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Abstract

The researchers examined the relationship between cognitive complexity, attribution styles, and demographic variables of 86 counselors-in-training concerning the cause of and solution to clients' problems. A significant relationship was found between counselors' moral attribution styles and cognitive complexity levels. Differences were found in general preferences for specific attribution styles for the counselors studied as well as by training level. Implications of the findings for counselor preparation and training are discussed.

Keywords

Attributions, Counselor Preparation, Cognitive Complexity

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The researchers examined the relationship between cognitive complexity, attribution styles, and demographic variables of 86 counselors-in-training concerning the cause of and solution to clients' problems. A significant relationship was found between counselors' moral attribution styles and cognitive complexity levels. Differences were found in general preferences for specific attribution styles for the counselors studied as well as by training level. Implications of the findings for counselor preparation and training are discussed.

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The attributions that counselors make regarding the cause of and solution to clients' problems directly affect both the counseling process and the client outcomes (e.g., symptom reduction, behavior change, or quality of life improvement; Stepleman, Darcy, & Tracey, 2005; Wall & Hayes, 2000). Researchers have argued that the attributions counselors make about their clients' problems have a direct influence on: selection of counseling strategies (Zinnbauer & Pargament, 2000); formation and completion of counseling goals; evaluation of treatment success (Kernes & McWhirter, 2001); assessment of the issues presented by the client (Hayes & Wall, 1998); decision-making process (Jackson, Holt, & Nelson, 2005); recognition of symptoms (Murdock & Fremont, 1989); case conceptualization processes; early termination rates (Tracey, 1988; Worthington & Atkinson, 1993); the counseling relationship and therapeutic alliance (Wall & Hayes, 2000); and the overall quality of service delivery (Stepleman et al., 2005).

Despite the significant role counselor attributions demonstrably have in relation to both the counseling process and client outcomes, little is known about the factors that influence how attributions about clients' problems are made. In the last two decades, only a few studies have focused on this issue, factor influence and counselor attribution (Kernes & McWhirter, 2001; Murdock & Fremont, 1989; Stepleman et al., 2005; Tracey, 1988; Wall & Hayes, 2000; Worthington & Atkinson, 1993; Zinnbauer & Pargament, 2000). Thus, an examination of personal variables that may contribute to the attribution styles constructed by counselors-in-training may be an important focus for research and may have implications for therapist training and practice. For the purpose of this research study, attributions are defined as inferences counselors make regarding the cause of and solution to difficulties reported by clients (Brickman et al., 1982).

Cognitive Complexity and Conceptualization of Client Problems

Cognitive complexity is one variable that can impact counselor attribution styles. Cognitive complexity is "the ability to absorb, integrate, and make use of multiple perspectives" (Granello, 2010, p. 92). Counselors frequently manage multiple variables when assessing their clients' problems; and cognitive complexity can be viewed as the method used to differentiate and organize those variables. Numerous factors can impact the myriad responsibilities inherent in counseling, including: gathering multiple sources of data and looking at the consistency in information from these data (i.e., referral information, client statements, nonverbal cues, histories, and test results); formulating hypotheses concerning the nature, origin, and treatment of client issues; attending to multicultural dynamics; understanding the counseling process; and utilizing counseling theories, each of which require complex cognitive processes (Pfeiffer, Whelan, & Martin, 2000; Stoltenberg, McNeill, & Delworth, 1998).

The importance of developing a counselor's cognitive complexity skills is clear, considering its impact on treatment decisions. Fortunately, it's been shown that cognitive complexity responds and develops well within closely supervised training experiences (Duys & Hedstrom, 2000). From these experiences, a counselor's cognitive complexity is usually able to demonstrate an improvement in several clinically beneficial areas. Researchers have found that higher conceptually functioning counselors are: (a) less apt to consider their clients in a negative light, more objective when reporting events in sessions, and are more focused on the counseling process (Borders, 1989); (b) more comfortable with ambiguity, more multiculturally sensitive, more confident, and demonstrably less biased and anxious (Jennings & Skovholt, 1999); and (c) more flexible in the selection of counseling strategies and are more empathic communicators (Benack, 1988). Considering the array of problems facing today's client, it is more critical than ever to further these higher-level counseling skills through cognitive complexity development within all counselor-in-training programs. The authors define cognitive complexity as the degree of social differentiation or the number of interpersonal constructs a person can use to define social reality (Crockett, 1965; Kelly, 1955).

Brickman's Models of Helping and Coping

A useful approach to understanding counselors' attribution styles can be found in Brickman et al.'s (1982) four models of helping and coping. Brickman et al.'s (1982) models of helping and coping provide a theoretical framework for assessing and classifying the specific types of behaviors counselors engage in when they try to help others or themselves. These models describe case conceptualization polarities using a combination of possibilities that attribute whether clients are held responsible or not for causing and solving their problems. The models focus on three areas: the decisions counselors make to help their clients (i.e., material aid, psychotherapy, support groups, etc.), which choices are most appropriate, and the consequences of those choices. For example, counselors who hold clients responsible for the cause of and solution to their problems may have different expectations for their clients than a counselor who acknowledges the influences that multiple ecological systems have on a client's well-being.

Brickman's et al.'s (1982) four orientations of helping and coping attribute whether a person has a high or a low self-responsibility for the cause and solution to personal issues and problems, with the attribution made to one of the four models. The Moral model is the first

choice (in no particular order), and according to its perspective, clients are attributed the responsibility for creating their problems and likewise, solving them. Problems are seen as resulting from the lack of effort deemed necessary and sufficient to create change. Counselors who ascribe to the Moral model remind clients of their personal responsibility for overcoming their problems. In contrast, counselors who subscribe to the second model, the Medical model, see clients as having low responsibility for both the cause of and solution to their problems. Counselors who endorse the Medical model view clients as incapable of helping themselves without expert assistance. The third model, the Enlightenment model, posits that clients are not responsible for the solutions to their problems, but are held responsible for the cause of their problems. Counselors adhering to the Enlightenment model determine that client difficulties can be solved by enlightening clients to the reality that problems are beyond their control, and that an expert can help create change. Finally, the fourth model, the Compensatory model, views clients as not responsible for causing their problems, but they are responsible for solving them. Problems are seen as resulting from a lack of resources and opportunities necessary to create change. Based on this last model, advocating with and on behalf of clients is an important tool for change, as well as empowering an egalitarian partnering relationship.

As previously mentioned, little is known about the causal attributions that counselors make, or about how those attributions relate to levels of cognitive complexity. To date, no published study has been found that examines the relationship between attribution styles and levels of cognitive complexity. Indeed, the examination of similar attribution variables within the counseling field is relatively nonexistent in the literature and clinical research (Stepleman et al., 2005). Therefore, the purpose of this research study has been to examine the relationship between cognitive complexity and attribution style and the affect several counselor demographic differences have on this relationship. To address this purpose, the researchers posed the following research question: What is the relationship between the level of cognitive complexity and the attribution style of a counselor-in-training? The sub-question was: How are the demographic variables of sex, race/ethnicity, age, program affiliation, theoretical orientation, and level of training related to the attribution styles of counselors-in-training?

Method

Participants

The participants were master's-level graduate students enrolled in a counseling program at two Midwestern Universities, both accredited by the Council for Accreditation of Counseling and Related Educational Program (CACREP). Eighty-six counselors-in-training volunteered to participate in the research study. The percentage of female and male participants in this study was 84% (n = 73) and 15% (n = 13) respectively. The ethnic composition (percentages rounded) of participants was 81% Caucasian/White (n = 70), 8% African American (n = 7), 7% Hispanic/Latino (n = 6), 1 % Asian/Pacific Islander (n = 1), 1% Multiracial (n = 1), and 1% Middle Eastern (n = 1). The majority of the sample at 47% was aged 25 or under (n =40), 43% of participants were between the ages of 26-40 (n = 37), 8% were between ages 41-56 (n = 7), and 2% of participants were 57 or older (n = 2). Of the 86 graduate students who volunteered to participate in the study, 50% were enrolled in a school counseling program (n = 43), 38% mental health counseling (n = 33), 8% rehabilitation counseling (n = 7); 2% career counseling (n = 2), and 1% student affairs/student development (n = 1). Perceived theoretical orientation break

down was as follows: 24% Person-Centered (*n* = 21), 17% Cognitive Behavioral (*n* = 15), 17% Adlerian (*n* = 15), 8% Reality (*n* = 7), 5% Existential (*n* = 4), 3% Behavioral (*n* = 3), 3% Eclectic (n = 3), 2% Gestalt (n = 2), 1% Psychoanalytic (n = 1), 1% Humanistic (n = 1), 1% Solution Focused (n = 1), 1% Family Systems (n = 1), and 14% undecided (n = 12). Counselors were asked to report the number of completed and currently enrolled credit hours. 34% (*n* = 29) had completed between 0-9 credit hours, 23% (*n* = 20) had completed 10-21 credit hours, 31% (*n* = 27) had completed 22-31 credit hours, and 11 percent (*n* = 10) had completed 32- 41 credit hours. Lastly, 48% (*n* = 41) were currently enrolled in 0-6 credit hours, 50% (*n* = 43) were enrolled in 7-12 credit hours, and 2% (*n* = 2) of participants were currently enrolled in 13-18 credit hours.

Instruments

In this study, attribution styles were measured by the Helping and Coping Orientations Measure (HCOM; Michlitsch & Frankel, 1989). The HCOM was developed to measure how the attribution of a client's responsibility for the cause of and solution to their problem affects counseling interventions, making HCOM valuable in counselor training. The HCOM contains 25 statements related to the general population about which participants in the study indicate their agreement by using a 5-point scale ranging from strongly disagree (1) to strongly agree (5). Each statement relates to one of Brickman et al.'s (1982) four models of helping and coping. The HCOM contains four subscales, each consisting of 5 to 7 items corresponding to the four models of helping and coping (Medical, Enlightenment, Moral, and Compensatory). For example, the statement "For the best results people should rely upon experts to solve their problems" corresponds to the Medical model. The statement "Behind every problem faced is someone not doing something they should have" corresponds to the Enlightenment model. The statement "The real solution to people's problems must come from them" corresponds to the Moral model. Finally, the statement "People are not given an opportunity [to] solve their problems" corresponds to the Compensatory, or Empowerment, model. Participants are classified into the model for which they had the highest subscale score on the HCOM. Internal consistency for the subscales has been reported to range from .56 to .86 (McCracken, Hayes, & Dell, 1997; Michlitsch, & Frankel, 1989), which is generally higher than other instruments used to measure Brickman et al.'s theory (Karuza, Zevon, Gleason, Karuza, & Nash, 1990; Tracey, 1988). In order to directly compare the scale results to each other, the scores on the HCOM were converted to percentiles due to an unequal number of statements associated with each attribution scale.

Cognitive complexity (Crockett, 1965; Kelly, 1955) was measured by the Role Category Questionnaire (Crockett, Press, Delia, & Kenney, 1974), and standardized by Burleson and Waltman (1988). The Role Category Questionnaire (RCQ) consists of two open-ended questions asking the examinee to describe in writing two personally well-known peers. The first peer is identified as someone the examinee likes, and the second is identified as someone the examinee does not like. The RCQ generates a score that is an estimate of social differentiation. This is obtained by counting the number of distinct constructs a person can hold constant at one time about another individual. Because written responses are limited to five minutes per question, responses are considered to be a sample of the participant's level of differentiation or cognitive complexity.

Test-retest reliability values of .84 and .86 for the RCQ over a 1-month period were reported by O'Keefe, Shepherd and Streeter (1982). Another study reported a test-retest

reliability value of .95 over a 4-month period (Crockett et al., 1974). With regard to validity, higher RCQ scores were shown to be positively associated with higher levels of trait differentiation (Meyer, 1996). Persons who scored higher on the RCQ were able to activate more conceptual knowledge of another individual (Meyer, 1996). Higher RCQ scores were found to be associated with higher social cognition skills, such as social perspective-taking and social construct abstractness (O'Keefe & Sypher, 1981). Although positive correlations were found between higher chronological age and elevated scores on the RCQ (Scarlett, Press, & Crockett, 1971), RCQ scores have been shown to be unrelated to intelligence (Allen, Mabry, & Preiss, 1997). The RCQ scores have also been shown to be unrelated to writing skill levels (Burleson & Rowan, 1985).

Data Collection

The researchers obtained Institutional Review Board (IRB) approval before data collection. A brief, prepared script was orally presented to participants in their classrooms by the first author, which outlined key information regarding the proposed study and which invited students to participate on a voluntary, non-incentive basis. Participants responded to a three-part paper-and-pencil survey. In Part 1 of the survey, participants answered multiple choice demographic questions about their sex, age, race/ethnicity, number of course credit hours completed in the counseling program, number of credit hours currently being taken in the counseling program, program affiliation, and preferred theoretical orientation. In Part 2 of the survey, participants filled out the HCOM scale, which queried participants' beliefs about helping. Part 3 of the survey was explained in detail on the subsequent page of the survey. Participants were given 10 minutes to complete the RCQ. The data collection took approximately 25-30 minutes to complete (either before or after class) and was accomplished in multiple classrooms on the campuses of the two Midwestern universities used in the study.

Results

The present study examined the relationship among cognitive complexity levels, demographic variables, and attribution styles of counselors-in-training. Scores on the RCQ were correlated with the HCOM survey results, along with the identification of demographic variables. The cognitive complexity levels of counselors were somewhat related to attribution. Specifically, RCQ scores and the Moral model were found to be significantly related (r =.32, p = .003). While statistically significant, this is a relatively small effect size. Gender differences, race/ethnicity, and attribution styles were not found to be significantly related. However, this may simply be an artifact associated with the small numbers of male participants and persons of color. Completed course hours were found to be negatively correlated with the Enlightenment (r = -227, p = .035) and Medical model attribution styles (r = -223, p = .039).

Counselors showed significant differences between preferences for models when grouped by program affiliation (p=.041). Graduate students in school counseling programs scored slightly higher (M = 72.7) on the Compensatory model than students in mental health programs (M = 69.1). However, a much larger difference (p = .000) was observed between counselors' preference for the Compensatory (M = 70.74) and Moral (M = 70.83) attribution styles versus the Medical (M = 45.45) and Enlightenment (M = 44.03) attribution styles. Counselors' theoretical orientations and attribution styles were not found to be significantly different. Lastly,

a multiple regression analysis was performed that included all significant correlations described above. This was done to examine the overall contribution of significant variables to variance, as explained by attribution style and the nature of the measured regression slope; results showed no significant findings.

Lastly, multiple regression analyses were performed on the attribution style categories-including all significant correlations described above [A11]. This was done to examine the contribution of these variables to the variance in attribution scores (specifically, the RCQ scores, program membership, and the number of course hours completed). Only the regression results associated with the Enlightenment style showed a significant predictive relationship. The regression model was Enlightenment = 46.3 - 0.072 RCQ + 2.65 Program of Study - 2.18 Completed Credit Hours (R = 32.7, p=.026).

Discussion

The purpose of this study was to examine the relationship between cognitive complexity and attribution style. In addition, the study investigated how demographic variables of gender, race/ethnicity, program affiliation, theoretical orientation, and level of training related to the attribution styles of counselors-in-training. This study yielded some significant findings.

First, particular attribution styles appear to be positively related with cognitive complexity. In this study, counselors-in-training who ascribed to the Moral model had higher levels of cognitive complexity. The Moral model of helping holds clients responsible for creating and solving their own problems. By extension, counseling interventions based on this model would stress client empowerment, enabling clients to design and effect their own problem-solving actions. The limitation of this perspective, however, is its disregard for the impact of oppression and other external, systemic factors on the well-being of clients. Further, collaborative efforts to develop multi-systemic counseling strategies (i.e., advocacy, social action, partnerships) to overcome barriers may be overlooked (Greenleaf & Williams, 2009).

Second, the number of completed graduate course hours seems to have a negative relationship with certain attribution styles. Specifically, the further students were in their counseling program, the less likely they were to adhere to the Enlightenment and the Medical models of helping and coping, models which attribute low responsibility for clients solving their own problems. This finding seems to support the emphasis that counselor training programs place on client-lead solutions and empowerment approaches. Empowering methods help clients recognize their strengths and abilities, successfully solve future problems on their own, and often relate to shorter periods of treatment for successful change (Kettunen, Poskiparta, & Liimataninen, 2000).

Our third analysis revealed that counselors-in-training showed significant differences between counseling tracks (i.e., school and mental health counseling) and their preferences for specific models of helping and coping. For example, school counselors-in-training scored higher than mental health counselors-in-training on the Compensatory model subscale. Under the Compensatory model, clients are seen as being responsible for overcoming the problems created by barriers and obstacles in their social environment. In order to address these obstacles and barriers, counselors-in-training must learn to collaborate with other individuals and organizations to provide more comprehensive services for their clients. Therefore, counselors-in-training as a whole would do well to familiarize themselves with models of collaboration that guide them in building relationships with clients, families, and communities as partners in the assessment and

treatment process (Bryan, 2009). Such collaborations are important for addressing the social barriers that inhibit client growth and development, and contribute to their problems in living.

Fourth, the Enlightenment regression showed a significant result with the combination of the RCQ score and a counselor-in-training's completed course hours. It appears as students work through their graduate training program, their level of cognitive complexity increases and Enlightenment attribution of client problems decreases. The Enlightenment model views the solution to a client's problem as outside the client; therefore, clients are given scant hope of any real change as a result of their own efforts. The deficiencies of the Enlightenment model include the elevation of a counselor's expertise and the disempowerment of a client to solve personal problems.

Lastly, our fifth result supports Jackson et al.'s (2005) hypothesis that White/Caucasian counselors-in-training may, more often than not, identify with a Moral or a Compensatory model of helping; both share the perspective that clients are ultimately responsible for solving their problems. It remains unknown whether this pattern exists with other racial and culturally marginalized groups.

Implications

Counselors-in-training tend to make individualistic attributions. This means the focus is on individual people and problems, with solutions determined to be found within the client, whether that person has the resiliency or ability to solve issues or not. By locating the cause and solution of the problem strictly within the individual (i.e., the source and solution of the problem lies within the individual), counselors may fail to account for support systems and personal connections within the client's community, church, and family which could be significant factors in facilitating client healing (Minuchin, Colapinto, & Minuchin, 1998). This calls for more exposure to theories that identify the support systems and solutions which are available and may contribute to a healthy, affirmative resolution to the problem.

Counseling training programs which expose students early in their education to systemic/ecological perspective/theories of counseling would allow more time and opportunity for students to develop a broader perspective to the many social justice concerns that inhibit client growth and development. Actual training opportunities where students work directly with various diverse groups, have involvement in service-based learning experiences, and participate in unique practicum/internship situations would heighten awareness of the complexities that contribute to a client's situation. In other words, these opportunities may increase counselors-in-training awareness and understanding of the oppressive and pervasive nature of a client's situation and how it may affect overall well-being.

Moreover, developing the practice of formulating multiple or alternative hypotheses about a client, rather than allowing the first impression to guide the counseling interaction, is important initially and throughout the counseling relationship (Morrow and Deiden, 1992). Attributing problems after all situational factors have been assessed for their possible influences makes for a more confident and accurate decision, and one that will likely include external factors. Counselor educators could focus on multisystem case studies, community genograms, and ecological mapping exercises as a method to improve student case-conceptualizations skills. In addition, multicultural training, experiential learning, diversity discussions, and volunteer opportunities could expand awareness and cultural sensitivity. These opportunities might give

added insight into situational factors, which could help counselors-in-training guard against attribution bias and the determination that problems are solely based on internal factors.

Since the majority of mental health counselors-in-training who are White/Caucasian tend to choose the Moral model, this decision may be influenced by the cultural values and social norms prevalent in society (Sue & Sue, 2003). For example, some cultural value systems (e.g., Asian American, African American, Native American) may instead emphasize external causes for client difficulties (i.e., racism, oppression, lack of resources; Burkard & Knox, 2004). According to Burkard and Knox (2004), counselors from a Western cultural background are more inclined to emphasize an internal locus of control for client problems. Thus, it may be beneficial if all training programs incorporated a broader focus to include multiculturalism, social justice, advocacy and leadership, instead of relying on a single class (e.g., Multicultural Counseling) to do this work. Perhaps an opportunity to assess personal biases and stereotypical attitudes, regardless of a person's cultural heritage, would allow for adjustments to the prevailing viewpoints which affect the attributions made by all counselors-in-training. Why school counselors-in-training in this study were more likely to choose a Compensatory model than their mental health counterparts is not readily clear. It may be possible that the focus of school counseling on young people brings with it a recognition that students' academic, personal, and career concerns are heavily influenced by external factors outside their control, e.g., inadequate or abusive parenting, lack of food and health care, obstacles at home to studying.

Limitations and Future Research

The primary limitation of this study was our small sample size of diverse counselors-in-training. Counselors-in-training of different ethnic and racial backgrounds, geographical regions, and genders may have given a significantly different response from the 86 graduate students who participated in the current study. In addition, because the overall RCQ scores for the sample population were higher than average, the results may have been dampened by a ceiling effect. The inadequate sample size, characteristics, and demographic variables make the conclusions of this study more tentative. However, we believe these finding may still be meaningfully relevant for counselor educators and clinical supervisors as they make decisions concerning their counselor-in-training programs.

Future studies could examine other variables which may contribute to attribution preferences. Clearly, cognitive complexity is only one of the variables with an impact on attribution scoring. Other factors associated with developmental variables contributing to a preferred attribution style include worldview schemas, life experiences, orientations, assumptions about the human condition, and stereotypical thinking. Accordingly, a replication of this study using more male participants and more persons of color would elevate detection of group differences in attribution styles.

Conclusion

In determining "who's to blame," or how counselors-in-training make their causal attributions concerning client problems, this study has focused on cognitive complexity and its role in differentiating and organizing the numerous variables that affect the cause(s) and solution(s) of problems. Considering its impact on the counseling dynamic, the importance of developing cognitive complexity skills within counselors-in-training is paramount. It has been

demonstrated that carefully supervised training experiences improve this required, and acquired, skill (Duys & Hedstrom, 2000).

Given the results of this study, it appears the development of cognitive complexity may have an effect on a counselor's inclination toward certain attribution models, usually ones more valued within the counseling field. That is, counselors tend to value approaches which empower client choice and client responsibility for problems, apart from environmental issues. To facilitate the development of cognitive complexity, an early introduction in the course curriculum to microskills training, theoretically oriented courses and multicultural training would be helpful. An earlier practicum along with earlier internship training, yet offered only after sufficient course work has been completed, would help supervisors identify attribution styles favored by trainees. Students would thus become cognizant of unrecognized, personal variables and antecedents which could affect client evaluation. Also, in order to both heighten awareness of assessment issues and to challenge assumptions about the nature of client problems, the inclusion of attribution theory along with the required counseling theory course work would benefit counselors-in-training.

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