THE IMPACT OF TWO CLINICAL PEER SUPERVISION MODELS ON SCHOOL COUNSELORS' JOB SATISFACTION, COUNSELING SELF-EFFICACY, AND COUNSELING EFFECTIVENESS

by

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At present, most school counselors receive little or no consistent counseling supervision (Borders & Usher, 1992; Roberts & Borders, 1994). Considering trends in the literature which imply that consistent supervision produces both personal and professional development, two forms of clinical peer supervision were provided for a sample of practicing school counselors. A pretest/post test design was employed to assess the counselors' level of each variable both before and after the supervision was provided.

The sample of practicing school counselors (n = 29) from several rural counties in northwestern North Carolina was divided into three groups (two treatment and one control). The first treatment group (n = 8) participated in the Structured Peer Consultation Model for School Counselors (SPCM-SC; Benshoff & Paisley, in press), a dyadic model of peer supervision. Participants in this group provided supportive yet challenging peer consultation/supervision to their partners following an adapted structured protocol. The second treatment group (n = 10; two groups of 5) participated in Systematic Peer Group Supervision (SPGS; Borders, 1991a). This model employs systematic assignments of particular feedback roles (e.g., counselor, student, student's teacher) within the group of supervisees during audiotape reviews. The length of each treatment was nine weeks. Members of the control group (n = 11) were asked to focus individually on their plans for professional development during the time of the study. The data gathered from this group provided a comparison point for the two treatment groups.

All participating school counselors completed established measures of job satisfaction, counseling self-efficacy, and counseling effectiveness (including a written measure of empathic responding and a written measure of adaptability and flexibility in counselor response) at both pretest and post-test. There was also a measure of client behavior change which participating counselors asked teachers to complete for a specified sample of their clients and a control group of students.

A one-way ANCOVA on post-test scores with pretest scores used as the covariate was performed on all but one of the dependent measures (counselor assessments), using an overall .05 alpha level. For the measure of client change (TRF), a three-way ANCOVA on post-test scores with pretest scores, client gender, and client groups used as covariates was performed. None of the ANCOVAs examining treatment effects were significant. There was no significant improvement in school counselors' job satisfaction, counseling self-efficacy, or counseling effectiveness. However, these individually nonsignificant results showed movement in the right direction in each instance, indicating small but pervasive effects of treatment. In line with the consistent positive trends on each of the counselor measures, participants' qualitative session evaluations supported the idea that clinical peer supervision is helpful to school counselors.

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CHAPTER I

INTRODUCTION

Today's children face a burgeoning list of problems and concerns, both in school and at home. Nearly 20% of all children in America live in poverty, with percentages substantially higher for minorities (U.S. Bureau of Census, 1991). With divorce rates on the increase (over half of all first marriages today end in divorce), more children suffer from shifting family roles, living arrangements, and expectations (Zimmerman, 1992). Homicide and suicide are rapidly becoming leading causes of death for children under the age of 18 (National Center for Health Statistics, personal communication, November 14, 1994). Even very young children are beginning to take weapons to school (Garbarino, 1994). Living with these concerns, children often have a difficult time adjusting to any learning environment. Within the public schools, the person best trained to help children combat their problems while continuing their healthy development is the school counselor. Well versed in counseling skills and techniques, school counselors work with children individually and in small groups, and provide large group guidance lessons when needed (American School Counselor Association, 1993). Despite their skills in these areas, however, it is becoming increasingly more difficult for school counselors to provide adequate services.

With so many children experiencing such serious problems, many school counselors have a hard time effectively serving their students. There are several reasons for this. First, while most mental health counselors work in settings with other counselors present, many elementary and middle school counselors are isolated in their settings (Peace, 1995). In fact, the elementary counselor often serves two or more schools on an itinerant basis. Second, unlike mental health counselors, school counselors usually receive little or no consistent counseling supervision (American Association of Counseling and Development, 1989; Roberts & Borders, 1994). Consequently, school counselors often

become unsure of their counseling abilities, even possibly becoming less skilled than they were upon receiving their counseling degrees (Peace, 1995; Spooner & Stone, 1977). Lack of sufficient supervisory support also increases stress and intensifies immense workloads. Thus, school counselors may feel overworked, alone, burnt out, and unhappy with their roles. As a result, counselors may become less effective, and therefore less able to provide meaningful help to the children in their schools. Third, in some cases school counselors may have completed training before many skills needed to address today's problems (e.g., family counseling, suicide assessments) were offered in training programs. While continual professional development is encouraged for school counselors by the American School Counselor Association (ASCA, 1993), there is rarely a systematic means available for providing such ongoing training.

Clinical Supervision for School Counselors

One way to combat the deficient support for school counselors is through clinical supervision. A structured though varying set of activities which encourages counselor self-awareness and growth, clinical supervision can focus on skill enhancement, professional identity development, case conceptualization, or other aspects of the school counselor's role in providing direct service to young clients (e.g., Bernard & Goodyear, 1992). The prevalent assumption in the field is that clinical supervision is helpful. By providing feedback and questions from an objective third party, clinical supervision allows the counselor to view the client and/or the counseling situation from multiple perspectives, thus stimulating the counselor's integrative thinking about the case (Biggs, 1988). In fact, Wiley and Ray (1986), when comparing the effects of supervised vs. unsupervised counseling experience, concluded that counselors benefited more professionally from the supervised experience.

Several writers have suggested that clinical supervision would offer school counselors the needed support and growth experiences required for effectively working with the contemporary concerns of students (e. g., Borders, 1991b; Peace, 1995; Schmidt, 1990). Clinical supervision provided by an experienced counselor trained in counseling supervision is the most appropriate way to ensure continued professional

development of practicing school counselors (Borders & Drury, 1992; Boyd & Walter, 1975). Henderson and Lampe (1992) emphasized the personalized nature of counseling supervision as an enhancer of school counselor professional development. The school counselor who engages in supervised clinical experiences is likely to make positive professional changes which will lead to greater effectiveness and accountability (Borders, 1991b).

Such supervisory experiences, however, are not typical, as school counselors in two recent surveys indicated. Borders and Usher (1992) found that school counselors were receiving the least supervision of counselors in a variety of settings. Similarly, Roberts and Borders (1994) found that, although counselors spent 44% of their time in counseling and consultation, they received little or no supervision in these areas. The authors also reported that elementary counselors indicated skill-building as an important goal of their desired clinical supervision. These findings demonstrate the immense discrepancy between existing supervision practices and school counselors' needs for supervision.

It is also clear that the small amount of clinical supervision school counselors receive generally is being provided by administrative personnel (e.g., principals) with no formal training or experience in counseling (Borders & Drury, 1992; Borders & Usher, 1992; Roberts & Borders, 1994; Schmidt & Barret, 1983). This is problematic in that these persons have little understanding of the counseling process. Rather, clinical supervision can best be provided by experienced counselors with additional training in clinical supervision skills (Borders & Drury, 1992; Dye & Borders, 1990; Schmidt, 1990). Therefore, even those school counselors who are receiving 'counseling supervision' probably are not receiving appropriate clinical supervision. It comes as no surprise that one professional association concluded that "proper supervision for school counselors is lacking at best, non-existent at its worst" (American Association for Counseling and Development School Counseling Task Force, 1989). While this sad state is often attributed to school systems' limited funds available to provide trained supervisors, it also is due in part to time limitations on the part of the school counselors. School

administrators are increasingly cognizant of time spent in direct service to students, and clinical supervision may be seen as taking counselors away from this direct service. Admittedly, providing individual clinical supervision for school counselors may be an inappropriate goal, due to both time and budget constraints within school systems. There are, however, more efficient approaches to providing clinical supervision.

Peer Supervision Approaches

Peer consultation and supervision are becoming increasingly popular approaches of efficiently providing clinical supervision to practitioners (Benshoff & Paisley, 1993; Remley, Benshoff, & Mowbray, 1987). And, just as group counseling is more time efficient than individual counseling when working with students, group supervision is seen as an effective means of providing clinical supervision for a number of counselors (Borders, 1991a; Holloway & Johnston, 1985). Not only does peer interaction save time and money for the school system; it also relays the message that school counselors care about each other's work and development. The collegial support and egalitarian setting of peer dyads and/or groups offer school counselors a rare opportunity to interact with other school counselors in productive exchanges about professional issues.

Practicing school counselors have expressed the desire for clinical supervision as a means of professional growth and support (Roberts & Borders, 1994). School counselors participating in ongoing clinical supervision have found it to be professionally stimulating, challenging, and exciting to know that someone is actually interested in what they are doing (Henderson & Lampe, 1992). Without the opportunity for consistent clinical supervision, school counselors are at risk of becoming less than effective professionals.

Purpose of the Study

There are several strong statements supporting clinical supervision of school counselors, suggesting that such supervision would help them grow professionally and personally. To date, however, there has been no empirical demonstration of this. Thus, to investigate this assumption, two forms of clinical peer supervision were provided for practicing school counselors and the impact of these interventions on job satisfaction, counselor self-efficacy, and counseling effectiveness was measured. In order to determine

whether or not clinical peer supervision makes a difference for practicing school counselors, a pretest/post test design was employed to assess the counselors' level of each variable both before and after the supervision was provided.

Need for the Study

Information about the effects of clinical peer supervision on school counselors' professional performance and satisfaction, as well as their personal growth, is limited. It is known that, in general, counselors become more effective with supervised counseling experience (e.g., Wiley & Ray, 1986). This means that students will directly reap the benefits of clinical peer supervision through interacting with more effective school counselors. When counseling supervision for practicing school counselors is consistently provided, their young clients should be better served. If it is established that clinical peer supervision has a positive impact on the personal and professional development of school counselors, perhaps there will be a greater effort on the part of school systems to provide for this professional development need.

Statement of the Problem

The study investigated the effects of clinical supervision (specifically, peer supervision) on practicing school counselors' job satisfaction, perceived self-efficacy, and counseling effectiveness. The specific research questions were as follows:

1. What effect does clinical peer supervision have on practicing school counselors' job satisfaction perceptions?
2. What effect does clinical peer supervision have on practicing school counselors' perceptions of counseling self-efficacy?
3. What effect does clinical peer supervision have on practicing school counselors' counseling effectiveness?
4. Which model of clinical peer supervision is most helpful to practicing school counselors?

Definition of Terms

Clinical supervision - refers to activities which encourage counselor self-awareness and growth through counseling skill enhancement, case consultation, and educational

activities. In the schools, it is not administrative (e.g., educational professionalism, staff relations) or program (e.g., program planning, coordination of activities) supervision (Roberts & Borders, 1994). Instead, clinical supervision is "characterized by a cycle of feedback, practice, and additional feedback" (Borders, 1991b, p. 253), focused on the counseling aspects of the school counselor's job. The term 'counseling supervision' may be used interchangeably.

Counseling effectiveness - refers to school counselors' skill levels and their abilities to successfully induce positive responses and/or growth on the part of their clients. For the purposes of this study, counseling effectiveness was measured by the Index of Responding - Empathy Scale (IRE; Gazda, Asbury, Balzar, Childers, Haynie, & Walters, 1984), the Counselor Behavior Analysis Scale (CBA; Howard, Nance, & Myers, 1986), and the Teacher Report Form (TRF; Achenbach, 1991).

Job satisfaction - refers to one's reported satisfaction with one's job and perceptions that characteristics of one's job are rewarding. For the purposes of this study, school counselors' job satisfaction was measured by an adaptation of the Job Satisfaction Blank (JSB; Hoppock, 1977).

Perceived self-efficacy - refers to one's expected levels of performance and/or successful achievement in specific situations (Larson, Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992). For the purposes of this study, school counselors' self-efficacy estimates pertained only to the counseling component of their professional role. Perceived self-efficacy was measured by the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992).

Peer supervision - refers to clinical supervision provided by one's colleagues (in this case, other practicing school counselors), as opposed to clinical supervision provided by a person in an evaluative or authority role, which offers counselors "an opportunity to monitor their practice on a regular basis for the purpose of improving specific clinical counseling skills" (Remley et al., 1987, p. 59).

Practicing school counselor - refers to a practitioner with graduate training in school counseling or a closely related field who is currently fully (or provisionally) State

Department licensed and working as a counselor in a school setting. This does not include school counselors-in-training functioning in internship positions.

Overview of the Study

The study is presented in five chapters. Chapter I is a brief introduction to the literature and survey findings on the need for and status of clinical supervision of school counselors. The purpose of the study, need for the study, research questions, definition of terms, and overview of the study are also described.

Chapter II provides a complete review of the literature, and is composed of six sections. The first section introduces the concept of clinical supervision. In section two, developmental models of supervision and the implications of these models for the clinical supervision of school counselors are discussed. The administrative challenges of providing clinical supervision for school counselors are presented in section three. An historical overview of school counseling supervision, as well as statistics regarding existing and preferred practices of supervision with school counselors, are presented in section four. In section five, some possible alternatives to the traditional individual supervision most often utilized in training programs are discussed. The specific outcome variables (job satisfaction, self-efficacy, and counseling effectiveness) are reviewed in section six.

Chapter III describes the methodology used in the study. It includes hypotheses, pre- and post-test measures, interventions, participants, procedures, and data analysis.

Chapter IV explains the results of the data analysis. Discussion of the analysis and results parallel the research questions and hypotheses.

Chapter V includes a summary of the study, discussion of the conclusions, and implications for school counselors, counselor education and supervision, and public policy. An examination of the limitations of the study and recommendations for further research are included as well.

CHAPTER II
REVIEW OF RELATED LITERATURE

The literature relevant to this study can be divided into the following sections: (a) the concept of clinical supervision; (b) developmental models of supervision and their implications for the clinical supervision of practicing school counselors; (c) the administrative challenge of providing clinical supervision for school counselors; (d) pertinent statistics regarding existing and preferred practices of supervision with school counselors; (e) an overview of two developmentally and site appropriate approaches of clinical peer supervision of school counselors; and (f) studies focused on each of the three dependent variables (school counselor job satisfaction, self-efficacy, and effectiveness). These sections are presented below.

The Concept of Clinical Supervision

Clinical supervision has been defined in numerous ways, some highly specific and others very broad (e.g., Bernard & Goodyear, 1992; Hart, 1982; Loganbill, Hardy, & Delworth, 1982; Random House Dictionary, 1987). The dictionary definition of supervision is "to oversee (a process, work, workers, etc.) during execution or performance" (Random House Dictionary, 1987). In contrast, Loganbill et al. (1982) more restrictively defined supervision as "an intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). Despite their differences, however, these definitions have many similarities. Each includes the basic roles of supervisor and supervisee: the one who provides the interventions and the one who learns from them. Through a structured though varying set of activities encouraging counselor self-awareness and growth, clinical supervision can focus on skill enhancement, professional identity development, case conceptualization, and thinking skills. There is also an evaluative component, as with any type of educational experience (Bernard & Goodyear, 1992).

There is the implication that all of these definitions apply to the supervision of any counselor, including those in training or in practice. However, only the developmental models of supervision address the concept of supervision across the professional lifespan, including years as a practitioner. These models indicate that professional development is an ongoing process, and clinical supervision is a key component in attending to practicing counselors' developmental needs.

Developmental Models of Supervision

As a whole, authors of developmental models describe counselor/supervisee growth as a series of hierarchical stages of development (e.g., Hogan, 1964; Loganbill et al., 1982; Sansbury, 1982; Stoltenberg, 1981). According to Loganbill et al. (1982), stages are not considered mutually exclusive, as evolving counselors can revisit various stages throughout the growth process. The key to effective developmental supervision is in knowing which type of intervention will best enable the counselor to learn and grow and thus advance to the next developmental stage.

In general, developmental models owe much to the work of developmental psychologists such as Erikson (1963, 1968) and Chickering (1969). These influential developmental pioneers gave us richly described conceptual models for the development of young children and adolescents. Authors of the developmental models of supervision built their ideas upon these early stage models, adapting them for application to developing professional counselors. For example, Loganbill et al. (1982) incorporated the Eriksonian concept of developmental crises into their second developmental stage, confusion. Loganbill et al. (1982) pointed to Erikson's (1968) particular focus on optimism and potentiality as an appropriate starting place for the developmental supervision process.

As illustrations, two important examples of developmental supervision models, the Counselor Complexity Model (Stoltenberg, 1981) and the comprehensive model described by Loganbill et al. (1982), are discussed below. Both of these models help us understand the continuing professional development which occurs for practitioners beyond their graduate training experiences.

Counselor Complexity Model: Stoltenberg

Building upon an earlier, more basic developmental model of supervision (Hogan, 1964), Stoltenberg (1981) delineated a Counselor Complexity Model in which he described four levels of supervisee development, along with expected counselor characteristics and recommended supervisory environments for each level. Generally, level 1 counselors are counselors-in-training or novice counselors, those with minimal counseling experience. Counselors at this level are quite dependent on the supervisor for direction with clients, as they are only beginning to develop their own counseling identities. Supervisors often must take on the role of teacher, while also allowing a certain degree of autonomy for these counselors.

Level 2 counselors have reached a state of conflict between dependency and autonomy. They are more likely to experiment with different counseling approaches, while often still feeling dependent on the supervisor for support (Stoltenberg, 1981). Here, supervisors need to teach less often but still provide a great deal of support and empathy. These supervisory approaches most often will help move the Level 2 counselor to Level 3, characterized by an increased sense of professional self-confidence and a more stable counselor identity. At this level, supervision can be more of a peer interaction, with the supervisor better able to reveal his or her own counseling weaknesses without fear of losing the respect or attention of the supervisee (Stoltenberg, 1981).

Stoltenberg (1981) refers to the Level 4 counselor as the "master counselor." This counselor is competent to practice alone, secure in his or her counseling identity, insightful, and motivated. Supervision should be more of an egalitarian, collegial exchange with other master counselors. It is not often that individuals reach the point of master counselor, as this implies the pinnacle of personal and professional integration.

Although Stoltenberg's (1981) model has had much intuitive appeal, and has been supported by a rather substantial body of literature (see Worthington, 1987), the developmental levels are rather static. Thus, the model is perhaps not as complex as one which allows for a recycling through the various stages of development. A more cyclical developmental supervision model is presented below.

A Comprehensive Conceptual Model: Loganbill, Hardy, and Delworth

In the model presented by Loganbill et al. (1982), a comprehensive complexity is achieved through the authors' cyclical notions regarding the interactions between developmental stages and supervisory issues. According to Loganbill et al. (1982), there are three developmental stages and eight supervisory issues. Counselors can be at any of the three stages with each of the eight issues at any given time, and can recycle back through the stages with each issue, depending on their cognitions, growth experiences, awareness levels, and external stimuli (e.g., initial exposure to material or ideas through a graduate course or workshop).

Loganbill et al. (1982) hypothesized the following three developmental stages: 1) stagnation, 2) confusion, and 3) integration. The stagnation stage is characterized by the supervisee's unawareness of problems or blind-spots regarding certain issues of supervision, with thinking often being very linear and narrow. The confusion stage is marked by the supervisee's realization that there is a problem within one or more of the supervisory issues, with ensuing conflict and disequilibrium. This shattering of the earlier, narrow way of thinking can lead to the third developmental stage. In this integration stage, new understanding and increased creativity and flexibility are experienced by the supervisee regarding certain issues. It is obvious that if the supervisee reaches this developmental stage, growth has occurred. As presented by Loganbill et al. (1982), assessment of the supervisee's developmental stages and supervisory issues are integrated consistently with the supervisor's interventions. One must assess before one can know how to intervene, and then further assessment is needed in order to evaluate the success of the intervention.

The eight supervisory issues identified by Loganbill et al. (1982) are as follows: issues of 1) competence; 2) emotional awareness; 3) autonomy; 4) theoretical identity; 5) respect for individual differences; 6) purpose and direction; 7) personal motivation; and 8) professional ethics. In the next few paragraphs, each of these issues are briefly described and applied to one or more variables in the present study.

Issues of competence involve gaining the ability to enact the skills one has learned in training (Loganbill et al., 1982). The more competent the counselor is in skills, the more

likely that counselor is to have a high sense of self-efficacy in counseling situations. Likewise, the more varied the skills a counselor learns and adopts, the more flexible the counselor is in responding to clients at their own levels of development and need.

Emotional awareness refers to the counselor's recognition of his or her own personal feelings and reactions within the counseling relationship. These issues can become a source of conflict when the counselor has negative feelings in reaction to a client (Loganbill et al., 1982). At any rate, the counselor's ability to recognize his or her own feelings and emotions is likely to be linked with his or her ability to show counseling effectiveness through the appropriate use of empathic responding.

Issues of autonomy often are embedded within the supervisory relationship itself (Loganbill et al., 1982). Due to earlier educational experiences with teachers, parents, and other figures of authority, the supervisee may feel that the supervisor wants to control him or her, and may act out as a means of testing his or her own independence. These issues could have an impact on the level of the counselor's reported job satisfaction and/or perceived self-efficacy.

Loganbill et al.'s (1982) identity issues are focused on the counselor's sense of theoretical identity. Flexibility is addressed with this issue, as one of the major tasks here is to develop a common thread which stretches from one counseling session to the next, a basic consistency within counseling which still allows for individualization with different clients.

The theme of respect for individual differences (Loganbill et al., 1982) is directly related to empathic responding. The counselor must struggle with the need to accept, understand, and respect clients of differing backgrounds, cultures, and world views. This issue can be very painful to resolve; dealing with our own values in relation to others' is often quite challenging.

Issues of purpose and direction (Loganbill et al., 1982) involve the goal-setting aspects of counseling. Within this theme, counselors must develop strategies for taking clients in a certain direction. If counselors are successful in helping clients set and work towards appropriate goals, they are likely to perceive themselves as efficacious.

Personal motivation issues (Loganbill et al., 1982) revolve around counselors' reasons for entering the profession. Counselors working through these issues will become more aware of their professional motivators, which might possibly have an impact on their levels of job satisfaction.

And, finally, issues of professional ethics (Loganbill et al., 1982) involve the counselors' integration of professional ethical standards into their daily functioning. A mature understanding of ethical issues brings with it a greater flexibility in dealing with whatever situations may arise. This greater flexibility also may affect perceptions of self-efficacy.

Implications for the Supervision of School Counselors

As this brief overview of developmental models indicates, school counselors, like all other counselors, have developmental needs and the potential for further development across their professional lifespans (Borders & Schmidt, 1992). In fact, development may not occur without ongoing supervision (e.g., Wiley & Ray, 1986). Thus, the need for clinical supervision of practicing school counselors exists. A key issue, also based in developmental models (Blocher, 1983; Hogan, 1964; Loganbill et al., 1982; Sansbury, 1982; Stoltenberg, 1981), is providing clinical supervision in an appropriate format which fits the setting and the developmental needs of school counselors. The developmental guidance and counseling approach preferred by most school counselors (American School Counselor Association, 1990) may set the stage for their acceptance and appreciation of a developmental approach to supervision as well. The following sections will first provide an overview of the setting, then address the needs of school counselors based on two recent surveys. Finally, two supervision models that appear to be consistent with developmental models, and which seem to fit the setting and the counselors, will be presented.

Supervision of School Counselors

While many speculations about the clinical supervision of school counselors have been published, little has really been known until recently. This section will give an overview of the historical literature about clinical school counseling supervision, then

discuss in detail two recent surveys addressing existing and preferred supervision practices for school counselors.

Historical Overview

As early as 1972, recommendations began appearing in the literature regarding the need for supervision of school counselors. Segrist and Nelson (1972) suggested a model of collaboration between counselor educators and practicing school counselors as a means of dealing with the isolation and struggle of a beginning school counselor. Their model consisted of on-site supervision provided by the counselor educator, which benefited both the supervisee and the supervisor. Through this supervisory relationship, the supervisee gained support and direction in the professional role of the school counselor. The counselor educator, as supervisor, gained from the continued exposure to a real school setting. In 1975, Boyd and Walter exclaimed that school counselors were not getting the optimal amount of supervision needed to survive the harsh environment of their isolated settings. The authors compared the school counselor to a cactus, saying that, by necessity, both must grow and thrive with the minimal amount of "nutrients" (p. 103).

Since the 1970s, many other authors have expressed similar concerns about the almost non-existent supervision of school counselors (AACD Task Force, 1989; Barret & Schmidt, 1986; Borders, 1991b; Borders & Schmidt, 1992; Schmidt, 1990; Schmidt & Barret, 1983; Wilson & Remley, 1987). It has been well documented that what is called supervision for school counselors is most often administrative oversight being supplied by school principals (AACD Task Force, 1989; Borders & Drury, 1992; Roberts & Borders, 1994; Schmidt & Barret, 1983; Wilson & Remley, 1987). While this lack of supervision is often attributed to school systems' limited funding for trained supervisors (e.g., Schmidt & Barret, 1983), it also is due in part to school administrators' increasing concerns about counselor time spent in direct service to students. Clinical supervision may be seen as a less-than-useful reason for taking school counselors away from this direct service. Nevertheless, there is empirical support for the theoretical need (developmental models; Blocher, 1983; Hogan, 1964; Loganbill et al., 1982; Sansbury, 1982; Stoltenberg, 1981; see Worthington, 1987, for a review of the literature) and the desire of counselors

themselves to receive clinical supervision (Borders & Usher, 1992; Roberts & Borders, 1994).

In light of the recent increase in professional emphasis on supervision (Barret & Schmidt, 1986; Dye & Borders, 1990), two important surveys have been conducted. The first was a national survey, targeting National Certified Counselors (NCCs) from all specialty areas, including school counselors (Borders & Usher, 1992). The second survey was conducted in North Carolina and targeted practicing school counselors only (Roberts & Borders, 1994). Details of both surveys are presented below.

The National Survey

In 1992, Borders and Usher reported results of a national survey regarding counselors' existing and preferred supervision practices. A stratified random sample of National Certified Counselors (N = 729) was asked to complete a mailed survey questionnaire. The two stratification variables were a) geographic region and b) date highest degree was received. The total for the final sample was N = 357, yielding a response rate of 51.4%.

The survey questionnaire consisted of five parts. The first section included items related to counselor demographics, especially noting the total number hours of direct supervision respondents had received. Section 2 consisted of items about the supervision respondents were currently receiving, including questions about frequency, supervisory format, supervisor characteristics, and methods of supervision used. The third section was made up of similar questions regarding their preferred supervision practices. Sections 4 and 5, concerning respondents' preferences for style and emphasis of supervision, were reported in a later publication (Usher & Borders, 1993). In the following paragraphs, each section will be described and results discussed.

From part one, a description of respondent characteristics was compiled. The highest percentages of respondents were White (88%), female (66%), between 40 and 49 years old (44%), master's level (62%), and presently working in a full-time counseling position (83%). It was concluded that the sample was highly similar demographically to the total NCC population, though there were more educational specialist and doctoral level

respondents and slightly more ethnic diversity in the sample than in the population. The highest percentage of respondents were school counselors (39%), then private practitioners (19%).

There was a great deal of variance in the respondents' total months of counseling experience. The range was from 3.25 months to 363 months, with a mean of 133.28 and a standard deviation of 79.89. School counselors had the highest mean total for months of full-time counseling experience (M = 168.34; SD = 73.29).

Respondents were asked to approximate their total hours of post-degree, direct counseling supervision, and the modal response was 0 (28%). The mean of 124.25 hours reflected the fact that some people answered with very large numbers. One person estimated receiving 1,200 hours of post-degree supervision. This was an especially variable item, with some comments suggesting that respondents may have been defining supervision in different ways (e.g., case management, administrative oversight, etc.). Significantly fewer hours of supervision were reported by school counselors than by agency or private counselors. In fact, just under half of the school counselor respondents (45%) reported receiving no supervision since graduating from their counselor training program.

Regarding currently experienced practices of supervision (section two), 32.1% of the total sample reported that they were receiving no counseling supervision. However, 34.8 % indicated that they were receiving supervision once a month. The largest number of current supervisors held doctoral degrees (n = 89). Most often, the current supervisor was reported to be credentialed as a licensed psychologist (n = 53). The primary identity of the current supervisor was most often reported as "other" (e.g., administrator) (38%).

When questioned about methods used in current supervision, the most predominant response was self-report of counseling sessions. A majority of the respondents reported that they were receiving individual supervision only (n = 181), and respondents most often reported that they engaged in supervision because it was required in their work setting (n = 110) and that it provided a means of professional development (n = 101).

According to Chi-square analyses, there were significant differences related to work

setting. For example, while school counselors were more likely to be receiving no supervision, agency and private counselors were more likely to be receiving supervision at least once per month. Private practitioners were more likely to be supervised by a licensed psychologist, while school counselors were most likely to be supervised by administrators who had no counseling training. For school counselors, live observation with the supervisor present in the session was the predominant method of supervision. This last finding is probably a result of administrators observing classroom guidance as a means of evaluation, an activity that often is (incorrectly) equated with supervision within the schools (Borders, 1991b).

The survey's third section was focused on preferred supervision practices of respondents. A majority of respondents reported that they preferred at least monthly supervision (63.1%). Those who reported experiencing more frequent current supervision also preferred more frequent supervision, suggesting that if the habit of supervision is endorsed from the start, it might be seen more favorably throughout the counseling lifespan. Receiving professional support was the number one goal of supervision reported by the respondents.

The most frequently preferred supervisor ($n = 137$) was a credentialed counselor with advanced training in supervision. Ideally, respondents preferred on-site supervision (81%) by their employers (74%), individually (56%) or a combination of individual and group supervision (39%). School counselors wanted less frequent supervision than did counselors in other settings, with mental health counselors preferring weekly supervision. School counselors also were more likely to prefer a counselor (vs. a psychologist or other professional) for a supervisor. There was a significant relationship between degree level and supervision goals. Respondents at the master's level were more likely to desire professional support, while respondents with advanced degrees more often saw supervision as a renewal, a way to avoid burnout.

Borders and Usher (1992) concluded that, for the most part, practicing counselors want regular supervision, preferably from a counselor with supervision training. The respondents in this study comprised two distinct groups: school counselors and non-

school counselors. In comparing counselors' preferences with their existing practices, the greatest discrepancy was with the group of school counselors. They recommended further research to study the separate work settings in greater detail. When examining the data for parts four and five of the survey (style preferences and supervisory emphasis), they took their own advice and examined preferences separately for possible differences between school counselors and counselors in other settings (Usher & Borders, 1993).

In order to study supervisory style preferences, respondents were asked to complete the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984). This instrument measures three dimensions of supervisory style: attractive - collegiality, as measured by items such as warm, friendly, open, etc.; interpersonally sensitive - relationship oriented, as measured by items such as committed and perceptive; and task-oriented - content, as measured by items such as thorough and focused (Friedlander & Ward, 1984). Preferences for supervisory emphasis were measured with a revised version of the Supervisor Emphasis Rating Form (SERF-R; Lanning & Freeman, 1994). The SERF-R measures the following four possible areas of supervisor emphasis: professional behaviors, process skills, personalization skills, and conceptual skills.

Regarding supervisory styles, both groups preferred the task-oriented style the least. School counselors' preference for this style, however, was significantly greater than that of counselors in other settings. In terms of supervisory emphasis, school counselors preferred a greater emphasis on process skills than did counselors in other settings. In general, it appears that school counselors might prefer a teacher-supervisor who will provide instruction and support regarding specific counseling skills and techniques (Usher & Borders, 1993). In order to examine this and similar possibilities further, Roberts and Borders (1994) conducted a similar survey specifically targeting school counselors in North Carolina. The following section delineates this school counselor survey.

A State Survey: For School Counselors Only

In agreement with Barret and Schmidt's (1986) recommendations, Roberts and Borders (1994) designed their survey to investigate three different types of supervision specific to school counselors: administrative, program, and counseling. The authors'

questions regarding existing and preferred practices of supervision were based on the 1992 Borders and Usher survey items (e.g., frequency of supervision, supervision interventions, etc). Surveys were mailed to a random sample (N = 450) of North Carolina School Counselors Association (NCSCA) members. A final response rate of 37.3% emerged when a total of 168 usable surveys were returned.

This survey consisted of three parts. In the first, demographic data were gathered from participants, including school setting, percentage of time spent in various school counseling activities, and perceived similarities between supervision and evaluation. The second section related to current supervisory experience. Respondents were allowed to respond to each item in three different ways, thus delineating the three different types of school counseling supervision. In the third section, participants responded to questions regarding preferred supervision practices, again allowing for the three different types of school counseling supervision. Here respondents also were asked about their prioritized goals for receiving counseling supervision. In the paragraphs that follow, findings from each of the three sections are described in detail.

The demographic questions of section one provided the profile of a typical respondent. Most respondents were White (83%) females (88%) around 42 years old (SD = 8.39) with a master's degree in counseling (95%), presently employed full-time as a public school counselor (100%). The largest percentage of respondents were employed in an elementary school setting (45%), with 31% employed as high school counselors. Schools were most often in rural (46%) or suburban (31%) locations.

School counselors in the study reported that they spent a large portion of their time in individual and/or group counseling (31.6%). The sample mean for total years of school counseling experience was eight. Just over half (54%) of the respondents thought that supervision and evaluation were very dissimilar.

In section two, respondents described the supervision they were currently receiving in administrative, program, and counseling areas. A large majority of school counselors (85%) reported that they were receiving some administrative supervision, most often from their principals. Most of these current administrative supervisors held master's degrees

(n = 55). This administrative supervision most often was provided as a part of their annual review and evaluation (n = 98). That administrative supervision was required as part of their evaluation was the most often stated reason for receiving this type of supervision (n = 87).

Within the sample, 70% of the respondents reported they were receiving some program supervision. Again, this supervision was most often provided by a female (n = 49) principal (n = 23) with a master's degree (n = 49). The most often cited reason for receiving program supervision was that it had to be done for evaluation purposes (n = 69). The lowest frequency of receiving no program supervision at all was reported by elementary school counselors.

Only 37% of the total sample indicated that they were receiving counseling supervision. Current counseling supervisors were either directors of counseling (n = 12) or principals (n = 9). There was a great deal of variation in the reported frequency of counseling supervision sessions, ranging from once a week (n = 8) to once a year (n = 10). Again, the most often cited reason for receiving counseling supervision was that it was required for the purposes of evaluation (n = 69).

In the third section of the questionnaire, preferences for supervision in all three areas were addressed. Overall, 59% of the respondents preferred some administrative supervision. The preferred provider of this supervision was the principal (n = 62). The preferred frequency of this administrative supervision was once a month (n = 62). Some program supervision was preferred by 86% of those sampled. The most frequently preferred program supervisor was the director of counseling (n = 36), and program supervision was most often preferred to occur at least once a month (n = 72).

Of the entire sample, 79% reported that they preferred some counseling supervision. The preferred counseling supervisor was most often desired to have a counseling (rather than administrative) background. While all respondents wanted their counseling supervisor to have a master's degree or higher, a relatively large number (n = 61) preferred someone with a doctorate. The most often preferred frequency of counseling supervision was at least once a month (n = 93). The two highest overall goals for receiving

counseling supervision were enhancing professional development (80%) and receiving professional support (80%). The elementary and the least experienced counselors more often reported learning specific skills as a goal of counseling supervision.

The authors of the study (Roberts & Borders, 1994) concluded that there was a great mismatch between existing and preferred school counseling supervision. While, in general, counselors reported spending the majority of their time in counseling and consultation, they were in fact receiving the least amount of supervision in this area. School counselors preferred less administrative supervision than they were currently receiving, but wanted substantially more program and counseling supervision than they were getting.

Unfortunately, barriers to providing the preferred amount of supervision do exist. For example, rarely do current supervisors have a counseling background. State regulations and budget constraints also are problematic. In light of these restrictions, Roberts and Borders (1994) called for an effort to find innovative means of providing the needed and desired supervision for school counselors. The following sections attempt to address this call by reviewing suggested means of innovative supervision within the professional literature.

Providing Clinical Supervision for School Counselors: Some Options

Various suggestions for time- and cost-effective approaches to supervision have been made in the literature (e. g., Benshoff & Paisley, in press; Borders, 1991a; Fraleigh & Buchheimer, 1969; Henderson & Lampe, 1992; Hillerbrand, 1989; Holloway & Johnston, 1985; Lewis et al., 1988; Peace, 1995; Remley et al., 1987; Roth, 1986; Spice & Spice, 1976; VanZandt & Perry, 1992; Wagner & Smith, 1979). In general, these approaches address restrictive administrative needs within public schools through the use of mentors, peer dyads, and peer groups. The more salient of these are discussed below.

For the purposes of this study, dyadic peer supervision and peer group supervision are discussed in greater detail. Research has shown that structured models of counseling supervision are more preferred by practitioners (Benshoff & Paisley, in press; Remley et

al., 1987). While mentoring can take a very structured approach, the training recommended for such approaches is in-depth and time-consuming (Peace, 1995). This factor limits the applicability of the mentoring approach in research efforts. Also, mentoring (by definition) may or may not include clinical supervision training for the mentor or supervision for the mentee. Mentoring of school counselors, while valuable, will not be a focus of this research.

Peer Supervision and Consultation

Peer supervision is different from traditional supervision due to its egalitarian nature. One peer seldom has power or evaluative influence over the other, as is often the case in supervisory relationships. Thus, peer supervision also can be referred to as peer consultation (Benshoff & Paisley, in press), reflecting the lack of formal evaluation involved in the process. For school counselors, who have experienced very little counseling supervision (Borders & Usher, 1992; Roberts & Borders, 1994), peer consultation can be a more inviting, less threatening approach to self-examination and professional growth than is supervision within a hierarchy. Peers can provide one another support and encouragement, as well as the challenge to think about their clients in new ways (Benshoff & Paisley, in press; Remley et al., 1987).

Early literature on peer supervision focused on its use within counselor training programs (Spice & Spice, 1976; Wagner & Smith, 1979). Wagner and Smith (1979) discovered that counselors-in-training benefited by exposure to peer supervision in their training programs. Their structured rotating model, used within a weekly three-hour field experiences class, was dyadic, with the rest of the group observing the peer session. One other person was designated the "coach" of the session, and could communicate with the peer supervisor through a remote control device. Feedback from the students suggested that, after participating in this peer supervision process, they saw themselves as more actively involved in supervision, and thus were able to assume more responsibility for their own learning (Wagner & Smith, 1979). After graduation, these students also were more likely to engage in peer support networks within their employing agencies and schools.

An example of triadic peer supervision for counselors-in-training was described by

Spice and Spice (1976). The main purpose of this supervision model was to increase confidence in supervision skills for students, so that they might participate in peer supervision and support in meaningful ways after graduation. The three members of the triad included the supervisee, the commentator, and the facilitator. The supervisee supplied some form of work sample (e.g., an audiotape, a case report, etc.) to the commentator in advance of the supervision session. It was the commentator's job to review the work sample and prepare a commentary to share with the supervisee during the triadic session. The facilitator was present in the session to focus on the supervision process itself, with the goal of a richer supervision experience for all involved.

The authors maintained that four distinct processes were involved in this supervision model (Spice & Spice, 1976). First, the presentation of the work sample was representative of the supervisee's development up to that time. Therefore, the student was required to take a great risk by submitting this sample for critique. Second, the positive yet critical commentary provided by the commentator was crucial to that individual's supervision skills training, as well as for promoting self-confidence in the supervisee. The third important process was the engagement of the supervisee and the commentator in meaningful dialogue surrounding the work sample. This provided a deeper, more growth-producing experience for those involved. And fourth, the facilitator's focus on the here-and-now and the relationship process provided a richer, more in-depth understanding of communication in supervision.

Another look at peer supervision within a counselor training program was provided by Seligman (1978). This study was conducted with advanced counselors-in-training serving as peer supervisors for less advanced students in the same program. The dyad was not a reciprocal relationship, as only the less advanced students were submitting work samples and receiving supervision. Peer supervisors received no formal supervision training, and supervision pairs were randomly assigned. Counseling tapes submitted by both supervisors and supervisees supplied trained raters with a means of determining overall effectiveness levels regarding the core counseling conditions.

The results of this study indicated that peer supervision was effective in maintaining

or improving students' performance in the core conditions. There was no correlation, however, between the ratings of supervisors' counseling effectiveness and improvement in counseling effectiveness for students. This suggests that a good counselor neither necessarily nor automatically makes a good supervisor, as other authors also have posited (Borders, 1992; Holloway & Hosford, 1983; Leddick & Bernard, 1980; Spice & Spice, 1976). Seligman (1978) also suggested that peer supervisors actually might be more effective than counselor educators, due to the fact that they are much closer to the student experience. Also, the supervisees may have felt more comfortable sharing their concerns with peers, thus setting the stage for a more productive supervisory relationship.

More recent literature on peer consultation and supervision has focused on its use by practitioners rather than counselors-in-training (Benshoff & Paisley, in press; Remley et al., 1987; Roth, 1986; Runkel & Hackney, 1982). Peer consultation teams have been successfully used with pastoral counselors, with findings recommended as important to all professional counselors (Runkel & Hackney, 1982). Runkel and Hackney (1982) especially suggested peer consultation as a possible means of supervision for school counselors, who often have difficulty finding adequate supervision.

Peer supervision within the community mental health center was the focus of Roth (1986). The author concluded that peer supervision in mental health can be helpful and growth-producing if it is set up in the right manner. Extensive training and supervision of supervision (at least in the beginning stages) would be needed to ensure the success of a peer supervision model which pairs up professionals from different disciplines and experience levels. If it is assumed that all therapists are automatically capable of supervision, there will be some small chance that most peer supervisees will encounter at least one positive supervision experience over an extended length of time. Otherwise, there most likely will be a regression toward the mean, and mediocrity (Roth, 1986).

While authors of earlier models suggested the need for specific structure within peer supervision, Remley et al. (1987) proposed actual activities, providing a structured peer supervision model adaptable to numerous counseling settings. The authors of this model indicated a peer supervisory relationship which was reciprocal, so that both counselors

benefited from the exchange. The peer supervision dyad was selected according to similar interests and comfort levels of both individuals involved. A structure of 10 supervision sessions, each lasting one hour, was outlined, with specific activities set to occur during particular sessions (Remley et al., 1987). For example, session two involved oral case study presentations from each counselor, with discussion pertaining to developing strategies for more effective counseling with the client. Tape reviews and discussions of readings were other specific activities recommended (Remley et al., 1987).

Recently, the model created by Remley et al. (1987) was adapted specifically for practicing school counselors (Benshoff & Paisley, in press). Called the Structured Peer Consultation Model for School Counselors (SPCM-SC), this model was tested with a small sample of school counselors in North Carolina. Participants were volunteers who sought consultation/supervision due to their own desires for professional development and skill enhancement. They met together in dyads on a biweekly basis for a total of nine sessions, each one and one-half hours long. A half-day training workshop was conducted before the initial peer consultation session (Benshoff & Paisley, in press). In session one, background information and specific goals for the consultation/supervision were shared. Peers were to give thought to the overall counseling programs in their schools before the next session, focusing on time spent in various roles and duties. Counselors also were asked to bring with them to session two an audiotape to be reviewed for session three.

In session two, participants spent time discussing their school counseling programs, evaluating the programs, and setting goals for improvements. At the session's end, peer consultants exchanged audiotapes to be reviewed for the next session. Specific guidelines for reviewing tapes were explained and distributed at the training meeting. During the third, fifth, and seventh sessions, participants took turns serving in the two different roles (consultant/supervisor and consultee/supervisee), while tapes were being reviewed and critiqued. Guidelines for giving and receiving feedback were included in the training as well. Participants were expected to prepare a case study for sessions four, six, and eight, once again switching roles mid-way through the consultation/supervision sessions. In the final session, counselors were given the opportunity to evaluate the peer

consultation/supervision experience and review their progress toward their specific goals.

Overall, the participating school counselors reported that they had positive consultation/supervision experiences during the study. Counselors agreed that they would participate in peer consultation/supervision again and would recommend it to their colleagues. They also reported that participation in the model had helped them develop better consultation skills, as well as improved their counseling skills and techniques (Benshoff & Paisley, in press). Finally, 100% of the participants believed that the peer consultation/supervision had provided them with valuable support and new ideas, and that it had been a helpful experience. Most believed that the experience would have been less valuable without the structure provided.

Peer supervision does not have to be conducted in dyads or triads, however. Often peer supervision occurs within groups of six to eight counselor colleagues, usually with at least one expert supervisor present. A more in-depth look at peer group supervision will be provided in the following section.

Group Supervision

Group supervision is widely touted as an efficient means of providing productive supervision to a number of counselors concurrently (e. g., Borders, 1991a; Fraleigh & Buchheimer, 1969; Greenburg, Lewis, & Johnson, 1985; Hillerbrand, 1989; Holloway & Johnston, 1985; Lewis, Greenburg, & Hatch, 1988). Thus, peer groups can provide support and encouragement, as well as enhance skills and promote personal and professional development (Lewis et al., 1988; Yalom, 1985). However, as Holloway and Johnston (1985) pointed out, little empirical research has been conducted in this area. What follows is a brief look at the group supervision literature most relevant to the study at hand.

In 1969, Fraleigh and Buchheimer noted that the main purpose for the peer group was to provide support and safety for the individual members. A secondary function of the peer group was to reinforce the confrontations and suggestions made by the supervisor (Fraleigh & Buchheimer, 1969). It also was noted that peer group members modeled for one another their various approaches and counseling styles, which in turn led to more

divergent thinking.

The authors' (Fraleigh & Buchheimer, 1969) focus was on peer group supervision for counselors-in-training, though they suggested the same principles apply for practitioners as well. Allowing counselors-in-training to meet occasionally as a peer group, without the supervisor present, was seen as a way to encourage productive future peer interactions. They concluded that peer group supervision was a valuable supplement to individual supervision for counselors-in-training, but that individuals' needs change with experience. One might assume, therefore, that peer group supervision reasonably could take the place of individual supervision for practitioners, whose greater experience would affect their needs for a leader.

In fact, a study of peer groups for private practitioners found that most existing peer consultation groups for these psychologists were leaderless (Lewis et al., 1988). In this study, a national survey was conducted to explore the status of existing peer consultation groups for psychologists in private practice. The sample (N = 800) was randomly selected from members of the National Register of Health Service Providers in Psychology. A six-page survey consisting of 30 closed-ended questions was developed for this study, then mailed to the 800 psychologists in the sample. After follow-up mailings, a response rate of 71% was achieved, with a total of 563 surveys returned. Only 480 of these were usable, due to the requirement that respondents be currently engaged in private practice.

Within the sample, 23% of respondents were current members of peer consultation groups, and 24% had been involved in such group in the past (Lewis et al., 1988). Of the respondents not presently group members, 60% reported a desire to participate in a peer group, if one were available. The average respondent was a 46 year old (M = 45.5 years) male (70.3%) PhD level psychologist who had 11 years of experience (M = 11.3 years), in full-time private practice (62.7%). While the majority of the peer consultation groups (62.2%) were reported to be leaderless, a good number of groups (23%) reported having a permanent leader, and some groups rotated leaders (14.4%). A large majority of the groups met at least once per month (93.5%), for a mean length of 1.89 hours each time.

The most highly reported reasons for joining the groups were chances to discuss

1) difficult cases and 2) ethical issues, and 3) to prevent the ill effects of isolation (Lewis et al., 1988). Respondents exhibited high expectations for their groups, and reported high satisfaction with their group experiences. It appears that, for those involved, peer group consultation provided a constructive means of support and information needed to help them carry out their professional duties. However, no mention was made of whether or not these usually unstructured, leaderless groups promoted developmental growth for the professionals involved.

In a much more systematic approach, Borders (1991a) delineated a model of structured peer group supervision designed to promote skill development as well as conceptual growth. Without such structure, peers often stray from the supervisory task or give each other advice rather than productive feedback (Roth, 1986; Runkel & Hackney, 1982). Borders' (1991a) model, reported to be appropriate for both counselors-in-training and experienced practitioners, provided a specific format for group supervision sessions. In the following paragraphs, this model's procedures, supervisor roles, types of peer feedback, and focus on cognitive skills are described in further detail.

A maximum of six counselors and one trained supervisor generally are involved in the Structured Peer Group Supervision model (SPGS; Borders, 1991a). The group meets weekly, for 1.5 hours per session. Early sessions are devoted to the identification of individual learning goals and the establishment of a sense of support and belonging. Subsequent supervision sessions involve case presentations by individual counselors, utilizing videotapes of counseling sessions. At the beginning of each case presentation, the counselor asks questions and requests specific feedback from the group regarding the taped counseling session. At this point, peers are assigned roles or tasks for reviewing the tape. These roles and tasks will be described further below.

After the assignment of roles, the counselor presents the taped segment for peer review. Then peers give their feedback, responding to the questions and goals previously delineated by the presenting counselor. Throughout the ensuing discussion, the supervisor serves as both a moderator, helping the group stay on task, and a process observer, describing and acknowledging various group dynamics and interactions among peers . At

the end of the session, the supervisor summarizes the discussion and asks the counselor to signify if supervision needs were met.

It is important to the model that the supervisor remain aware of counselor developmental levels (Loganbill et al., 1982; Stoltenberg, 1981), so that appropriate interventions can be employed. For example, when working with more experienced counselors, the supervisor would expect to spend more time on more complex process issues (Loganbill et al., 1982; Stoltenberg, 1981). Counselors' developmental needs are also considered when assigning feedback roles and tasks.

To ensure that each group member participates, peers are assigned specific roles, perspectives, or tasks for providing feedback (Borders, 1991a). For example, a group member might be asked to view the tape from the perspective of the client, then provide feedback to the counselor from the client's point of view. The peer's speaking in first person (using I-language) may seem less threatening to the counselor receiving feedback. Another example might be asking a group member to view the taped segment focusing on non-verbal communication between the counselor and the client. This task could be assigned to the group member who is unaware of his/her own non-verbal counseling behaviors, as a way of challenging that member to grow in this area.

In addition to assigning roles and specific focused observations, the supervisor at times asks members to respond from specific theoretical perspectives. This can promote experimentation with different theories and approaches, in order to enrich and deepen theoretical understandings. Finally, some peer group members may be asked to come up with a symbol or an image of the counseling session or interactions being reviewed. This development of a metaphor often presents novice counselors, who tend to be very concrete and self-focused, with a new way of thinking abstractly about the client or the counseling relationship. More advanced counselors often use metaphors to more richly examine the interpersonal dynamics of the counseling session (Borders, 1991a).

In this peer group model, Borders (1991a) very intentionally included strategies for promoting cognitive skills development. According to numerous authors (e. g., Biggs, 1988; Blocher, 1983; Borders, Fong, & Neimeyer, 1986; Holloway, 1988), higher-

functioning counselors (those at higher cognitive developmental levels) are more likely to think independently, objectively, and flexibly, and to express empathy with a greater variety of clients. This flexibility and empathy could translate into greater counseling effectiveness by providing the counselor with a larger repertoire of counseling approaches and techniques. Within the Borders (1991a) model, divergent thinking was promoted by the provision of multiple perspectives through the assignment of diverse roles, multiple theoretical approaches, and creative metaphors.

Structured Peer Group Supervision (Borders, 1991a) is highly adaptable. It can be used with different populations of counselors in various settings. Though not specifically recommended by the author (Borders, 1991a), it appears that this model of group supervision might be helpful to practicing school counselors.

Supervision: Making a Difference for School Counselors

Because school counselors generally receive little or no counseling supervision (Borders & Usher, 1992; Roberts & Borders, 1994), any research regarding the impact of counseling supervision for school counselors must by definition be exploratory. Through a review of the literature, three variables were identified which might possibly be affected by the experience of counseling supervision. In the following section, each of those variables is listed and discussed in detail. And, because counseling supervision is such a multidimensional and complex process (Friedlander, Keller, Peca-Baker, & Olk, 1986; Holloway, 1986), the need for multiple measures is explored as well.

Need for a Variety of Measures

One of the greatest difficulties in conducting outcome research in supervision is identifying appropriate dependent variables. Supervision is a complex process, always involving at least three different people (thus six different relationships). Thus, it is even more difficult to research supervision outcomes than outcomes in counseling (Bernard & Goodyear, 1992; Hill & Corbett, 1993). Various authors have discussed the distinct challenge of measuring supervision outcome variables (e.g., Bernard & Goodyear, 1992; Borders, 1989; Holloway, 1984; Holloway & Hosford, 1983), yet the call for future researchers to "rise to the challenge" still remains (Bernard & Goodyear, 1992, p. 234).

According to Holloway and Hosford (1983), supervision research is difficult in part due to the lack of clearly identified outcome variables and the scarcity of dependable measures. For example, many studies have used supervisee self-report of satisfaction with supervision as an outcome measure, but Borders (1989) questioned the continued value of measuring this variable. Instead, some measure of counseling effectiveness, such as actual client outcome behavior, was suggested (Borders, 1989).

The present study constitutes an attempt to address some of these issues. Multiple measures will be utilized in an attempt to identify appropriate variables, as well as to capture the complexity of the constructs being measured. In the following section, the three identified school counselor variables (job satisfaction, perceived self-efficacy in counseling, and three measures of counseling effectiveness, including level of empathic responding, response flexibility, and client behavior change) which may be affected by counseling supervision will be explained and discussed.

Job Satisfaction

The construct of job satisfaction is complex and often difficult to measure (Hansen, 1967, 1968; Hoppock, 1977; Smith, Kendall, & Hulin, 1969; Wiggins, 1984). It has been established, however, that job satisfaction is significantly discriminant from such similar constructs as organizational commitment and job involvement (Brooke, Russell, & Price, 1988; Mathieu & Farr, 1991). According to Hansen (1967), job satisfaction has a significant effect on job behaviors.

In the school counseling literature, job satisfaction has received ample attention (e.g., Gade & Houdek, 1993; Hansen, 1967, 1968; Stickel, 1991; Wiggins, 1984; Wiggins & Weslander, 1986). Overall, research results have shown that less effective school counselors displayed lower job satisfaction scores (Hansen, 1968; Wiggins & Weslander, 1986). (Similar findings were reported for a sample of agency counselors [Wiggins & Moody, 1983]). It is unclear whether counselors who were less effective were therefore less satisfied with their jobs, or whether those who were dissatisfied with their jobs were in turn less effective counselors.

In other studies, school counselors serving more than one school (Gade & Houdek,

1993) and school counselors in rural settings (Stickel, 1991) scored lower on job satisfaction scales. Both Gade and Houdek (1993) and Stickel (1991) concluded that counselor isolation and role overload contribute to school counselors' dissatisfaction with their jobs. In light of recent surveys concerning existing and preferred practices of supervision for school counselors (Borders & Usher, 1992; Roberts & Borders, 1994), it appears that a possible deterrent for isolation and role overload, counseling supervision, has been systematically withheld from the school counselor population.

There is a precedent for examining job satisfaction in supervision research. In 1992, Olk and Friedlander utilized the Job Descriptive Index (JDI; Smith et al., 1969) as one means of testing construct validity for their Role Conflict and Role Ambiguity Inventory. The authors (Olk & Friedlander, 1992) found that the level of experienced role conflict in the sample was positively correlated with the level of dissatisfaction in general clinical work. It is not much of a conceptual leap, then, to assume that the school counselor, whose role is constantly being redefined (ASCA, 1990), might experience high levels of both role conflict and job dissatisfaction. Supplying the desired counseling supervision may well have a significant impact on the job satisfaction of school counselors. This study will take supervision research a step forward in this area.

Self-efficacy

Due to Bandura's (1977, 1982, 1984) social learning theory, the construct of self-efficacy has been widely studied in psychology and counseling research in recent years. While earlier studies examined such varied constructs as aspirations and expectancy for success (see Kirsch, 1986), Bandura (1977) clarified the single construct of self-efficacy as "the conviction that one can successfully execute the behavior required to produce [certain] outcomes" (p. 193). In 1984, Bandura reported that individuals exhibiting high self-efficacy will challenge themselves, persevere in the face of failures, and experience less stress. He also stated that less self-efficacious individuals tend to avoid difficult tasks, give up easily, dwell on their perceived personal shortcomings, and experience high levels of stress and anxiety (Bandura, 1982, 1984). Self-efficacy is cyclically reinforced through positive experiences, though negative experiences tend to have more lasting power in

lowering self-efficacy perceptions (Bandura, 1977, 1982).

Poidevant, Loesch, and Wittmer (1991) found that counselor education doctoral students reported higher levels of self-efficacy in professional activities such as providing supervision, consultation, and training than did counseling psychology doctoral students. This was perhaps due to more experience in these activities provided in counselor education programs (Poidevant et al., 1991).

In their study of the impact of several social cognitive variables on client motivation, Longo, Lent, and Brown (1992) found that self-efficacy contributed significantly to clients' persistence in the counseling process. How might this knowledge be applied to counselors' persistence in the supervision process? It could logically be posited, in line with Bandura's theory, that counselors with high perceived counseling self-efficacy might be more persistent in learning and changing through supervision.

Recently, it was recommended that counselors' perceived self-efficacy be studied in future supervision research, as both an independent and a dependent variable (Bernard & Goodyear, 1992). To date, however, this construct has been explored only in tangential ways (e.g., Friedlander et al., 1986; Friedlander & Snyder, 1983; Johnson, Baker, Kopala, Kiselica, & Thompson, 1989). Friedlander et al. (1986) examined self-efficacy as one of three dependent variables in their study of role conflict in supervision. They found no significant relationships, suggesting that role conflict has little effect on the self-statements, behaviors, or anxiety levels of counselors-in-training (Friedlander et al., 1986). However, the significant negative correlation between self-efficacy and anxiety elicits thoughts of further research in this area.

In a study of counselors'-in-training expectations of supervision, Friedlander and Snyder (1983) found that trainees' expectations of supervision were significantly predicted from their self-efficacy scores. More self-efficacious counselors-in-training expected more of their supervisors in every way, as measured by the Supervisor Rating Form (SRF; Corrigan, 1982) and the Supervisor Questionnaire (SQ; Worthington & Roehlke, 1979). Expecting more of oneself may well lead to having high expectations of others, especially of valued and respected supervisors.

The main problem with research on self-efficacy occurs with instrumentation. In the studies mentioned above, as well as the Johnson et al. (1989) study of self-efficacy and counseling competence, the measures of self-efficacy were created for the individual studies. It is possible that these instruments did not truly measure the construct of self-efficacy, as Kirsch (1986) has suggested. A recent measure, the Counselor Self-Estimate Inventory (COSE; Larson et al., 1992), has established reliability and validity. This measure could prove to be invaluable in this and future self-efficacy studies.

Counseling Effectiveness: Empathic Responding

Over the years, counseling research has placed an emphasis on accountability and counseling effectiveness. However, effectiveness often has been measured through the use of supervisor, peer, and/or client evaluations (Perry, 1991; Ritchie, 1989; Wiggins & Moody, 1987), which can be highly subjective and problematic (Borders, 1989; Borders & Fong, 1991). In response to Holloway and Hosford (1983), a need to examine more objectively measurable outcomes such as counselors' "change in performance in the counseling relationship" (p. 75) is recognized. This section, and the two following, will delineate three possible means of measuring counseling effectiveness through pencil and paper instrumentation.

The first of these counseling effectiveness constructs is empathic responding. One of Rogers' (1957) core conditions, empathy has long been a mainstay in the counseling profession. There has been continued evidence in the literature that empathic responding is important to effective counseling (e.g., Davis, Hector, Meara, King, Tracy, & Wycoff, 1985; Harris & Packard, 1985; Lyons & Zingle, 1990; Rogers, 1951, 1957). The use of empathy can bear more or less importance within the counseling relationship, depending on one's theoretical approach (Wycoff, Davis, Hector, & Meara, 1982), although empathy has been cited as a common therapeutic component shared by all therapies (Frank, 1982; Grencavage & Norcross, 1988).

Understanding how the client makes sense of the world, and responding empathically from that understanding, is crucial to the counseling relationship (Ivey, 1991). According to Aubrey (1982), modeling empathy and multiple perspective taking for

students were important functions of school counselors. If a counselor can communicate to clients that s/he is with them empathically, then the true process of helping and healing can begin.

Counseling Effectiveness: Counselor Adaptability/Flexibility

Flexibility in thinking and responding to clients is invaluable to counseling effectiveness. According to Mahon and Altmann (1977), "It is not the skills themselves which are all important, it is the control of their use, the intentions with which they are used, and their flexibility or changeability that is so crucial" (p. 49). Nowhere is this need for adaptability and flexibility more apparent than in cross-cultural counseling (Sue, Arredondo, & McDavis, 1992), where counselors must literally adapt their counseling style and approach to a totally different culture. Most school counselors serve diverse populations of students. Even without such an extreme, flexibility in counseling response holds much merit.

One of the ultimate goals of developmental models of supervision is that of counselor flexibility in conceptualizing and responding to clients (L. D. Borders, personal communication, January 26, 1994). Blocher's (1983) focus on cognitive development presupposes that at higher levels of thinking, counselors function more optimally. Indeed, cognitive developmental theorists posit that higher levels of functioning involve greater flexibility (Harvey, Hunt, & Schroeder, 1961; Kohlberg, 1969; Loevinger, 1976; Perry, 1970), with research also linking higher cognitive developmental levels with more effective counseling skills (Bowman & Allen, 1988; Holloway & Wampold, 1986; Strohmer, Biggs, Haase, & Purcell, 1983). Similarly, Ivey (1991) built his developmental theory of counseling on the premise that counselors must be able to respond to clients at various levels of cognitive development.

A specific form of flexibility, that related to the skill of self-disclosure, was the focus of two similar studies (Fong, Borders, & Neimeyer, 1986; Neimeyer & Fong, 1983). In each case, the more flexible the counselor, the more effective the counseling skills. Fong et al. (1986) called for further research in this area, using different measures of flexibility. One such measure, the CBA (Howard et al., 1986) was utilized recently

(Kivlighan, Clements, Blake, Arnzen, & Brady, 1993). The results of this recent study indicated that counselor flexibility was significantly and positively correlated with client ratings of the therapeutic relationship.

Counseling Effectiveness: Client Behavior Change

The most obvious measure of counseling effectiveness would appear to be client change due to the counseling experience (Roffers, Cooper, & Sultanoff, 1988). In fact, Borders (1989) referred to client outcome as the "ultimate measure" (p. 20) of counseling effectiveness. However, little research has been conducted in this area (Holloway, 1984). Often the client outcome measured has been self-report of the effectiveness of counseling (e.g., Roffers et al., 1988) or satisfaction with counseling, methods which are problematic for obvious reasons (Borders, 1989).

In the schools, a somewhat more sound method of gauging client outcome, a behavior checklist for students, has been employed (Cobb & Richards, 1983; Ritchie, 1989). These studies yielded improved behavior ratings for the students involved in various counseling and guidance services within the schools. The major concern with these ratings lies in the subjectivity level of the person completing the checklist. Nevertheless, measures completed by teachers (and/or sometimes parents) appear to provide more objective evaluations of student (client) change than does client self-report. This may be particularly true for elementary and middle grade students, who can provide only very concrete "ratings" of their counseling experiences.

Summary

A review of the pertinent literature indicates school counselors' critical need for clinical supervision, and thus the importance of designing and testing supervision approaches that are appropriate to the school setting and the developmental needs of school counseling practitioners. In this study, the feasibility of two developmentally sensitive peer methods, the Structured Peer Consultation Model for School Counselors (Benshoff & Paisley, in press) and the Systematic Peer Group Supervision model (Borders, 1991a), were investigated. In light of critiques of supervision research, the impact of these two methods were examined via multiple outcome measures, including job satisfaction,

counselor self-efficacy, and three measures of participants' counseling effectiveness (i.e., empathic responding, flexibility in responding, and client behavior change). Results may provide guidance for school administrators regarding the professional developmental needs of school counselors.

CHAPTER III
METHODOLOGY

A thorough review of the related literature supports the concept that clinical supervision may enhance school counselors' professional development and growth. Job satisfaction, perceived counselor self-efficacy, and counseling effectiveness are variables which the literature suggests are indirect ways to measure that growth, yet the impact of clinical supervision on these variables has not been explored empirically. This chapter presents the design and methodology for the study intended to address this void in the literature. Included are: research hypotheses, description of instruments, interventions, and participants, overview of procedures, and description of statistical analyses.

Hypotheses

The following hypotheses were tested:

1. Two clinical peer supervision method treatments will significantly improve school counselors' job satisfaction, as measured by performance on the Job Satisfaction Blank (Hoppock, 1977); their perceived counseling self-efficacy as measured by the Counseling Self-Estimate Inventory (Larson et al., 1992); and their counseling effectiveness as measured by the Index of Responding Empathy Scale (Gazda et al., 1984b), the Counselor Behavior Analysis Scale (Howard et al., 1987), and the Teacher Report Form (Achenbach, 1991), in comparison with a control group.
2. Both the dyadic Peer Consultation/Supervision model (Benshoff & Paisley, in press) and the Systematic Peer Group Supervision model (Borders, 1991a) will result in equally significant improvements in school counselors' job satisfaction as measured by performance on the Job Satisfaction Blank (Hoppock, 1977); their perceived counseling self-efficacy as measured by the Counseling Self-Estimate Inventory (Larson et al., 1992); and their

counseling effectiveness as measured by the Index of Responding Empathy Scale (Gazda et al., 1984b), the Teacher Report Form (Achenbach, 1991), and the Counselor Behavior Analysis Scale (Howard et al., 1987).

Instruments

Participants completed a packet of four instruments (see Appendix A) as measures of the three dependent variables: the Job Satisfaction Blank (Hoppock, 1977), the Counseling Self-Estimate Inventory (Larson et al., 1992), the Index of Responding (Gazda et al., 1984b), and the Counselor Behavior Analysis Scale (Howard et al., 1987) (in that order), at pretest and at post-test. A demographics questionnaire (Appendix A) was completed at pretest only. A fifth instrument, the Teacher Report Form (Achenbach, 1991), which was completed by teachers of counselors' clients (see below), served as a third measure of counseling effectiveness. A copy of this instrument appears in Appendix B (Section I). As a means of record-keeping for the TRF, counselors also maintained a Student Log (Appendix B, Section II).

For exploratory and informational purposes only, the Post-Session Helpfulness Questionnaire, an adaptation of Hill's (1989) Client Post-Session Questionnaire, was administered at the end of each supervision session to gather general feedback about the most and least helpful aspects of each session. See Appendix D for a copy of this instrument.

Job Satisfaction: The Job Satisfaction Blank

The adapted version of the Job Satisfaction Blank (JSB; Hoppock, 1977) (included in Appendix A, Section I) used in this study consists of four items in a Likert-scale format. A global score of job satisfaction is derived by summing the weighted responses to the four items, with higher scores suggesting higher global job satisfaction. Scores can range from 4 to 28, with high satisfaction designated as scores of 23 and up; average satisfaction scores designated as 16-22, and low satisfaction scores as 15 and below (Wiggins & Moody, 1983). Hoppock (1977) reported split-half reliability as $r = .87$, and Brayfield and Roethe (1951) found a correlation of .67 between the JSB and the composite score of 257 questions regarding conditions of work and job satisfaction.

For the purposes of this study, a brief measure of job satisfaction was desired. The JSB is not only a brief, reliable, and valid measure (McNichols, Stahl, & Manley, 1978); it also has been used successfully with samples of school counselors (Gade & Houdek, 1993; Wiggins & Weslander, 1986).

Perceived Self-Efficacy: The Counseling Self-Estimate Inventory

The Counseling Self-Estimate Inventory (COSE; Larson et al., 1992) (included in Appendix A, Section II) is designed to measure counselors' perceived self-efficacy, or individualized judgment of their capacity to perform satisfactorily in a given counseling situation. The self-report, 37-item questionnaire utilizes a six-point Likert-type rating scale, ranging from "strongly disagree" (1) to " strongly agree" (6). In scoring the COSE, the 19 negatively worded items are reverse scored, and then the numbers assigned to each item are summed. The highest possible final score is 222. The higher the score, the higher the person's self-estimate of counseling efficacy (Larson et al., 1992). This instrument is the first general measure of counseling self-efficacy to be developed, and the only one with established validity and reliability information. For the purposes of this study, COSE total scores served as the pretest/post-test comparison points.

Through a series of five studies, Larson et al. (1992) provided psychometric data for the COSE. A factor analysis ($n = 213$) yielded five factors around which the 37 retained items were clustered: Microskills (alpha = .88), Process (alpha = .87), Difficult Client Behaviors (alpha = .80), Cultural Competence (alpha = .78), and Awareness of Values (alpha = .62). Computed internal consistency for the total inventory was alpha = .93.

Convergent validity was established ($n = 51$) through comparison of COSE scores with scores on the Tennessee Self-Concept Scale (TSCS; Fitts, 1965, 1988), the State-Trait Anxiety Inventory (STAI; Spielberger, 1983), and the Problem Solving Inventory (PSI; Heppner, 1988). As expected, higher scores on the COSE correlated with more positive scores on both the TSCS and the PSI, and with less anxious scores on the STAI. In terms of discriminant validity, the COSE scores correlated minimally with scores on faking and defensiveness as measured by the TSCS Self-Criticism score and the Social

Desirability Scale (SDS; Crowne & Marlow, 1960, 1964). COSE scores also were correlated minimally with aptitude as measured by the Graduate Record Examination (GRE; Educational Testing Service, 1988), with achievement as measured by self-reported undergraduate grade point averages (GPAs) ($n = 27$), and with personality type as measured by the Myers-Briggs Type Indicator (MBTI; Myers, 1962; Myers & McCaulley, 1985) ($n = 30$).

A short form of the COSE (COSE-SF) (30 items) correlates highly ($r = .99$) with the COSE total score (Larson et al., 1992). Using the short form with an n of 60, Larson et al. (1992) found three week test-retest coefficients of $r = .87$ (COSE-SF total), $r = .83$ (Awareness of Values), $r = .80$ (Difficult Client Behaviors), $r = .74$ (Process), $r = .71$ (Cultural Competence), and $r = .68$ (Microskills).

Additional validity tests (Larson et al., 1992) ($n = 321$) indicated that counselors-in-training had lower COSE scores than did practicing counselors and counseling psychologists, and that COSE scores differed significantly between those with more and less counseling experience and semesters of supervision. In a related study (Larson et al., 1992), there were small but recognizable increases in COSE scores of counselors-in-training ($n = 10$) over the span of a semester. Finally, COSE scores did not differ across counselors' theoretical orientations.

Counseling Effectiveness: Empathic Responding

The Index of Responding Empathy Scale (IRE; Gazda, et al., 1984b) (included in Appendix A, Section III) is a skill-oriented measure which requires participants to write an actual empathic response. The 10-item scale consists of helpee statements to which participants are asked to respond empathically, writing out the empathic response directly below the helpee statement. For the purposes of this study, minor changes in wording were made to the measure, so that the participant responded as the counselor (vs. teacher) in all cases, and the helpee was identified either as a student/client or a parent or teacher consultee.

The instrument is scored by a group of raters using the Gazda et al. (1984b) four-point empathy scale. A response which would be rated at level 1.0 on the scale is

considered irrelevant to the helpee's statement; it is also hurtful to the helpee, because it does not attend even to the surface feelings involved. A level 2.0 response communicates the content of the helpee's statement accurately, but is still considered subtractive because it only partially attends to the surface feelings. A response at level 3.0 reflects the helpee's surface feelings adequately and, if content is included, it is accurate. A level 4.0 response is considered additive because the helpee's underlying feelings are identified, and content may be used to add a deeper meaning (Gazda et al., 1984b). If raters supply different scores, a consensus on the rating is required.

Test-retest reliability coefficients ranging from .90 to .92 have been reported (Black & Phillips, 1982; Gazda et al., 1984a) for this measure. Gazda et al. (1984a) also reported split-half reliability as .77. In a more recent study, Cummings and Murray (1990) examined internal consistency and conducted a factor analysis of the instrument. As expected, a trend toward a single wide loading factor was found. Two factors emerged at first (in an unrotated factor analysis), with the first factor accounting for 38% of the total variance and the second factor accounting for nearly 15% more of the variance. The authors attributed the lack of a clear single factor in part to their homogeneous, restricted sample ($n = 70$), and suggested that there was a good possibility that a single general factor might more readily be found within the general population. Based on this analysis, they concluded that the Index's overall score can be considered a general measure of empathy skill. In a second, rotated factor analysis, Cummings and Murray (1990) found that the Index of Responding items clustered around two clear factors. The first factor was labeled Negative Affect, and the second was Contrasting Affect.

Internal consistency was computed as alpha = .76 (Cummings & Murray, 1990). In addition, numerous experts agree that the instrument holds a great deal of face validity (Black & Phillips, 1982; Cummings, 1989; Cummings & Murray, 1990; Davis et al., 1985; Hector, Davis, Denton, Hayes, Patton-Crowder, & Hinkle, 1981). The IRE has been widely used in research as a general measure of empathy (e. g., Haynie, 1982), including studies of human relations training for student teachers (Bellucci, 1980; Black & Phillips, 1982; Hurt, 1977; Schmidt, 1981) and junior high school students (Casey &

Roark, 1980), counselor training for responding to depression and anger(Davis et al., 1985; Hector et al., 1981), and novice counselor response modes (Cummings, 1989).

Other reliability and validity tests (Cummings & Murray, 1990) revealed that the reliability coefficient for a single rater was .91. Interrater agreement was 100% at the end of training (defined as all raters being within .5 of each other on the Gazda et al. (1984b) four-point empathy scale). In the present study, trained raters used a manual developed by Cummings (1989). This manual contains specific examples of responses at each possible level. Training consisted of at least 10 hours of discussion and practice using written materials and responses produced by individuals not participating in this study. Once an acceptable level of inter-rater reliability (70%) was obtained, training was complete. Final inter-rater reliability ranged from .57 (on pretest, agreement between rater 1 and rater 2) to .79 (on post-test, overall agreement). The mean inter-rater reliability (for pre- and post-test) was .67.

Counseling Effectiveness: Flexibility of Responding

The Counselor Behavior Analysis-Long Form (CBA-Long; Howard, Nance, & Myers, 1987) is a 24-item self-report measure of counselor adaptability. The first 12 items from the CBA-Long make up the CBA-A, and the second 12 items make up the CBA-B. According to Adaptive Counseling and Therapy (ACT) theory (Howard, Nance, & Myers, 1986), the basis for the CBA, counselors respond from four different developmental levels, which are on a continuum from low maturity to high maturity. High maturity (adaptable) counselors are better able to match their clients' developmental level within therapy, which maximizes the therapeutic process. The instrument is reported to be "content-free" by the first author (G. S. Howard, personal communication, October 12, 1994), making it appropriate for counselors in all settings.

In a series of three studies, psychometric data for the CBA were explored (Gabbard, Howard, & Dunfee, 1986). Internal consistency was demonstrated ($n = 44$) by computing part-whole correlations for the CBA-A and the CBA-B scores with CBA-Long score. For the CBA-A, $r = .78$, while $r = .77$ for the CBA-B. Gabbard et al. (1986) reported a median test-retest reliability coefficient (Kappa) of .60 across three months for

the CBA-Long total score.

In the second study, Gabbard et al. (1986) examined the instrument's sensitivity to change in counselor adaptability levels. Using a pretest - post-test design, 11 counselors-in-training took the CBA-Long and then participated in a workshop on ACT theory. Post-test adaptability scores were significantly higher than pretest adaptability scores, $t(9) = 2.59$, $p < .05$. In the third study ($n = 42$), Gabbard et al. (1986) used a multitrait, multimethod approach to test convergent and discriminant validity. This approach included a confirmatory factor analysis, which confirmed independent factor loadings for the adaptability ratings. In addition, counselor adaptability ratings correlated highly with overall counseling effectiveness, $r = .98$.

For the purposes of this study, only the 12 items on the CBA-B were administered (included in Appendix A, Section IV). In an informal pre-pilot study, a group of school counseling experts found the CBA-Long to be too time-consuming and tiring. These experts agreed that form B alone would be less intimidating to school counselors. According to the senior author, both form A and form B can stand alone as a valid measure of adaptability (G. S. Howard, personal communication, October 12, 1994).

Counseling Effectiveness: Client Behavior Change

The Teacher Report Form (TRF; Achenbach, 1991) is a standardized measure of teacher judgment regarding students' adaptive functioning and problems in school. The instrument consists of a demographic sheet, ratings of academic performance, comments on four ratings of adaptive functioning, and 118 possible problems classified into eight syndrome scales. Utilizing these syndrome scales, the Problem Scales may be separated into two groupings: Internalizing (e.g., somatic complaints, anxieties) and Externalizing (e.g., delinquent behavior, aggression) problems. For the purposes of this study, only the demographic sheet and problem scales were utilized.

When completing the TRF, teachers use a Likert-type scale, ranging from 0 (Not true [as far as you know]) to 2 (Very true or often true). In scoring the TRF, total raw scores for each scale are computed by adding the 1s and 2s entered for that scale. A graphic display of raw scores allows the utilization of both normed percentiles and T scores

for each scale. For the purposes of this study, raw scores were compared to normed percentiles, to place them below, within, or above the normal range.

In the instrument manual, Achenbach (1991) reported test-retest reliability ($n = 44$) over a mean of 15 days of $r = .90$ for academic and adaptive scores and $r = .92$ for problem scores. Content validity was established by comparing scores of mental health or special education referred students with those of non-referred students ($n = 2,600$) (Achenbach, 1991). Referred students scored significantly higher ($p < .01$) on nearly all of the problem score items, suggesting that the TRF items are related to mental health needs. Achenbach (1991) established construct validity by a comparison of TRF scores and scores on the Conners Revised Teacher Rating Scale (Goyette, Conners, & Ulrich, 1978). The correlation between the TRF and Conners Total Problems scales was $r = .83$.

Demographic Information

Demographic questions for participants (included in Appendix A, Section V) included the following: age, gender, ethnic group, highest degree held, year highest degree was earned, current school level, years of experience as a school counselor, professional memberships held, previous work experience (classroom teacher, administrator, mental health counselor, social worker, other), certification, information about counselors' graduate counseling programs, and previous post-degree supervision experience (peer, individually contracted, structured models, other). This information was used for descriptive purposes only.

Helpfulness of Supervision Sessions

For exploratory purposes only, the Post-Session Helpfulness Questionnaire (Hill, 1989) (Appendix D) was used as a measure of the helpfulness of the supervision sessions. This measure is made up of three items. On the first item, participants are asked to rate the supervision session based on a five-point Likert-scale, where 1 = not helpful and 5 = extremely helpful. The remaining items are open-ended questions aimed at gathering general feedback about possible helpful and harmful elements of each session. When used with counseling sessions, Hill's (1989) category scheme (e.g., Therapist techniques, Therapist manner, Client tasks, Client manner, and Working alliance) is used to classify the

open-ended responses. Using these categories as a starting point the researcher attempted to derive, from the responses themselves, a category scheme specific to supervision sessions. Further details regarding the results of this measure are included in Chapters IV and V.

Interventions

Participants were assigned to one of three groups after taking into consideration several factors relevant to the feasibility of group membership. Because of the wide geographic region represented by the counselors, they first were grouped by area (e.g., counties). Also, some of the counselors had previous experience with one of the two treatment models; these counselors were assigned to the control group. No counselor in either treatment group had had post-degree experience with either of the supervision models. As numbers permitted, counselors within each geographic region were assigned to one of the three experimental groups. Finally, due to the nature of the two treatment groups, counties with larger numbers of participants were more likely to be assigned to the peer group supervision model.

The first treatment group participated in the Structured Peer Consultation Model for School Counselors (SPCM-SC; Benshoff & Paisley, in press). This group was trained in the model of dyadic peer consultation/supervision by a trained supervisor familiar with the model. Participants in this group provided supportive yet challenging peer consultation/supervision to their partners, following an adapted structured protocol. Peer consultation/supervision sessions included setting individual goals, review and discussion of counseling session audiotapes, and case presentations and discussions.

Training of participants consisted of a general introduction to the model (Benshoff & Paisley, in press), followed by a videotaped demonstration of its use within a consultation/supervision session. A training manual, created in consultation with the authors (see Appendix C, Section I), was distributed to participants, and all questions were addressed.

The second treatment group participated in Systematic Peer Group Supervision (SPGS; Borders, 1991a). This model employs systematic assignments of particular roles

(e.g., counselor, student, student's teacher) within the group of supervisees during audiotape reviews. After the taped segment has been heard, each group member responds to the counselor's pre-stated questions in the first person, from within the role they were assigned. Listening and responding to tapes from within these roles encourages conceptualization and skill-building participation by each of the members. The supervisor facilitates the process by asking specific questions of the different roles, asking the counselor to respond, and summing up the statements and suggestions of the group.

Training of participants consisted of a brief general introduction of the model (Borders, 1991a), followed by a videotaped demonstration of its use within a supervision session. A training manual, created in consultation with the author (see Appendix C, Section II), was distributed to participants, and all questions were addressed. During the eight weeks of group supervision, the large group of ten met in two smaller groups of five, each led by a trained supervisor experienced in the model.

The third group served as the unstructured "pseudo-treatment" (control) group, and completed the pre- and post-test battery of questionnaires only. Members of this group were asked to focus individually on their plans for professional development during the time of the study. The data gathered from this group provided a comparison point for the two treatment groups.

Participants

Participants for this study were primarily elementary and middle school counselors (and one high school counselor) who were employed in several school systems in northwestern North Carolina and receiving no on-going clinical supervision at the time of the study. A total of 31 participants volunteered, with 10 counselors in the first (dyadic) treatment group, 10 in the second (peer group) treatment group, and 11 in the unstructured (control) group. Two weeks into the study, both participants in one of the dyads of group one chose to drop out. They stated personal, time-consuming issues as their reasons for leaving the study. Thus, the final number of participants in the first treatment group was eight. Due to the availability of grant monies, each participant received a small stipend, with those in the treatment groups being paid slightly more than those in the control group.

Descriptive information concerning participants is reported in Tables 1 and 2. The largest percentage of participants were elementary (K-5) school counselors (44.8%), followed closely by elementary/middle (K-8) school counselors (41.4%). The majority had a master's degree (82.8%) as the highest degree earned.

The majority of participants were female (79.3%), and all were white. Ages ranged from 25 years to 56 years, with the majority of participants (69%) falling in the 33 - 46 year range. Just over half (55.2%) had nine or fewer total years of experience as a school counselor. When recalling previous work experience, 55.2% ($n = 16$) reported experience as a school teacher. Other types of previous experience included: mental health/private practice ($n = 6$), social worker ($n = 3$), school administrator ($n = 1$), and other ($n = 13$).

Due to possible variability of training and credentials among practitioners, questions regarding training programs, credentials, and professional membership were included. Nearly half of the participants (46.4%) reported completing degree programs of 48 semester hours, with 28.6% reporting degree programs ranging from 51 to 144 semester hours. Nearly two-thirds of the participants (64.3%) graduated from a CACREP accredited counseling program. Only one participant was a National Certified Counselor, and none were National Certified School Counselors. A small number of participants (27.6%) reported membership in the American Counseling Association, while a similar number (31%) were members of the American School Counselor Association. Other professional memberships included: North Carolina Counseling Association (27.6%), North Carolina School Counselor Association (75.9%), and Other (27.6%).

A majority of the participants (67.9%) had received some counseling supervision beyond their graduate programs. About half (51.7%) of the participants reported receiving peer supervision. Other types of supervision reported were: individually contracted (13.8%), some structured model (any delineated model of supervision with a specific protocol of activities) (13.8%), and other (13.8%).

Because the opportunity to participate in this study was offered to all elementary and middle school counselors in the selected counties, demographic information about those counselors who chose not to participate also was gathered. This made it possible to

Table 1

Demographic Characteristics of Participants

Characteristic	N	Percent
School Level		
Elementary	13	44.8%
Middle	3	10.3%
High	1	3.4%
Elementary/Middle	12	41.4%
Highest Degree Held		
Bachelors	3	10.3%
Master's	24	82.8%
Education Specialist	2	6.9%
Gender		
Female	23	79.3%
Male	6	20.7%
Ethnicity		
Caucasian	29	100.0%
Age		
25 - 32	4	13.8%
33 - 40	9	31.0%
41 - 46	11	38.0%
51 - 56	5	17.2%

Table 1, continued

Characteristic	N	Percent
Total Years Experience as a School Counselor		
Less than 3 years	10	34.5%
3 - 9 years	6	20.7%
10 - 15 years	8	27.6%
More than 15 years	5	17.2%
Years of Previous Experience as a Classroom Teacher (n = 16)		
1 - 5 years	6	37.5%
6 - 11 years	7	43.7%
12 - 20 years	3	18.8%
Years of Previous Experience as a Mental health counselor or Private practitioner (n = 6)		
2 years	2	33.3%
4 years	1	16.7%
5 years	1	16.7%
6 years	1	16.7%
8 years	1	16.7%
Years of Previous Experience as a Social Worker (n = 3)		
2 years	1	33.3%
3 years	1	33.3%
14 years	1	33.3%

Table 1, continued

Characteristic	N	Percent
Years of Previous Experience as a School Administrator (n = 1)		
1 year	1	100.0%
Years of Other Previous Experience (n = 13)		
1 year	3	23.1%
2 years	4	30.8%
3 - 6 years	3	23.1%
7 or more years	3	23.1%
Semester Hours Required in Degree Program (Frequency missing = 1)		
30 - 47 hours	7	25.0%
48 hours	13	46.4%
49 or more hours	8	28.6%

n = 29

Table 2

Professional Characteristics of Participants

Characteristic	# Yes	% Yes
Attended CACREP Accredited Counseling Program	18	62.1%
National Certified Counselor	1	3.4%
National Certified School Counselor	0	0%
Professional Membership		
American Counseling Association	8	27.6%
American School Counseling Association	9	31%
North Carolina Counseling Association	8	27.6%
North Carolina School Counseling Association	22	75.9%
Other	8	27.6%
Counseling Supervision Beyond Graduate Program	9	31%
Peer	15	51.7%
Individually contracted	4	13.8%
Structured model	4	13.8%
Other	4	13.8%

n = 29

compare demographics of volunteers with those of non-volunteers.

Non-participants for this study were the elementary and middle school counselors who were employed in several school systems in northwestern North Carolina and chose not to participate in this study. A total of 45 demographic questionnaires were mailed out to the non-participating schools in the participating counties, and 38 completed questionnaires were returned. This was a response rate of 84.4%, enough to appropriately generalize the results to the population of 45.

Descriptive information concerning non-participants is reported in Tables 3 and 4. The largest percentage of non-participants were elementary (K-5) school counselors (56.8%), followed by middle (6-8) school counselors (27%). The majority had a master's degree (86.8%) as the highest degree earned.

The majority of non-participants were female (89.5%), and all were white. Ages ranged from 25 years to 61 years, with the majority of non-participants (65.4%) falling in the 35 - 50 year range. Exactly half (50%) had nine or fewer total years of experience as a school counselor, with the outer range reported at 39.75 years. When listing previous work experience, 60.5% ($n = 23$) reported experience as a school teacher. Other types of previous experience included: mental health/private practice ($n = 2$), social worker ($n = 5$), and other ($n = 10$).

Due to possible variability of training and credentials among practitioners, questions regarding training programs, credentials, and professional membership were included. A majority of the non-participants (71%) reported completing degree programs of 30-48 semester hours, with 29% reporting degree programs ranging from 51 to 100 semester hours. Seven respondents failed to answer this question. Over half of the non-participants ($n = 21$) graduated from a CACREP accredited counseling program. Nine respondents failed to answer this question. Only five non- participants were National Certified Counselors, and two were National Certified School Counselors. A small number of non-participants (13.2%) reported membership in the American Counseling Association, while 28.9% were members of the American School Counselor Association. Other professional memberships included: North Carolina Counseling Association (39.5%), North Carolina

Table 3

Demographic Characteristics of Non-Participants

Characteristic	N	Percent
School Level		
Elementary	21	56.8%
Middle	10	27.0%
Elementary/Middle	6	16.2%
Highest Degree Held		
Bachelors	2	5.3%
Master's	33	86.8%
Education Specialist	3	7.9%
Gender		
Female	34	89.5%
Male	4	10.5%
Ethnicity		
Caucasian	38	100.0%
Age		
25 - 35 years	9	23.7%
36 - 45 years	15	39.5%
46 - 50 years	9	23.6%
Over 50 years	5	13.2%

Table 3, continued

Characteristic	N	Percent
Total Years Experience as a School Counselor		
Less than 3 years	11	28.9%
3 - 9 years	8	21.1%
10 - 15 years	9	23.7%
More than 15 years	10	26.3%
Years of Previous Experience as a Classroom Teacher (n = 23)		
1 - 5 years	11	47.8%
6 - 11 years	6	26.1%
12 - 20 years	6	26.1%
Years of Previous Experience as a Mental health counselor or Private practitioner (n = 2)		
2 years	1	50.0%
4 years	1	50.0%
Years of Previous Experience as a Social Worker (n = 5)		
1 years	1	20.0%
3 years	1	20.0%
6 years	1	20.0%
11 years	1	20.0%
32 years	1	20.0%

Table 3, continued

Characteristic	N	Percent
Years of Other Previous Experience (n = 10)		
1- 3 years	4	40.0%
4 - 11 years	4	40.0%
12 or more years	2	20.0%
Semester Hours Required in Degree Program (Frequency missing = 7)		
30 - 47 hours	11	35.5%
48 hours	11	35.5%
49 or more hours	9	29.0%

n = 38

Table 4

Professional Characteristics of Non-Participants

Characteristic	# Yes	% Yes
Attended CACREP Accredited Counseling Program	21	55.3%
National Certified Counselor	5	13.2%
National Certified School Counselor	2	5.3%
Professional Membership		
American Counseling Association	5	13.2%
American School Counseling Association	11	28.9%
North Carolina Counseling Association	15	39.5%
North Carolina School Counseling Association	25	65.8%
Other	11	28.9%
Counseling Supervision Beyond Graduate Program	20	52.6%
Peer	16	42.1%
Individually contracted	3	7.9%
Structured model	7	18.4%
Other	1	2.6%

$n = 38$

School Counselor Association (65.8%), and Other (28.9%).

A slight majority of the non-participants (52.6%) had received some counseling supervision since finishing their degrees. Just under half (42.9%) of the participants reported receiving peer supervision. Other types of supervision reported were: individually contracted (7.9%), some structured model (any delineated model of supervision with a specific protocol of activities) (18.4%), and other (2.6%).

Overall, the participants and non-participants were very similar to each other demographically. In both groups, about half were elementary (K-5) school counselors, with slightly more middle (6-8) school counselors (27% vs. 10.3%) in the non-participant group. Over four-fifths of each group had a master's degree as the highest degree earned.

The majority in both groups were female and all were white. Ages were nearly identical, with a few older outliers in the non-participant group. In each group, about half had nine or fewer total years of experience as a school counselor, with a few members of the non-participant group reporting 25 - 40 years experience. A little over half of the subjects in each group reported previous experience as a school teacher. One small difference was noted: 21% of those in the participant group reported previous experience in mental health/private practice, while only 5% of non-participants reported such experience.

In comparing training and credentials among groups, some interesting results were found. Similar requirements for degree programs were reported, with over half in each group graduating from CACREP accredited counseling programs. A larger percentage of non-participants (13.2% vs. 3.4%) were National Certified Counselors, and 5% of non-participants (as compared to 0% of participants) were National Certified School Counselors. In terms of professional memberships, both groups were highly similar, with the greatest numbers reporting membership in the North Carolina School Counselor Association.

Considerably more non-participants (52.6% vs. 31%) reported receiving some counseling supervision since finishing their degrees. However, about half in each group reported receiving peer supervision. Other types of supervision were minimally reported

by both groups.

Procedures

In July 1994, the researcher contacted the director of the Appalachian State University/Public School Partnership, Dr. Elizabeth W. Long of Appalachian State University. An invitation for Partnership Superintendents to allow their counselors the opportunity to participate in this study was discussed. Dr. Long agreed to extend such an invitation, and a letter regarding the proposed study was faxed to each Superintendent (see Appendix E), then followed up with a telephone call by the researcher. As a result, all Superintendents agreed to allow the researcher access to their school counselors in order to solicit participation in the study.

The participating counties were contacted by phone in October 1994 in order for the researcher to schedule initial meeting times with the elementary and middle school counselors. At these initial meetings, held in late October and early November 1994, the researcher explained the study in detail (including confidentiality issues) and asked for volunteers. Follow-up meetings in January were scheduled, during which the pretest packets were administered and volunteers signed a consent form (see Appendix F). Also during this meeting, the counselors were assigned to their treatment or control group.

At the pretest meetings in January 1995, groups of participants were given the pretest packet of instruments and asked to complete the measures in the order in which they appear in Appendix A. Participants were encouraged to answer as honestly as possible, and reminded that all information would be kept confidential, with only identification numbers used on the instruments. Completion of the packets took approximately one and one-half hours. At this point participants were asked to set up their schedules for the supervision sessions, which began during the second week in January 1995.

After the pretest and scheduling were completed, the use of the TRF (Achenbach, 1991) was explained and participants each received 10 copies of the instrument. For the purposes of this study, participating school counselors had teachers of the first five clients they saw during the study complete the Demographic information and the Problems Checklist of the TRF (Achenbach, 1991) as soon as possible after the first counseling

session. Counselors were asked to choose students whom they expected to see at least three times over the course of the study. During the final week of the study, this instrument was completed again by the teachers of each of these clients who was seen at least three times by the participating school counselors. Teachers also were asked to complete TRFs (at pre- and post-test) for one control student per client. This student was the twelfth student on the teacher's roll, in the same class as the client. Counselors were asked to match the students by gender; thus if the twelfth student was not the same gender as the client, the thirteenth student (or the next student who was the appropriate gender) was used. It was left up to the participating counselors to decide who the control student would be, then ask the teacher to complete the forms. The teacher was to remain blind to the designations of client and control student. Problem Checklist scores were compared to assess the degree of client behavior change.

In order for participating school counselors to keep a record of their clients (for TRF purposes), copies of the Student Log were distributed (see Appendix B, Section II). On the log, counselors were asked to note the following: client's name (or identification number), grade, and gender; teacher's name; main presenting problem at each session, number and duration of sessions, and any pertinent comments. A brief summary of the information gathered from the logs follows (see Table 5).

Overall, clients were fairly evenly distributed regarding gender. Boys made up 53.2% of the sample, and 46.8% were girls. Concerns about family (31.7%) and behavior in the classroom (23.2%) were the most frequent presenting problems. Also noted were personal concerns (19.4%), problems with grades/school (16.4%), and trouble with friends (9.3%). Clients were seen an average of six sessions during the ten week study period, with an average session length of 25-30 minutes. Counselors' written comments about these sessions generally were concrete, brief descriptions of session content. No comments particularly pertinent to the purposes of this study were identified.

Dyadic Peer Consultation/Supervision

Treatment group one ($n = 8$), the dyadic peer consultation/supervision group (SPCM-SC; Benshoff & Paisley, in press), had one large initial meeting for training

Table 5

Description of Student Log Information

Characteristic	N	Percent
Gender		
Male	42	53.2%
Female	37	46.8%
Presenting Problem		
Family Concerns	139	31.7%
Classroom Behavior	102	23.2%
Personal Concerns	85	19.4%
Grades/School	72	16.4%
Friend Concerns	41	9.3%

n = 79

Characteristic	Mean	Range
Number of Counseling Sessions	6	3 - 15
Length of Counseling Sessions (minutes)	27	2 - 120

purposes. The first consultation/supervision session was held immediately following training. During this session, dyads shared their philosophies and approaches to counseling and set specific individualized goals for the experience. They were asked to bring an audiotape of one of their counseling sessions to the next session. Counselors were given a sample form for permission to tape their counseling sessions, to be signed by the student's parent or guardian (see Appendix G). At the end of each peer consultation/supervision session, each participant completed the Post-Session Helpfulness Questionnaire (PSHQ; Hill, 1989), a self-report measure of the most and least helpful aspects of the supervision session. Dyad participants mailed the completed PSHQs to the researcher weekly, using stamped envelopes provided for this purpose. During the second session, dyads discussed and evaluated their overall counseling programs, each identifying one goal for change or improvement. This goal was not a focus of subsequent sessions, but was evaluated in the final session. Tapes were exchanged to be reviewed and critiqued before the third session, within the specific guidelines provided. Guidelines emphasized that the focus was on the counselor's performance, not the client's behavior.

In subsequent sessions, counselors alternated between tape reviews and case study discussions (a total of three each). In tape review sessions, participants took turns giving and receiving feedback on their counseling performance (based on audiotape review), according to specific guidelines. In case study sessions, participants each gave a brief description of a difficult case, then worked together to produce new strategies for helping the student. Case study sessions also might have focused on conceptualization of the student or issues of the counselor's personal or professional growth. Tapes were exchanged at the end of each case study session in order to be reviewed for the following week. The final peer consultation/supervision session included an evaluation of the process, movement toward goals, and termination of the peer consultation/supervision relationship. Following the final peer consultation/supervision session, counselors were asked to return their completed TRFs and Student Logs. All participants in this intervention met together one final time, during the week following the final dyad session. At this final meeting, the post-test packets were administered.

Structured Peer Group Supervision

Treatment group two (n =10), the structured peer group supervision group (Borders, 1991a), also had one large initial meeting for training purposes. During the first group session (immediately following training), the group of ten split into two groups of five, and individual goals were set within each group. There was then a general sharing of activities and incidents at participants' schools, and a case presentation schedule was developed. This general sharing time was offered at the start of each of the remaining sessions, in order to maintain positive group morale and a supportive atmosphere. The group member who was to present at the next session was required to bring a tape of a counseling session, with a brief segment ready to be played for the group. Counselors were given a sample form for permission to tape their counseling sessions, to be signed by the student's parent or guardian (see Appendix G). At the end of each group supervision session, each participant completed the PSHQ (Hill, 1989), a self-report measure of the most and least helpful aspects of the supervision session. Group supervisors collected the PSHQs after each session.

In each of sessions two through eight, one participant presented a case, assigned roles to the other participants, and played the taped segment. Each participant listened to the tape from the perspective of his/her assigned role and gave feedback to the presenter in the first person point of view. During the final session, evaluation of the experience and movement toward individual goals, as well as termination of the group, occurred. Counselors were asked to return their completed TRFs and Student Logs at this time. Upon completion of the final group session, participants remained to complete the post-test packets.

Control Group

As described above, an initial meeting was held for the unstructured group to complete pretest packets. Also at this meeting, participants were asked to keep a list of all professional development activities they engaged in during the course of the study. Upon completion of the pretest measures, a date and time were set for the final meeting.

During the second week in March, participants in the control group had their final

meeting in order to complete the post-test packets. At the end of this administration, participants turned in a written summary of their professional development activities during the time of the study, as well as their completed TRFs and Student Logs, were debriefed regarding the study, and future training in one of the two methods of peer supervision was offered. About half (55%) of the counselors expressed an interest in the supervision training. A training meeting was scheduled for mid-June for those able to attend.

Data Analysis

Descriptive Results

Using the SAS statistical package, descriptive statistics were calculated. Frequencies and percentages were calculated for each item on the demographic questionnaire for a) all participants and b) all non-participants in the participating counties. For the purposes of this study, a summary of demographic data was compiled into tables of descriptive statistics (see Tables 1-4). Also, means and standard deviations for each measure, pre and post, were calculated for the sample overall and by group.

Analyses of Covariance

Each of the hypotheses was tested through analyses of covariance (ANCOVAs). The first hypothesis states that the two models of supervision will significantly improve school counselors' scores for the dependent variables (job satisfaction, perceived counseling self-efficacy, and counseling effectiveness [measured by level of empathic responding, counselor flexibility in responding, and client behavior change]). A series of one-way ANCOVAs was used to test for significant treatment effects on each of the dependent counselor variables, in comparison with the control group. Three-way analysis of variance was used to test for significant treatment effects on the dependent variable of client behavior change.

The second hypothesis states that both models of supervision will prove to be equally effective in improving school counselors' scores for the dependent variables listed above. The same series of one-way and three-way ANCOVAs was used to judge this hypothesis.

CHAPTER IV
RESULTS

This chapter consists of results of the study, along with explanations of the results. Information is presented in subsections paralleling the research hypotheses and data analyses discussed in Chapter III.

Results reported in this section are based on descriptive and inferential statistics which were used to examine relationships among the independent and dependent variables. Descriptive statistics, including means and standard deviations, were calculated to describe participant pre- and post-test performance on the instruments. (Additional descriptive analyses regarding participants and non-participants were reported in Chapter III.) Inferential statistics used include one-way and two-way analyses of covariance. From the results of these analyses, findings relevant to the hypotheses are presented below.

Descriptive Results

Pretest and post-test scores on each of the instruments were calculated for participants. The means and standard deviations on the scores are reported in Tables 6.1 and 6.2 by pre- and post-tests. All scores were plotted for each measure and the distributions appeared normal. In general, pretest results revealed average job satisfaction scores (JSB), with a mean of 20.9 (on a scale of 4 to 28, with 22 as the upper cutoff for average scores). Self-efficacy scores (COSE) were relatively high, with a mean of 168 (on a 222 point scale). For the written measure of empathy (IRE), scores were fairly low, with a mean of 2.2 (on a 4 point scale, with 2 signifying a subtractive empathic response). Adaptability scores on the CBA-B were slightly above average, with a mean of 35.6 (on a scale from 12 to 48). On the style range scale of the CBA-B, 86.2% of the participants utilized 3-4 styles of responding (on a scale of 1 to 4).

At post-test, job satisfaction scores (JSB) again were average, with a mean of 21.2 (on a scale of 4 to 28, with 22 as the upper cutoff for average scores). Self-efficacy scores

Table 6.1

Descriptive Statistics for Each Dependent (Counselor) Measure at Pretest and Post-Test

Instrument Scale	Pretest Mean	Pretest SD	Post-Test Mean	Post-Test SD
Job Satisfaction Blank - Total	20.9	2.78	21.2	3.13
Counseling Self-Estimate Inventory - Total	168.1	22.8	172.3	16.8
Index of Responding Empathy Scale - Average	2.2	0.3	2.4	0.3
Counselor Behavior Analysis Scale - Adaptability	35.6	3.2	36.4	2.9

(n = 29)

Table 6.2

Descriptive Statistics for Teacher Report Form at Pretest and Post-Test

Instrument Scale	Pretest Mean	Pretest SD	Post-Test Mean	Post-Test SD
Internalizing-				
Boys	8.06	7.81	7.14	7.52
Girls	8.92	7.84	6.46	6.05
Externalizing-				
Boys	13.18	14.30	13.49	13.90
Girls	10.12	14.00	8.36	12.93
Total-				
Boys	40.27	31.53	40.12	29.79
Girls	31.64	30.90	25.15	26.65

(n = 156)

(COSE) were still relatively high, with a mean of 172.3 (on a 222 point scale). On the written measure of empathy (IRE), scores again were fairly low, with a mean of 2.4 (on a 4 point scale, with 2 signifying a subtractive empathic response). Adaptability scores on the CBA-B were still slightly above average, with a mean of 36.4 (on a scale of 12 to 48). On the style range scale of the CBA-B, 79.3% of the participants utilized 3-4 styles of responding (on a scale of 1 to 4).

Analysis of TRF scores is based on gender and age. For this group, overall raw scores on the TRF were high-normal, meaning that, in general, students had raw scores within the range of normal behavior, though at the high end of this range. Scores above the cutoff for the normal range imply the presence of clinical behavioral problems. Cutoff scores for the normal range are as follows: (for boys ages 5-11) on Internalizing, 9; on Externalizing, 14; on Total, 40-42; (for girls ages 5 - 11) on Internalizing, 9; on Externalizing, 8; on Total, 31 - 33. For the boys, the TRF Internalizing subscale had a pretest mean of 8.06, while on the Externalizing subscale, their pretest mean was 13.18. The boys' total TRF mean at pretest was 40.27. Boys' post-test means were as follows: Internalizing = 7.14, Externalizing = 13.49, and Total = 40.12.

For the girls, the TRF Internalizing subscale had a pretest mean of 8.92, while on the Externalizing subscale, their pretest mean was 10.12. The girls' total TRF mean at pretest was 31.64. Girls' post-test means were as follows: Internalizing = 6.46, Externalizing = 8.36, and Total = 25.15. TRF scores will be separated by gender for clients and controls below (see Table 7.2).

Scores for all the measures also were calculated by treatment group (see Tables 7.1 and 7.2). For the counselors' dependent measures at pretest, groups were very similar (with a few notable exceptions). Though there were no significant differences, counselors in the dyadic model scored somewhat lower (roughly 20 points of a 222 point scale) on the COSE than counselors in either of the two other groups ($F = 3.07$, $p = .0635$). This test statistic suggests a trend toward significance. On this same measure, the control group had both the highest mean score and the lowest variance. Counselors in the peer group model scored, on average, substantially lower (about .3 points of a 4 point scale) on the IRE than

Table 7.1

Descriptive Statistics for Each Dependent (Counselor) Measure by Group (Pretest and Post-Test)

Treatment Group	Measure	Pretest Mean	Pretest SD	Post-Test Mean	Post-Test SD
Dyadic Model					
	Job Satisfaction Blank	20.75	2.96	21.37	3.50
	Counseling Self-Estimate Inventory	152.62	24.49	164.75	18.46
	Index of Responding Empathy Scale	2.34	0.29	2.53	0.38
	Counselor Behavior Analysis Scale - Adaptability	36.63	4.24	37.38	3.85
Peer Group Model					
	Job Satisfaction Blank	21.10	2.47	21.80	2.04
	Counseling Self-Estimate Inventory	171.64	25.21	174.27	14.98
	Index of Responding Empathy Scale	2.05	0.38	2.30	0.23
	Counselor Behavior Analysis Scale - Adaptability	34.82	3.21	35.10	2.18
Control Group					
	Job Satisfaction Blank	20.82	3.16	20.55	3.78
	Counseling Self-Estimate Inventory	176.26	13.47	176.09	16.83
	Index of Responding Empathy Scale	2.27	0.31	2.42	0.26
	Counselor Behavior Analysis Scale - Adaptability	35.64	2.21	37.00	2.53

($n = 29$)

Table 7.2

Descriptive Statistics for Teacher Report Form by Group (Pretest and Post-Test)

Supervision Treatment Group	Student Treatment Group	Pretest Mean	Pretest SD	Post-Test Mean	Post-Test SD
Dyadic Model					
	Client				
	Internalizing-				
	Boys	15.18	8.11	11.45	8.56
	Girls	11.47	7.96	8.20	6.20
	Externalizing-				
	Boys	15.64	13.92	14.00	12.03
	Girls	13.33	15.33	11.27	13.83
	Total-				
	Boys	59.00	23.94	51.36	24.98
	Girls	41.33	33.81	33.53	26.23
	Control				
	Internalizing-				
	Boys	6.00	7.07	3.62	5.88
	Girls	6.15	7.22	3.92	4.37
	Externalizing-				
	Boys	10.46	14.12	11.00	13.78
	Girls	3.85	5.05	3.00	3.24
	Total-				
	Boys	33.46	28.02	28.38	28.89
	Girls	16.46	18.77	11.85	10.50
Peer Group Model					
	Client				
	Internalizing-				
	Boys	7.76	7.33	7.24	5.63
	Girls	14.94	8.49	10.71	6.77
	Externalizing-				
	Boys	14.82	12.18	19.94	14.64
	Girls	18.65	17.05	16.06	18.66
	Total-				
	Boys	43.29	28.61	53.00	23.36
	Girls	58.41	30.22	46.59	34.66

Table 7.2, continued

Supervision Treatment Group	Student Treatment Group	Pretest Mean	Pretest SD	Post-Test Mean	Post-Test SD
Peer Group Model					
	Control				
	Internalizing-				
	Boys	4.59	4.99	5.82	5.65
	Girls	5.35	5.66	3.94	4.84
	Externalizing-				
	Boys	5.82	9.23	5.47	6.95
	Girls	6.82	13.70	4.82	8.85
	Total-				
	Boys	23.06	19.04	23.76	20.05
	Girls	17.88	25.13	13.06	16.54
Control Group					
	Client				
	Internalizing-				
	Boys	13.62	8.63	12.92	10.52
	Girls	5.83	3.82	5.83	5.12
	Externalizing-				
	Boys	27.77	16.33	23.38	15.89
	Girls	9.17	9.79	8.83	9.68
	Total-				
	Boys	73.85	32.31	67.23	29.63
	Girls	25.83	17.51	26.17	15.55
	Control				
	Internalizing-				
	Boys	3.46	3.69	2.85	3.26
	Girls	4.67	2.94	3.33	3.56
	Externalizing-				
	Boys	6.69	10.24	7.69	11.16
	Girls	1.83	4.02	0.50	0.84
	Total-				
	Boys	16.23	18.50	19.77	22.79
	Girls	9.17	5.98	5.50	4.51

($n = 156$)

did the other two groups, although these differences were not statistically significant (F = 1.97, p = .1593). And while there was little difference among the mean CBA-B scores for the three groups (F = .71, p = .5031), the variance for this measure differed widely. The CBA-B variance for the dyadic group was one point higher than that for the peer group, which was in turn one point higher than that for the control group. At post-test, nearly identical similarities and differences were found as at pretest.

Regarding the client information, results by treatment groups were again very similar. The small differences that did occur were between the two groups of students (clients and controls). On the pretest, student clients scored significantly higher on all scales than did control students (Internalizing: F = 36.26, p = .0001; Externalizing: F = 26.93, p = .0001; Total: F = 53.27, p = .0001), as might reasonably be expected (higher scores indicate more problematic behaviors). No significant differences were noted for post-test results by counselor treatment group, but control students did achieve significantly greater gains on the post-test (resulting in significantly lower problem behavior scores) than did clients (F = 7.03, p = .0089). There were also significant differences between the genders, with girls showing significantly lower post-test scores than boys (F = 9.29, p = .0027).

Post-session questionnaires

The exploratory PSHQs, completed after each session by counselors in the two treatment groups, provided qualitative responses of participants. The first item on the questionnaire, based on a 5-point Likert scale, is a request for an opinion of the level of helpfulness of the session. Means and standard deviations were calculated for this item by treatment group, per session and overall (see Table 8). For the dyadic model (n = 8), the overall mean was 4.1. The peer group model (n = 10) had a mean of 4.6. Over both treatment groups, the overall mean was 4.4. This indicates that supervision sessions, regardless of modality, were seen as relatively helpful.

There was great consistency in the PSHQ responses, with approximately 90% indicating that the feedback and/or the support received was most helpful. Comments about helpful feedback typically referred to suggestions and ideas offered by other

Table 8

Descriptive Statistics for Post-Session Helpfulness Questionnaire Item #1 by Group

Treatment group	Mean	Standard Deviation
SPCM-SC		
Session 1	4.0	1.07
Session 2	3.6	.75
Session 3	3.8	.71
Session 4	4.6	.74
Session 5	4.1	.76
Session 6	4.4	.54
Session 7	3.8	.71
Session 8	4.3	.72
Session 9	4.2	.98
Total	4.1	.81
SPGS		
Session 1	4.3	.68
Session 2	4.8	.63
Session 3	4.8	.42
Session 4	4.9	.33
Session 5	4.8	.44
Session 6	4.6	.73
Session 7	4.7	.71
Session 8	4.3	.71
Session 9	4.3	.87
Total	4.6	.64
Overall		
Total	4.4	.77

counselors, as well as new insights achieved as a result of discussing cases and/or listeningto tapes. Responses concerning support expressed interest in a continuing dialogue with other counseling professionals, with comments such as "It's good to know there are other counselors struggling with similar issues." Regarding the most harmful aspect of the sessions, most participants (70%) stated that nothing was harmful. Those who did answer this item (30%) provided very concrete responses which often did not really address the question. Example responses were: "It was difficult to hear the tape." "We didn't have enough time to cover everything we needed to talk about." "People came in the room and interrupted us." "I had a hard time getting parental permission to tape." "Scheduling a time to meet was tough."

Inferential Statistics

Hypothesis 1

> Two clinical peer supervision method treatments will significantly improve school counselors' job satisfaction, as measured by performance on the Job Satisfaction Blank; their perceived counseling self-efficacy as measured by the Counseling Self-Estimate Inventory; and their counseling effectiveness as measured by the Index of Responding Empathy Scale, the Counselor Behavior Analysis Scale, and the Teacher Report Form, in comparison with a control group.

To test the first hypothesis, a one-way ANCOVA on post-test scores, with pretest scores used as the covariate, was performed on each of the dependent measures (the counselor assessments), using an overall .05 alpha level (See Tables 9.1 - 9.4). For the JSB, there was no significant main effect by treatment group, F (2, 25) = .90, p = .4201, nor was there any significant main effect by treatment group for the COSE, F (2, 25) = .11, p = .8953. Neither of the other two counselor measures showed significant main effects by treatment group; for the IRE, F (2, 25) = .25, p = .7809, and for the CBA-B, F (2, 25) = .1.34, p = .2808.

For the measure of client change (TRF), a three-way ANCOVA on post-test scores with pretest scores, client gender and client groups used as covariates was performed. (See Tables 9.5a - 9.5c). On the Internalizing scale (signifying problem behaviors such as

Table 9.1

Analysis of Covariance on JSB Post-Test Scores with JSB Pretest as Covariate

Source	df	SS	MS	F	p
JSB Pretest	1	179.72	179.72	51.95	0.0001
Group	2	6.21	3.11	0.90	0.4201
Error	25	86.48	3.46		
Total	28	274.76			

n = 29

Table 9.2

Analysis of Covariance on COSE Post-Test Scores with COSE Pretest as Covariate

Source	df	SS	MS	F	p
COSE Pretest	1	4137.17	4137.17	33.38	.0001
Group	2	27.54	13.77	.11	.8953
Error	25	3098.25	123.93		
Total	28	7888.23			

n = 29

Table 9.3

Analysis of Covariance on IRE Post-Test Scores with IRE Pretest as Covariate

Source	df	SS	MS	F	p
IRE Pretest	1	.90	.90	18.11	.0003
Group	2	.03	.01	.25	.7809
Error	25	1.25	.05		
Total	28	2.38			

N = 29

Table 9.4

Analysis of Covariance on CBA-B Post-Test Scores with CBA-B Pretest as Covariate

Source	df	SS	MS	F	p
CBA-B Pretest	1	7.46	7.46	.92	.3473
Group	2	21.75	10.87	1.34	.2808
Error	25	203.32	8.13		
Total	28	239.17			

n = 29

Table 9.5 a

2 (Student Client Group vs. Student Control Group) x 2 (Student Gender) x 3 (Treatment Group) Analysis of Covariance on TRF Post-Test (Internalizing) Scores with TRF Pretest (Internalizing) Scores as Covariate

Source	df	SS	MS	F	p
TRF Internalizing Pretest	1	2729.17	2729.17	133.66	.0001
Treatment Group	2	43.09	21.54	1.06	.3508
Student Group (Client/Control)	1	58.39	58.39	2.86	.0930
Student Gender	1	41.80	41.80	2.05	.1547
Treatment Group x Student Group	2	55.70	27.85	1.38	.2543
Treatment Group x Student Gender	2	13.17	6.56	0.32	.7248
Student Group x Student Gender	1	2.86	2.86	0.14	.7090
Treatment Group x Student Group x Student Gender	2	17.46	8.73	0.43	.6529
Error	145	2960.74	20.42		
Total	157	7383.04			

n = 158

Table 9.5 b

2 (Student Client Group vs. Student Control Group) x 2 (Student Gender) x 3 (Treatment Group) Analysis of Covariance on TRF Post-Test (Externalizing) Scores with TRF Pretest (Externalizing) Scores as Covariate

Source	df	SS	MS	F	p
TRF Externalizing Pretest	1	13477.18	13477.18	215.25	.0001
Treatment Group	2	61.47	30.73	0.49	.6131
Student Group (Client/Control)	1	150.40	150.40	2.40	.1234
Student Gender	1	255.53	255.53	4.08	.0452
Treatment Group x Student Group	2	192.77	96.39	1.54	.2180
Treatment Group x Student Gender	2	35.52	17.76	0.28	.7534
Student Group x Student Gender	1	0.16	0.16	0.00	.9595
Treatment Group x Student Group x Student Gender	2	140.06	70.03	1.12	.3296
Error	145	9078.52	62.61		
Total	157	29274.76			

n = 158

Table 9.5 c

2 (Student Client Group vs. Student Control Group) x 2 (Student Gender) x 3 (Treatment Group) Analysis of Covariance on TRF Post-Test (Total) Scores with TRF Pretest (Total) Scores as Covariate

Source	df	SS	MS	F	p
TRF Total Pretest	1	42681.20	42681.20	149.56	.0001
Treatment Group	2	487.98	243.99	0.85	.4274
Student Group (Client/Control)	1	2006.78	2006.78	7.03	.0089
Student Gender	1	2650.58	2650.58	9.29	.0027
Treatment Group x Student Group	2	233.08	116.54	0.41	.6655
Treatment Group x Student Gender	2	267.40	133.70	0.47	.6269
Student Group x Student Gender	1	90.13	90.13	0.32	.5750
Treatment Group x Student Group x Student Gender	2	175.24	87.62	0.31	.7361
Error	145	41380.92	285.39		
Total	157	134343.17			

n = 158

depression), there was no 3-way interaction effect, F (2, 145) = .43, p = .6529, and no 2-way interaction effects for treatment group by student group, F (2, 145) = 1.38, p = .2543, or by student gender, F (2, 145) = .32, p = .7248. There also was no significant main effect for treatment group, F (2, 145) = 1.06, p = .3508. On the Externalizing scale (signifying problem behaviors such as delinquincy), there was no 3-way interaction effect, F (2, 145) = 1.12, p = .3296, and no 2-way interaction effects for treatment group by student group, F (2, 145) = 1.54, p = .2180, or by student gender, F (2, 145) = .28, p = .7534. There also was no significant main effect for treatment group, F (2, 145) = .49, p = .6131. And finally, on the Total scale, there was no 3-way interaction effect, F (2, 145) = .31, p = .7361, and no 2-way interaction effects for treatment group by student group, F (2, 145) = .41, p = .6655, or by student gender, F (2, 145) = .47, p = .6269. There also was no significant main effect for treatment group, F (2, 145) = .85, p = .4274.

In sum, none of the ANCOVAs examining treatment effects were significant. Thus, there was no significant improvement in school counselors' job satisfaction, counseling self-efficacy, or counseling effectiveness. However, these individually nonsignificant results showed movement in the right direction each time, indicating small but pervasive effects of treatment (see means as reported in Table 7.1). Therefore, hypothesis 1 was only partially supported.

Hypothesis 2

> Both the dyadic Peer Consultation/Supervision model and the Systematic Peer Group Supervision model will result in equally significant improvements in school counselors' job satisfaction as measured by performance on the Job Satisfaction Blank; their perceived counseling self-efficacy as measured by the Counseling Self-Estimate Inventory; and their counseling effectiveness as measured by the Index of Responding Empathy Scale, the Teacher Report Form, and the Counselor Behavior Analysis Scale.

To test the second hypothesis, the same ANCOVA on post-test scores with pretest scores used as the covariate was utilized. No significant differences in treatment effects were found. There was no significant difference by treatment group in school counselors'

pre-post improvement in job satisfaction, counseling self-efficacy, or counseling effectiveness (see above). Therefore, hypothesis 2 was partially supported. That is, while there were no significant treatment effects, neither were there differences between the two treatment groups.

CHAPTER V
SUMMARY, LIMITATIONS, CONCLUSIONS, RECOMMENDATIONS FOR FUTURE RESEARCH, AND IMPLICATIONS

This chapter contains five sections: summary of the research; limitations of the study; conclusions that may be drawn from the study; recommendations for future research; and implications of the results for school counselors, their supervisors, and public school administrators.

Summary

This study was an examination of the effects of two types of clinical peer supervision on school counselors' job satisfaction, counseling self-efficacy, and counseling effectiveness. Developmental models posit that clinical supervision is needed across the professional lifespan in order for continued professional growth to occur (e.g., Loganbill, Hardy, & Delworth, 1982; Stoltenberg, 1981). In fact, there is some evidence that counseling experience without clinical supervision does not lead to counselor growth (e.g., Wiley & Ray, 1986), and may even result in the regression of counseling skills (Spooner & Stone, 1977). Therefore, if school counselors are to achieve maximal professional development, the literature suggests that they need to receive clinical supervision.

Peer consultation and supervision have become increasingly popular approaches of efficiently providing clinical supervision to practitioners (Benshoff & Paisley, in press; Borders, 1991; Remley, Benshoff, & Mowbray, 1987). And, just as group counseling is more time efficient than individual counseling when working with students, group supervision is seen as an effective means of providing clinical supervision for a number of counselors concurrently (Borders, 1991; Holloway & Johnston, 1985). The collegial support and egalitarian setting of peer dyads and/or groups offer school counselors a rare opportunity to interact with other school counselors in productive exchanges about

professional issues. Thus, two peer supervisoin approaches were employed in this study.

Several school systems in northwestern North Carolina participated in this study. Elementary and middle school counselors (n = 29) within these systems volunteered for participation. This quasi-experimental research design involved three groups of practicing school counselors: two treatment groups and one control group. Pretests were conducted during week one, treatment interventions (peer supervision methods) implemented during weeks two through eight, and post-tests administered during the final week. At both pre- and post-test, established measures of each variable were used: as a written measure of job satisfaction, the Job Satisfaction Blank (Hoppock, 1977); as a written measure of counseling self-efficacy, the Counselor Self-Estimate Inventory (Larson, et al., 1992); as a written measure of counseling effectiveness (empathy), the Index of Responding Empathy Scale (Gazda, et al., 1984); as a second written measure of counseling effectiveness (adaptability), the Counselor Behavior Analysis Scale (Howard, et al., 1986); and as a third written measure of counseling effectiveness (client behavior change), the Teacher Report Form (Achenbach, 1991). All of these measures are pencil/paper tests; one, the Index of Responding (Gazda. et al., 1984), required trained raters for scoring.

The first treatment group (n = 8) participated in the Structured Peer Consultation Model (Benshoff & Paisley, in press). This group was trained in the model of dyadic peer consultation/supervision by a trained supervisor familiar with the model. Participants in this group provided peer consultation/supervision to their partners, following a structured protocol.

The second treatment group (n = 10) participated in Systematic Peer Group Supervision (Borders, 1991). This model employs systematic assignments of particular roles (e.g., counselor, student, teacher) within the group of supervisees in order to encourage conceptualization and skill-building participation by each of the members. During the treatment period, the large group of ten met in two smaller groups of five, both led by trained supervisors.

The third group served as the "unstructured" (control) group (n = 11), and completed the pre- and post-test battery of questionnaires only. As their "treatment,"

participants in this group were asked to keep a record of their professional development activities during the study, and turn this in at the post-test administration meeting.

Three dependent variables, with three separate measures for the third (i.e., job satisfaction, counseling self-efficacy, and counseling effectiveness [measured by level of empathic responding, flexibility in responding, and client behavior change]), were examined in two ways. First, ANCOVAs were conducted to test for treatment effects on the dependent variables. Second, results were examined for differences between treatment group scores and control group scores.

Results of the study indicated that, over a brief period of time (approximately 2.5 months), clinical peer supervision did not have a statistically significant impact on job satisfaction, self-efficacy, or counseling effectiveness. When using a basic sign test, however, small gains on each measure were consistently noted. That is, where change did occur from pretest to post-test, the scores moved in a positive (or desired) direction. This would seem to indicate that the two supervision treatments did have a slight positive impact on each of the counselor-related dependent variables. Nonetheless, scores on job satisfaction remained in the average range (possibly characteristic of a volunteer group), while counseling self-efficacy scores remained fairly high. These results seem to support previous researchers' findings and conclusions regarding the overall stability of job satisfaction and self-efficacy as constructs in adults (Bandura, 1977, 1982; Hoppock, 1977; Smith et al., 1969; Wiggins & Weslander, 1986).

Counseling effectiveness scores as measured by flexibility in response style remained somewhat above average. However, counseling effectiveness scores as measured by empathic responding remained low. In fact, as an aggregate, these school counselors tended to problem-solve instead of responding empathically, which was the main reason for their receiving subtractive ratings on the IRE. Instead of clearly reflecting the feelings the client expressed to them, participants often responded something like this: "I'd like to try to help you figure out a way to resolve that dilemma. What are some things you could do to begin improving the situation?"

And, finally, clients showed significantly higher scores (indicating increases in

undesirable behavior) than did controls across the brief span of time covered in the study. This could well be an instance of problem behaviors escalating before they improve. However, the brevity of the study did not allow an investigation of this possibility. The significant difference found between genders (boys consistently scored significantly higher than girls on the problem behavior scales) supports the norm set of the instrument (Achenbach, 1991).

In line with the consistent positive trends on several of the measures (i.e., JSB, COSE, IRE, and CBA), participants' subjective responses supported the idea that clinical peer supervision is helpful to school counselors. On the Post-Session Helpfulness Questionnaires, written comments indicated the value of discussing clients and approaches, as well as the helpfulness of role-plays in viewing the situation from different perspectives (in the peer group). In debriefing sessions after the post-test administrations, counselors made similar positive comments. Some examples of verbal responses include: "This type of interaction with other counselors improves my ability to assess and evaluate students." "It helped me look at the whole client." "I realized I have been really isolated, and it's been good to meet regularly with another counselor." "The role-plays helped renew my enthusiasm for the profession." "It provided validation that what I'm doing is important."

In gathering this qualitative data, two major themes appeared. Participants felt they had gained from the interventions in the areas of: 1) collegial/professional support; and 2) concrete feedback on counseling skills, approaches, and perspective taking. However, empirical results indicated that no significant changes were made. There are three possible explanations for these conflicting results/reports. First, it is possible that the peer supervision interventions do not actually work to increase counseling effectiveness. This was the first attempt in the literature to actually quantify differential changes in counseling effectiveness through two different peer supervision interventions, as both models were previously untested in terms of their theoretical outcomes. Perhaps, with the dyadic model, there was too much inconsistency without a trained supervisor present to provide structure. It was assumed that the counselors using this model knew what to do during their sessions, and that they followed through with the established protocol. There may not

be enough quality control of skill learning within this model for its use to encourage development in this area. With the peer group model, the greater awareness levels of differing perspectives and skill enhancement experienced within the group sessions may not have been easily generalized to the school setting.

Secondly, it is possible that the measures used in this study were either inappropriate for school counselors and/or did not measure variables or aspects of the counselors' effectiveness or roles that did change. For example, no measure of case conceptualization was used, a cognitive skill implied by several of the counselors in the debriefing sessions as an area of growth. In addition, the measures may not have been sensitive enough to measure subtle beginnings of positive developmental change exhibited by the participating counselors.

A third possible explanation is that the interventions were too brief. It may be that the outcome variables require a much longer time or longer treatments to affect change, particularly for counseling practitioners who have had little or no counseling supervision since graduating from their counselor training programs (0 - 21 years for participants in this study). Benshoff and Paisley (in press) implemented one of the treatments over an entire semester. No pre-post comparison measures were utilized (school counselor only completed a general measure of satisfaction with and evaluation of the experience. As a result, no data are available to determine if this longer intervention period was more effective. It should be noted, however, that participants in the Benshoff and Paisley study indicated a desire for a much longer period (at least a year) of peer consultation/supervision before they thought lasting professional change would occur. It may well be, then, that with such a brief intervention as the one used in the present study, small but pervasive effects in a positive direction are the best one can hope for.

Limitations of the Study

In this section, factors that limited the scope of the study are presented. Limitations are identified in terms of their impact on the conclusions and provide a basis for recommendations for future research.

Several limitations of the design of this study undoubtedly affected the results.

Limitations related to the sample are evidence of the numerous difficulties encountered in conducting field-based experimental studies (Borders, 1989). The sample consisted solely of volunteers. Though demographic characteristics were very similar between the volunteers and non-volunteers, it is not known what other factors, if any, differentiated the two groups. Did participants choose to volunteer because, in their judgement, they had time to follow through with the study? Or did they volunteer because they had a greater professional commitment than the non-participants? How might these (or other) factors have affected the results?

In addition, these volunteers came from a restricted, although quite large, geographical area in North Carolina. Not only did this create a limited sample; it also had quite an impact on assignment to treatment groups. Participants typically needed to travel 30 to 90 minutes to arrive in a central location for meetings. Because of these geographical restrictions, true random assignment to experimental groups was not feasible. Counselors' previous post-degree experience with one of the models also affected the sampling process. There were two participants who had training in the dyadic model used in this study. Both of these counselors were assigned to the control group so that the two treatment groups remained comparable. The sample size also was rather small, leading to low statistical power. All of these sampling issues limit the generalizability of the results, as well as the types of data analysis possible and the ability to detect any real changes.

There also may have been personal factors beyond the control of the study which greatly influenced the job satisfaction, self-efficacy, or effectiveness of the school counselors involved. Deliberate care was taken to schedule the interventions during a time of the school year which is typically less hectic and demanding for counselors. However, any number of crises, both personal and professional, could have arisen during the study and affected counselors' responses on the various measures.

Another limitation was found within the instruments. All measures in this study involved self-report, which can be a questionable measure of any variable (Borders, 1989). Both the job satisfaction and self-efficacy measures were strictly self-report. The measure of empathic responding required written responses to printed client situations, which may

not be as valuable as responding verbally to observed client behaviors. The measure of flexibility in response styles required the counselor to choose the response s/he was most likely to use in given situations. This is similar to self-report, in that the counselor was asked not to choose the ideal response, but the one s/he was most likely to employ. The TRF relies on teachers' self-reports of their perceptions of student behaviors. If the teacher has developed a set of expectations for a certain student's behavior, a change of student behavior might not be reported even though it had definitely occurred. Teacher reports, however, seemed less problematic than other measures of outcomes we might have employed, such as student reports of satisfaction with counseling sessions (particularly those of elementary students) (Cobb & Richards, 1983; Ritchie, 1989).

Conclusions

This study found little empirical support for the hypotheses that positive effects would result from short range clinical peer supervision interventions. However, the small, nonsignificant, but consistent increases that did occur, coupled with the positive qualitative responses from participants, suggest that clinical peer supervision can be helpful. As stated earlier, all three groups (treatments and control) changed at about the same rate, albeit minimally. It may be that any attention to school counselors' professional development is helpful to a limited degree, at least from the counselors' self-report on non-counseling measures.

It should be noted, however, that more objective measures of actual counseling behaviors and skills indicated average performance. In particular, ratings of empathic responses were in the non-helpful range. Even though these ratings were based on written responses (versus verbal responses to actual clients), these results are somewhat alarming. Do school counselors lack ability in this most basic common therapeutic component (Frank, 1982; Grencavage & Norcross, 1988) and one of Rogers' (1957) core conditions? It may be that, without ongoing supervision, these school counselors had regressed in their ability to perform basic counseling skills. This explanation would be in line with Spooner and Stone's (1977) study, in which they found that without consistent supervision, counselors' experienced stagnation and/or regression in the counseling skills taught in their

training programs. If such regression has - and does - occur, there are dire implications for the counseling effectiveness of consistently unsupervised school counselors.

It is not clear, however, how representative these low empathic scores are of all school counselors. In a small pilot study involving school counselors from another rural area in North Carolina (Crutchfield, 1995), similarly low empathic responses were noted. In addition, these results seem in line with school counselors' requests for help with specific skills, as reported in two surveys of supervision needs and preferences (Borders & Usher, 1992; Roberts & Borders, 1994). Nevertheless, additional studies are needed to verify the actual counseling performance of a variety of school counselors on measures of empathy and other counseling skills.

During the final meetings with the school counselors in the treatment groups, the researcher requested general impressions of the sessions. Without fail, each participant enthusiastically reported how helpful the experience had been. Many expressed a desire to continue meeting, perhaps once a month instead of once a week. There was a sense of rejuvination and collegial support among the participants, and most were sorry to see it end.

An examination of the Post-Session Helpfulness Questionnaires uncovered an interesting trend. In general, the school counselors participating in peer consultation dyads reported support to be the most helpful thing about the sessions, while school counselors in the peer groups reported specific feedback on skills and techniques to be most helpful. This evidence suggests that, in the absence of a trained supervisor, the focus is on collegial support. With a trained supervisor present, it may be more likely that skill development and enhancement can occur, although not in a brief time period such as in this study. Perhaps some combination of the two models would be a more effective approach to fulfill the supervision needs of school counselors. If peers met in dyads weekly, then in a group once a month, there may be more consistency in the structure provided, as well as the more appropriate balance of challenge and support needed to produce growth and development.

Recommendations for Future Research

The following recommendations are based on the results of the study and designed to address the limitations described above. When researching this topic in the future, it would be best to engage in a long-term study (six months to one year). This attempt to find an impact on counseling effectiveness over a brief period was fruitless, but not futile. It appears that more time may be needed for supervision interventions to impact counselors, and their work, especially those who have had little clinical supervision in their careers.

Based on the limited demographic data collected from the non-volunteers, it seems that the only major difference between volunteers and non-volunteers was their willingness to participate (and possibly their valuing counseling supervision). Thus, it would be best if future studies could obtain a more randomized sample. Possibilities for this might occur within large school systems, particulary if the counseling supervisor at the central office level is willing to set up an experimental program for clinical supervision for all the school counselors in the system, over a year's time. If, as is often the case, the central office supervisor is not trained in counseling supervision, collaboration with a nearby counselor education program, or other available resource, would be needed. Of course, in order for results to generalize nationally, this type of study would have to be replicated in several areas throughout the country.

The results of this study underscore the need for the continued use of multiple measures of counseling effectiveness, given the range of scores obtained on the three instruments. Any replication of this research would be strengthened by the addition of a measure of actual counseling performance (e.g., rating counseling tapes). Also, in future studies with large enough samples, outcome measures should be checked for intercorrelations. If the measures are correlated, then one could expect all of them to show increases at a similar rate over the course of the study.

In any future research utilizing these two models of peer supervision, it might be more helpful to use outcome measures which address the more specific goals of the models, rather than supervision effects in general. For example, with the Borders (1991) peer group model, one specific goal of supervision is the enhancement of the counselor's

ability to take on multiple perspectives of a client and/or counseling issue. Thus, an outcome measure of multiple perspective-taking might be more likely to result in statistical significance. In future studies, researchers would do well to come up with measures more specific to the models in order to actually document the value of the models within the process of counselor development.

Implications for Practitioners and Administrators

The supervision literature lacks an empirical base in examining the effects of clinical supervision on school counselors' effectiveness, largely due to the fact that school counselors traditionally have received little or no clinical supervision. This study, conducted to address that void, has given more qualitative than empirical support that clinical peer supervision for school counselors is wanted, needed, and viewed as helpful. The school counselors participating in this study were hungry for dialogue and feedback about their counseling work. Their effectiveness scores were average to low, yet their efficacy scores were fairly high. This suggests a counselor in the developmental stage of stagnation (Loganbill et al., 1982); in other words, these counselors may need to improve in counseling and conceptualization skills, yet may not be aware that they need work in this area. How much more effective, thus helpful to students, faculty, and parents, might school counselors be if regular clinical supervision were provided on an ongoing basis?

School counselors and counselor educators can utilize the results of this study to take a proactive stance on the issue of the fullfilment of school counselors' professional development needs. Realizing that clinical peer consultation and supervision can help meet some of those support needs can have an empowering effect on the isolated practitioner.

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Appendix A: Section I ID#_____

Job Satisfaction Blank

You are asked to help in a scientific study by answering the questions in this blank. Please answer as honestly as possible. Choose **one** of the following statements which best tells how well you like your job. Place a check (√) in front of that statement:

_____ I hate it.
_____ I dislike it.
_____ I don't like it.
_____ I am indifferent to it.
_____ I like it.
_____ I am enthusiastic about it.
_____ I love it.

Check **one** of the following to show **how much of the time** you feel satisfied with your job:

_____ All of the time.
_____ Most of the time.
_____ A good deal of the time.
_____ About half of the time.
_____ Occasionally.
_____ Seldom.
_____ Never.

Check **one** of the following which best tells how you feel about **changing** your job:

_____ I would quit this job at once if I could get anything else to do.
_____ I would take almost any other job in which I could earn as much as I am earning now.
_____ I would like to change both my job and my occupation.
_____ I would like to exchange my present job for another job in the same line of work.
_____ I am not eager to change my job, but I would do so if I could get a better job.
_____ I cannot think of any jobs for which I would exchange mine.
_____ I would not exchange my job for any other.

Check **one** of the following to show how you think you compare with other people:

_____ No one likes his/her job better than I like mine.
_____ I like my job much better than most people like theirs.
_____ I like my job better than most people like theirs.
_____ I like my job about as well as most people like theirs.
_____ I dislike my job more than most people dislike theirs.
_____ I dislike my job much more than most people dislike theirs.
_____ No one dislikes his/her job more than I dislike mine.

Adapted from: Hoppock, R. (1977). Job satisfaction. New York: Arno Press.

Appendix A: Section II ID #_____

COUNSELING SELF-ESTIMATE INVENTORY

This is not a test. There are no right or wrong answers. Rather, it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item - rather, answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

PLEASE - Put your responses on this inventory by marking your answer to the left of each statement.

_____1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.

_____2. I am likely to impose my values on the client during the interview.

_____3. When I initiate the end of a session I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.

_____4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).

_____5. I am certain that my interpretation and confrontation responses will be concise and to the point.

_____6. I am worried that the wording of my responses like reflection of feeling, clarification, and probing may be confusing and hard to understand.

_____7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs, etc.

_____8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).

_____9. I am worried that the type of response I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.

_____11. I feel confident that I will appear competent and earn the respect of my client.

_____12. I am confident that my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.

_____13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.

_____14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.

_____15. I feel that I have enough fundamental knowledge to do effective counseling.

_____16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.

_____17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.

_____18. I am not sure that in a counseling relationship I will express myself in a way that is natural without deliberating over every response or action.

_____19. I am afraid that I may not understand and properly determine probable meanings of the client's nonverbal behaviors.

_____20. I am confident that I will know when to use open or closed ended probes, and that these probes will reflect the concerns of the client and not be trivial.

_____21. My assessments of client problems may not be as accurate as I would like them to be.

_____22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.

_____23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____24. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.

_____25. I feel competent regarding my abilities to deal with crisis situations which may arise during the counseling sessions (e.g., suicide, alcoholism, abuse, etc.).

_____26. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.

_____27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.

_____28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

_____29. When working with ethnic minority clients I am confident that I will be able to bridge cultural differences in the counseling process.

_____30. I will be an effective counselor with clients of a different social class.

_____31. I am worried that my interpretation and confrontation responses may not over time assist the client to be more specific in defining and clarifying the problem.

_____32. I am confident that I will be able to conceptualize my client's problems.

_____33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.

_____34. I am confident that I can assess my client's readiness and commitment to change.

_____35. I feel I may give advice.

_____36. In working with culturally different clients I may have a difficult time viewing situations from their perspectives.

_____37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.

Appendix A: Section III ID #_____

INDEX OF RESPONDING: EMPATHY SCALE

In this exercise you will apply the principles of responding empathically by writing responses to client statements. When responding, attempt to reflect back to the client the feelings and content the client has expressed. This shows the client that you have attempted to hear and understand what he or she said. Read each stimulus situation carefully, perceiving the surface and underlying feelings. Write a natural response for each, expressing the feeling and content you perceived in the client's statement in good conversational style.

Situation 1

Student to counselor: "I used to really enjoy going to the skating rink and sitting around talking with the people there. But it all seems so trivial to me now."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 2

Student to counselor: "I really like my history teacher and I like history, but I don't see how history will help me make a living."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 3

Teacher to counselor: "I really dread coming to work in the mornings. Teaching isn't fun anymore."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 4

Student to counselor: "I work so hard to get all A's, but every semester something happens and I mess up."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 5

Teacher to counselor: "That Sanders girl is really driving me up the wall. I don't know how to deal with her attitude."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 6

Teacher to counselor: "I try to treat everyone the same, but it's tough. I have my biases too!"

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 7

Student teacher to counselor: "I'm really in trouble. My parents are coming to visit me and they will probably figure out my relationship with Paul is more than just a roommate."

COUNSELOR RESPONSE: _____

_____

_____

Situation 8

Teacher to counselor: "I'm worried about how well I'm doing with my classes. No one complains, but I just have a feeling the students are not happy with my teaching style."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 9

Parent to counselor: "Something's going on. Jane seems so afraid of coming to school in the morning. She actually gets physically sick at times to avoid coming."

COUNSELOR RESPONSE: _____

_____

_____

_____

Situation 10

Student to counselor: "I won't be able to play football this year. My parents are forcing me to get a part-time job after school."

COUNSELOR RESPONSE: _____

_____

_____

_____

Adapted from: Gazda, G. M., Asbury, F. R., Balzar, F. J., Childers, W. C., & Walters, R. P. (1984b). Human relations development: A manual for educators (3rd ed.) (pp. 95-97). Boston: Allyn & Bacon.

Appendix A: Section IV ID #_____

COUNSELOR BEHAVIOR ANALYSIS SCALE (FORM B)

Directions

In answering the following questions, assume that you are the counselor involved in the situation described. Think about what action you would choose in that situation, and then circle the response that most closely resembles the action you would take. Please circle only one response to each situation. Remember to answer as you think you would if you were the counselor, not as you think an ideal counselor should respond. Please answer the questions in order, without spending too much time on any situation. Finally, do not go back over your answers or make changes.

(1) You have been seeing Paul for five interviews. He complains of being depressed and lonely. As you have come to understand his current situation, being depressed and lonely matches his isolated, inactive life. Considerably overweight and socially inept, Paul sees little likelihood of change. You would:

(a) Ask him what he's getting out of his depression. Raise the issue of his experiencing secondary gain from remaining in current circumstances.

(b) Let him continue to explore and talk about his depression and isolation.

(c) Propose a program of exercise and weight loss via a social, structured weight watchers program.

(d) Try to develop a very supportive relationship to decrease Paul's isolation.

(2) A couple come to you for marital counseling. They both report their previously good marriage is now in considerable trouble and both are experiencing a lot of pain. The husband also reports being depressed. During the interview you have determined that the relationship started deteriorating when the husband's fourteen-year-old son came to live with his father. Frequent conflict in the house centered around the son's surly attitude, choice of friends, and loud rock music. The couple have two children, three and five years old, who seem to be doing fine. After the initial hour of information gathering, they begin the second hour by pleading with you to save their marriage and saying they will do whatever you think is best. You would:

(a) Acknowledge and understand their desire for answers from you but give no specific directions.

(b) Share your view of the problem and recommend a series of specific changes in their behavior.

(c) Indicate that any answers will be the result of insights they come to as part of the counseling process.

(d) Reassure them that they seem to have a basically OK relationship. Begin to work with them around skills for parenting a teenager.

(3) The parents of a mentally retarded child have come to you for help. New to the community, they feel at a loss in their new environment. They had coped well with parenting when they had family support close by. After exploring the issue with them, you feel that the Parents of Special Children (PSC) program in your community would be an excellent referral source. As you mention the program, they seem unfamiliar with it and the husband makes a comment that they aren't "joiners." You would:

(a) Discuss with them their unique needs and various options they have been considering and don't push the PSC.

(b) Indicate that your recommendation remains that they contact the PSC program but leave the contacting up to them.

(c) Encourage them to give the PSC program a try and make the referral call with them still in the office to get specific information on time, location, and contact person.

(d) Tell them if they care about themselves and their child they should let nothing stand in their way from going to the PSC meetings.

(4) You have been seeing Nancy, a young professional woman, for over four months. She originally came due to a mild depression, which subsided after several weeks. Since that time, Nancy requests appointments whenever she feels the need to talk. She continues to do well at work and has increased her social activities and recently began a satisfying personal relationship. During the appointment you would:

(a) Require Nancy to make regular appointments and to set specific goals for treatment.

(b) Suggests that she might be using the counseling to avoid close relationships with others and work with her to explore this area further.

(c) Be supportive and empathic about whatever subject she brings to the session.

(d) Allow Nancy to continue making the decisions about scheduling appointments.

(5) Mike is seeking help due to pressure from his wife. She is threatening to leave if he doesn't get counseling. The client has for ten years seen and heard things that other people couldn't. This is a gift rather than a problem from the client's perspective. The incident that created the ultimatum from his wife was one in which she found him sitting in the corner of the living room late one night with a loaded gun. He pointed the gun at her and accused her of being a creature imitating his wife in order to kill him. Mike is hoping that through his coming for help the wife will learn to appreciate the reality of his gift. You would:

(a) Support Mike's belief in his gift and work with him to persuade his wife.

(b) Tell Mike directly that he has a problem and you will try to help him understand and cope.

(c) Let him tell you all about his visions and make no attempt to have him admit that he has a problem.

(d) Label the behavior as you see it and tell him he has a serious problem and you will have him committed unless he agrees to treatment.

(6) The client, who grew up in a physically and emotionally abusive family, has been living with the current "friend" for three months. The "stupid" and "ugly" messages from the family are reinforced by this friend. You have for four months been focusing on building the client's confidence and self-esteem. In reporting a recent incident, the client becomes aware of how he lets his friend put him down. He becomes very angry and proclaims, "I don't have to take that abuse from anyone." You would:

(a) Tell the client, "I see how difficult it is to admit these things to yourself."

(b) Reinforce the statement and point out how the client has been repeating the family pattern in the current relationship.

(c) Make no effort to focus on the statement.

(d) Strongly reinforce the client's anger and tell him that he should do something about it.

(7) After actively working on assertiveness training for a month, including reading a book and role playing and also successfully completing outside counseling homework assignments in the counseling session, Maria comes in very excited and pleased at her successful assertion with her supervisor. She also reports how much her interaction with her supervisor reminded her of her father. You would:

(a) Get excited with her and celebrate her success.

(b) Ask Maria to recount specifically what had taken place with the supervisor and reinforce the learning points.

(c) Recommend a book on advanced assertiveness techniques.

(d) Let Maria decide on what direction the session would go.

(8) You are called in to consult with a talented, dedicated staff of a residential home for delinquent adolescents. The home has been using a token economy program in which the consequences for all target behaviors are published. Each resident receives a copy upon admission to the program and knows the rules. The staff has successfully administered this program for several years. After excellent performance for over three months, the current group of residents have been "backsliding" in the last month.

(a) Support the staff in their frustrations and draw out from them the options they see.

(b) Praise their willingness to examine their system. Present your recommendations and seek their reactions.

(c) Suggest that the staff brainstorm about possible solutions to the problem.

(d) Analyze the current program and present your recommended changes.

(9) Fred, diagnosed as paranoid schizophrenic, has been doing pretty well for six months since his last hospitalization on a program of medication and weekly outpatient counseling with you. You have been mostly supportive in the counseling sessions. In the last two weeks Fred has become increasingly delusional and has just informed you he has stopped taking the medication because the pharmacist cannot be trusted. You would:

(a) Tell Fred that he is slipping badly and you have arranged for him to be hospitalized. Tell him to call his home to arrange for additional clothes to be brought to the hospital.

(b) Try to support his efforts to sort out thoughts and feelings in areas he brings up. Express your concern over his current state of mind.

(c) Listen to the delusional content to try to better understand Fred's dynamics. Don't challenge or even engage around the delusions.

(d) Indicate your concern for Fred's current state of mind. Sell the need for taking medication as an alternative to hospitalization.

(10) You have supported a client through a painful divorce process. You have been primarily empathic and affirming. As the client accepts the divorce as fact and begins to talk of getting on with life, he or she expresses considerable anxiety about the prospect of dating. The ex-spouse was a childhood sweetheart. The client has denied any interest in dating but complains of loneliness. The level of affect toward you as counselor is rising. You believe the person is afraid of dating due to lack of experience. There are no other factors that would suggest it would be difficult to date. What would you do?

(a) Share your interpretation of the avoidance and make the client focus on it while affirming your confidence in him or her.

(b) Figure he or she can choose to date of he or she wishes to and not press the issue.

(c) Tell the client that by next week he or she must have made one step toward dating.

(d) Reflect and empathize with the client and raise the questions about fear of dating but don't push.

(11) Juanita, a client who terminated treatment more that six months ago, called for an appointment. The prior counseling had been very successful in resolving some major anxiety and self-esteem issues. In the session she describes herself as continuing to do well at home and at work but has begun to experience some anxiety prior to beginning work on Mondays, particularly when the weekend had been meaningful or enjoyable. You would:

(a) Reassure her about her feelings and ask her how she plans to handle the feelings when they crop up.

(b) Let Juanita talk about her feelings but provide little active support or direction.

(c) Design, with her input, an anxiety management program to handle the Monday morning anxiety.

(d) Listen to the description of the situation and tell her specifically how to process when the anxiety occurs.

(12) You receive a phone message that Ho, a client who lacks confidence, has called saying he "has a question about how to handle a 2:00 p.m. meeting with the boss." The client has in the past three months done well in such meetings though anxious. For the last month you have been mostly reassuring Ho on this issue. You would:

(a) Not return the call until after the meeting.

(b) Call Ho back reaffirming your confidence in his ability.

(c) Call the client. Reassure and review the points to be kept in mind.

(d) Call and indicate it's time Ho stopped depending on you and stood on his own two feet.

Taken from: Howard, G. S., Nance, D. W., & Myers, P. (1987). Adaptive counseling and therapy: A systematic approach to selecting effective treatments (pp. 20-28). San Francisco, CA: Jossey-Bass.

Appendix A: Section V ID#_____

Demographic Questionnaire

1. Current school level:

   Elementary school _____
   Middle school _____

2. Highest degree held:

   Bachelor's in _____
   Master's in _____
   Education Specialist in _____
   Doctorate in _____
   Other (please specify): _____

3. Year highest degree was earned: _____

4. How many semester hours were required in your degree program? _____ sem. hrs.

5. Gender:

   Female _____
   Male _____

6. Age: _____ years old

7. Ethnicity:

   African American (Black) _____
   Asian American _____
   Caucasian (White) _____
   Hispanic (Latino) _____
   Native American (Indian) _____
   Other (please specify) _____

8. Years (and months) of experience as a school counselor:

   _____ years and _____ months - fulltime

   _____ years and _____ months - parttime

9. Are you a National Certified Counselor?
   _____ yes
   _____ no

10. If you marked "yes" above, are you a National Certified School Counselor?
    _____ yes
    _____ no

11. Current professional memberships held:

_____ American Counseling Association (ACA, formerly AACD)
_____ American School Counselors Association (ASCA)
_____ North Carolina Counseling Association (NCCA, formerly NCACD)
_____ North Carolina School Counselors Association (NCSCA)
_____ Other (please specify below)

12. Previous (or current other) fulltime and/or parttime work experience:

Classroom teacher	_____ years
Counselor in a mental health or private practice setting	_____ years
School administrator	_____ years
Social worker	_____ years
Other (please specify below):	_____ years

13. Have you had any counseling supervision of your school counseling work since you completed your degree?

Yes _____ No _____
[If yes, please mark the type(s) of counseling supervision you have received.]

_____ Peer
_____ Individually contracted (e.g., with a counselor educator or private practitioner)
_____ Structured model, including training
_____ Other (please specify below):

14. Did you graduate from a CACREP accredited counselor education program?
_____ yes
_____ no

Thank you for participating in this study!

Appendix B

ID#_____

Counselor's Log for Teacher Report Form (TRF)

Presenting Problem Codes: (Choose the most prevalent problem presented within each session.)

1 = Family concern
2 = School/grades concern
3 = Friends concern
4 = Classroom behavior concern
5 = Personal or self-concern

Child's name:_____

Grade:_____

Gender:_____

Teacher's name:_____

Session:	1	2	3	4	5	6	7	8
Date:								
Length: (min.)								
Presenting Concern: (code #)								
Comments:								

Appendix C: Section I

Structured Peer Consultation Model for School Counselors

(Benshoff & Paisley, in press)

TRAINING AGENDA for Saturday, January 7, 1995

8:30 - 9:00 a.m.	Light breakfast, informal introductions
9:00 - 9:45 a.m.	Consent to participate, pretest administration, paperwork for stipends
9:45 - 10:00 a.m.	Brief introduction of trainer (the researcher) and the model, with handouts distributed showing format for sessions. Other important paperwork for study explained at this time as well
10:00 - 10:40 a.m.	View training videotape, consisting of a segment of a counseling session and the corresponding peer consultation session
10:40 - 11:00 a.m.	Questions and answers; brief break
11:00 - 12:00 noon	Peer consultants break up into dyads and complete session one from the format handout; dyads schedule their next sessions on their own
12:00 noon	The final group meeting (for post test) is tentatively scheduled for a day in March. Training ends; participants are reminded of the required paperwork for data collection, then dismissed

FORMAT FOR THE STRUCTURED PEER CONSULTATION MODEL FOR SCHOOL COUNSELORS (SPCM-SC)

General instructions

Dyads will meet weekly for nine consultation sessions, each lasting 90 minutes. During each session, you should complete the activities required for that particular session. Please note that homework assignments for the following week are clearly noted at the end of each session description. Immediately following each session, please complete the Post-Session Helpfulness Questionnaire and mail it to the researcher in the addressed, stamped envelope provided.

Session 1: Background Information and Goal-Setting

In this first session, peer supervisors should begin by explaining to each other your approaches to counseling. This involves discussing your ideas and beliefs regarding "What is counseling?" and "How does it help clients?" It is important that you each clearly understand what certain concepts (such as congruence, empathy, and unconditional positive regard) mean to the other. This discussion should include:

* educational experiences (e.g., during your graduate study) which have influenced your approach to counseling
* other training or work experiences that have influenced you as a counselor
* particular theorists or writers who have influenced your counseling style
* your general philosophy of life
* a description of the process that typically occurs when you counsel clients, and
* any experiences you may have had as a client that have influenced your thinking.

In the initial stage of peer consultation, you should discuss and clarify the goals that each of you would like to achieve during the nine supervision sessions. It is important that you

discuss and establish your individual goals for the peer consultation experience. Some examples of goals include: becoming more flexible in using counseling techniques, improving skills in giving critical feedback to others, or becoming more effective in dealing with feelings in counseling (your own or your client's). Setting goals such as these will provide you with a sense of purpose and direction in peer consultation and will help your peer consultant to focus on areas of particular interest to you.

Using what you know as a counselor about setting obtainable, clearly measurable goals, develop a set of personal goals that will help you meet your needs and get the most out of this peer consultation experience. As you establish your goals, consider the following questions:

* Does each of you clearly understand your partner's goals?

* How will peer consultation help you achieve your goals?

* What kinds of strategies might help you accomplish your goals?

* Are there specific changes in your counseling style that you would like to see occur during peer consultation?

Before the next session: For Session two, each of you should bring in materials related to classroom guidance or small group counseling activities you have conducted in your school, or materials you are considering using. During the next session, you will have the opportunity to share these materials, give and receive feedback on such programs, and discuss the types of programs you are using (or planning to use) in your school. In addition, you will each bring an audiotape of an individual counseling session to Session two, to exchange with your peer consultant.

Session 2: Discussion of Counseling-Related Activities

During this session, you will discuss with your peer consultant classroom guidance and/or small group counseling activities that you have conducted (or are planning) for your school. You may want to share programs that have been particularly successful for you, as well as programs you would like some help in improving. You are encouraged to provide a copy of your materials for your peer consultant. As you discuss your programs, consider the following questions:

* What was your goal for this activity?

* How did you determine the need for this type of program or activity in your school?

* How did you design the activity? What resources (written, audiovisual, people) were helpful in developing your program?

* What did you particularly like about the program? Why?

* What did you (or will you) learn from this program that you will be able to use in working more effectively with students, teachers, administrators, and/or families in your school?

* What would you like to change or improve about this activity to make it more effective next time?

* What are your recommendations for school counselors who would like to present this activity in their schools?

* How can you use the programs your peer consultant shares with you in your own school?

During any remaining time, briefly discuss experiences at your school. You will exchange tapes to be reviewed prior to Session 3

Before the next session: Listen to your partner's counseling tape and be prepared to provide critical feedback in the next session. Focus both on strengths and on areas for improvement. Pay particular attention to client responses to counselor interventions and to client information to which the counselor does not respond. It will probably be helpful for you to make notes to use in the next session. Questions to consider as you listen to the tape include:

* What did the counselor say?

* How did the client react?

* What seemed to work or not work?

* Was there a sense of direction and purpose in the counselor's interventions?

* Were the interventions consistent with the counselor's stated approach to counseling or style (as discussed in Session 1)?

* What did the counselor do particularly well in the session?

* Did the counselor develop good rapport and "stay with" the client throughout the session?

Session 3: Tape Reviews

During the first half of this session, one of you will assume the role of consultant with the other counselor taking the role of consultee. In the second half of the session, you will switch roles so that each has an opportunity to receive feedback on his/her taped counseling session.

Probably the best approach to reviewing tapes is to let the consultee set the direction and focus of the session. You can do this initially by asking your partner what s/he would like feedback on. The consultee has probably identified some concerns that came up in trying to work with the client, and these might provide a good starting point for your tape review.

Your role as the peer consultant is to raise issues and provide constructive feedback on the counselor's effectiveness in the taped counseling session. You have a responsibility to be open and direct in sharing both your positive and your critical reactions to the consultee's counseling techniques. The primary goal of the tape review is to help the consultee leave with new ideas of how to work more effectively with the client. As a consultant, you can provide a different , more objective perspective on the session and help your consultee explore both strengths and areas for improvement. Together the two of you can brainstorm some new ways of working with the client.

In providing feedback, it may be helpful to use specific examples from the tape. You may also need to get some additional information about the client's background, presenting concerns, or other significant details which were not apparent in your review of the tape.

Before the next session: Select one of your clients and develop (i.e., mentally or on paper organize) a case study to present at the next session.

Session 4: Oral Case Study Presentations

In this session, each peer consultant will present a brief case study of a client with whom the counselor is having some difficulty, switching roles at the midpoint of the session. The oral case study should be a familiar method of discussing clients, a fairly non-threatening activity which provides peer consultants the dual opportunity of critically examining client issues as well as developing trust and rapport in the consultant dyad.
An oral case study presentation might include the following steps:

1. Review persona data about the client (e.g., age, gender, family information, source of referral, and presenting concern).

2. Summarize the counseling history of the client, including number of sessions to date, original presenting problem, accomplishments to date, etc.

3. State current problem for the counselor (i.e., what makes this case particularly challenging?).

4 Allow peer consultants to pose questions or make observations.

5. Discuss the client's issue.

6. Develop new strategies for approaching the problem and for working more effectively with the client.

At the conclusion of this session, peer consultants will exchange tapes for review prior to Session 5.

Before the next session: Critically review your partner's tape using the guidelines discussed at the end of Session 2 description.

Session 5: Tape Reviews

Following the format outlined in Session 3, you will take turns providing critical feedback to each other on the taped counseling session. You will split the session in half, with each of you taking on both the consultant and the consultee roles.

Before the next session: Select one of your clients and develop (i.e., mentally or on

paper organize) a case study to present at the next session.

Session 6: Oral Case Study Presentation

Following the format outlined in Session 4, each peer consultant will present a brief case study of a client with whom the counselor is having some difficulty. Partners will take turns presenting their case studies, and receiving feedback. At the end of this session, partners will exchange tapes for review prior to Session 7.

Before the next session: Critically review your partner's tape using the guidelines discussed at the end of Session 2 description.

Session 7: Tape Reviews

Following the format outlined in Session 3, you will take turns providing critical feedback to each other on the taped counseling session. You will split the session in half, with each of you taking on both the consultant and the consultee roles.

Before the next session: Select one of your clients and develop (i.e., mentally or on paper organize) a case study to present at the next session.

Session 8: Oral Case Study Presentation

Following the format outlined in Session 4, each peer consultant will present a brief case study of a client with whom the counselor is having some difficulty. Partners will take turns presenting their case studies, and receiving feedback.

Before the next session: Take time to think about how you have felt about the peer consultation experience, evaluating your progress toward your individual goals.

Session 9: Evaluation and Termination

In this session, you and your peer consultant will evaluate the peer consultation arrangement and your own progress in developing counseling and consultation skills during the previous eight sessions. You should discuss with each other how you have progressed toward meeting the goals that you established for yourself in the initial session. Taking time to evaluate the peer consultation experience in this session allows you to:

* compare and contrast your expectations about consultation

* review the steps and activities of the consultation model and discuss any modifications or adaptations you would like to make or suggest

* determine whether or not the peer consultation relationship has promoted your personal and professional development as anticipated

* discuss strategies for maintaining or enhancing skills you have developed during the peer consultation process, and

* effect closure for your peer consultation relationship

In addition, you may want to discuss whether or not to continue the peer consultation arrangement.

Appendix C: Section II

Structured Peer Group Supervision Model

(Borders, 1991a)

TRAINING AGENDA for Saturday, January 7, 1995

12:30 - 1:00 p.m.	Light refreshments, informal introductions
1:00 - 1:45 p.m.	Consent to participate, pretest administration, paperwork for stipends
1:45 - 2:00 p.m.	Brief introduction of trainers (the researcher and one other advanced doctoral student trained in the model) and the model, with handouts distributed showing format for sessions. Other important paperwork for study explained at this time as well
2:00 - 2:40 p.m.	View training videotape, consisting of a segment of a counseling session and the corresponding peer group supervision session
2:40 - 3:00 p.m.	Questions and answers; brief break
3:00 - 4:00 p.m.	Peers break up into two supervision groups and complete their first group supervision session; groups schedule their next sessions on their own
4:00 p.m.	Training ends; participants are reminded of the required paperwork for data collection, then dismissed

FORMAT FOR THE STRUCTURED PEER GROUP SUPERVISION MODEL (SPGS)

General instructions

Groups will meet weekly for nine consultation sessions, each lasting 90 minutes. The final session will last approximately 2.5 hours, so that post tests can be administered after completion of the last group session. During each session, members should complete the activities required for that particular session.. Immediately following each session, please complete the Post-Session Helpfulness Questionnaire and return it to the supervisor in the envelope provided.

Session 1: Background Information and Goal-Setting

During the first group session, group members will be assisted by the supervisor in setting clear and measurable individual goals. The remainder of the time will be spent in a general sharing of activities and incidents at counselors' schools, in order for group-building to occur. Finally, a meeting schedule for the following eight weeks will be set and a case presentation schedule will be developed. The group member who will make the presentation at the next session will be required to bring a tape of a counseling session the following week, with a brief segment ready to be played for the group. In order to prepare for this presentation, the counselor should carefully review the tape, considering the following questions:

* What occurred in this session which correlates with my supervision goals?

* What in particular stands out about this counseling session?

* What is the client's history in counseling, background, or other pertinent information the group might need to know in order to successfully review the tape?

* What specific feedback would I like regarding this session?

The presenting counselor should be prepared to give a five minute description of the case, ask for specific feedback, then play a five to ten minute segment of the tape.

Sessions 2 through 7: Case presentations

In Sessions 2 through 7, after a brief sharing time, the following format will be observed:

1. The presenting counselor will briefly describe the case, identify questions about the client or the taped session, and request specific feedback from the peer group. For example:

   What I need help with ...
   What I'm unsure of ...
   Help me rephrase this more effectively.
   Help me understand my feelings of frustration toward this student.
   Help me be less hesitant when confronting, as I am in this session.
   I want to be less of an advice-giver.
   How did I get into this "yes, but..." routine with this student?
   Am I forcing my values on this student?

2. The supervisor will facilitate the choosing or assignment of roles, perspectives, or tasks to peers, for reviewing the audiotape segment. Some possibilities:

   Focused observations of
   - counselors use of silence
   - instances of advice-giving
   - specific counseling skills

   Role-taking
   - client/student
   - counselor
   - teacher
   - parent, friend, or other significant person in the student's life

   Theoretical perspectives on the
   - assessment of student
   - conceptualization of the issue or problem
   - goals of counseling
   - choice of interventions (how to choose and what to choose)
   - evaluation of student progress

Descriptive metaphors for
student
counselor
counseling process

3. The presenting counselor will then play the audiotaped segment, with peers listening from your assigned or chosen role, perspective, or task.

4. Group members will give feedback from your roles or perspectives, keeping in mind the goals and questions that were specified by the counselor.

5. Throughout this process, the supervisor will facilitate the discussion as needed, functioning in two roles:

   Moderator who helps the group stay on task, and
   Process commentator who give feedback on interpersonal group dynamics

6. Finally, the supervisor will summarize the group feedback and discussion, asking the presenting counselor to indicate if supervision needs have been met.

Session 8: Extra case presentation

At the end of Session 7, group members will be given a chance to volunteer to bring in a final tape for presentation in Session 8. The person chosen to present will follow the above format for case presentations, as used in previous sessions. Before the next session, counselors will be asked to reflect on your progress toward your original individual goals for supervision and be prepared to evaluate the process and terminate the supervision group. Completed paperwork (Student Logs and TRFs) will be due to the supervisor at the final session as well.

Session 9: Evaluation and Termination

In Session 9, counselors will evaluate the SPGS experience and movement toward individual goals. Termination of the group also will occur. Counselors will be asked to return their completed TRFs and Student Logs at this time. Upon completion of the final group session, counselors will remain to take the post test packet.

Appendix D

ID #_____
Session #_____
Date _____

Post-Session Helpfulness Questionnaire

Directions: For the first question, please circle the number on the continuum which most accurately reflects your opinion of today's supervision session. Please answer the next two questions in one or two sentences.

1. How helpful was today's supervision session?

1	2	3	4	5
not helpful				extremely helpful

2. What was the most helpful, meaningful, or important thing that happened during today's session?

3. What was the most unhelpful, hindering, or harmful thing that happened during today's session?

Modified from: Hill, C. E. (1989). Therapist techniques and client outcomes: Eight cases of brief psychotherapy. Newbury Park, CA: Sage.

Appendix E: Letter to Superintendents

Lori B. Crutchfield
Certified School Counselor
343 Laurel Lane
West Jefferson, NC 28694
June 20, 1994

Superintendents
Public School Partnership

Dear Superintendents:

Dr. DiAnne Borders, of UNC-Greensboro, and I plan to conduct a research study to empirically document the effects of counseling supervision on elementary school counselors' attitudes and skills. We would like to provide counseling supervision to 36 practicing school counselors, then measure their attitudes and skill levels on a number of relevant variables. If allowed the opportunity to ask your elementary counselors to volunteer for our study, we will contact them early in the school year. One training session will be held before the winter break, then starting in January, the counselors will be asked to meet weekly for nine weeks, in order to receive the counseling supervision. Our weekly meetings will be conducted in the afternoons, after school. In order to make scheduling somewhat easier, we would appreciate it if you could allow the counselors to leave their schools when the busses load to take the students home.

Dr. Borders and I are writing a grant to fund this project. As part of this process, we are required to submit letters of support from "public school officials who have the authority to approve and facilitate the work." The deadline for this proposal is July 15, 1994. This is the main reason I am contacting you at this time. If you agree to support this research study, I will be available to meet with you to answer questions and hear your suggestions. We welcome any comments you or your Directors of Student Services might have regarding the planning and/or facilitation of this study. If our proposal is funded, we will offer a small stipend to the participating school counselors.

Today's children face a burgeoning list of problems and concerns, both in school and at home. Within the school, the person best trained to help children combat their problems while continuing their healthy development is the elementary school counselor. Well versed in counseling skills and techniques, school counselors can work with children individually, in small groups, and provide large group guidance lessons when needed. However, while most mental health counselors work in settings with other counselors present, most elementary school counselors are isolated in their settings. Often the elementary counselor serves two or more schools on an itinerant basis. And unlike mental health counselors, school counselors usually receive no consistent counseling supervision. Consequently, elementary school counselors often become unsure of their counseling abilities, or may even become less skilled counselors than they were upon receiving their counseling degrees. They may feel overworked, isolated, and unhappy with their roles. This can make counselors less effective and less likely to provide meaningful help to the children in their schools. When counseling supervision for elementary school counselors is consistently provided, students are better served.

Thank you for your consideration of this research proposal. I hope you are able to give us your support.

Sincerely,

Lori B. Crutchfield

Appendix F ID #_____

THE UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

Consent to Act as a Human Subject

Subject's Name _____

Date of Consent _____

An explanation of the procedures and/ or investigations to be followed and their purpose, including any experimental procedures, was provided to me by Lori Crutchfield, principal investigator. Ms. Crutchfield informed me about benefits, risks, or discomforts that I might expect. Any questions I had regarding the research were answered. Ms. Crutchfield told me that I am free to withdraw my consent to participate in this research at any time without penalty or prejudice. Ms. Crutchfield also told me that I will not be identified by name as a participant in this project.

The research and this consent form have been approved by the UNC Greensboro Institutional Review Board, which insures that research involving people follows federal regulations. Questions regarding the research and my rights as a participant in this study can be answered by calling Beverly Maddox-Britt at 334-5878. Other kinds of questions will be answered by Lori Crutchfield at (704) 262-2448.

Any information that develops during this project will be provided to me if the information might affect my willingness to continue participation in the project.

_____ _____

Subject's Signature

Witness to Oral Presentation and Signature of Subject

Appendix G ID #_____

Permission to Tape Counseling Session(s)

[SCHOOL LETTERHEAD]

I agree to allow _____, the school counselor, to tape my child's counseling sessions (audio and/or video) for educational purposes. I understand that the content of their sessions is confidential, and that as soon as the tapes are used for supervision research purposes, they will be erased. My child has also agreed to this taping, and understands that all information will be kept confidential.

_____
Student/Client's name

_____
Signature of Parent/Guardian

_____
Date permission was granted