditious route toward desired goals.

10. The counselee should recognize in relationship counseling that diag-

nosis and therapy usually develop hand in hand.

In medical practice and certain types of counseling, diagnosis is seen as a necessary prerequisite to therapy. This assumption, as stated previously, is not held by relationship counselors. This group believes that assessment (diagnosis) and therapy can develop more or less simultaneously, especially during the early phases of counseling. Consequently, to this group, assessment is seen as a more or less dynamic, continuous process which lasts throughout the entire counseling relationship. The counselor's assessment role is seen as an integrative as well as a continuous one. He attempts to encompass all the data as it unfolds, in order to obtain a progressively sharpened focus upon the counselee's total personality functioning as well as upon his specific difficulties. This process of continuous evaluation provides the counselor, not with a definitive diagnosis, but with a set of tentative hypotheses which serve him as aids in perceiving, understanding, and helping the troubled person.

11. The counselor tries to keep the initial counseling session oriented toward the long-term goals of counseling and to avoid letting it get bogged

down in "emergency" problem-solving activities.

Any counselor can easily be so caught up in the counselee's immediate problem situation that he loses sight of his ultimate aim. For example, some counselors get so involved in trying to provide specific answers or solutions to problems that they end up as prescription writers rather than collaborative problem-solvers. Another pitfall occurs when the counselor takes on the counselee's problem as if it were his own. Counseling is a professionally prescribed role which involves the deployment of empathy, not sympathy. The counselor who becomes too emotionally involved in a counselee's problems is reacting more as a person than as a professional counselor, thereby reducing his effectiveness. Still another hazard is permitting the counselee to overexpose himself emotionally by trying to cover all his problems in the first in-

terview. In the first place, it is impossible to do so; and in the second, it is usually not advisable to let a counselee delve too deeply and too extensively into emotional matters at any one time.

To avoid such pitfalls, during the initial interview the counselor tries constantly to keep the long-term goals of counseling foremost in his mind. He wants the counselee to become a more constructive, problem-solving, self-directive person. The counseling experience should be one which induces growth, increases maturity, and enhances self-realization. The counselee who emerges from a successful helping relationship should feel he can more effectively use his own resources in coping with life and its problems, and thereby senses he has attained a greater degree of self-fulfillment and self-reliance.

12. Finally, the counselor recognizes that the fundamental goal of the initial interview is the establishment of a therapeutic relationship with the counselee.

If at the end of the first interview, the counselee feels he has met someone in the person of the counselor who accepts him, problems and all, then the initial relationship has achieved its main goal. If such is attained, both counselee and counselor will recognize that many problems and issues are still unexplored, but both will feel they have passed through a worthwhile experience, and that a sound basis has been laid for any future collaborative effort.

conclusion. There is no doubt that the initial interview puts maximum demands on the counselor's skill, knowledge, and abilities. How the initial interview is structured and developed will have a strong influence on the subsequent developments and outcomes of a counseling relationship. Errors made in the first session are usually much more costly than those made after a good working relationship has been established. If the initial interview has developed toward goals as outlined herein, then the counselee will find he has been able to express and explore some of life's difficulties which have been bothersome or disturbing to him. He is likely to feel some progress has been made. The counselor should recognize that a major counseling goal has been achieved when, at the end of the initial interview, he feels he has established a helping or working relationship with the counselee. Such a relationship is the crucible in which personality change can evolve.

## \*AIDS FOR THE COUNSELOR IN DETECTING EARLY MALADJUSTMENT

\* Reprinted with permission, from Pastoral Psychology, February, 1963

Many persons are able to recognize rather easily the signs of serious behavior disorders, such as suicidal or homicidal acts, psychotic delusions or hallucinations, unconscious spells or seizures, alcoholism or drug addiction, or very queer acts. On the other hand, most people feel uncertain when it comes to detecting and evaluating the early signs of personal maladjustment. This is understandable, since this task is often a difficult one even for experts because there is no sharp line of demarcation between mild and more serious maladjustments or between the temporary and more prolonged ones. Consequently, counselors often come face to face with the difficult task of evaluating case materials and data when trying to reach an intelligent decision as to the problems and needs of counselees.

Specifically, the purpose herein is to help sharpen the perceptive powers of the counselor by pointing out and discussing some of the early or incipient signs of personal and social malfunctioning. Such knowledge should aid the counselor in discharging one of his most important functions, namely, his screening role in the counseling process. This diagnostic function is an essential part of each counseling relationship. With each counselee the counselor must decide whether he is qualified to help the person or whether he should refer him to a more specialized type of help. This decision-making in the screening task is therefore an important and crucial function.

Mental health experts state that early detection of personally and socially maladjusted individuals is one of the first and foremost steps in the improvement of the mental health and welfare of our society. Oddly enough this task falls not on the psychiatric and psychological experts but on those professionals who have more frequent daily contacts with people, such as ministers, teachers, welfare workers, and others who counsel people in need. Too often the psychiatrists and psychologists do not see persons until serious troubles or disorders have developed. Therefore the screening function in our society falls upon our counselors, and this responsibility demands that our counselors have a knowledge and skill in the detection of early signs of maladjustment.

To aid the counselor in his evaluative task, this paper presents thirteen signs or indicators of level of adjustment. Their appearance singly or with others often gives clues to the level of functioning of the individual. These signs or symptoms are not presented as separate psychological entities, but only as observable facets of the dynamic functioning of a total personality. While the counselee may often report only one symptom or difficulty, the trained counselor is aware that often there are others in the total pattern. Of course the following signs do not constitute a complete list of signs, but they are some of the more frequently occurring ones that are observable and often helpful in the screening task.

#### COUNSELOR AIDS

1. Overactivity Overactivity is noted when there is a definite speeding up of any simple or more complex aspect of human behavior. Increase in activity may be detected in a person's rate of speech, flow of ideas, motor behavior, or patterns of social interaction. Shifts in such behavior are experienced from time to time by practically everyone and, if transient, are con-

sidered normal. However, when any noticeable increase in activity persists or intensifies, then it should be taken as a possible clue that all is not well in the individual's well being.

A speed-up in rate of speech may serve as a warning signal. Persons should be observed closely when they start "talking a blue streak," shift to loud talking or begin incessant babbling. The counselor noting such activity gets the feeling the person is uncontrollably impelled to verbalize and to override all others in conversations. Ideational overactivity becomes significant when a person seems flooded with ideas all rushing to be expressed at once. He seems to jump from one topic to another without much logic or sequence in his chain of thought. He becomes "hard to follow." Sometimes this ideational flow is characterized by overexpansiveness, and the individual is seen as boastful, overcome by his "big idea," or keyed up in his gaiety, wit, and mental activity. In general, overactivity in the ideational realm becomes a warning sign when the counselor or average person does not seem to be able to "tune in" or keep up with the flood of ideas that comes from a person who was previously understood.

In the area of motor behavior, a warning sign is given when there is a sudden and persistent speeding up in physical activity. This may be noted in general body motion and tension levels. Such a condition can be noted by unusual restlessness, unexplainable nervousness, pacing back and forth, clinching fists, getting up and down, "jumping out of his skin" at sudden noises, rushing from one place to another, irritability, or excitability. In more segmental aspects of behavior, the speeding up may be noted in blinking of the eyes, constant movements of the hands, restless shuffling of the feet, rubbing or scratching the body, heavy sweating, and so on.

In social behavior the individual may rush from one job, party, meeting, or activity to another without really establishing any real relationships with members of the group. Such behavior is often seen in the social "butterfly," the party "hopper," the job "jumper," and other "rushing in and out," of social contacts.

In summary, overactivity becomes a sign in detecting maladjustment when there is a noticeable and persistent speeding up of verbal, motor, or social activity from previously established rates which were characteristic of the individual. Consequently, the counselor must acquaint himself with the individual's customary level of activity in order to know whether a change is

taking place. If a "shift in gears" does occur and persist for a period of time, then the speeding up or overactivity becomes a signal of possible maladjustment.

- Most persons have frequently experienced a reduction 2. Underactivity or "let down" of physical and mental activities when temporarily fatigued, physically ill, or emotionally depleted. This is normal adjustive behavior if recovery is achieved after the debilitating or disturbing forces pass. If a noticeable and continuing reduction in activity persists, then it may be a warning signal. Such a decrease in activity from a normal pattern may be noted in verbal, motor, or interpersonal behavior. For example, underactivity is noted when the rate of speech is perceptibly slowed and the usual flow of ideas is noticeably retarded. The whole communicative process of such a person seems to be grinding to a halt. It appears as a most difficult physical and mental task for the person to talk or to express his ideas and feelings. A reduction may also be noted in motor activity, and the person may appear as quiet, passive, shy, and withdrawn. Other symptoms may include sleepiness, listlessness, and being near the point of exhaustion. Social behavior may show a reduction in the number and quality of normal social interactions. The person appears to have lost his usual interest in people, work, recreation, and ordinary everyday activities. In summary, underactivity carries a warning concerning the adjustive processes when there is a perceptible and persistent reduction from the usual level of activity characteristic for a given individual whether it be verbal, motor, or social, or in all of these.
- 3. Depression From time to time all persons experience transitory periods when they become blue, sorrowful, discouraged, or mildly depressed because of life's frustrations, difficulties, and problems. Such depressive feelings are normal experiences of practically all human beings. However, when symptoms of depression and despondency become more severe, increase in duration, and have no logical explanation, then a signal of maladjustment is evident. Contrary to popular belief, depressions may accompany overactivity as well as the more common setting of underactivity. With underactivity, motor activity subsides and the person appears quiet, withdrawn, and uncommunicative. Outwardly the depressed person appears worried, sad, and dejected. On the other hand, depression in overactivity is marked by restlessness, crying and sobbing, the wringing of hands, beating on the chest, and with other expressions of suffering and despair.

Since depressions are primarily mood disturbances, the person's own reports regarding his thoughts and feelings are important clues. He may state that he feels blue, fearful, unhappy, sad, or depressed. Usually in depressions there is a considerable element of self-concern. He reports he is worried about his health, his family, or his job. Doubts may be expressed as to his ability to carry on his responsibilities. The feeling of failure may stalk him. As the depression deepens, self-esteem falls and he may experience feelings of unworthiness, sinfulness, and wrong-doing. Often at this point he feels he deserves and should receive punishment for his failure and misdeeds. His troubles may appear insurmountable to him and his life situation seems hopeless. He may even consider life not worth the effort, and he may harbor thoughts of suicide, or he may even make actual attempts. Whenever signs of intense, fixed, and deepening depression appear, they should always be taken as serious danger signals. Immediate referral to a physician or psychiatrist is indicated.

- 4. Emotional variability Every person experiences emotional "ups and downs" in daily living. These may be mild or intense, but usually they are temporary or transitory in nature. Such emotional swings or upsets are often associated with a personal frustration, disappointment, failure, illness, fatigue, bereavement, and other such life experiences. However, emotional upsets become signals of possible maladjustment when they become disproportionate in intensity or duration to the range of reactions of other persons in similar situations or when they occur without any relationship to life's events. Such behavior is evident in the person who suddenly "blows his top for no good reason at all," weeps for "no reason at all," or is easily "triggered off" into strong emotional outbursts. Likewise, it is seen in the child who suddenly bursts into tears when someone "points a finger at him." Other examples include temper tantrums of children and the hysterical spells of adults. In general, the counselor should note any sudden and unpredictable emotional outburst, whether it be talking, laughing, screaming, weeping, or wild bodily movements. Such behavior is usually indicative of emotional difficulty. The critical element in evaluating emotional disturbances of a counselee is whether or not they are proportionate in intensity and duration to the person's previous pattern of emotional adjustment and to the general norms of his culture.
- 5. Psychosomatic difficulties or disorders When a person is under social or personal stress, it is not unusual that some temporary manifestation of the

condition will be evident in the individual's organic structure and functioning. This is a part of the normal adjustive processes of the human body. For example, temporary disturbances, such as a passing headache after an emotional upset, are a common experience. When, however, bodily changes or disturbances persist solely because of psychological pressure, then the symptoms take on more critical aspects, and the possibility of psychosomatic difficulty or disorder should be considered.

Psychosomatic complaints are legion. The person may report he has such symptoms as loss of appetite, nausea, vomiting, stomachache, diarrhea, constipation, heart "pounding," skin trouble, sudden loss of hair, asthma or hay fever, profuse sweating, excessive fatigue, backache, eye strain, shaking or trembling, paralysis, or frequency of urination. There may be a sudden loss in weight or appetite or a sudden increase in weight or appetite. Psychosomatic indicators can be very complex and can involve any aspect of body structure and functioning. Whether these are physical or psychic, or both, in origin can be determined only by a competent medical diagnostician.

Usually, psychosomatic symptoms show a history of persistence and defy organic diagnosis and treatment. Often when symptomatic treatment or attention is given to one disorder, it will disappear only to be replaced by another. Often such persons "shop around" from one doctor to another, one type of counselor to another. Generally, the person is very concerned with his psychosomatic symptoms and usually offers some organic explanation as to the cause. Seldom do such counselees show much insight into the psychological aspects of their disorders. Usually they are unhappy persons and are lacking in satisfying interpersonal relationships.

The counselor should be sensitive to signs that may be indicative of psychosomatic difficulties and disorders, and when noted he should refer such cases to a physician for diagnosis and treatment. The counselor should carefully avoid making any diagnosis of a psychosomatic nature, as this is purely a medical task.

6. Odd or unusual behavior Most intelligent persons develop from their total experience a subjective set of norms by which they recognize acceptable and appropriate behavior. Even less frequent patterns of behavior that are a part of phantasy life or creative endeavor are considered within acceptable limits, providing the person's general behavior is anchored within the realms of reality and normal expectations. Somewhere along the line, however, the

careful observer recognizes when ideas and behavior go beyond these broad normal limits and become odd, unusual, queer, inappropriate, or bizarre. Such deviations are signs that must be considered in the evaluative process

of an individual's adjustment.

Odd or unusual behavior may appear in a person's motor activities, ideational processes, or social activities. Deviations in physical activity may be seen in odd mannerisms, queer stances, grimaces, unusual bodily movements, and so on. A person may be noticed as unusual because he "stares into space" and is unresponsive to environmental demands. Odd characteristics may be observed in such behavior as peeping, secretive activities, hiding of objects, unexplainable purchases, meaningless repetition of acts, and so forth.

In the ideational realm certain unusual characteristics may also appear. The person's thoughts become hard to follow or comprehend because of a private and personal meaning given to them. Words and ideas with such people lose their common meaning which permits ordinary communication and understanding. The meaning and flow of the ideational processes seem to rise from a private inner world rather than from environmental and interpersonal surroundings. Consequently, the observer finds the person's words and ideas vague, elusive, or odd when trying to understand his conversation.

Such odd or unusual behavior as described above may indicate the person so behaving is retreating from healthy social living and is withdrawing into a private world of phantasy and unreality. The counselor should put several tests to the suspected odd or unusual behavior in order to establish its true significance. First, can the questioned behavior be understood in terms of the person's age and peer culture? If not, then a closer study is required. A second test would be whether or not the behavior appears to arise from deep inner forces which have little or no relationship to the external world in which the person is living. A third index is whether or not the person shows a steady withdrawal from normal social living into a solitary and isolated world of his own. Finally, does he fail to meet the regular and normal demands of his environment? When clear signs of bizarre behavior are evident, then the counselor should refer the person to medical or psychiatric help.

7. Tension-reducing habits Numerous repetitive-type acts are signs that the person is, or has been, under emotional or mental tension. These tension-reducing acts include nail-biting, head-banging, thumb-sucking, frequent

bed-wetting after age five, nose-picking, tremors, bodily tics, twisting and pulling the hair, scratching or pulling body parts, eye-blinking, biting lips or inner cheeks, ritualistic habits, and other compulsive behavior which has little relevance to accomplishment of any real end. The chain-smoking and five-o'-clock cocktail habit may also fall into this classification. If a person with a tension-reducing habit is asked why he does these things, he reports he is unable to control them or he feels uncomfortable if he tries to stop them. The counselor should recognize such acts as symptoms which often reflect deeper level tensions and problems. Attention or treatment directed toward symptoms removal is usually inadvisable and unprofitable. Sometimes such symptoms, if of long standing, may be only remnants of earlier maladjustments and may be best left alone. Tension-reducing symptoms therefore need expert evaluation. This is especially true if they are just emerging as a symptom or are becoming more pronounced after a period of stabilization.

- 8. Periods of unconsciousness Any reported or observed period of unconsciousness, other than in sleep, is a warning signal that should be heeded by the counselor. The loss of consciousness may arise from organic or emotional causes. However, regardless of the cause, the condition should be noted as one demanding attention. Black-outs, fainting, hysterical "passing out," amnesic spells, and other forms of unconsciousness may be signs of emotional conflicts or disorders. Periods of unconsciousness also may be caused by injury, disease, or other organic problems. Again, regardless of cause, loss of consciousness, other than sleep, should be recognized as a critical event and referral for expert diagnosis and treatment is demanded.
- 9. Negative attitude toward others and self Persons who are mentally healthy have in general a rather positive set of attitudes and feelings toward self and others. They have basic trust in the world and participate in it by sharing, loving, and caring. To the healthy, life and living have purpose and meaning; it warrants dignity and respect. There are times in everyone's life when he violates this creed by negative, hostile, or aggressive behavior toward self or others. This is being only human. The normal individual, however, usually returns sooner or later to a more positive orientation toward self and others. A critical point is reached in adjustment, however, whenever a person is more or less dominated by a generalized and undifferentiated set of negative attitudes and reactions toward self and the world about him.

Negative orientation toward others can be seen in persons who chronically exhibit attitudinal behavior described as jealous, suspicious, sullen, resentful, hateful, selfish, unfriendly, and so on. Verbally this negative focus is seen in repetitive patterns of sarcastic remarks, depreciation of others, criticism, "back-biting," damning and cursing, and heckling. In social behavior, negativism is seen in such acts as always being late for scheduled events, frequently interrupting others, habitually disrupting on-going activities, repeatedly indulging in attention-getting behavior, and through open violation of group standards. More serious forms of negativism emerge when attitudes are expressed or held that "people cannot be trusted," "the world is against me," "others are out to use me," and "people are no damn good." This trend can develop into more serious symptoms of persecutory ideas and paranoid reactions.

A negative view of the world and others is consistently correlated with a negative evaluation of self. Negatively oriented persons see the world about them as unfriendly, non-loving, threatening, rejecting, and possibly even persecuting. Such sufferers may report they have feelings of worthlessness, incompetence, inferiority, guilt and wrong-doing, and helplessness. Persons with such negative orientations to others and self may "take up arms against it" or withdraw into a tighter and tighter defensive shell. This negativistic trend becomes even more serious when overt and destructive thoughts and acts develop against the world or self. In some cases the sufferer's guilt is so strong he may beseech condemnation and punishment of self, or even death. To the counselor, negative orientation becomes critical when it is generalized, pervasive, and indiscriminate in relation to the world, the persons in it, and to self.

10. Anxiety and fear reactions Among the most common emotional and psychological experiences of man are anxiety and fear reactions. These are part and parcel of the human adjustive and survival structure. Persons under threat usually experience some degree of anxiety or fear when the body mobilizes its resources to cope with the situation. After the crisis is past the emotional feelings along with other body functions usually return in time to their previous state of equilibrium. This is a normal process.

A critical adjustive condition arises, however, when the person's fear reaction overwhelms him emotionally and his adaptive and survival capacities become impaired. Such a rupture in the adjustive processes may be mild or

intense, transitory or continuous, generalized or highly specific, and partially or totally disabling.

In acute anxiety and fear reactions the person may experience some degree of uncomfortable and unpleasant feelings, exhibit various overt manifestations, undergo certain physiological changes, and suffer some impairment in mental functioning. For example, in such disturbances the person may state he feels afraid, anxious, worried, and apprehensive. Outwardly he may exhibit trembling, shaking, sweating, weeping, breathing irregularities, blockage of speech, blanched face, coughing or choking. He may run away or "freeze in his tracks." Physiologically he may report such feelings as a lump in his throat or stomach, need to urinate or defecate, heart "pounding," "cold sweat," and so on. In acute cases the person may show a temporary mental impairment by acute or chronic inability to make decisions, fear of committing himself to action, inability to concentrate, and mild confusion.

Anxiety and fear-laden behavior range all the way in intensity and severity from mild disturbances to those associated with panic and terror. In extreme cases, the person may be overwhelmed with catastrophic feelings, run into headlong flight, become completely immobilized and dazed, fall unconscious, become violently aggressive or attempt suicide. Physiologically he may lose sphincter control, vomit, develop violent muscular spasms, or pass into a comatose state. Mental functioning may completely disintegrate

and amnesia may develop for the whole event.

Attention here is not directed toward normal defensive reactions to anxiety and fear, but to those which are disorganizing, disabling, and crippling. These non-adaptive reactions have several characteristics which help distinguish them. The person usually reports he feels uncomfortable and usually is unable to understand (or explain) why he so reacts. The symptom pattern becomes indicative of maladjustment when the symptoms persist long after the threat situation is past or when the intensity of the reaction is disproportionate to the threat factor. Also in these cases the emotional feeling component may no longer be attached to its original cause but shifted to some fragment in the original situation; or it may be illogically ascribed to an unrelated cause; or it may become completely dissociated from any anchorage. The counselor who detects any of the above described characteristics or deviations should recognize them as crippling anxiety symptoms that deserve skillful professional attention.

11. Over-resistance and over-submission to authority — Social organization and living demand certain minimum adherence to standards of interpersonal behavior if social functioning is to be maintained. These standards are evident in family rules, community norms, cultural mores, and our laws. Every person has experienced at times psychological difficulties because of the conflict between his own personal desires and authority figures and symbols. Practically all persons have upon occasion resisted regulating forces and have deviated from set rules and standards. This testing and exploring limits is part of the growth and development of most persons. A warning signal of maladjustment, however, begins to appear when a generalized and undifferentiated resistance to authority characterizes a person's behavior.

Over-resistance to authority may be noted in an individual's attitudes or acts which can be described as rebellious, defiant, selfish, arrogant, impertinent, contemptuous, stubborn, resentful, non-compliant, distrustful, antagonistic, and negativistic. At the verbal level, over-resistance to authority may be seen in such behavior as derogatory name-calling, contemptuous remarks, argumentative tirades, verbal outbursts, belittling others, and so on. A more direct form of defiance of standards is seen in repetitive acts of lying, stealing, cheating, sulking, truancy, running away, domineering tactics, and destruction of property. It may also be a factor in "job hopping," repeated marital failures, joining "out groups," deviant dress and speech, "bad" manners, and the like. Resistance becomes more deviant when it is directly expressed in open aggression against others, such as in persistent teasing, bullying, fighting, and the more serious assaultive acts.

At the other extreme the reaction to authority expresses itself in oversubmission. The average person recognizes and submits to authority when it is deemed the appropriate and necessary response to the social situation. The over-submissive persons, however, are those few who use submission as a generalized and fixed pattern of adjustment regardless of the situation. Persons with such a handicapping pattern of behavior seldom receive more than passing attention from others, as they are not socially disturbing or disruptive. Actually they are taking out their maladjustment by inflicting it on self rather than others. Over-submissiveness therefore can present itself as just as serious a problem as over-resistance to authority.

Over-submissive behavior appears in persons who are characterized as quiet, ingratiating, servile, highly compliant, the "yes man" (or woman), the

"henpecked," "Mr. Milquetoast," self-sacrificing, long-suffering, and "sweet and sticky." Such persons, in addition to being over-compliant to authority, often pay any price to avoid conflict by taking little notice of, or even denying any aggressive words and acts that are directed toward them.

Regardless of whether the symptoms are those of over-aggression or over-submission to authority figures and forces, the person is suffering from a breakdown in basic human relationships. The hurts and frustrations in living created hostile impulses which in one set of conditions are expressed outwardly, in another inwardly. The psychological common core of over-resistance or over-submission is seen in the occasional sudden shift from one pattern to the other. To the counselor, the acute signs of either over-resistance or over-submission serve as indicators of impairment in basic human relationships and psychological well-being.

12. Speech difficulties Speech disturbances and disorders may arise from organic or psychological factors, or both. Attention here is focused on the non-organic. Most people at one time or other have experienced some psychogenic speech disturbances when they have become emotionally upset, or excessively fatigued, or physically debilitated from disease. This is normal adjustive behavior when it involves a temporary impairment of speech and communicative processes. On the other hand, if a speech disturbance persists it may signal underlying psychological stress which produces not only the verbal handicap but points to possible inadequacies in the person's social operations and security.

Speech disturbances may be evident by temporary speech blockage (stage fright), mispronunciations, stuttering, stammering, repeating words or phrases, or complete hysterical mutism. The general speech pattern may be noted as unusual because it is inappropriately too loud or too low (the whispering voice), too fast (verbal manic) or too slow, too high pitched or too low, too jerky or too explosive (spits out words), too thick or too labored, and so on. Persons with such speech disorders may appear somewhat tense, rigid, and fearful. The face may show tense muscular involvement with spasms or tremors around the mouth and throat. Clenching and grinding of teeth may occur. Breathing may be irregular and labored. Eyes may show squinting or blinking. Hands may be clenched into fists or held in a tense manner. In other words, speech disturbances are often associated with many other signs of bodily tension.

Most persons with functional speech handicaps also face social and interpersonal problems. Often they may appear withdrawn and isolated personalities even if they move among others. If questioned, they often report they are lonesome, lack self-confidence, and are fearful of their social abilities. Their

handicap is a worry and a concern to them.

The counselor who notes any clustering of the above speech and personality deviations usually finds it valuable to inquire about the time of onset of the difficulties. It is important to determine whether the speech difficulty has existed for some time as a fixed pattern or is currently emerging or intensifying. Stabilized speech impairment usually indicates some adjustive equilibrium has been achieved in the past but probably at some psychological cost to the individual. Any newly appearing or intensifying set of symptoms indicates present inroads are being made upon the psychological forces of the individual. When crippling changes are appearing, it is a critical time if more serious damage is to be avoided. The diagnosis and treatment of speech disorders, whether established or emerging patterns, call for intensive knowledge of personality dynamics and special treatment skills. Persistent speech problems should be referred to speech clinicians or psychiatrists.

13. Sleep disturbances Practically everyone suffers from temporary sleep disturbances from time to time. Transitory difficulties in sleeping may result from absence of familiar surroundings, emotional upsets, or from physical causes, such as disease, injury, or fatigue. However, sleep disturbances become a critical index of adjustment when they persist after the precipitating circumstances or trauma are past. When this occurs, the condition may well point to a disturbance within the psychological forces of the individual. The counselor may, therefore, view reports regarding sleep and associated phenomena as valuable diagnostic data.

Many types of sleep difficulties may be reported or observed. A frequent complaint is insomnia or an inability to go to sleep for hours. Others state their sleep is fitful and punctuated by repeated and sudden wakings. With some, the problem is awaking after a few hours of sleep and then finding it impossible to go back to sleep. At the other extreme are those persons who sleep excessively, or fall asleep repeatedly during normal waking periods, or take long naps when not needed, or pass into a coma-like sleep for days. Still another group seem caught in sleep schedules unlike others and which are often inconsistent with life's demands upon them. The counselor should note

any extreme deviations in too little sleep, too much sleep, or other irregular patterns.

Disturbed sleep may also be indicated by associated phenomena occurring during sleep, such as "bad" dreams, frequent tossing and turning, crying out or screaming, moaning and groaning, grinding of teeth, heavy sweating and breathing, trembling and shaking, nightmares, sleepwalking, and night terrors. All of these signs give evidence of emotional difficulty which is being

reflected during the sleeping process.

Usually persons who experience sleep disturbances report on waking, regardless of the hours of sleep, that they are tired and exhausted. They may or may not recall the nature or extent of their sleep disturbances. Most generally they are distraught because of their sleep irregularities but seem unable to overcome the difficulties. The counselor should recognize that persistent sleep disturbances, regardless of cause or type, often yield significant clues to the individual's adjustive processes.

are types of behavioral phenomena that to some extent or degree might occur in the experience of any human being from time to time. These aspects of behavior are exaggerations of some of the normal functioning patterns which are characteristic of every human organism. Such deviations arise when the body is functioning under stress because of accidents, illness, natural disaster, bereavement, social and economic dislocations, and other traumatic events. Upsets arising from such events are considered normal disturbances if the person is able to regain his usual equilibrium after the precipitating force is past.

On the other hand, a personality adjustment problem arises when such reactions persist beyond the usual or expected recovery time. In order to help discriminate between normal adjustive reactions and those which indicate

more serious impairment, the following principles may be useful:

1. Any behavioral pattern or patterns which cripple, disable, handicap, interfere with, or prevent a person from achieving his potential level of satisfying, creative, productive living should be considered as a signal of impairment to some degree in the adjustive processes.

2. Any persistence of a disturbing behavior or combination of unusual acts

should be viewed as evidence pointing toward maladjustment.

3. Any intensification of the unusual in behavior over a period of time is to be taken as a warning sign in evaluating a person's level of adjustment.

4. Whenever reactions or signs such as those described in this paper become *disproportionate* to any discernible causes, then they should be read as critical factors in assessing personal adjustment.

5. Whenever emotional responses become generalized or undifferentiated, they usually indicate an unhealthy spreading of a disturbance or disorder.

#### ROLE RELATIONSHIPS IN COUNSELING

Theoretically, the nature of the counseling process appears amenable to analysis in certain critical ways by a study of the various role relationships which can occur between counselor and counselee. Role relationship as used here defines the activities portrayed by the interacting systems of the counselor and counselee. More specifically, the focus will be upon the modes of interaction which occur in the counseling session. In such a setting, the counselor comes with certain concepts, beliefs, attitudes and feelings about his role, and so does the counselee. The thesis developed here is that the nature of the role relationship which emerges from the interaction defines to a large extent the structure, movements, and goals of the counseling process. Therefore, a consideration of some of the variables involved in role relationships between counselor and counselee appear to offer a basis for a better understanding and control of the counseling process.

One major way in which the role relationship in counseling lends itself to

analysis is by noting the nature of the distribution of initiative and responsibility that develops between counselor and counselee. Theoretically this can range from putting all the initiative and responsibility into the hands of the counselor, through equal distribution between both parties, to placing all these components in the hands of the counselee. The contention made here is that any shift in distribution of initiative and responsibility between the two participants results in some alteration or modification of the counseling process and its goals. Consequently, the question as to what proportion of the initiative and responsibility is held by the counselor and what proportion is held by the counselee appears highly relevant.

In order to reveal how various distributions of initiative and responsibility affect the counseling process, three widely separated points on a spectrum are selected for examination.\* The first in which theoretically the counselor holds most of the control will be called Model I. Second, Model II relates to the situation in which the counselee holds most of the control. Finally, in Model III both parties share somewhat equally in the control. Obviously these models deal with a relative distribution of initiative and responsibility. As an example, if in Models I and II there was absolute inactivity on the part of the counselor or counselee, little, if any, meaningful interaction would re-

sult.

#### MODEL I, COUNSELOR HOLDS MOST OF THE INITIATIVE AND RESPONSIBILITY

Historically, the first widely used role relationship model in counseling, and in psychotherapy, was one in which the counselor assumed most of the initiative and responsibility (Zilborg, 1941). This pattern appears to have emerged as an imitation of the previously established relationship between "doctor" and "patient" in which the practitioner held the authority "to do something to" or "act upon" those calling or sent to him for help or services. The physician's role according to such a model was one in which he was to examine, diagnose, prescribe, operate, medicate, order, direct and perform other similar tasks. The patient's role was one in which he was to submit to, undergo, take as directed, follow orders and to carry out other acts of compliance to the authority of the medical-surgical expert. In such a role relationship the physician is seen as an authoritative and active agent; the client submissive

 $<sup>^{\</sup>circ}$  The writer is indebted to Robert R. Blake (1961) whose general power theory of social institutions has contributed to this paper.

and passive. It is easy to understand why the medical-surgical model was imitated when people with personal and emotional problems called upon

physicians, clergymen, and others for assistance.

Let us turn our attention to those counselors and therapists who have chosen to imitate the medical-surgical model. This group according to Model I assumes most of the initiative and responsibility for structuring and directing the counseling process. Their control of the relationship is exercised either by use of physical force or by various verbal techniques for purposes of managing the person, directing his treatment, or establishing a corrective program. First the physical method of control will be examined; then verbal control.

1. Control by Physical Force. One of the purest forms of Model I is seen when the counselor or physician actually employs physical force in his care and treatment of patients or clients. With certain types of cases, designated practitioners are empowered by the law of the land to use force, if necessary, to incarcerate, hospitalize or institutionalize patients or charges. Those types of cases that may be so managed include suicidal and homicidal persons, sexual deviants, chronic alcoholics, psychotics, and mental defectives. Medical therapists in charge of such patients furthermore may also be empowered to use physical force, if necessary, to impose upon such patients certain forms of care or treatment. Such treatment programs may involve the use of physical restraint, isolation, various shock treatments, medication, intravenous injections, lobotomies, and hydrotherapy. Similarly, non-medical personnel may employ physical force in some aspects of the care and treatment of the criminal, delinquent, abandoned and neglected, alcoholic, senile and others who are relatively helpless or who appear to need restraint.

In such role relationships as described in the previous paragraph, the practitioner holds almost all the initiative and responsibility; the subject, very little. In such a distribution those in "charge" initiate, direct, and carry out custodial or treatment practices which they think are "best" for the person. The client's role is primarily one of submitting or complying, voluntarily or

involuntarily, to the prescribed care and treatment program.

2. Control by Verbal Means. The counselor or psychotherapist who structures his relationship according to Model I has available a variety of verbal techniques and procedures for directing his clients. Two examples will

illustrate this type of role relationship. First, attention is directed to the work of the directive counselor; and secondly, to the structure and functioning of the more orthodox psychoanalyst.

a. Directive Counselors. Among non-medical counselors such as clergymen, deans, advisers, social workers, teachers, psychologists, and personnel directors, there are many who, at least at times, assume the initiative and responsibility in carrying out the counseling process. Counselors when functioning in such an orientation often follow the general pattern of appraising the client's situation, deciding what is "best" for him, and then providing him with "the answer." The client's prescribed role is to provide information, listen to the counselor, and then follow his advice.

In the appraisal phase of such a relationship, the counselor may obtain information about the client by the use of the question-answer technique, gather it from case history materials, test results, rating scales, personal inventories, performance appraisals, personal impressions or hearsay reports. After the information-and-opinion gathering phase, a directive counselor usually assumes the major obligation for making a judgment as to what is "best" for the client. Often this decision is based not only on the information he collects but also upon his personal beliefs and values. He may, with all the authority of self and office, disapprove, judge, warn, forbid, condemn, or give other types of negative evaluation. At the other extreme he may praise, approve, condone, encourage, reward, absolve or offer other positive evaluations of the client's conduct. For example, such counselors may tell a client: save more money, get a divorce, drop mathematics, buck up, take a vacation, punish the child, drop algebra, go to church, take it easy, apologize, enroll in college, forgive him, take a bath, and on and on. Occasionally, these counselors will even go further and personally engage in actions which alter or manipulate the client's environment and relationships.

In directive counseling, it is clearly evident that the counselor holds a considerable amount of the initiative and is quite authoritarian in his approach. He directs the interview, collects information, renders judgments, provides answers, and often offers a plan of action. The counselee in such a setting is given little control of the counseling process. His prescribed role is passive. He is expected to answer, report, confess, undergo testing, be examined and, in general, comply to the wishes of the counselor. The counselee is usually expected to listen to the counselor's decision or plan of action to "help" him

and to follow the proffered "prescription." This pattern indeed fits Model I.

b. Directive Nature of Orthodox Psychoanalysis. The more classical or orthodox psychoanalytic framework also roughly fits into Model I. It allocates considerable initiative and responsibility to the therapist for structuring and directing the therapeutic process. In such a relationship the analyst is the one who sets the goals for therapy, initiates procedures, directs processes, applies techniques and offers interpretations. On the other hand, the patient in such a setting is generally perceived as one who complies with requests, responds as directed, listens to interpretations, and, in general, is expected to follow his physician's directives.

Freud did shift onto the patient more of an obligation for participation in the treatment process than was inherent in the early medical-surgical model. The patient had to come willingly to therapy and commit himself to some degree to the task assigned by the analyst. The patient was expected to share in the therapeutic process according to the therapist's directives. He was expected to recall past events, offer free-associations, relate phantasies, and so on. To a large extent, however, the patient functioned strictly within the terms set by the therapist. Consequently, while Freud gave the patient a greater degree of involvement, the control of the relationship still remained firmly in

the hands of the analyst.

The goal of orthodox psychoanalytic theory is set by Freudian theory, itself. The patient does not participate in goal setting but can only accept the terms as established by the psychoanalyst. Zetzel (1956) clearly defines this psychoanalytical goal when she writes, ". . . analysis of the infantile-oedipal situation in the setting of the transference neurosis is still considered the primary goal of the psychoanalytical therapy." Freud's (1920) statement on this point is as follows, "The decisive part of the cure is accomplished by means of the transference through which new editions of old conflicts are created." Other classical analysts who support this core hypothesis include Brill (1946); Lorrand (1946); Fenichel (1945); Healy, Bonner, and Bowers (1930); Ferenzi (1916); Henrick (1948); and numerous others. In utilizing the classical transference neurosis, the therapist's role is largely one of inducing and directing the transference process. The patient's role is a prescribed one in which he is scheduled to become involved in a neurotic dependency relationship with the therapist. Certainly the role of the counselee in such a relationship is one that envisions him as a somewhat "weak" or "sick" person who unconsciously becomes dependent on the "strong" analyst and his

controlling techniques.

Another major determinant of the role relationship between the orthodox psychoanalyst and the patient is the emotional stance the therapist assumes. In the classical literature the emotional set advocated is described as impersonal, objective, authoritative, a "mirror," a "blank screen," a detachment. Among others, Hendrick (1948) described the emotional position of the analyst as follows, "Many details of the analyst technique are devised to maintain as much of a 'blank screen' as possible." Lorrand (1946) writes about this issue in these words, "It is no exaggeration to say that success in curing patients largely depends upon one's ability to remain objective." The same viewpoint is given by Fenichel (1945) who states, "The analyst makes interpretation effective by not reacting emotionally to any of the patient's emotional wishes, to his love, hatred, or anxiety; he remains the mirror that does nothing but show to the patient what he is doing." Such an Olympian, non-reacting emotional stature taken by the orthodox psychoanalyst assumes a great degree of power and authority. Again such a posture is consistent with Model I concepts.

Still another controlling technique congruent with Model I and which is employed by the orthodox group is the use of interpretation, perhaps the most powerful tool in the psychoanalyst's armamentarium. The therapist, speaking from his expertness and authoritative position, tells the patient what he thinks his behavior means. Hendrick (1948) emphasizes this point when he writes, "The chief implement in his technique is interpretation." Fenichel (1945) equally emphasizes the importance of interpretation by his statement, "... however, whenever possible, interpretation is used." The technique of interpretation is an extremely one-sided affair since it is the therapist who "gives" and the patient who "listens and receives." The therapist who gives meaning to all that has been presented is certainly in an authoritative role while the patient is expected to be in a submissive and accepting role. Interpretation as a technique, therefore, gives the therapist another strong control over the relationship and places the patient in an acquiescent role.

The orthodox psychoanalyst has several other commonly used techniques which give him considerable dominance over the therapeutic relationship. For example, the patient is usually required to recline on a couch out of sight of the analyst while the therapist sits above and behind the patient. The psy-

chological significance of such a physical relationship is obvious. Another procedure frequently used is free association which Fenichel (1945) describes, "... the patient is requested to say everything that comes into his mind without reflection." Other demands made upon the patient include reporting dream materials, daytime phantasies, and early life experiences. In all of these practices, it is the psychoanalyst who determines the nature of the task, directs its application, and gathers the data so elicited. Finally, the therapist interprets the materials so obtained. In the utilization of such techniques the therapist is operating from a powerful position in keeping with Model I principles.

The preceding paragraphs described several of the assumptions and techniques which are basic to the practice of orthodox psychoanalytic therapy. The evidence seems fairly clear that in general the tools and techniques invest the therapist with considerable power and authority over the therapeutic relationship. The initiative and responsibility for directing the therapeutic process clearly rests with the therapist while very little is reserved for the patient. While the writer does not attempt here to explain the rationale which underlies this rather one-sided assignment of initiative, responsibility, and authority, he does acknowledge the fact such does exist. The purpose here, however, is to point out that such an allocation of power has a tremendous impact on the nature of the role relationship, its therapeutic goals, the processes employed, and the ultimate outcomes.

## MODEL II, COUNSELEE HOLDS MOST OF THE INITIATIVE AND RESPONSIBILITY

Partly as a reaction to the more directive model of counseling relationship in which most of the initiative and responsibility were placed in the hands of the counselor, there emerged a contrasting model in which these components of counseling were largely given to the counselee. This shift basically inverted the role relationship between the counselor and counselee. Carl Rogers in his 1942 book, Counseling and Psychotherapy, pioneered this theoretical position in his presentation of non-directive or client-centered counseling and psychotherapy. In his original presentation Rogers invested most of the initiative and responsibility to the client for entering therapy, directing the process, setting goals, and carrying out other therapeutic activities. One term that Rogers (1942, 1951) employed to describe his model is "client-centered therapy," which clearly indicates that he placed the locus of control in the hands of the client.

Another term used by Rogers (1942, 1951) to describe his approach to counseling and psychotherapy is "non-directive." By this term, of course, he referred to the role of the Rogerian counselor. Theoretically such a counselor would hold little or no directional authority for the counseling process. The antipodal position of Rogers to the procedures in counseling and psychotherapy as described in Model I is seen in the long lists of "Don'ts" which he enunciates for non-directive counselors. In general, he denies the nondirective counselor the use of the directive tools and techniques employed by Model I. For example, Rogerians do not use a couch, employ free association, give advice, direct inquiry into past life events, request dream materials, set goals, manipulate the environment, induce hypnosis, use physical force, establish a transference neurosis, or urge any specific plan of action. Furthermore, Rogers to a large extent denied the non-directive counselor the use of the technique of interpretation. In the following paragraphs are cited some of the statements made by Rogers in his original 1942 formulations which reflect the allocation of participation he makes between counselor and client.

Rogers (1942) repeatedly emphasized the incompatibility of authority and counseling. He stated his viewpoint clearly when he wrote, "It seems to the writer that the counselor cannot maintain a counseling relationship with the client and at the same time have authority over him." Elsewhere he stated, "Therapy and authority cannot be co-existent in the same relationship." More specifically, Rogers pointed out how authority is removed from the counselor's role in his statements, "It is not his (counselor's) function to urge a certain course of action . . . ," "A fourth characteristic of the (non-directive) counseling relationship is its freedom from any type of pressure or coercion," and "The skillful counselor refrains from intruding his wishes, his reactions, his biases into the therapeutic situations." On the other hand, Rogers clearly placed the responsibility for initiating and carrying out therapeutic activity directly upon the client. He (1942) stated that the client is the one who ". . . accepts the responsibility for bringing himself (to therapy); he also accepts responsibility for working upon his problems."

In regard to goal setting, Rogers placed the responsibility fully upon the client. He (1942) wrote, "Non-directive counseling is based on the assumption that the client has the right to select his own life goals, even though these may be at variance with the goals that he counselor might choose for him." Elsewhere he (1942) stated, ". . . the counselor takes no responsibility for

directing the outcome of the process." Thus it is seen that Rogers explicitly

makes goal setting a function of the client.

The Rogerian counselor also was instructed not to give advice or offer solutions to problems. On this point Rogers (1942) declared, "It is not his (therapist) function . . . to give advice." Elsewhere he commented, "From the first the client is made aware of the fact that the counselor does not have the answers. . . ." Furthermore, Rogers (1942) generally disapproved of the counselor's giving verbal reassurances, taking case histories, giving diagnostic evaluations, offering any judgments of behavior, and engaging in any other type of directive or evaluative activity.

Since non-directive counselors are given little or no leeway for directing the counseling process, then the question arises as to what constitutes their assigned role. Rogers (1942, 1951) described some of their functions in such terms as: to listen, repeat, accept, recognize, reflect, mirror, clarify, and understand the psychological materials and feelings offered by the client. These words certainly do not describe a directive counselor; they are, however, trademarks of the non-directive counselor. However, Rogers did prescribe further functions for his counselors, as will be seen in the following

paragraphs.

Another dimension of any counseling method concerns the nature of the emotional relationship which develops between counselor and counselee. The Rogerian viewpoint on the nature of this aspect of counseling appears somewhat difficult to decipher. Rogers (1942) unequivocally rejected the transference neurosis concept of the Freudians as a therapeutic procedure and consciously attempted to avoid this type of emotional involvement in his counseling process. On the other hand it appears that Rogers did not clearly perceive of the therapist's own emotional resources as offering a positive therapeutic dimension to the counseling process. The writer feels Rogers originally took a somewhat neutral position on this issue. Apparently the counselor's role, according to Rogers' earlier thinking, seemed to be one in which the therapist attempted to achieve an understanding and acceptance of the client's emotional feeling in order that the therapist can reflect these back to the person. The following statements made by Rogers in 1942 and 1951 may throw some light on his position at that time regarding this matter: "... it is the therapeutic function to help him (the client) to recognize and clarify the emotions he feels." "Here it is especially important that he (the therapist) should recognize his function as that of a mirror which shows the client his real self." In another place Rogers stated, "In effective counseling and psychotherapy one of the major purposes of the counselor is to help the client to express freely the emotionalized attitudes which are basic to his adjustment problems and conflicts."

In his early works Rogers (1942) also carefully warned the non-directive counselors against the dangers of becoming emotionally involved or trapped in the counseling relationship. On this issue he stated, "He (the counselor) will do better to face openly the fact that to some extent he is himself emotionally involved, but that this involvement must be strictly limited for the good of the patient." Again on this point he wrote, "He is sufficiently sensitive to the needs of the client, however, to control his own identification in order to serve best the person he is helping." Thus Rogers at that time appeared to say that counselors should be careful to avoid or control as far as humanly possible any emotional involvement in the counseling process as this type of relationship is likely to be hazardous to therapeutic progress.

Judging from the statements made by Rogers in 1942 in the preceding two paragraphs, it appears he places the responsibility upon the client to express his emotions and feelings while the counselor maintains himself emotionally as a somewhat neutral, passive reflecting agent. Because the non-directive counselor is warned to be wary of emotional involvement in the therapeutic process, his own emotional resources evidently are not seen as offering a

positive therapeutic potential.

However in Rogers' (1961) more current writings, he has modified his original position and now emphasizes the emotional commitment of the therapist in the counseling relationship. This development in Rogers' thinking is a contribution to the development of Model III and will be examined in the follow-

ing section.

Finally, the Rogerian orientation which puts much of the burden of both process and progress in the counseling relationship upon the client caused a shift in the nature of the agenda of interaction between counselor and counselee. This forced a change from psychological probing for historical evidence (depth) to a focus upon the "here and now" events of life. This shift is also a significant contribution made by Rogers to the evolution of Model III which will be discussed later.

In summary, Rogers in his earliest formulations of his non-directive theory

allocated most of the initiative and responsibility to the counselee, and conversely denied it to the counselor. He advocated that the client should come freely and of his own will to counseling. He alone may initiate or avoid any given therapeutic activity. He directs the process and sets his own goals. In general he is supposed to assume considerable responsibility for working out his own therapy. On the other hand, Rogers clearly denied the authority role to the counselor by warning him not to give advice, set goals, offer solutions to problems, provide interpretations, evaluate behavior, render judgments, direct outcomes or manipulate the client's environment. In other words, Rogers reduced the authority of the counselor to the minimum. At the same time, he invests it as far as possible in the counselee. This role relationship with the counselee in ascendency is based upon a certain set of philosophical values and a unique set of theoretical constructs. However, these issues are not discussed in this paper. The contention made here is that many of the determinants of the counseling relationship and its subsequent outcomes are set, once the distribution of initiative and responsibility is made according to nondirective concepts and principles.

## MODEL III, CO-EQUAL DISTRIBUTION

When in the counseling relationship the initiative and responsibility is more or less equally shared between counselee and counselor, then another rather unique set of therapeutic conditions and goals is defined. No theorist, as yet, has fully developed a unifying philosophy or a comprehensive set of principles for Model III, yet the general shift in this direction is evident in the writings of several therapists and counselors. The term, co-equal\*, has been chosen to indicate this model, as no generally accepted name has been given to it.

Historically, the first significant movement from the traditional medicalsurgical model toward greater participation by the patient was made about 1900 by Freud (1938). Simply stated, one of Freud's basic beliefs was that the psychiatric patient's role required more involvement in the treatment process than merely "submitting to" or "being operated upon" as demanded by the traditional practice of medicine. Freud stated that the patient had to take a more active part in the therapeutic process and his involvement was an

<sup>\*</sup> Co-equal as a term means a mutual commitment and involvement in the therapeutic process with each participant sharing the initiative and responsibility for carrying out the therapeutic process.

essential ingredient to the outcome of treatment. Freud invited the patient to "tell," "relate," "recall," "report," or "free associate" regarding his present or past, real or phantasized, pleasant or unpleasant, life events. This change added a new dimension to medical treatment concepts. "Words" became a treatment modality. No longer was the physician perceived as the one "who got the patient well." However, it was far from a co-equal distribution. Freud unquestionably held the control of the relationship firmly in his hand. The patient's performance was strictly on terms directed by the psychoanalyst.

Following Freud a number of therapists announced formulations and practices that moved the counseling process still closer to an equalitarian relationship. These would include Sullivan (1947, 1953, 1954), Moreno (1953, 1958), Horney (1939), Frieda Fromm-Reichmann (1959), Alexander and French (1946), Alexander (1948, 1956), Rank (1945) Fromm (1941) and May (1951). The group just cited, and several others, reflect their basic concept of greater equality between patient and counselor. Their position is clearly reflected in the terms they use to describe the therapeutic interaction. Among these are: participant observer, joint determination, joint experience, reciprocal involvement, reciprocal emotions, collaborative effort, collaborative participation, collaborative teamwork, empathetic sharing, empathetic communication, mutual participation, active collaboration, "the encounter," spontaneous interaction, interpersonal integration, and social interchange.\* These words clearly reflect a sharing, living relationship not only at the intellectual level but also at the feeling or emotional level. These therapists seemed to consider their own emotional resources as having potentially a positive value in the therapeutic relationship. Such intellectual and emotional involvement tends to place the co-equal therapist more fully "inside" the counseling relationship, than the authoritarian and early non-directive models. Being "inside," the co-equal therapist appears to be operating in a system which is more "open" and in which there is the possibility of more involvement and feedback than in the more emotionally "closed" structures characteristic of the prototypes of the other two models.

It is interesting to note that this theoretical shift toward the center forced

<sup>&</sup>lt;sup>6</sup> The co-equal type of relationship is not to be confused with the "Laissez-Faire" type as described by Cartwright and Zander (1953) as it involves very different concepts and principles.

a change even in the physical setting and arrangement in which a more coequal oriented counseling takes place. Emphasis on authority is reduced by the spatial relationship between counselor and counselee. For example, many of these therapists gave up the analytic couch and have moved from "above and behind" the counselee to a nearer face-to-face relationship. Some have emerged from the "chair behind the desk" and seat themselves so as to face the client across an open space. Others have reduced the emphasis on, or entirely eliminated, the obvious symbols of authority such as diplomas, professional books, pictures of the "great," technical jargon, white coats, certificates of professional membership, and other signs of status. Such changes in the physical arrangements and surroundings in the therapist's office usually accompanied a theoretical shift by the practitioners toward a more co-equal model in his thinking and his doing.

This distribution of initiative and responsibility toward the co-equal position has forced several basic theoretical changes in psychotherapeutic concepts. Some dimensions of therapy, effected by the conceptual modification include: the goal setting process; the movement from "depth" to a more "here and now" focus; dropping the emotional "blank screen" for a more open and sharing relationship; changing from a "sick" orientation to a more positive or healthy approach; controlling or eliminating the use of the transference neurosis; curtailing or abandoning the use of interpretation; and finally, questioning the importance of insight as a therapeutic factor. Behind each of these moves can be seen the reduction in the power of the authoritarian therapist over the counseling process and the enhancement of the control given to the counselee. The proponents of this position claim that by placing more initiative and responsibility upon the client, his own dignity and integrity are enhanced. He becomes more actively involved in the counseling relationship. His spontaneity of interaction increases. He is challenged to use his own problem solving abilities. He is held accountable for his share in facilitating the therapeutic process.

As stated previously, in traditional psychoanalysis the analyst alone sets the goals of therapy. In non-directive counseling this function is turned over to the counselee. In the co-equal relationship, however, goals are seen as emergents of the creative interaction which arises between the counselor and counselee. The emerging goals are seen in terms of client growth, maturity, creativity, problem-solving capacity, self-realization, and so on. Thus

the co-equal goal is seen more as a creative process rather than viewed as the attainment of certain specific end-products such as removal of symptoms, offering solutions to problems, or uncovering oedipal conflicts. This emergent point of view is reflected by Erhrenwald (1956) who writes, "It [therapy] is a process aimed more at creation than at the finding of psychological evidence." Rogerians would undoubtedly accept all these goals as valid but would cast more of the responsibility of achieving them upon the counselee

than does the co-equal counselor.

Another theoretical innovation which the more equalitarian relationship brought about is the attenuation or elimination of the amount of probing into the past experiences (depth psychology) and the increased emphasis upon the "here and now." Rogers (1942, 1951, 1960) is to a large extent responsible for initiating this change. He avoided all probing into the past life of the counselee and thereby caused the counseling interaction to shift to a more current and conscious level of phenomena. Many of the co-equal therapists also have supported the "here and now" emphasis, and consequently have contributed significantly to its acceptance as a guiding principle in present

day counseling and psychotherapy.

The contention made by the supporters of the "here and now" focus is that the counselee will bring forth whatever is psychodynamically relevant and at whatever time he is best able to handle it. Thus, the counseling agenda more or less spontaneously arises from the counselee's thoughts and feelings, rather than being determined by the psychotherapist's searching for historical events in the early life of the patient or probing the unconscious for repressed material. The "here and now" principle is seen by co-equal counselors as the most economical and expeditious route for the attainment of therapeutic goals. Sullivan (1954) writes concerning the "here and now" issue, "... it is very important indeed to conduct the interview on the basis of that which is given in the interview." Alexander and French (1946) state on this point, "We should center the patient's attention upon his real problems and should turn his attention to the past only for the purposes of throwing light upon the motives for emotional reactions in the present." Moreno's (1958) position is, "The production (psychodrama) is focused upon the present instead of the past."

Still another adaptation accompanying the more co-equal distribution of control is the dropping of the "blank screen" role by the therapist. In its place

a more genuine, living relationship with the client is sought. Alexander and French (1946) speak on this point as follows, "We project the patient's behavior not against a blank screen but against a background of normal behavior, and the very fact that our behavior does not encourage the patient's irrational tendencies makes them all the more conspicuous when they do occur." Noted in this shift is the emphasis on the therapist taking a positive, healthy orientation toward the client instead of the Freudian approach focused on illness. Alexander and French (1946) also emphasize a more healthy focus when they state that they center, ". . . attention upon the dynamic potentialities of the patient's personality for healthy development, upon forces that must be actually utilized in the therapeutic process rather than upon the pathological mechanisms that are obstacles to treatment."

The classical psychoanalyst believes that a complete transference neurosis is the core of the therapeutic process. The non-directive counselor makes no use of the transference concept. The group of therapists leaning toward a coequal relationship generally modify or even abandon this technique. Therapists of this latter persuasion speak of controlling, diminishing, dampening, or keeping within limits the transference relationship. Some believe that in certain cases it is inadvisable or even dangerous to employ the technique. While many in the co-equal group advocate a very carefully controlled use of the transference phenomena, and even at times avoid its use, there are some who have completely renounced the conceptualization or have so

broadened the definition that its original meaning has been lost.

Alexander and French (1946) reflect this shift away from considering a transference neurosis as essential to treatment when they state, "... in therapy based upon emotional support, a transference neurosis is always a complication and has little positive value." At another place they write, concerning this issue, "A transference neurosis of moderate activity can be very profitably utilized ..." Horney (1939) broadens the concept of transference, by dropping the original meaning of "reactivation of past feelings," or "repetition of compulsions." She states her position as follows, "... neuroses are ultimately the expression of disturbances in human relationship, the analytic relationship is one special form of human relationship and existing disturbances are bound to appear here as they appear elsewhere. ..." Horney is even willing to abandon the term "transference." This attenuation or abandonment of the transference neurosis as a core element in therapy means that the dependency

relationship of the client is greatly reduced. The therapist, then, perceives and reacts to the patient's normal as well as neurotic behavior as it, more or less, spontaneously unfolds in the therapeutic relationship.

Still another shift noted in therapists' movement toward a more equal relationship is a sharp reduction in their use of the technique of interpretation. This tool is one of the most power-laden in the armamentarium of the directive counselor or the classical psychoanalyst. Theoretically, any extensive use of interpretation would be inconsistent with a co-equal philosophy of counseling. Consequently, those adhering to a more equalitarian relationship make very limited and judicious use of interpretation in their counseling. Interpretations offered by this group often take on more the characteristics of a tentative hypothesis suggested to the patient for exploration rather than as an authoritative dictum. In regards to the use of interpretation, Sullivan (1947) writes, "The supply of interpretations, like that of advice, greatly exceeds the need for them. Every patient has enough of his own misinterpretations and may well be spared the uncritical, autistic reveries of his physician." Sullivan continues, "Some psychiatrists, particularly some psychoanalysts, are prone to much interpretation of the material expressed by their patients." Yet Sullivan does not deny the value of interpretation as a therapeutic technique. He states, ". . . at the same time some interpretations are indispensable." Fromm-Reichmann's (1959) position concerning the use of interpretation has been described as follows, "She never insisted that a single interpretation was the correct one;" and "She was ever reluctant to offer interpretations herself and preferred to listen."

Finally, even the most basic concept in counseling and psychotherapy, namely insight, has been challenged by Hobbs, Diethelm, and others. As Monroe (1955) points out, practically all schools of counseling and psychotherapy view insight as the crux of the therapeutic process. Diethelm questions this core concept in his (1958) statement, "The therapeutic stress on insight is linked to the high value placed on intellectual functions in our culture and to insufficient evaluation of emotional, biological and social factors—a bias in favor of intelligence which many protagonists of the importance of insight would deny indignantly." Hobbs' (1962) attack upon insight as a therapeutic tool is stated in this manner, "I suggest that insight is not a cause of change but a possible result of change. It is not the source of therapeutic gain but one of a number of possible consequences of gain. It may or may not

occur in therapy; whether it does or not is inconsequential, since it reflects only the preferred modes of expression of the therapist or client. It is not a change agent, it is a by-product of change." The questioning of insight as a core concept in psychotherapy presents a serious challenge to the basic role and function of traditionally oriented counselors.

In retrospect, the changes which are bringing about the evolution of Model III, the co-equal participation of counselor and counselee, are in no small way a resultant of the inverse theoretical position taken by Rogers (1942, 1951), to Model I, the authoritarian role of the counselor and the acquiescent compliance of the counselee. Rogers' non-directive model brought into focus many of the issues which are involved in the shift toward a more co-equal type of counseling relationship. Recently even Rogers (1961) appears to accept a nearer middle viewpoint, at least in terms of the emotional commitment and involvement of the counselor in the therapeutic process. His shift seems apparent in his more current statements: "The failure of any such approach through the intellect has forced me to recognize the change appears to come about through experience in a relationship." "It is a real achievement when we can learn, even in certain relationships or at times in those relationships, that it is safe to care, that it is safe to relate to the other person for whom we have positive feelings." "Most of all I want him (client) to encounter me as a real person." "What I am and what I feel are good enough to be a basis for therapy." Rogers apparently no longer fears a genuine and real emotional involvement between counselor-counselee and now apparently even sees this dimension of interpersonal relationship as holding potential therapeutic possibilities.

The "co-equal" model of counseling and psychotherapy appears to be gaining clarity through its practical use in counseling. The therapeutic potentialities and dimensions of this co-equal approach need to be pursued not only in practice but also by theoretical explorations followed by systematic research in order to establish further its strengths and to point out its weaknesses. At this time, the co-equal type model of distribution of authority between counseler and counselor appears to hold great promise and also to offer challenge to counselors, to counseling theory and, hopefully, to productive research in this area.

SUMMARY. Analysis of the distribution of initiative and responsibility be-

tween counselor and counselee reveals it as a basic determinant of many of the important variables inherent in current theories and practices of counseling and psychotherapy. The theoretical position presented here is that once the distribution of these components is established between counselor and client, then rather clear-cut statements can be made about the nature of the therapeutic relationship and its outcomes.

This paper points out how the allocation of initiative and responsibility in counseling and psychotherapy determines who sets the goals, who directs the therapeutic process, who makes evaluations and judgments, who determines plans and actions, and so on. Furthermore, the distribution is shown as being related to the physical setting and arrangement in which counseling takes place; what types of therapeutic tools and techniques become available to the therapist; who defines the nature of therapeutic processes involved; and how attainable goals are to be delineated. Finally, even the nature of the emotional relationship which evolves between counselor and counselee is considered as directly related to these variables.

WHICH MODEL? The question is often raised, "Which model is best?" This question is faulty in itself because it implies an inherent superiority of one model over another. A better question would be, "When is it appropriate to use a given model?" There appear to be times when each of the three models of counselor-counselee relationship (and those in between) might appropriately be employed. Likewise, there are circumstances in which each can be inappropriately used. The selection of a model by which the counselor functions seems dependent first upon the client's needs and problems, and secondly upon the counselor's ability to utilize a particular type of interpersonal relationship according to the demands of the situation. The fitting of the most effective model to a client's needs raises many interesting and challenging theoretical and research issues.

In actual practice, a counselor may employ one model with one person and a different one with another. It is also likely that a counselor may shift from one model to another at different times when working with the same individual. In general, it would appear that the counselor who has the ability to work across a wide range of role relationships appears to be better qualified to serve a greater number of counselees and assist with a greater variety of problems. While such a flexible position increases the potential

effectiveness of the counselor, it, at the same time, demands of him much greater knowledge and skill as well as much deeper understanding of self than if he adheres to a single model.

The writer's contention is that no one model has universal application. The counselor who must religiously hold to one model probably should accept as clients or patients only those whom he believes can profit by its application. Those clients whose needs cannot be served by the counselor's orientation should be referred to others. In conclusion, it would appear to be evident that all models have some merit in certain situations. The use of any one, or a variety of, models in any given counseling situation is a professional decision which the therapist must make and for which he must take the responsibility for its outcomes.

## \*THE REFERRAL TASK IN COUNSELING

\* Reprinted, with permission, from *The Personnel and Guidance Journal*, American Personnel and Guidance Association, January, 1962

Every professional worker whose role is to help other people frequently encounters cases which, for one reason or another, involve the referral aspect of counseling. This is true regardless of the amount of training or experience of the counselor. This referral task often presents many complex issues and problems which are not easily resolved. The challenge of this responsibility is felt by ministers, lawyers, social workers, mental health specialists, psychologists, and other professionals who are in a service or helping relationship with persons. There are no easy rules to follow or prescribed ways of handling this important aspect of the counseling relationship, but some contribution may be made by considering some of the issues and problems which are involved in the referral process.

Referral is an old, recognized, and frequently used aspect of counseling, but a survey of the literature shows that it is a much neglected topic. It is only meagerly treated in training textbooks and professional journals and almost totally neglected as an area of research. The field of social work has given the most extensive treatment to the subject.

This paper attempts to serve an exploratory function by raising some of the issues and problems involved in the referral process, possibly stimulating some objective observations and research, or perhaps providing some help for those professionals who must make referral decisions in their daily work.

For purposes of analysis and discussion, the referral task is broken down into three phases: factors involved in the counselor's decision to make a referral; the referral act itself: and the "follow-up." Each of these aspects is treated in the following three sections of this paper.

The referral decision is a professional responsibility of the counselor. Since persons coming to a non-medical counselor are usually not screened, the counselor probably will come face to face, sooner or later, with the gamut of human ills and woes. Problems will range from simple requests for factual information to those involving serious mental disturbances. A professional counselor is expected to have sufficient skills and abilities which will enable him to make a preliminary appraisal of the person's trouble. Some will present problems which easily define themselves, while others will present a more difficult situation. The non-medical counselor is not expected or permitted to make a medical diagnosis, but he is expected to recognize signs which indicate in general whether medical or other type referral is needed. The primary responsibility of a counselor is to get the person to more adequate sources of assistance if he himself is unable or unqualified to render the necessary services.

In analyzing the referral decision, attention will first be given to criteria that can be used in the decision making. Second consideration will be given to the counselor's need for factual knowledge of community resources if an intelligent referral is to be made.

Criteria for Referral Decisions. Presented here are three sets of criteria which may guide the counselor in making a referral decision: (1) professional competency; (2) legal regulations; and (3) personal factors. Underlying these criteria is the guiding principle that all referral decisions must be made in terms of what is best for the person involved.

1. The professional criteria fall into two categories. Both involve a professional appraisal by the counselor. First, he must make an evaluation of the

needs of the person with whom he counsels. Second, he must assess his own ability and resources to render the necessary services.

Appraisal of a client's needs is one of the most demanding in the whole counseling process. The initial phase of the counselor-client relationship calls for the application of maximum counseling skills, extensive use of technical and professional knowledge, and the integration and interpretation of complex personality data. When a person calls for help, the experienced counselor has many questions running through his thinking, such as:

Why does this person come to me? What are his needs and problems? What does this person expect of me? In what role does he perceive me? What are my resources for helping this person?

Sometimes the answers to such inquiries come quickly and easily, but more often it is a slower and more complex task. In the end the counselor must

make a decision as to major problems the client is presenting to him.

The second phase of the professional aspects involved in a referral decision comprises an assessment of the counselor's competency and resources to meet the needs of the client. The test of professional competency involves an evaluation of his professional training, experience, skills, knowledge, areas of specialization, and command of services or resources. If he feels that the person's best interest and welfare may be, or can be, better met by another, then it is ethically mandatory that a referral be made. The referral can be for advisory opinion, joint care and responsibility, or complete transfer of the troubled person to another.

2. A second set of criteria involved in a referral decision are legal regulations. In certain cases the law designates which professional group or which particular agency has the authority to perform certain services. For example, medical diagnosis and treatment are restricted by law to licensed physicians. Likewise, the law may state which agency may care for certain types of cases, such as neglected and dependent children. Similarly, the law may establish certain regulations for admission to hospitals or eligibility for welfare services. The counselor should know the laws of his state and community so that when necessary he can make referrals expeditiously and in ac-

cordance with the legal provisions.

3. Any counselor may refer a person to another counselor if, for personal reasons, he prefers not to work with him or cannot work with him at the time. Even in such instances, the counselor is professionally responsible for the referral to sources where the person can receive the care or services his case demands.

Knowledge of Community Resources. The counselor's knowledge of community resources is a prerequisite if he is to function satisfactorily in referral. Locating available sources of help is often a difficult task for both clients and counselors. This is true because of the changing nature of professional memberships and service agencies in a community, the often limited resources available in the area, and the lack of central clearing agencies. Such knowledge of a community can be acquired only by an investment of counselor time and effort. Often in larger communities central agencies, such as the county medical society, a mental health information center, child and family welfare agencies, schools and universities, Red Cross, juvenile authorities, various state and national agencies, and others, can help the counselor to locate professional and institutional services. Many communities have contributed to the health and welfare of their area by establishing central clearing offices whose task is to maintain a current listing of available resources for the benefit of both clients and professional workers.

Not only does the counselor need to know the names and locations of referral resources, but he also should have some knowledge concerning how the client will be received and treated. Only a personal knowledge of institutions and professional workers will provide information as to their respective

ways of functioning and the quality of services rendered.

A vexing problem arises when no appropriate help and resources are available in a community. The counselor in such a situation can look to more distant resources, such as state and federal offices, philanthropic agencies and institutions, national professional societies, and so on. Often such high-level resources can direct the inquirer to available assistance if they are not able to render direct help.

The counselor who observes an absence of needed services in the local community may profitably call the situation to the attention of professional groups, service clubs, educational organizations, religious bodies, and other influential groups. Often when local needs are spelled out, communities re-

spond by developing needed services or attracting required professional assistance to meet local demands.

THE REFERRAL ITSELF. Once a counselor decides that a referral is indicated, then another set of issues and problems arises. Some of these are reflected in the following questions:

How shall the counselor relate the referral decision to the client?

How about the confidence of the record if others are to be involved in the case?

Should the client be involved in the selection of the person or place to whom he is referred?

Should the client participate in the actual making of referral arrangements? What should the counselor transmit to the referral agency?

Such questions as these raise some fundamental issues which have roots in various current theories of counseling.

One question that confronts the counselor in each referral action is: How is he to transmit the decision to the client? It is a simple task for the counselor to give the counselee such facts as the agency or professional's name, address, telephone number, and so on. Another, and usually a more difficult task, is encountered in handling the emotional or psychological elements involved in a referral suggestion. Often it is precisely at this point that the referral process breaks down, as a client is unable to accept the recommendations or to carry them out. The counselor should be ready to handle these important psychological dimensions of referral as well as the more factual aspects.

The referral process at this point appears to be facilitated by getting the client to participate in working out his own problems with the counselor's assistance. This procedure can be approached by getting the client to discuss his problems, consider reasons for the referral, evaluate possible sources of help, and assist in the selection of a specific agency or professional. The skilled counselor knows that a client who is given the chance to participate in his future can resolve some of his feelings, anxiety, and resistance to a referral. This in itself is therapeutic progress.

Sometimes the problem that blocks a referral is the resistance of parents, relatives, and friends of the person. In such cases the counselor may have to work with these other persons in an effort to help them understand

the referral. The client who accepts the referral and is supported by those around him is seen in general as having a more favorable prognosis for the ultimate outcome of his care and treatment.

Another issue which can arise in referral counseling is whether or not the counselee should be told the facts about a referral. Except for very disturbed persons, the general opinion supports a forthright statement to him of the facts and opinions involved in the decision. This may include a discussion of the nature of the counselee's problem, the need for a particular type of care, and the nature of the agency or professional help to whom he is being referred. The counselor should have the ability to make simple and understandable statements concerning facts in the case so the communication and procedure are meaningful. This does not mean giving a detailed diagnostic description or being brutally frank. Certainly the element of honesty suggests that it is best to avoid euphemistic terminology, evasive statements of issues, misrepresentation of facts, or any other distortion of the situation which is of concern or of importance to the person. Often deceptive reporting practices can lead the counselee into subsequent situations which may have deleterious consequences. The counselor must be prepared to accept the reality factors of the referral decision and work through any emotional reactions which the suggestion invokes in the counselee.

After referral has been accepted by the client, then other issues logically arise. One of these is the degree to which the counselee should be involved in the selection of the referral source and in the subsequent arrangements for an appointment. Again, except for severely disturbed or incapacitated persons, it usually appears beneficial for the client to participate in the process. He might be given several sources of help and then encouraged to express his feelings and preferences in the matter. Likewise, joint planning for the

specific appointment frequently seems desirable.

Still another problem is encountered in handling the confidence of the record when a referral is to be instituted and others become involved. Many persons are fearful of the release of case material, and the counselor needs to work through this problem with them. In most instances the counselor can, by careful treatment of the subject, obtain consent and approval for the transfer of data needed by those who will care for the client. The counselor must take the responsibility for assiduously protecting the confidence of the record at all times, and he should only release it to those professional persons bear-

ing a direct responsibility for the continuing relationship with the counselee.

The counselor has an obligation to give the client all the necessary facts to get him to the referral source. This may include giving the name of the agency or professional worker to whom he is to be sent, the address, date and time of appointment, means of transportation, cost of service, person to contact, and other facts. Many a referral has broken down because the client was not given specific instruction when the referral was made. The counselee should not be sent on a "shopping tour" to find help for himself.

Finally, the counselor should transmit to the professional person who will receive the counselee all the necessary facts and opinions he has which appear relevant to the client's future. These data should be transferred sufficiently in advance so that those who are to assume responsibility will have time to read the report and make adequate preparation for the client's arrival. This exchange of case material can be made by telephone, mail, or office visit according to the practices and preferences of those to whom the client is sent.

The counselor can feel a real accomplishment when the client realizes that the whole referral process was a continuous, orderly, and friendly act where his care and welfare have been the principal concern of all involved.

THE FOLLOW-UP. The counselor's job is not done when the counselee leaves his office. Every counselor has a professional responsibility of evaluating the appropriateness and effectiveness of his referral work. Follow-up involves an assessment as to how the counselee judges the referral and how the agency or professionals who receive the case evaluate the referral transaction. Such feed-back data can help the counselor to determine the quality of his services and to improve his future referral work.

The counselor's professional responsibility during the follow-up period is reflected in such questions as these:

Did the client keep the referral appointment? If not, why not?
Did the counselor select the appropriate source of help for the client?
Could the referral have been better executed administratively?
Did the client feel the referral was properly and effectively carried out?

The answers to such inquiries permit the counselor not only to check the effectiveness of a specific referral but also provide "feedback" which should add

to his general referral knowledge and should improve the future effectiveness of such transactions. However, breakdowns in the referral process may be due to forces beyond the control of the counselor. It is only by follow-up studies that a proper assessment of the counselor's work can be achieved.

The follow-up evaluation can be done by telephone, personal contacts, letters, or reports. In carrying out the task the counselor should keep within the policies and procedures of the agency or professional group involved and make a minimum demand upon time of others. There is a growing practice of agencies and professionals who receive a client to report back to the person making the referral. Basically, the evaluation of the referral process is a

professional responsibility of both sides involved in such a transfer.

In a referral action the shift in professional reponsibility must be clearly defined. If the decision is continuing joint responsibility, then the counselor may keep active according to his delegated duties. If others are to take over the total professional reponsibility, then the counselor should carefully avoid future involvement. This does not mean a counselor cannot inquire about the progress of the client after a referral has been completed, nor does he need to refrain from giving his views if he is asked to do so.

conclusion. The referral function of counselors is today recognized as crucial. The early detection of mentally, physically, or socially ill individuals is seen as a most important link in the national effort to improve the health and welfare of our society. Non-medical counselors, such as ministers, lawyers, welfare workers, and others, are in a critical position to render aid in this task of early detection and referral because of their daily contacts with people. Society expects counselors to recognize serious problems and discharge the referral function appropriately.

At the same time, counselors know they must not overstep the limits of their own ability and training; hence the necessity to evaluate each counseling relationship and come to a careful decision concerning whether a referral

is demanded.

## REFERENCES

Alexander, F., Fundamentals of Psychoanalysis. New York: Norton, 1948.

Alexander, F., Psychoanalysis and Psychotherapy. New York: Norton, 1956.

Alexander, F. and French, T. M., Psychoanalytic Therapy. New York: Ronald, 1946.

Blake, R. R. and Morton, Jane S., Group Dynamics-Key to Decision Making. Houston: Gulf Publishing Co., 1961.

Brill, A. A., Lectures on Psychoanalytic Psychiatry. New York: Knopf, 1946.

Cartwright, D. and Zander, A., Group Dynamics: Research and Theory. Evanston, Ill.: Row, Peterson and Co., 1953.

Diethelm, O., "Some Guiding Concepts in Dynamic Psychotherapy," *Progress in Psychotherapy*. J. H. Masserman and J. L. Moreno (eds.) New York: Grune and Stratton, 1958, pp. 55–62.

Erhrenwald, J., "Doctrinal Compliance in Psychotherapy and Problems of Scientific Methodology," *Progress in Psychotherapy*. J. H. Masserman and J. L. Moreno (eds.) New York: Grune and Stratton, 1958, pp. 44–54.

Fenichel, O., The Psychoanalytic Theory of Neurosis. New York: Norton, 1945.

Ferenczi, S., Contributions to Psychoanalysis. Boston: Bager, 1916.

Ferenczi, S., Further Contributions to the Theory and Technique of Psychoanalysis. London: Holgarth, 1926.

Freud, S., A General Introduction to Psychoanalysis. New York: Boni and Liverright, 1920.

Freud, S., The Interpretation of Dreams. New York: Modern Library, 1938. Fromm, E., Escape from Freedom. New York: Farrar and Rhinehart, 1941.

Fromm-Reichmann, Freida, Psychoanalysis and Psychotherapy. Chicago: University of Chicago Press, 1959.

Gill, M., Newman, R. and Redlick, F. C., *The Initial Interview*. International Universities Press, New York, 1954.

Healy, W., Bronner, A. F., and Bowers, A. M., The Structure and Meaning of Psychoanalysis. New York: Knopf, 1930.

Hendrick, I., Facts and Theories of Psychoanalysis. New York: Knopf, 1948.

Hobbs, N., "Sources of Gain in Psychotherapy," American Psychologist. 1962, Vol. 17, pp. 741–747.

Horney, Karen, New Ways in Psychoanalysis. New York: Norton, 1939.

Lorrand, S., Techniques of Psychoanalytic Therapy. New York: International Universities Press, 1946.

May, R., The Meaning of Anxiety. New York: Ronald Press, 1951.

Moreno, J. L., Who Shall Survive? Beacon (N.Y.): Beacon House, 1953.

Moreno, J. L., "Fundamental Rules and Techniques of Psychodrama," Progress in Psychotherapy. J. H. Masserman and J. L. Moreno (eds.) New York: Grune and Stratton, 1958. Monroe, Ruth, Schools of Psychoanalytic Thought. New York: Henry Holt and Co., 1955.

Rank, O., Will Therapy and Truth and Reality. New York: Knopf, 1945.

Rogers, C. R., Counseling and Psychotherapy. Boston: Houghton Mifflin, 1942.

Rogers, C. R., Client-Centered Therapy. Boston: Houghton Mifflin, 1951. Rogers, C. R., On Becoming a Person. Boston: Houghton Mifflin, 1961.

Sullivan, H. S., Conceptions of Modern Psychiatry. Washington: William Allison White Psychiatric Foundation, 1947.

Sullivan, H. S., The Interpersonal Theory of Psychiatry. Helen Swich Perry and Mary Ladd Gawel (eds.). New York: Norton, 1953.

Sullivan, H. S., The Psychiatric Interview. Helen Swich Perry and Mary Ladd Gawel (eds.). New York: Norton, 1954.

Wolberg, L. R., The Technique of Psychotherapy. Grune and Stratton, New York, 1954.

Zetzel, Elizabeth R., "Current Concepts of Transference," International Journal of Psychoanalysis, 1956, Vol. 37, pp. 369–376.

Zilborg, G., A History of Medical Psychology. New York: Norton, 1941.

