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Prevention in Counseling Psychology: Theory, Research, Practice and Training is a publication of the Prevention Section of the Society for Counseling Psychology. The publication is dedicated to the dissemination of information on prevention theory, research, practice and training in counseling psychology, stimulating prevention scholarship, promoting collaboration between counseling psychologists engaged in prevention, and encourages student scholars. The publication focuses on prevention in specific domains (e.g., college campuses) employing specific modalities (e.g., group work), and reports summaries of epidemiological and preventive intervention research. All submissions to the publication undergo blind review by an editorial board jury, and those selected for publication are distributed nationally through electronic and hard copies.

SUBMISSION GUIDELINES

The Prevention Section of the Society of Counseling Psychology publishes Prevention in Counseling Psychology: Theory, Research, Practice and Training. This is a blind peer reviewed publication presenting scholarly work in the field of prevention that is distributed nationally. Contributions can focus on prevention theory, research, practice or training, or a combination of these topics. We welcome student submissions. As a publication of the Prevention Section of Division 17, presentations and awards sponsored by the section will be highlighted in these issues. We will also publish condensed reviews of research or theoretical work pertaining to the field of prevention. All submissions need to clearly articulate the prevention nature of the work. Submissions to this publication need to conform to APA style. All submissions must be electronically submitted. Please send your documents prepared for blind review with a cover letter including all identifying information for our records. Submissions should be emailed to the Editor, Debra L. Ainbinder at DAinbinder@lynn.edu.
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MESSAGE FROM THE CHAIR:  
PREVENTION AND THE EVER-CHANGING WORLD

Jonathan P. Schwartz  
New Mexico State University

I will finish my tenure as the chair of the Prevention Section of Division 17 at APA this August. I have greatly enjoyed my experiences as the Prevention Section Chair. The highlight has been the opportunity to work with a wonderful group of colleagues and a cause that is I feel strongly about. I believe prevention is consistent with a focus on social justice and is vital in the current mental health care climate. I also believe this publication has great potential to publicize the wonderful and impactful prevention work occurring in Division 17 and more widely in psychology.

The world is changing and the field of psychology is working to effectively adapt to those changes. Currently in the United States, there are new economic realities, changing demographics, particularly in relation to age and ethnicity/race, and developing technology changing our everyday lives. With these changes comes new opportunities as well as new challenges to our field. I believe prevention as an “adaptive science” offers a way to proactively and impactfully deal with our ever-changing world.

For example, the United States is becoming more diverse (U.S. Census Bureau, 1999; 2000; The National Center for Public Policy and Higher Education, 2008). With increased diversity comes greater need for approaches that are successful with diverse populations. Prevention allows the practitioner to focus on systemic change and address community issues and societal issues such as poverty and oppression (Hage et al., 2007). Rather than attempting to address the impact of new technology after they develop in individuals, prevention can be on the forefront of utilizing new technology to create change as well as attempt to prevent early problems from becoming more widespread. I believe research and theory, such as the ones published in this publication, are on the cutting edge of effectively addressing our ever-changing world.


EDITOR’S NOTE

Debra L. Ainbinder
Lynn University

This publication is a product of the dedication and purpose of the members of the Prevention Section of the Society for Counseling Psychology of the American Psychological Association. Now more than ever in our nation’s history, a focus on prevention seems an ethical imperative to which we must respond. Thanks to the scholars in this field, we continue to offer research developments and theoretical propositions with a prevention orientation. This publication will remain committed to providing its readership with the most updated information in the field of prevention.

As you read this issue you will see the work of the Prevention Section at the APA National Conference this summer. In our next issue, look for more detailed information on those presentations and award winners. The empirical articles published in this issue provide the reader with clear interventions and implications for prevention promotion and future research. This quality of work will continue in our next issue as well.

Special thanks to the Prevention Section leadership, Division leadership, and the Editorial Staff for their support of this publication.
The purpose of this paper is to present systems of care as an example of how counseling psychology and public health overlap with regards to prevention and intervention approaches for children’s mental health. A framework for prevention is presented as is the state of children’s mental health promotion, with a particular focus on ecological and systemic approaches to children’s mental health and how these approaches cut across multiple perspectives. Systems of care are highlighted as an example of the congruence of prevention and ecological or systemic approaches to address the mental health promotion of children and their families, with the potential to impact at the universal, selective, and indicated levels of risk. Results from a longitudinal outcome study of a school-based system of care are presented to exemplify the positive outcomes experienced by children. An increase in the awareness and implementation of systems of care across mental health perspectives is recommended, along with continued research from the public health and counseling psychology communities focused on which prevention and intervention services within systems of care work, why they work, and how they can be improved upon.

A Framework for Prevention & Promotion

Preventive interventions are typically classified into three categories: universal, selective, and indicated. Interventions directed at the whole population of interest are universal interventions, while interventions aimed at populations at increased risk are selective, and prevention programs targeting those at greatest risk or who have early signs of a disorder or problem are referred to as indicated (Kellam & Langevin, 2003). However, as Waldo and Schwartz (2008) highlight, recognizing that any intervention addresses all three categories allows for a maximization of benefits. Rather than placing interventions in discrete categories, it is better to describe the potential impact an intervention may have in each category.

The National Institute of Mental Health (NIMH, 1998, 2001) posits that the focus of prevention interventions and prevention research in the mental health field has broadened over time. As Figure 1 demonstrates, the first generation (1930s to late 1960s) of prevention focused on universal interventions for healthy populations; while the second generation (late 1960s to late 1990s) expanded focus to include selective and indicated interventions for individuals at risk for mental disorders, but without a diagnosed disorder. The NIMH reports that current prevention research is part of the third generation, which has expanded prevention research to minimize gaps between prevention and basic risk-factor research at one end of the spectrum, and between prevention and treatment at the other. This third-generation perspective encompasses basic research on antecedents and risk factors that can inform the design and implementation of prevention interventions, as well as research on clinical populations with acute or chronic mental disorders who are at risk of relapse, co-occurring mental, substance abuse, or physical disorders, or disability (NIMH, 1998, 2001). This perspective coincides with the proposed addition of risk-reduction strategies to the conventional tri-fold prevention framework (Romano & Hage, 2000). In a complementary trend, prevention research has also begun to emphasize the importance of protective factors, resilience, and...
health promotion. While the field of counseling psychology has been slow to incorporate prevention work, many argue that historical and demographic developments highlight the need for a prevention focus and how such a focus naturally overlaps with the central tenets within counseling psychology perspective, such as emphases on health, client strengths, diversity and multicultural issues, and context (Heppner, Casas, Carter, & Stone, 2000; Romano & Hage, 2000).

The Promotion of Children’s Mental Health

Across all age groups, mental illnesses are the leading causes of disability worldwide (Substance Abuse and Mental Health Services Administration, 2007). The majority of mental health problems begin during childhood and adolescence. Research suggests that half of all diagnosable cases of mental illness begin by age 14, and 75% start by age 24. Reports estimate that 21.8% of youth ages 12-17 receive treatment or counseling for emotional or behavioral problems and 10% of this age group experiences a mental health problem that causes significant impairment in functioning at home, school, or in the community. In contrast, it has also been estimated that 60 – 80% of children in need of treatment do not receive it (Hoagwood & Koretz, 1996). If early intervention does not occur, childhood mental disorders may intensify and persist, and can lead to school failure, poor employment opportunities, poverty, or long-term health and mental health consequences (Substance Abuse and Mental Health Services Administration, 2007).

The foundations of prevention in counseling psychology are based in the vocational guidance movement and the subsequent development of child guidance clinics, which targeted “at-risk” children and families (Vera & Reese, 2000). Since the mid-1960s, scientists have generated considerable knowledge about early factors that increase the risk of later mental and behavioral problems and disorders (Davis, 2002; Kellam & Langevin, 2003). The identification of malleable risk and protective factors is the crux of successful promotion and prevention efforts. Evidence suggests that prevention programs focused on enhancing strengths and resilience of

children and families may be particularly effective for families that have one or more risk factors (e.g., low-income, exposure to trauma, family history of mental illness) but are not yet in crisis and may not have had contact with child protective services or Systems of Care

Systems of care were developed in response to the need for more appropriate and accessible preventive and treatment services for children with severe emotional and behavioral difficulties and their families. In 1992, the United States Congress established the Comprehensive Community Mental Health Services (CMHS) for Children and Their Families Program, which has provided funding to 126 communities over the past 14 years for the development of local systems of care (Foster, Stephens, Krivelyova, & Gamfi, 2007). The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA)/CMHS is to facilitate the high-quality implementation of tested, effective prevention programs in communities throughout this country (Kellam & Langevin, 2003). A system of care is a coordinated network of community-based services and supports that is created to meet the challenges of children and youth at risk for or diagnosed with serious emotional disturbance (SED) and their families. Central to the philosophy of systems of care are community-based alternatives to out-of-home placements, family involvement, cultural sensitivity, and interagency collaboration (Stroul & Friedman, 1986). As a result, system of care communities offer an array of wrap-around services individualized to each family’s needs. These services vary by community, but may include assessment and evaluation, case management, outpatient therapy, inpatient services, intensive home-based care, respite care, therapeutic foster care, vocational training, and juvenile justice services.

More than 70,000 children and their families have received services through the CMHS Program (Miech et al., 2008). Research on these systems has shown some mixed effects. For example, one study revealed that although service access and amount increased in a system of care, children who did not receive any services improved at the same rate as children who received services (Bickman, Noser, & Summerfelt, 1999). In contrast, Foster and colleagues (2007) compared two system-of-care sites to two matched non-CMHS-funded communities and found that the system of care communities provided more family-focused care, supportive collaboration, individualized plans, adequate access, and less restrictive services. Similarly, another study demonstrated that the more a child and family reported that services were consistent with the system-of-care philosophy, the fewer internalizing and externalizing symptoms in the child and the greater the family’s level of satisfaction one year after receiving services (Graves, 2005).

Systems of Care and a Prevention Framework: The PARK Project

Systems of care were designed with the ecological and systemic perspectives in mind; they challenge service providers to coordinate and create partnerships with each other and with families (Anderson & Mohr, 2003). Moreover, according to Hoagwood and Koretz (1996), prevention research fits well within a system-of-care approach. Prevention is a service, and systems of care are designed to include a variety of services, including preventive, remedial, and supportive.

Waldo and Schwartz (2008) argued that describing how interventions apply across categories – rather than identifying them as universal, selective, or indicated – is more comprehensive, accurate, and utilitarian. Systems of care answer this call because they have the potential to impact different populations at different levels of risk. As the lead evaluation team for a system of care, we have had the opportunity to look at the application of services at various levels of risk and prevention, as well as the effectiveness of the services for children and families served. Although systems of care tend to focus on children with severe emotional disturbance (SED), many systems offer services to individuals and families with varying levels of risk. One such system of care is the Partnership for Kids (PARK) Project, a school-based system of care in the Northeast. PARK was funded by the SAMHSA/CMHS from 2002 to 2008. During the years of its funding, PARK served 284 youth and their families, the majority of whom were youth of color (65% Latino/a;
Youth and their families enrolled in the PARK Project received school-based care coordination services and an array of wraparound services individualized to each family’s needs including – but not limited to – therapeutic after school, therapeutic mentoring, psychiatric consultation, outpatient therapy, family advocacy, and family and youth empowerment. Because family involvement is strengthened through methods of service delivery that are easily accessible to families, the school setting presents a key opportunity to reach parents and caregivers.

In the PARK Project, the universal level was addressed through Positive Behavior Interventions and Supports (PBIS), the selective level was targeted via school services for at-risk youth, and the indicated population was provided with wraparound services through funded programs:

- **Universal** – All youth enrolled in the PARK system of care attended a school where PBIS was implemented. PBIS emphasizes school-wide systems of support for students including proactive strategies for defining, teaching, and reinforcing appropriate student behaviors to create positive school environments. PBIS schools employ a continuum of positive behavior support for all students within a school in classroom and non-classroom settings (e.g., hallways, restrooms, etc.). The PARK Project provided the support and funding which enabled the public school system to successfully adopt and implement the PBIS philosophy. Students in the schools implementing PBIS reported an improvement in overall school climate, student interpersonal relationships, and order and discipline. Their teachers also reported improvement in order and discipline. Additionally, schools that implemented PBIS to fidelity experienced a 50% reduction in office referrals for behavioral infractions and regained hundreds of hours of instruction time and administrative time, resulting in a significantly greater percentage of 6th-to 8th-grade students at or above proficiency on statewide math and reading tests (Kaufman, Griffin, & Whitson, 2009).

- **Selective** – Children and youth who were identified as “at-risk” for a mental health diagnosis were provided with selective services at school. Services were provided by school staff such as guidance counselors, school social workers and school psychologists and included social skills groups, anger management groups, peer mediation, and one-on-one supportive counseling.

- **Indicated** – Through the PARK Project, children and youth who were diagnosed with a mental health disorder were provided with wraparound services from funded programs (e.g., care coordination, family advocacy, therapeutic mentoring, after-school services, and psychiatric consultation). The outcome of focus was the prevention and/or reduction of mental health symptoms and functional impairment. The impact of PARK services on children at the indicated level are presented below, as part of the longitudinal outcome study.

**Outcome Study**

As part of the system of care evaluation, all families who enrolled in the PARK Project were invited to participate in a longitudinal outcome study. This outcome study allowed for the examination of children’s clinical problems over time while being served by the system of care. The purpose of the following study is to provide information regarding the children enrolled in the system of care and to assess if system of care services were associated with a decline in clinical problems.

**Method**

Families who elected to participate in the longitudinal outcome study were interviewed in their homes or a location of their choosing when they first entered services and then at 6-, 12-, 18-, 24-, 30- and 36-months. A total of 194 PARK families (68.3%), elected to participate in the longitudinal outcome study. The youth included in the outcome study were predominantly male (65.8%) with a mean age of 11.62 (SD = 3.58; Range = 4 – 18). The majority of the sample was youth of color: 61.9% were identified by caregivers as Latino/a, followed by 31.1% African American, 13.2% Caucasian, 2.5% Biracial, and 0.5% Asian or Pacific Islander. The following analyses present results from baseline through 30 months after entry into system of care services.
Child Behavior Checklist (CBCL); (Achenbach & Edelbrock, 1983). The CBCL is a well-established, empirically-derived, norm-referenced measure of problem behaviors in children and adolescents. It provides separate profiles for boys and girls between the ages of 4-18 and allows for standardized comparisons across individuals. Parents or caregivers are the respondents for this survey. For this analysis, the total problem scores scale was included. Each child or youth’s score is reported as a weighted t-score that permits comparison of children at different age groups and genders. A t-score of 63 or above falls within the clinical range, indicating a severe level of problem behaviors or symptoms.

Results

A total of 69.5% of the youth enrolled in the outcome study scored in the clinical range on the CBCL when they entered the system of care. Figure 2 presents the results of a repeated measures general linear model comparing CBCL total problem behavior scores from baseline through 30 months. As is shown, total problem behavior scores decreased significantly (Wilks’ Λ = .38; p < .001) from baseline to 30 months with a noticeable decrease in problem behaviors beginning 6 months after the youth entered the PARK Project, with these improvements continuing to 30-months after enrollment in PARK. Given that the average length of enrollment in the PARK Project was 9 months, these results demonstrate that the impact of PARK services was maintained nearly 2 years after services ended.

Implications for Prevention Research and Practice

Figure 2: CBCL Total Problem Scores

\[ p < .001; \text{ Dotted line represents clinical cutoff.} \]

Figure 2. CBCL total problem scores over 30 months for youth in the PARK outcome study.
For those who work directly with children at risk of mental health problems, the real-life benefits of promotion and prevention programs are obvious, particularly for children with multiple risk factors, including low family income. The costs of conducting these programs must be considered within the context of the costs of not conducting them. Prevention of even a small number of mental and substance abuse problems will result in substantial cost savings and improved quality of life for children, families, and communities (Substance Abuse and Mental Health Services Administration, 2007).

The critical next step is for more communities to be made aware of these programs and to begin implementing them, even while researchers continue to expand the knowledge base about what interventions work and why they work (Substance Abuse and Mental Health Services Administration, 2007). Expanding this knowledge base includes the identification of factors related to indicators of clinically significant change among children receiving mental health services and the need to pay increased attention to functional outcomes for children and youth. Moreover, a set of individual- and system-related outcomes for children with mental health problems needs to be identified and linked to publicly-financed public health strategies (Cooper et al., 2008; Huang et al., 2005).

In addition, researchers suggest that increased parenting and family supports in prevention, early intervention, and treatment are still needed (Cooper et al., 2008). Although many systems independently conduct child- and family-based programs, better coordination of programs across systems would maximize available resources (Substance Abuse and Mental Health Services Administration, 2007), reduce overlap, and avoid children and families falling through the cracks. Based on an ecological and systemic framework, a developmentally-appropriate system of care should provide age-appropriate family supportive services embedded across all service systems. Continued research on how to provide this support and increase family-based services would facilitate meeting this need.

Finally, programs such as systems of care demonstrate that counseling psychologists, in addition to community psychologists and public health professionals, can answer the call for a prevention-based agenda focused on: “greater use of systemic and integrative theoretical models and approaches; increased emphasis on early preventive interventions with children and youth; and prevention interventions that are sensitive to racial, ethnic, and other forms of diversity” (pg. 745, Romano & Hage, 2000). The profession can expand on this agenda by including a focus on prevention, and prevention services for children in particular, in training programs for future counseling psychologists (Vera & Reese, 2000). It is our hope that this paper illuminates the strong overlap between counseling psychology and public health with regards to prevention and intervention approaches for children’s mental health, and that it expands awareness of systems of care as a promising prevention and promotion model that cuts across multiple perspectives to serve the needs of children and families.

Reference


Prevention of Underage Drinking: The Link between Teens' Perceptions of Parent Alcohol Use and Monitoring and Teen Alcohol Use and Acceptance

Chelsea L. Jurman and Allyson J. Weseley
Roslyn High School

Research has established that a variety of factors are linked to the prevalence of adolescent alcohol consumption; however, the relationship between teens’ perceptions of parent drinking and adolescents’ own drinking behaviors has been inadequately researched. One hundred and thirty-two students were randomly selected to complete a 40-item survey on their drinking behaviors, attitudes towards alcohol, and perceptions of parent drinking and parenting behaviors. Given that Adolescent Alcohol Use and Adolescent Alcohol Acceptance were only moderately correlated ($r = .54$), separate multiple regression analyses were run to test the predictors of each outcome variable. The model accounted for 21.6% of the variance in Adolescent Alcohol Use. Parent General Monitoring was a negative predictor, while Parent Permissiveness and perceived Parent Underage Alcohol Use were positive predictors. The model also accounted for 21.7% of the variance in Adolescent Alcohol Acceptance. Parent Underage Alcohol Use was the strongest predictor and had a positive relationship with Adolescent Alcohol Acceptance, while Parent Support was a significant negative predictor. Although the study was correlational in nature, the results suggest that parents should be cautious about sharing stories of their own underage drinking with their children. To increase prevention of underage drinking, parents should also strive to maintain strict supervision while still creating a supportive atmosphere for their children.

Previous studies have shown that the more parental support adolescents perceive, the less adolescents will drink. Those who feel their parents approve of them are less likely to orient their behavior to that of their peers, in turn protecting them from possible problem behavior (Barnes & Farrell, 1992). Teens who believe their parents do not support them are more likely to depend upon peers for acceptance, and are therefore more likely to use drinking as a means to gain social support (Getz & Bray 2005; Goldstein, Davis-Kean, & Eccles 2005; van Zundert, van der Vorst, Vermulst & Engels, 2006). Research has also found that parental support is associated with more self-control in adolescents, defined as dependability and planfulness (Wills, Resko, Ainette, & Mendoza, 2004). Teens who perceive a lack of support also demonstrate impatience and distractibility, characteristics that are positively correlated with adolescent substance use (Wills et al., 2004).

Research has found that parental permissiveness is associated with teen drinking (Patock-Peckham & Morgan Lopez, 2006; Wood, Read, Mitchell, & Brand, 2004). Parental attitudes towards drinking may be explicitly or tacitly expressed and may be important in determining when adolescents begin to drink (Wood et al., 2004). Parental permissiveness is the construct that measures parents’ atti-
tudes towards drinking, and it has been found to be associated with teen drinking early on in adolescence (Patock-Peckham & Morgan-Lopez, 2006; Wood et al., 2004). If parents are perceived to be permissive, their children tend to be more impulsive, and therefore are more likely to drink (Patock-Peckam & Morgan-Lopez, 2006; Wood et al., 2004).

Conversely, parent monitoring has been shown to be negatively related to teen drinking (Barnes & Farell, 1992; Beck et al., 1999). Parent monitoring, defined as the extent to which parents attempt to track and control their children’s activities (Kerr & Stattin, 2000), has been found to be a protective factor in guarding against alcohol use among teenagers (Barnes & Farrell, 1992). The more actively committed parents are to monitoring their teenagers, the less their children drink (Beck, Shattuck, Haynie, Crump, & Simons-Morton, 1999). Additionally, teenagers who felt their parents behaviorally controlled them were found to be less likely to drink (van Zundert et al., 2006). In making an effort to know their teens’ whereabouts and whether activities will be supervised, parents show their children that they are serious about avoiding potential drinking (Beck et al., 1999). The present study sought to determine whether parents’ monitoring, specifically in terms of alcohol use, would be more effective than general parent monitoring in terms of preventing teen drinking. It was thought that by paying close attention to their teenagers’ actions in terms of drinking, parents would make it more difficult for teenagers to drink without getting caught.

Previous research has shown that parents’ current drinking behaviors are another factor associated with their children’s alcohol use (Barnes & Farrell, 1992; McGue, Elkins, Walden, & Iacono, 2005; Seljamo et al., 2006; van Zundert et al., 2006; Webb & Baer, 1995). One common way of ascertaining this relationship is through correlating parents’ and teens’ self-reports of their respective drinking behaviors. Current parent alcohol use is associated with adolescent alcohol use and is linked to the escalation of teen drinking (Seljamo et al., 2006; Webb & Baer, 1995). One longitudinal study explored the association between parent alcohol use and teen drinking at 14 and 17 years of age and found that parent self-reported drinking behaviors increasingly predicted teen alcohol use as adolescence progressed (Latendresse, Rose, Viken, Pulkkinen, Kaprio, & Dick, 2008).

An alternative method of measuring parent alcohol use is through asking adolescents about their perceptions of their parents’ drinking. One study asked children to evaluate how often they thought each of their parents had been intoxicated in a given period of time; perceptions of greater parent drinking were found to predict earlier alcohol debut (Pedersen & Skrondal, 1998). Another study revealed that the more teens reported their parents drank, the more they reported drinking themselves (van Zundert et al., 2006).

Interestingly, one study found that parents’ drinking habits do not even have to be current in order for them to be important factors in their children’s behavior during adolescence. Parents who reported drinking between the ages of 13 and 16 were twice as likely to have children that drank by the age of 15 as parents who started drinking at a later age (Seljamo et al., 2006).

To our knowledge, no studies have employed adolescent perceptions of parent underage alcohol use as a predictor of teen drinking. When utilized as a measure of parent drinking in the present, adolescents’ perceptions are likely to resemble what their parents would report, given that adolescents probably witness their parents drinking or witness the effects of that drinking. However, because adolescents were not present when their parents were teenagers, adolescents’ perceptions may differ from their parents’ self-reports. Adolescents have little factual basis for their perceptions about how their parents behaved as teenagers. Although teens’ perceptions might be inaccurate, they may shape teens’ behaviors nevertheless; the current study set out to explore that possibility. Additionally, the present study sought to assess the relative predictive power of adolescents’ perceptions of parents’ underage and current drinking.

As shown in Figure 1, it was hypothesized that adolescent alcohol use and adolescent alcohol acceptance would be negatively predicted by parent support, parent general monitoring and parent alco-
hol monitoring but positively predicted by perceptions of parent permissiveness, parent current alcohol use, and parent underage alcohol use.

Method

Participants

IRB approval was obtained from the school at which the research took place. Parental consent was required for students to participate. Students were informed that participation was voluntary and that their data were anonymous.

The sample for this study consisted of a total of 132 students (90.4% response rate) from seven randomly selected eleventh and twelfth grade English classes in an affluent, suburban high school. The sample consisted of juniors and seniors, because it was thought that by eleventh grade, teenagers have most likely had an alcohol-related experience or the opportunity to form opinions towards alcohol. Eighty-two students (62.1%) were female, while 50 (37.9%) were male; 54 students were in 11th grade (40.9%), and 78 students were in 12th grade (59.1%). A majority of students self-reported they were Caucasian (80.3%). The remaining participants self-identified as Asian (4.5%), African American (3.0%), Native American (1.5%), Hispanic (1.5%), Multiracial (3.0%), and Other (4.5%); two participants chose to omit the question.

Predictor Variables

All survey items, unless otherwise specified, were measured on a 5-point Likert-type scale ranging from Strongly Disagree (1) to Strongly Agree (5). Reported alpha values pertain to the sample. Higher scores on each scale indicate higher levels of the construct measured. The scales used can be found in the Appendix.

Perceptions of the parent-child relationship.

The Parent Support Scale was adapted from a scale used in earlier research (Wills et al., 2004). It measured participants’ perceptions of the parent-child relationship and had strong internal reliability on this sample (α = .87). The scale consisted of six items and asked participants to assess their relationship with their male and female guardians. The Parent Support Scale consisted of three questions repeated twice: once for participants’ perception of the support they receive from their female guardian and once for the support they receive from their male guardian. Items included, “I get sympathy and understanding from my mother/female guardian.”

The next three scales measured participants’ perceptions of how much their parents supervise them. The Parent General Monitoring scale was created for this study. It consisted of five items (α = .73) and evaluated how well parents or guardians knew their children’s friends and their children’s whereabouts. This scale consisted of items such as

![Image of study hypotheses diagram]

Figure 1. Study hypotheses
“My parents/guardians know where to find me when I am not in my home.” The Parent Alcohol Monitoring Scale ($\alpha = .66$) was created for this study to measure how closely supervised adolescents felt in terms of alcohol consumption. It consisted of three items, including “My parents would not notice if I took alcohol from them.” The Parent Permissiveness scale consisted of two items ($\alpha = .61$) used in previous research (van der Vorst, Engels, Meeus, Dekovic, & van Leeuwe (2005) and measured adolescents’ perceptions of their parents’ rules on drinking. Scale items were, “I am allowed to drink whenever my parents are home,” and “I am allowed to drink whenever I am outside my home.”

Two scales in the survey dealt with participants’ perceptions of parent alcohol consumption. The Parent Current Alcohol Use Scale ($\alpha = .77$) consisted of eight items on a 5-point Likert-type scale and two items that required the participant to write down their estimate of how many drinks their mother (or female guardian) and father (or male guardian) had consumed within the past week. The scale specified the definition of a “glass” and included items such as, “When my family attends parties (e.g., weddings, holiday parties), my father/male guardian drinks alcohol.” This scale was adapted from previous research (van der Vorst et al., 2005).

To determine adolescent perceptions of their parents’ drinking behaviors while in high school, the Parent Underage Alcohol Use Scale ($\alpha = .80$) was created for this study. This scale consisted of six items and assessed the degree to which adolescents believed their parents drank while underage. Adolescents were asked to evaluate statements such as “When he was my age, my mother/female guardian drank often.”

**Outcome Variables**

**Adolescent Alcohol Use.** Teen drinking was measured by the Adolescent Alcohol Use Scale ($\alpha = .64$), which consisted of three items; two of those items required the participants to fill in the number of times they drank within the past month and on how many of those days they had engaged in binge drinking. Participants were also asked to evaluate on a 5-point Likert-type scale whether they felt they had ever been drunk; this item was reverse-scored. This scale was adapted from one used in prior research (van der Vorst et al., 2005).

**Adolescent Alcohol Acceptance.** The Adolescent Alcohol Acceptance Scale ($\alpha = .78$) was created for this study; it consists of seven items. This scale was used to measure how favorably participants felt towards alcohol use, regardless of whether or not they drank. A sample item is, “Drinking is a good way to make social situations less awkward.” Two items were reverse-scored.

**Results**

**Data Analysis**

The same model was used to predict variance in Adolescent Alcohol Use and Adolescent Alcohol Acceptance. Given the lack of a theoretical basis on which to predict that some factors would be more important than others, simultaneous multiple regressions were used. Descriptive statistics were run for the sample population, and the data were checked for outliers. Values more than three standard deviations from the mean were eliminated to avoid skewed distributions. Scatter plots were run to ensure that the relationship between the predictor and outcome variables was linear. The cutoff for statistical significance was set at $p < .05$, and SPSS 12.0.1 software was used to run all the analyses.

A bivariate correlation was run to determine if the two outcome variables, Adolescent Alcohol Use and Adolescent Alcohol Acceptance, were highly related to one another. As shown in Table 1...
and Figure 2, the two variables were only moderately correlated \( (r = .54) \), and therefore warranted two separate simultaneous multiple regressions.

**Factors Predicting Adolescent Alcohol Use**

The model accounted for 21.6% of the variance in Adolescent Alcohol Use. Adolescent perceptions of Parent Underage Alcohol Use were a significant, positive predictor of teen drinking \( (p < .05) \). Parent permissiveness was also a positive predictor of teen alcohol use \( (p < .05) \), and Parent General Monitoring negatively predicted teen drinking \( (p < .05) \). Parent Support, perceptions of Parent Current Alcohol Use, and Parent Alcohol Monitoring were not significant predictors of Adolescent Alcohol Use.

**Factors Predicting Adolescent Alcohol Acceptance**

The model accounted for 21.7% of the variance in Adolescent Alcohol Acceptance. Perceptions of Parent Underage Alcohol Use was the strongest predictor \( (p < .01) \), and they negatively predicted Adolescent Alcohol Acceptance. Adolescent Alcohol Acceptance was also negatively predicted by Parent Support \( (p < .05) \). Perceptions of Parent Current Alcohol Use, Parent Permissiveness, Parent Alcohol Monitoring, and Parent General Monitoring were all insignificant predictors.

Table 1. Correlation matrix

<table>
<thead>
<tr>
<th></th>
<th>PS</th>
<th>PGM</th>
<th>PAM</th>
<th>PPP</th>
<th>PCA</th>
<th>PUA</th>
<th>AAU</th>
<th>AAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS</td>
<td>1.00</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
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<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>PAM</td>
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<td>.066</td>
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<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>PPP</td>
<td>-.043</td>
<td>-.074</td>
<td>-.044</td>
<td>1.00</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>PCA</td>
<td>.152</td>
<td>-.265*</td>
<td>-.162</td>
<td>.063</td>
<td>1.00</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>PUA</td>
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<td>-.109</td>
<td>-.080</td>
<td>.103</td>
<td>.461*</td>
<td>1.00</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>AAU</td>
<td>.216</td>
<td>-.302*</td>
<td>-.205</td>
<td>.205</td>
<td>.246*</td>
<td>.275*</td>
<td>1.00</td>
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<td>-.198</td>
<td>.099</td>
<td>.255*</td>
<td>.312*</td>
<td>.544*</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Note.* \( *p < .01, N = 132 \)

Parent Support (PS), Parent General Monitoring (PGM), Parent Alcohol Monitoring (PAM), Parent Permissiveness (PPP), Perceived Parent Current Alcohol Use (PCA), Perceived Parent Underage Alcohol Use (PUA), Adolescent Alcohol Use (AAU), Adolescent Alcohol Acceptance (AAA)

Table 2. Model summary for Adolescent Alcohol Use

<table>
<thead>
<tr>
<th>Variables</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficient</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>PS</td>
<td>-.20</td>
<td>.17</td>
<td>-.11</td>
<td>-1.19</td>
</tr>
<tr>
<td>PGM</td>
<td>-.46</td>
<td>.22</td>
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<td>-2.11</td>
</tr>
<tr>
<td>PAM</td>
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<td>.14</td>
<td>-.14</td>
<td>-1.66</td>
</tr>
<tr>
<td>PPP</td>
<td>.28</td>
<td>.14</td>
<td>.17</td>
<td>1.98</td>
</tr>
<tr>
<td>PCA</td>
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<td>.21</td>
<td>.06</td>
<td>0.60</td>
</tr>
<tr>
<td>PUA</td>
<td>.37</td>
<td>.18</td>
<td>.19</td>
<td>2.04</td>
</tr>
</tbody>
</table>

*Note.* \( R^2 = .216, N = 123 \)

a. Predictors: Parent Support (PS), Parent General Monitoring (PGM), Parent Alcohol Monitoring (PAM), Parent Permissiveness (PPP), Perceived Parent Current Alcohol Use (PCA), Perceived Parent Underage Alcohol Use (PUA),
b. Outcome Variable: Adolescent Alcohol Use (AAU)
Discussion

The Relationship between Adolescent Alcohol Use and Adolescent Alcohol Acceptance

Adolescent Alcohol Acceptance was only a moderate predictor of Adolescent Alcohol Use. Although attitudes do not perfectly predict behaviors, it is possible that adolescents with high levels of alcohol acceptance will grow into underage drinkers. The participants ranged from 16 to 18 years of age, and the legal drinking age is 21. As the participants age and enter a college or work environment, those with more accepting attitudes may be more likely to begin drinking. It may be helpful to prevent underage drinking by targeting teens that are accepting of alcohol use before they actually begin to drink. Once teens have begun to drink, it may be more difficult to change their habits.

Perceptions of Parent Drinking

As expected, Adolescent Alcohol Use was positively related to perceptions of Parent Underage Alcohol Use. The only prior study that looked at the role of parent drinking while underage found a similar relationship (Seljamo et al., 2006). This association may be explained through a teen mentality of “If they did it, why can’t I?” Teenagers may form ideas about their parents’ actions in order to rationalize their own drinking behaviors. Or, it is possible that teenagers perceive their parents’ previous actions as being the “right” ideas or actions, and model their own actions accordingly (Bandura & McDonald, 1963). Because the study is correlational in nature, it is unclear whether perceptions of parent underage drinking causes teen drinking, teen drinking impacts perceptions of parent underage drinking, or a third factor causes both. To learn more about the causal agent, it would be useful to conduct an experiment or a longitudinal study.

In addition, perceptions of Parent Underage Alcohol Use were also related to Adolescent Alcohol Acceptance, as hypothesized. The more teens believed their parents drank when they were underage, the more accepting the teens were of alcohol consumption. Children tend to look up to their parents and see them as models of acceptable behaviors (Bandura & Macdonald, 1963). Therefore, if adolescents believe their parents drank when they were underage, the adolescents may be likely to be accepting of such behaviors. Furthermore, adolescents may be resistant to shun behaviors in which they believe their family members to have participated. Adolescents have little factual basis on which to base their perceptions of their parents’ underage drinking; therefore it is fascinating that these perceptions predict teens’ own drinking. This finding highlights the need for parents to be wary of the impressions they create in their children, so as to prevent their children from underage alcohol use.

Surprisingly, adolescents’ perceptions of Parent Current Alcohol Use were not linked to either the adolescents’ own drinking behaviors or attitudes.

Table 3. Model summary for Adolescent Alcohol Acceptance

<table>
<thead>
<tr>
<th>Variables</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficient</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
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<tr>
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<tr>
<td>PAM</td>
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<tr>
<td>PPP</td>
<td>.07</td>
<td>.07</td>
<td>.08</td>
<td>0.94</td>
</tr>
<tr>
<td>PCA</td>
<td>.08</td>
<td>.10</td>
<td>.07</td>
<td>0.75</td>
</tr>
<tr>
<td>PUA</td>
<td>.26</td>
<td>.09</td>
<td>.27</td>
<td>2.83</td>
</tr>
</tbody>
</table>

Note. $R^2 = .217, N = 123$

a. Predictors: Parent Support (PS), Parent General Monitoring (PGM), Parent Alcohol Monitoring (PAM), Parent Permissiveness (PPP), Perceived Parent Current Alcohol Use (PCA), Perceived Parent Underage Alcohol Use (PUA),
b. Outcome Variable: Adolescent Alcohol Acceptance (AAA)
towards alcohol. While much previous research has looked at the relationship between parent alcoholism and teen drinking (Barnes & Farrell, 1992; McGue et al., 2005; van Zundert et al., 2006), this study asked adolescents to report how much their parents drank to explore more moderate levels of alcohol consumption. Based on the data reported, few, if any, participants’ parents were alcoholics, which may explain the difference in results. Additionally, adolescents probably recognize that their parents are over the legal drinking age whereas they are not.

Parental Supervision and Support

The findings suggest that adolescents are less likely to drink when they are supervised. Parent General Monitoring was inversely related to Adolescent Alcohol Use, which corresponds with prior studies that found the less watched adolescents were, the more they were able to become involved with peers who drink without being caught (Beck et al., 1999; Getz & Bray, 2005). In addition, the results show that the more permissive participants perceived their parents to be with regard to the participants’ alcohol consumption, the more likely the teens were to drink. This finding is in line with previous research that showed that perceived parent disapproval of alcohol consumption negatively predicted heavy episodic adolescent drinking, misconduct, drug use, and deviance (Barnes & Farrell, 1992; Beck et al., 1999; Latendresse et al., 2008; van Zundert et al., 2006). More generally, research has shown that teens who believed their parents were permissive were more likely to be impulsive than adolescents who perceived their parents as strict or authoritative (Patock-Peckham & Morgan-Lopez, 2006).

Although Parent General Monitoring was a significant predictor of Adolescent Alcohol Use in the regression analysis, Parent Alcohol Monitoring was not. The bivariate correlations between the types of monitoring and alcohol use and attitudes, however, were related, although weakly. The Parent General Monitoring questions may have dealt with aspects of parental monitoring that are more difficult for adolescents to circumvent. For instance, although parents can prevent their children from getting alcohol in their own homes (an item on the Parent Alcohol Monitoring Scale), it is more difficult to prevent teens from gaining access to alcohol outside of the home. On the other hand, the perception that their parents know the names of their friends and keep track of their whereabouts (an item on the Parent General Monitoring Scale) may prevent teenagers from going to unsupervised homes, associating with peers who drink, and drinking themselves. Alternately, it is possible that teenagers who drink justify their actions because they believe they are unsupervised and unable to get caught. There may also be a third factor predicting both Parent General Monitoring and Adolescent Alcohol Use that could explain the relationship between the two variables.

Parent Support was linked to lower levels of Adolescent Alcohol Acceptance, indicating less favorable attitudes towards alcohol among teens who believed their parents sympathized with and listened to them. As suggested by previous research, teens who believe their parents do not support them may be more likely to turn to peers for acceptance and therefore may be more likely to use drinking as a means to gain social support (Getz & Bray 2005; Goldstein, Davis-Kean, & Eccles 2005; van Zundert et al., 2006). Adolescents who felt supported by their parents were less likely to view drinking as a means to gain social support. Teens who feel approval from parents may be less likely to orient their behavior with their peers’, which, in turn, has been shown to protect adolescents from problem behavior (Barnes & Farrell, 1992).

On the other hand, Parent Support was not linked to Adolescent Alcohol Use, contrary to the hypothesis. This finding was surprising, as many previous studies have shown that adolescents who feel that they are supported by their parents are less likely to become involved in risky behavior (Getz & Bray 2005; Goldstein, Davis-Kean, & Eccles 2005; van Zundert et al., 2006). Additionally, Goldstein et al. (2005) found that adolescents who felt supported by parents were less likely to turn to their peers. However, the Goldstein study (2005) also found that adolescents with more educated parents were less likely to orient themselves with negative peer influences, regardless of perceived support. Participants in the present study were high school students in an upper middle class suburban area; it is possible that
the level of their parents’ education may have negated the relationship between parent support and teen drinking.

Conclusion

The model accounted for over 20% of the variance in both Adolescent Alcohol Use and Adolescent Alcohol Acceptance. This figure is impressive given the plethora of factors that influence human behavior. However, the generalizability of the findings is limited. Because the sample was largely homogenous, it would be valuable to extend this line of research by replicating the study on different populations. Additionally, because the sample was relatively small, some of the weaker relationships might be significant if replicated on a larger sample.

This study was also limited by the use of self-report data. To minimize the effect of social desirability, participants were informed both orally and in writing that their responses were anonymous. Given the high rates of drinking reported, it seems that most participants felt comfortable disclosing their underage drinking.

While teen perceptions of parent drinking seem likely to play a greater role in shaping teen behavior than parents’ actual drinking, it would be interesting to explore how well teens’ perceptions match parents’ reports. However, most important in terms of prevention is to determine the source of teens’ perceptions of Parent Underage Alcohol Use, as this factor predicted both teen drinking and teen alcohol acceptance. By pinpointing the root of teens’ perceptions, parents might be able to avoid creating the impression that they drank.

Prevention efforts need to be directed not only at students but also at their parents. Parents want the best for their children and can benefit from more information about how to encourage their children to make healthy choices. Most parents have engaged in at least some behaviors as adolescents that they would prefer their children not emulate. An age old question for parents is whether to share their experiences in the hopes that their children can learn from them or whether to keep silent about their past. This study suggests that parents should avoid giving their children the impression that they experimented with alcohol while under-age. Additionally, parents must pay close attention to their children’s whereabouts and activities. It is critical that parents support their children emotionally and monitor them closely, rather than being permissive in the hopes of acting as their children’s friends.

Reference


Appendix A

Parent Support Scale (α = .87)
1. I discuss my feelings with my mother/female guardian.
2. I discuss my feelings with my father/male guardian.
3. I get emotional support from my mother/female guardian.
4. I get emotional support from my father/male guardian.
5. I get sympathy and understanding from my mother/female guardian.
6. I get sympathy and understanding from my father/male guardian.

Parent General Monitoring Scale (α = .73)
1. My parents/guardians usually know where I am on weekends or after school.
2. My parents/guardians know where to find me when I am not at home.
3. My parents/guardians often ask me who I will be with when I leave the house.
4. My parents/guardians often call me to ask me where I am during the weekend.
5. My parents/guardians know the names of most of my friends.

Parent Alcohol Monitoring Scale* (α = .63)
1. My parents/guardians would not know if I had been drinking.
2. My parents/guardians would not notice if I took alcohol from them.
3. It is easy to take alcohol from my house.

Parent Permissiveness Scale (α = .61)
1. I am allowed to drink alcohol in my house whenever I want if my parents/guardians are at home.
2. I am allowed to drink alcohol when my parents aren’t with me.

Perceived Parent Current Alcohol Use Scale (α = .77)
1. My mother/female guardian drank alcohol frequently within the past month.
2. My father/male guardian drank alcohol frequently within the past month.
3. How many glasses of alcohol would you estimate your mother/female guardian drank within the past week?***
4. How many glasses of alcohol would you estimate your father/male guardian drank within the past week?***
5. When my family attends parties (e.g., holiday parties), my mother/female guardian drinks alcohol.
6. When my family attends parties (e.g., holiday parties), my father/male guardian drinks alcohol.
7. I have seen my mother/female guardian drunk.
8. I have seen my father/male guardian drunk.
10. My father/male guardian drives after drinking alcohol.

Perceived Parent Underage Alcohol Use Scale (α = .80)
1. When she was my age, my mother/female guardian drank often.
2. When he was my age, my father/male guardian drank often.
3. My mother/female guardian drank when she was in high school.
4. My father/male guardian drank when he was in high school.

Adolescent Alcohol Use Scale (α = .64)
1. How many days have you consumed alcohol in the past month?***
2. I have never drunk enough alcohol to get drunk.*
3. How many days in the past month have you binged on drinking?***
(Note: For boys, binge drinking = 5 or more drinks in less than one hour; for girls, 4 or more drinks)

Adolescent Alcohol Acceptance Scale (α = .78)
1. It is wrong to drink before turning 21.*
2. I don’t mind it when my peers drink around me.
3. I think getting drunk is stupid.*
4. Drinking is a good way to make social situations less awkward.
5. Drinking at parties or social gatherings helps me feel comfortable around people.
6. Hanging out with friends is more fun when you’re drunk.
7. People are more entertaining when they’re drunk.

*Item and/or scale is reverse scored
**Item requires students to fill in estimated number answer, 1 glass = 1 shot, 1.5 beers, 1 mixed drink
EXAMINING THE FIT BETWEEN MOTIVATIONAL INTERVIEWING AND THE COUNSELING PHILOSOPHY: AN EMPHASIS ON PREVENTION

Michael B. Madson, Andrew C. Loignon, Raquel Shutze, and Heather R. Necaise
*University of Southern Mississippi*

The counseling philosophy is a major factor that distinguishes counseling psychology from other mental health fields. One historically central aspect of the counseling philosophy is an emphasis on adopting a preventative role and implementing techniques focused on prevention. Today’s practice environment requires those in counseling psychology to implement prevention and intervention approaches with evidence for their efficacy. Motivational Interviewing (MI) is an evidence-based counseling approach with roots in person-centered therapy. MI has been shown to be an active ingredient in prevention efforts alcohol abuse and promoting health behaviors. This study explored the perceived fit between MI and the counseling philosophy through a survey of 167 members of the counseling profession. Results suggest that there is a fit between MI and the counseling philosophy. Moreover, participants expressed an excellent fit between the MI principle of supporting self-efficacy and the counseling philosophy. Implications for training counseling psychologists in this evidence-based practice and future research are provided.

Over the past 14 years there has been an increased emphasis placed on incorporating evidence-based practices (EBPs) in community practice settings to prevent or remediate a wide variety of behavioral problems (Bruce, & Sanderson, 2005; Chwalisz & Obasi, 2008; Gotham, 2006; Romano & Hage, 2000). As a specialized aspect of mental health services counseling psychology has also begun to use EBPs. However, concerns have been expressed about the consistency between EBPs and the unique counseling philosophy (Wampold, Lichtenberg, Waehler, 2005). Motivational Interviewing (MI) is a counseling approach that meets the various definitions of an EBP. Similarly, MI has been shown to be an active ingredient in successful alcohol prevention and health promotion efforts (Carey, Scott-Sheldon, Carey and DeMartini, 2007; Martins & McNeil, 2009). Further, at face value MI appears to fit well with the counseling philosophy. Thus, the purpose of this study was to investigate the degree to which counseling psychology students and professional see a fit between MI and the counseling philosophy.

*Philosophy of Counseling and Counseling Psychology*

Counseling psychology holds a distinct perspective towards aiding those in need of psychological services through various tasks including prevention and remediation (Atkinson, 2002; Gelso & Fretz, 2001; Munley Duncan, McDonnell & Sauer, 2004). Specifically, counseling psychologists have sought to “foster the psychological development of the individual” (American Psychological Association; APA, 1952, p. 175). Counseling psychologists have traditionally viewed people, whether experiencing normal life difficulties or more severe psychological disturbances, as being capable of improving both their current and future level of functioning (Munley et al., 2004). Along with this perspective, counseling psychology has often emphasized, and been defined by, a particular philosophy for assisting clients with their concerns and problems (Gelso & Fretz, 2001; Munley et al., 2004).

The counseling philosophy has been tied together by unique unifying themes (Atkinson, 2002; Gelso & Fretz, 2001; Murdock, Alcorn, Heesacker, & Stoltenberg, 1998). First, counseling psycholo-

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gists even when helping individuals with profound mental illness seek to identify skills and traits (i.e., strengths) that can be built upon and incorporated into the helping process (Gelso & Fretz, 2001). Second, counseling psychology often emphasizes working within a developmental framework. Counseling psychology also stresses the use of brief approaches to treatment (Munley et al., 2004). Along with treatment length, the counseling philosophy emphasizes placing special attention on the environmental and contextual factors (e.g., friends, family, job loss, etc.) that may impact a client’s functioning (Gelso & Fretz, 2001). Similarly, counseling psychologists are committed to the integration of a client’s diverse and unique background into their therapeutic activities (Munley et al., 2004; Vera, 2006). Trained as scientist practitioners counseling psychologists strive to empirically assess the methods that they use in order to ensure that they are having a beneficial impact on their client’s well-being. Finally, counseling psychologists also strive to utilize preventative techniques (Murdock et al., 1998). As such clients are assisted in not only resolving their current problems but are also taught skills that can be used in future situations (e.g., psycho-educational approaches). For many individuals adopting a preventative role is considered a defining characteristic of counseling psychology (Vera, 2000).

With this basic philosophy as a foundation, counseling psychologists have adopted a variety of roles (Atkinson, 2002; Gelso & Fretz, 2001). First, counseling psychologists have often fulfilled remedial functions in the treatment of mental health. Thus, counseling psychologists have sought to aid individuals who are in crisis resolve their current problems. Second, counseling psychologists can take on an educative or developmental role (Gelso & Fretz, 2001). Finally, counseling psychologists may adopt a preventative role in that they may seek to aid clients in avoiding or anticipating future challenges (Atkinson, 2002; Tipton, 1983). Although these roles are presented here as tasks that may be carried out separately, it is often the case that both counseling psychologists perform these functions in a dynamic fashion while working with their clients (Gelso & Fretz, 2001).

An emphasis on prevention in the counseling philosophy

As seen above prevention is a part of the counseling philosophy as a unifying theme and a role of counseling psychologists. In fact, prevention was identified as a unique perspective of counseling psychologists at the Georgia Convention on the Future of Counseling Psychology (Kagan, et al., 1988). However, in practice counseling psychologists may not engage in prevention perhaps because of an emphasis on remediation or training/accreditation standards (Romano & Hage, 2000). As such counseling psychologists and trainees may be forced to place emphasis on intervention and as a result counseling psychologists may be deviating from a fundamental part of the counseling philosophy. Thus, the counseling psychology profession is faced with the question on how to revitalize an emphasis on prevention and as a result realign counseling psychology with its fundamental philosophy. One possibly is if counseling psychologists identified evidence based counseling approaches that fit with the counseling philosophy and adaptable to prevention and remediation.

Recently the roles, as well as the fundamental philosophy, of counseling psychologists have received attention within the literature (Goodyear et al., 2008; Forrest, 2008; Munley, Pate, & Duncan, 2008). Forrest (2008) indicated that it “should be a top priority” for counseling psychologists to analyze and reflect upon their professional identity (p. 282). Furthermore, she argued that it is critical for the field of counseling psychology to address and adapt to both internal and external influences. One of these influences is the growing popularity of the evidence-based practice movement (Goodyear et al., 2008; Lichtenberg, Goodyear, & Genther, 2008; Wampold, et al., 2005). As EBPs grow in popularity it will be critical to assess their degree of congruence with the fundamental viewpoints of counseling psychology as some EBPs may be more aligned with the counseling philosophy than others. For instance, assessing the level to which EBPs fit with or are adaptable to the core philosophical underpinnings of counseling psychology may further help us to understand how best to integrate these EBPs into practice (Gelso & Fretz, 2001; Goodyear et al., 2008). Motivational Interviewing (MI) may be one EBP that fits well with the core philosophical underpinnings of coun-
Motivational Interviewing

Motivational Interviewing (MI), which was recently included within the National Registry of Evidence-based Programs and Practices (Substance Abuse and Mental Health Services, 2008), is a collaborative person-centered form of guiding aimed at eliciting and strengthening motivation to change behavior (Miller & Rollnick, in press). During the past 25 years MI has grown in popularity in a variety of professions, within and outside psychology (Madson, Loignon, & Lane, 2009). One reason for why MI has seen such an increase in popularity is its strong evidence-base. MI has been found to be efficacious in addressing many behavioral issues including alcohol and drug abuse, smoking cessation, weight loss, treatment adherence, diabetes, asthma, and increasing physical activity (Burke, Arkowitz & Menchola, 2003; Rubak, Sandbaek, Lauritzen, & Christensen, 2005). MI is primarily concerned with raising one’s level of intrinsic motivation for change. Miller and Rollnick (2002) argue that when faced with change it is common for people to grapple with both positive and negative feelings, and are inclined to remain with the status-quo. With MI, the goal is to elicit positive reasons and attitudes for change from within the client in order to bring about a resolution for his or her problem (Arkowitz & Miller, 2008).

MI is based upon a particular integral perspective, or spirit, that is comprised of three major tenets (Allsop, 2007). First, behavior change is brought about in a collaborative manner. The counselor interacts with the client in a partner-like fashion. Ideally, both the client and the counselor perceive each other as equals. There is a level of highly valued egalitarianism between the two (Moyers, Miller, & Hendrickson, 2005). Second, MI values an evocative relationship between the client and the counselor. Miller and Rollnick (2002) propose that change which rises from the client’s own goals and values will have a greater impact than if it was imposed by an outside source. Therefore educating or advice giving are not seen as the most conducive forms of interaction due to their tendency to increase resistance (Rollnick & Miller, 1995). Finally, the philosophy of MI holds that a counselor must respect the autonomy of his or her client. Thus, the ability and the decision to bring about change are entirely under the client’s control (Moyers et al., 2005).

The underlying philosophy of MI leads to four general principles that are intended to help promote behavior change (Arkowitz & Miller, 2008). First, the expression of empathy is highly valued within MI (Britt, Blampied, & Hudson, 2004). Here the counselor is able to conceptualize and respect the client’s current cognitive and emotional state while remaining a separate objective individual (Arkowitz & Miller, 2008). Miller and Rollnick (2002) maintain that another key principle to behavior change is to develop discrepancy. Ambivalence is viewed as a fundamental component of the change process. An important way of working through this ambivalence, and initially using it as a resource, is to elicit from the client their goals and values while juxtaposing them with their current situation (Rollnick & Miller, 1995). An MI consistent approach holds that rather than direct confrontation or arguing, a therapist should roll with resistance, the third principle (Miller & Rollnick, 2002). Resistance is seen as an indication that the counselor may be progressing too quickly and needs to change his or her behavior in order to avoid stifling the change process (Rollnick & Miller, 1995). Miller and Rollnick (2002) purport that rather than directly confronting this behavior one should come alongside clients and join them in their arguments against change. The final principle of MI encourages the cultivation of the client’s self-efficacy in regards to change. Miller and Rollnick (2002) state that it is not only important to develop positive reasons and attitudes for change, but also to cultivate a belief within the client that they can change. In MI, the counselor strives to help a client assess and build their level of confidence in moving away from the status quo towards changing their behavior (Britt et al., 2004).

Along with its previously mentioned body of evidence, MI’s growing popularity may also be due to the similarities between these principles for addressing behavior change and some of the tenets of the counseling philosophy. Although the principles and philosophical tenets of MI appear at face-value to be similar to the underpinnings of the counseling philosophy, this relationship has yet to be explored.
As MI continues to gain acknowledgement within counseling psychology, and professionals seek further training, it is important to establish its theoretical congruence the philosophy of those who will be applying its strategies in their daily routines. Such a relationship may help explain, or further support, the dissemination of this particular approach within counseling psychology. The purpose of the present study was to assess the degree to which practitioners, educators and students within the counseling profession view both the spirit of MI and its principles as being associated with the counseling philosophy. Due to the perceived high level of resemblance between these two philosophies it was hypothesized that a moderate to strong fit would be found between these two constructs.

Methods

Participants

Participants were 167 (118 female, 49 male) members of the counseling profession. Although these data seem skewed, they are representative of the current gender demographics in counseling psychology (Goodyear et al. 2008). Thirty four participants held bachelor’s degrees, 82 had master’s degrees, 39 held a Ph.D., 1 held a Psy.D., and 11 had an Ed.D. A large number of participants (n = 135) identified as White, with 11 participants identifying as African American, 5 as Asian American, 5 as Hispanic, two as multiracial, and 1 participant identified as Middle Eastern American. The average age was 36.31 (SD = 11.73). Participants provided clinical services for an average of 8.67 (SD = 9.77) years as a professional or student. Primary work environments for participants included university counseling centers (n = 45), students/trainee (n = 32), community mental health agencies (n = 26), and teaching (n = 24). Almost every participant (n = 161) took a counseling theories course. Participants identified their theoretical orientations as being either integrative (n = 41), humanistic (n = 39), cognitive (n = 21), interpersonal (n = 16), psychodynamic (n = 12), solution focused (n = 10), behavioral (n = 5), REBT (n = 1) or undecided/other (n = 22).

Procedure

Participants were recruited using a snowball sampling technique. First, e-mail messages were sent to the counseling and counseling psychology training directors. Next individual e-mails were sent to members of the Motivational Interviewing Network of Trainers who identified as counselors or counseling psychologists.

E-mail messages explained the study’s purpose, procedure, approximate length of time for completing the survey, a link to the on-line survey, and how to contact the principal investigator. These e-mails also asked individuals to forward the message to students and other counseling professionals. The link guided participants to the informed consent page of the survey that explained the study. Participants were informed that participation was voluntary, that no compensation was provided for study participation and by completing the survey they were consenting to participate. Participants were asked to complete this on-line survey using the Survey Monkey program. The survey included a demographic form and the 63 item Motivational Interviewing and Counseling Philosophy Questionnaire. Study procedures were conducted in accord with standards of the Institutional Review Board at the University of Southern Mississippi.

Measures

Demographic form. Participants completed a demographic form that asked questions about sex, age, race, highest degree earned, years providing clinical services and current training status if a student. The form also assessed whether participants had an introduction to counseling and counseling theories class as well as their exposure to and experience with MI.

Motivational interviewing and counseling philosophy questionnaire (MICPQ). The authors created the MICPQ for this study to measure participant’s beliefs about the fit between the spirit and principles of MI and the counseling philosophy. The MICPQ was developed using a rational-empirical approach. Criteria were developed for three components that encompass the spirit of MI (evocation, autonomy, and collaboration) and the four principles (expressing empathy, developing discrepancy, rolling with resistance, supporting self efficacy) based
on theoretical descriptions of these constructs (e.g., Arkowitz & Miller, 2008; Miller & Rollnick, 2002). Two authors independently generated 5 to 10 statements that reflected each of the 7 MI constructs (spirit and principles). All authors, who have training in MI, reviewed the items for clarity and consistency with descriptions of the construct. Through this process one statement for each construct was developed. Next, the list of items was reviewed by an independent expert in MI who reviewed the items for clarity and consistency with the MI constructs. Concurrently with development of these MI items, two of the authors reviewed counseling philosophy sources (e.g., Brown & Lent, 2000; Gelso & Fretz, 2001) to identify the major tenants of the counseling philosophy and definitions of each. The definitions were brought back to the entire research group and were reviewed for clarity and consistency with descriptions of each construct. This process resulted in definitions of three roles in counseling (remedial, preventative, developmental) and six foci (intact personalities, assets and strengths, brief interventions, person-environment interaction, education and career development, and multiculturalism). The final 63 item version of the MIPCQ asked participants to rate (on a 5-point Likert type scale; 1 = extremely poor fit to 5 = excellent fit) their belief as to how each spirit and principle construct fit with each role and foci of counseling philosophy. Thus there were seven MI items for each role and foci. It was estimated that the MIPCQ took about 10-15 minutes to complete.

Results

MIPCQ Psychometric Estimates

Internal consistency was estimated for the total MIPCQ and each role or foci of the counseling philosophy. The estimated internal consistency (α = .98) of the total MIPCQ scores suggest that it can provide consistent data. Internal consistency estimates for scores from the three counseling roles ranged from α = .89 (remedial role) to .92 (preventative role) and from α = .90 (assets and strengths) to .95 (education and career development) for the six counseling foci. To estimate validity for the MIPCQ, we examined the convergence between an item that explicitly asked participants about the degree of fit between MI and the counseling philosophy and the average fit across all MI and counseling philosophy items (i.e., MI items across each role and foci). A statistically significant correlation was found (r = .33, p = .01).

Experience with the counseling philosophy and MI

The majority of the participants (n = 138) have taken a professional seminar course as well as an introduction to counseling course (n = 150). Eighty six participants reported that they were familiar with the philosophy of counseling to a great extent while 62 reported being very much familiar, 15 somewhat familiar and 3 expressed little familiarity. Although the majority of participants had taken a counseling theories class, 93 participants indicated that MI was not covered at all, 37 reported MI was covered a little, 21 indicated MI was covered somewhat, 10 reported MI was covered very much, and 4 responded that MI was covered a great deal. However, the majority of participants (n = 114) reported that they were at least somewhat familiar with spirit of MI. Of those 114 participants, 35 indicated that they were very much familiar with the spirit of MI and 36 reported that they have a great deal of familiarity with the spirit of MI. Similarly, 112 participants indicated that they are at least somewhat familiar with the principles of MI of which 34 indicated that they are very much familiar with MI principles and 33 reported that they have a great deal of familiarity with MI principles. One hundred and six participants reported that they are at least somewhat familiar with MI strategies with 31 indicating that they are very much familiar and 32 with a great deal of familiarity. The majority of participants (n = 103) identified as novices in their experience with MI by having either no exposure (n = 30), only reading about MI (n = 50), or receiving didactic training (n = 23). Thirty-one participants identified as beginners engaging in minimal practice (n = 23) or using MI with half of their clients (n = 8). Thirty-three participants indicated having advanced experience with MI in either using it regularly with clients (n = 20) or supervising others using MI (n = 13).
ticular aspects of MI are congruent with the counseling philosophy participants’ responses were grouped based upon the principles and philosophical tenets (spirit) of MI. Averages of these grouped responses were then calculated. For example, subjects’ responses for all of the items corresponding with the principle of developing discrepancy were summed and divided by nine (three counseling roles, and six foci). As seen in Table 1 results indicated that the MI principle of supporting self-efficacy was viewed as the most congruent with the counseling philosophy, with average response indicating nearly an “excellent fit.” Rolling with resistance, on the other hand, showed the lowest average degree of congruence. Developing a collaborative relationship was the aspect of the MI spirit that was viewed as fitting the most with the counseling philosophy. However, it should be noted that none of the principals and tenets of MI averaged less than an “above average fit”.

Also of interest was the extent to which the three separate roles for counseling psychologists were congruent with the principles and spirit of MI. Respondents scores were averaged across the tenets and principles of MI for each role for counseling psychologists. For instance, all items associated with the Preventative Role were summed and divided by seven (four MI principles, and three MI philosophical tenets). Results indicated that participants viewed MI as being the most congruent with the Remedial Role (X = 4.47, SD = 0.53). However, both the Preventative Role (X = 4.45, SD = 0.59) and the Developmental Role (X = 4.39, SD = 0.61) were typically viewed as having an “above average fit”.

In order to assess whether the degree of congruence between these three roles were significantly different three separate paired samples t-tests were conducted. Results indicated that the average amount of congruence between the principles and philosophy of MI for the Preventative Role and Remedial Role was not statistically significant (t (166) = .856, p >.05). However, results indicated that the average degree of congruence with the principles and philosophy of MI was greater for both the Preventative Role (t (166) = 2.21, p < .05) and Remedial Role (t (166) = 2.34, p < .05) when compared to the Developmental Role.

Discussion

The goal of this study was to examine how individuals in counseling psychology viewed the degree of fit between MI and the counseling philosophy. The results suggest that while exposure to MI

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<td>Self-efficacy</td>
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<td>Rolling with Resistance</td>
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<td>Developing Discrepancy</td>
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<td>Expressing Empathy</td>
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N = 167
was variable, participants generally believed that there was congruence between MI and the counseling philosophy. Specifically, participants expressed that there is an excellent fit between the MI principle of supporting self-efficacy and the counseling philosophy. This finding is logical given that a focus on the strengths of clients has been at the cornerstone of counseling psychology and professional counseling throughout most of their histories (Kaczmarek, 2006; Lopez & Edwards, 2008).

Further, although not considered to be as congruent with the counseling philosophy as the principle of supporting self-efficacy, each of the other MI principles (expressing empathy, rolling with resistance, developing discrepancy) were perceived as having an above average fit. Beyond these relationships between MI and the counseling philosophy, the results of this study also suggest that MI fits well with the three roles traditionally associated with the counseling profession. The results of this study suggest that although participants felt there was an above average fit between each role and MI, the Remedial and Preventative roles fit significantly better than the Developmental role. These results are encouraging and several possible explanations are offered below. The implications of these results for the future of training in the counseling profession are also explored.

Through examining the historical and contemporary landscape of counseling psychology several reasons become apparent that may explain the perceived match between the counseling philosophy and MI. Perhaps this fit relates to the significance of person-centered therapy to the counseling profession. For example, Goodyear and colleagues (2008) explained that client-centered therapy historically has been an important theoretical approach in counseling psychology. MI is built on the foundation of client-centered therapy (Moyers, 2004) and as such emphasizes that the counselor communicate with the client in a manner similar to what Rogers referred to as “a way of being” with clients (1980). Specifically, MI’s emphasis on the core conditions of counseling, acceptance, collaboration, and a client’s ability to choose what is best for him or her reflects the influence of person-centered therapy. In fact, most often when MI is discussed in a counseling theories text it is often discussed as part of a chapter on person-centered therapy (e.g., Prochaska & Norcross 2008). As many in the counseling profession derive great value from the tenants of person-centered therapy they may find similar value in the principles and philosophy of MI. Another explanation for these findings is the emphasis both MI and counseling psychology place on strengths. As highlighted previously MI places great emphasis on the ability of clients to determine which course of action is right for them (autonomy) while strategically highlighting a client’s strengths for making change (self-efficacy). More specifically, the client’s own values, goals and motivations are elicited from and emphasized in relation to changing a behavior. At the same time, the MI-adherent counselor is strategically attuned to the opportunity to highlight a client’s abilities. As the counseling profession holds the recognition of a client’s autonomy (Gelso & Fretz, 2001) and the emphasis of their strengths (Kaczmarek, 2006) at the heart of its philosophy it is natural that our respondents would see a fit in this area.

**MI and Prevention**

Another reason for the perceived fit between MI and the counseling philosophy may relate to MI’s history in fostering preventative related behaviors. One example is found when examining the research on the use of screening and brief interventions (SBI) in preventing college student alcohol abuse. Carey, Scott-Sheldon, Carey & DeMartini (2007) conducted a meta-analysis that included 62 SBI studies and found that SBIs that emphasized motivational interviewing performed better than those not including these elements. Cary and colleagues findings emphasize the value of MI in enhancing an empirically based prevention program. Similarly, Martins and McNeil (2009) reviewed 37 studies that examined the use of MI in promoting health behaviors (diet and exercise, diabetes prevention, and oral health) and found that individuals who received MI demonstrated significant health promotion behaviors changes that were maintained. These two large research reviews combined with the results of our study suggest that MI has potential as a tool that can be used in prevention efforts, emphasizing its fit with the counseling philosophy. MI may be an approach that meets the call by Romano and Netland...
that counseling training infuse research and theories that are “germane to prevention science” (p. 779).

**Training Implications for Counseling Psychology**

For a variety of reasons, such as accountability, standards of practice, and reimbursement, the counseling psychologist must be able to implement EBPs whether in a remedial or preventative role (Lichtenberg et al., 2008). For this reason counseling psychology students need to be trained to implement EBPs. In 2000 Waeler, Kalodner, Wampold, & Lichtenberg outlined some specific issues and recommendations related to EBPs in counseling psychology. Specifically these authors expressed concern that (a) EBPs minimize the impact of individual differences for emphasis on specific techniques, (b) emphasize diagnostic specificity, and (c) focus on training in the use of manuals versus generic training. However, Waeler and colleagues (2000) highlighted the necessity for training programs to integrate EBP trainings and provided recommendations for such integration. Given MI’s growing evidence-base for addressing a multitude of behavioral concerns, in conjunction with our results suggesting a match between MI and the counseling philosophy, we will discuss how MI relates to Waeler and colleagues’ concerns and recommendations.

**EBPs minimize individual differences.**

Waeler and colleagues (2000) expressed concern that many EBPs minimize the individual (both client and counselor) while emphasizing technical procedures related to the intervention. In other words, if one favors working with a hammer everything looks like a nail. Clearly an essential value of counseling psychology is its emphasis on diversity and individual differences. Because of MI’s roots in person – centered therapy each client is seen as a unique individual with goals, values, backgrounds, experiences, needs and wants which impact their behavior change efforts (Rollnick, et al. 2008). Moreover, there is an increasing evidence base suggesting MI’s efficacy with individuals from diverse backgrounds (Anez, Silva, Paris & Bedregal, 2008; Hetma, Steele & Miller, 2005; Longshore & Grills, 2000; Resnicow et al., 2001, Thevos, Quick, & Yanduli, 2000). Furthermore, the emphasis on client autonomy in MI highlights its focus on individual differences and ability of clients to choose which change efforts are best for them.

**EBPs focus on Diagnostic Specificity.**

Waeler and colleagues (2000) highlighted the potential for counseling psychology’s focus on positive behaviors and client strength to be overshadowed by a focus on psychopathology when using EBPs since they can emphasize treatment for a specific disorder. MI addresses this concern on several fronts. A central theme in MI is avoiding the trap of prematurely focusing on an issue by remaining open to the various concerns a client brings into a session (Miller & Rollnick, 2002). For example, if counseling a client in relation to losing weight the counselor needs to avoid prematurely focusing on weight and remain open to the client’s concerns that may or may not relate to their weight. Similarly, those trained to implement MI are instructed explicitly to avoid the trap of labeling client behavior (Miller & Rollnick, 2002). Thus, an MI-adherent counselor would not require, and actually avoid, using the term alcoholic with a client who abuses alcohol. The emphasis on highlighting a client’s self-efficacy, regardless of presenting concern, remains true to counseling psychology’s focus on client strengths.

The results of this study indicate that MI fits with both an intervening and preventative role. There is an increasing evidence-base that MI is efficacious in helping individuals adopt positive healthy behaviors such as eating fruits and vegetables (Resnicow et al., 2001; Ahluwalia et al., 2007), exercising (Jackson, Asmiakopoulou, & Scammell, 2007), safe sex practices (Kalichman, Cherry, & Browne-Sperling, 1999), preventing escalation of harmful alcohol use (Martens et al., 2007), and engaging in and adherence to various forms of medical and mental health treatments (Aloia, Arendt, Riggs, Hecht & Borrelli, 2004). These findings highlight the preventative and healthy behavior applications of MI that are consistent with the counseling philosophy and in harmony with the changing trends toward promoting healthy behaviors versus solely focusing on pathology (Romano & Hage, 2000). Moreover, health care professionals traditionally trained in a disease focus model (e.g., physicians, nurses, dietitians) are being trained in MI as an alternate form of interacting with clients because of the general appli-
cability of MI and its emphasis on the relationship in facilitating client change (Rollnick et al., 2008). Thus, having competence in MI will equip counseling psychologists to provide services in a wide variety of settings which emphasize prevention such as medical facilities promoting health and preventing health problems (Chwalisz & Obasi, 2008), university counseling centers preventing substance abuse (Martens, Neighbors, & Lee, 2008) and eating disorders (Mintz, Hamilton, Bledman, & Franko, 2008), and teaching and supervising other health care professionals (Lichtenberg et al, 2008). As such, MI appears to have utility for further consideration as a prevention tool.

EBPs focus on manuals versus generic training. Waeler et al. (2000) cautioned that integrating training in EBPs may force counseling psychology training programs to reduce or abandon their traditional focus on general training. More specifically, Waeler and colleagues (2000) express concern that the traditional emphasis on the therapeutic relationship will be lost for a focus on specific techniques or manuals. Bill Miller, one of the originators of MI, has also cautioned about “manualizing” MI and emphasized that MI is best thought of as a communication approach versus a set of techniques to be implemented (Adams & Madson, 2006; Miller & Rollnick, in press). In fact, in order to become competent in the practice of MI one must learn the basic relationship building skills (Moyers & Miller, 2006).

Prevention training and MI. Romano and Hague (2000) highlighted the need for counseling psychology programs to recommit to prevention training. Further, these authors emphasized that in order for students to effectively engage in the prevention science and practice they need to acquire the necessary knowledge and skills. Similarly, Hage et al. (2007) in outlining best practice guidelines for prevention suggest that psychologists implement theory based and research supported prevention efforts that seek to reduce risks and promote strengths. As such, students need to be exposed to potentially effective prevention tools. Based on MI demonstrated efficacy in preventing alcohol abuse and in promoting health related behaviors and its fit with the counseling philosophy it may be beneficial to consider MI as an evidence based prevention tool.

Waeler and colleagues (2000) suggested that training programs in counseling psychology integrate EBP into their curricula and practica experiences. Further they recommended that trainers (a) provide illustrative examples of the EBPs, (b) use audio or video taping of students implementing a particular EBP, (c) use measures to assess the degree to which the student implemented the EBP and (d) assess client response to the EBP. The MI training community excels in meeting these recommendations with over 25 empirical studies examining MI training ranging from basic 1 hour workshops to more extensive practica like training (Madson, et al 2009). There are several different video tapes/DVDs that can be used to demonstrate MI consistent and inconsistent behaviors available for training purposes (see http://motivationalinterview.org/training/videos.html). Most notable in relation to Waeler and colleagues (2000) recommendations is the emphasis in the MI training community on assessing the competent use of MI (Madson, & Campbell, 2006). Multiple measures exist for use in assessing skill acquisition (Rosengren, Baer, Hartzler, Dunn & Wells, 2005) evaluating adherence (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005), and training and supervising (Madson, Campbell, Barrett, Bronfino, & Melchert, 2005; Martino, Ball., Nich, Frankforte & Carroll 2008) counselors using MI as well as its adaptations (Lane, Huws-Thomas, Hood, Rollnick, Edwards & Robling 2005). Recently measures have been developed to assess clients’ perception of counselors using MI (Madson, Bullock, Speed, & Hodges, n.d.).

MI appears to be an EBP that fits well with the counseling philosophy. Further, MI seems to meet the challenges and recommendations set forth by Waeler and colleagues (2000) related to integrating EBPs in counseling psychology training. MI may also be a tool that can be implemented as part of effective prevention programs and training in MI can help students acquire the knowledge and skill required for effective prevention (Hage et al., 2007; Romano & Hage, 2000). However, some limitations of this study call for caution in interpreting these results. Because this was an on-line survey and solicitation of participants was through e-mail those who do not have access to these electronic tools did not
have the opportunity to participate. Similarly, those who chose to participate may have had a bias toward MI, which may have positively skewed the results. In other words, those who have little information or exposure to MI may have chosen not to participate. Further, the use of the snowballing technique may have resulted in participants selecting others to refer to the survey. As such the sample may not be entirely representative of the counseling profession and call for caution. Thus, the fit between MI and the counseling philosophy may be overestimated based on those who chose to participate in the study. Finally, the survey used in this study was a post-hoc measure. Although the initial psychometric estimates are encouraging, further validity data could have enhanced confidence in the results found.

Given the importance of training counseling psychology students in EBPs and the need to provide training in prevention it would behoove trainers and researchers to further explore the fit between the counseling philosophy and MI. For example, qualitative methods could be utilized to explore in greater depth what are the specific reasons why MI may fit with the counseling philosophy. It may also be important to understand the perception of fit among different counseling psychologists such as practitioners, academics, and students. Further, the result that MI fits with the preventative and remedial role needs to be further evaluated. For example, with what aspects of prevention does MI fit the best or are there areas of prevention or intervention in which MI does not fit? Similarly, it may be helpful to examine how one’s training impacts their perception of this fit. For example, is there a difference in perceived fit among individuals who were trained in a more traditional counseling program versus those trained in a more contemporary counseling psychology program?

Beyond research on the MI and counseling philosophy fit, it is important to study the integration of MI as an EBP into counseling psychology training. More specifically, how can MI be taught in specific courses, practica, and other clinical training experiences? Similarly it would be important to examine how to train students in MI as both a prevention and intervention tool. Finally, it may be beneficial to evaluate how MI fits with and can be applied to other traditional counseling psychology activities such as career counseling or supervision (Madson, Bullock, Speed, & Hodges, 2008).

In sum, this project assessed the perceived fit between MI and the counseling philosophy. Results suggest that there is an above average or excellent fit between the philosophy of counseling and the spirit and principles of MI. As MI is a counseling approach with a strong evidence-base, which appears to share similar theoretical qualities with professional counseling, it may behoove counseling psychology training programs to strive for greater integration of MI into their training programs.

References


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2009 AWARDS, ACKNOWLEDGEMENTS, AND APA SYMPOSIUM INFORMATION

Awards

In 2009 at the APA National Conference, the Prevention Section of the Society for Counseling Psychology (Division 17) presented awards to members and new professionals in the field based on their proven interest and quality work. The following are the Award Recipients for 2009:

The Counseling Psychologist Life Time Achievement Award in Prevention was presented to Maureen Kenny, Boston College.

The Counseling Psychology Graduate Student Prevention Research Award was presented to Katherine Raczyński, University of Georgia. Ms. Raczyński is researching violence prevention, with an interest in cyber bullying, under the mentorship of Dr. Andy Horne.

The Prevention Section symposium was "Preventing Oppression: New Directions in Theory, Research, Practice, and Training" chaired by Joel Wong.

The Prevention Section received a record number of proposals for the Division 17 student poster session this year, permitting the section to accept the maximum number of proposals available to any one section.

The four successful students were:
FRIENDS Parent Project: Effectiveness of Parent Training in Reducing Parent and Child Anxiety Symptoms in School Children
Marnie Fukushima-Flores, The University of British Columbia

Girls With A Comeback! Self-Objectification Prevention Programming
Alysondra Duke, University of Nebraska-Lincoln

A Contemporary Prevention Model for College

Drinking
Ryan D. Weatherford, Lehigh University

Self Esteem, Healthy Entitlement and Feminine Gender Norms - Relationship to Women's Attitudes about Dating Violence
Stephanie Chapman, University of Houston

2009 APA Symposium Activity

The Prevention Section hosted two workshops at the APA convention to continue work on the proposed APA 'Guidelines on Prevention Practice, Research, Education, and Social Advocacy for Psychologists'. The Guidelines were introduced to APA Council as a new business item by Division 17 at the 2008 APA convention. The Guidelines received a first review by APA's Committee and Professional Practice and Standards (COPPS) and Board Professional Affairs (BPA) in May 2009. The Guidelines Work Group received feedback from the review. Dr. Terry Gock, member of COPPS, agreed to serve as consultant to the Workgroup to assist with the process of moving the Guidelines to eventual approval by APA. The Workgroup includes members of several divisions. The Prevention Section welcomes new members to the Workgroup. The Workgroup divided its tasks into sub-groups corresponding to the Guidelines, i.e. Prevention Practice, Prevention Research, Prevention Education, and Social Advocacy. To become a member of a sub-group contact Sally Hage (shage@albany.edu) or John Romano (roman001@umn.edu). The Workgroup plans to complete a draft of the Guidelines for BPA review by February 2010. Please visit the Prevention Section website (www.div17.org/preventionsection) for information about our publication, section activities, and becoming a member.