Journal of Professional Counseling: Practice, Theory, & Research

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From the Executive Editor:

The Spring 2007 issue of *The Journal of Professional Counseling: Practice, Theory, and Research* offers much to practicing counselors. For those working with international students, the Abbassi and Stacks article sheds some new light on some older, preconceived concerns. Barbee and associates offer a clear perspective on confidentiality in Texas, ethically defending the Texas stance of NOT WARNING identifiable victims. Lambie and Davis offer a rather thorough examination of adolescent heroin abuse. Matise brings us a thorough introduction to the enneagram, suggesting that it offers utility in both conceptualizing a client and identifying therapeutic interventions.

I must confess that my first reaction to the Barbee et al. article was to write a response countering their contentions. But after contemplating the merits of their argument, I must say that I am inclined to agree that the best course of action, for Texas counselors, is to strictly maintain clients' confidentiality except in instances of suspected child abuse or HIV/AIDS infection. However, as I frequently tell my students, “You must decide what you believe.”

The other article I will “highlight” here is the enneagram article authored by Matise. I had never heard or read of enneagrams before Dr. Matise submitted his manuscript. The more I read, the more intrigued I became. Here is a tool that offers us a way to help clients examine relationships, themselves, and, perhaps, possible roots of some of their issues. I look forward to confirmatory research regarding enneagrams.

Dr. Rick Balkin assumed the editorship of *The Journal* on July 1. The first issue published under his “watch,” however, will be the Spring 2008 issue. So, I'll save my farewells for the next issue.

Chester R. Robinson, Ph.D., NCC
Executive Editor
The Journal of Professional Counseling: Practice, Theory, and Research is a semi-annual publication seeking to advance clinical, theoretical, and empirical knowledge in counseling and psychotherapy. The journal invites manuscripts that are directed to the mutual interests of counselors and personnel workers in schools, colleges, community agencies, and government agencies. Especially welcome is stimulating writing dealing with: (a) practical and unique applications of counseling techniques in schools and clinical settings, (b) significant quantitative and qualitative research, (c) critical integrations of published research, (d) theoretical and social policy, and (e) scholarly reviews of professional materials.

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Reviewing: Reviews of a new book, a recent article in a professional journal, a new test or inventory are encouraged.

(Continued on following page)
4. Avoid footnotes wherever possible.

5. Shorten article titles so that they do not exceed 50 letters and spaces.

6. Author’s name with position, title, and place of employment should appear only on the cover page.

7. Double-space all material, including references.


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Heroin use among adolescents has increased significantly over the past decade. This increase poses a considerable danger for adolescents potentially resulting in serious psychological, social, educational, and legal consequences. Professional school counselors are in a position to support and intervene through school-based consultation services. This article: (a) introduces the recent trends in adolescent heroin abuse, (b) reviews the potential consequences and warning signs of heroin abuse, and (c) presents school-based consultation as an intervention strategy for supporting these students.

Heroin use poses a significant danger for adolescents possibly resulting in serious psychological, social, educational, and legal consequences. A substantial proportion of adolescent heroin abusers end-up incarcerated or deceased (Hopfer, Khuri, Crowley, & Hooks, 2002). In recent years, adolescent heroin use has seen a statistically significant increase (Johnson, O’Malley, & Bachman, 2002; National Institute of Drug Abuse [NIDA], 2002). Between 1990 and 2000, emergency room reports of heroin abuse rose from 182 to 1,067 among 12-17 years olds, while among 18-25 year olds the rate...

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increased from 4,654 to 18,400 (Drug Abuse Warning Network [DAWN], 2002). Heroin admissions to substance abuse treatment centers increased by 44 percent between 1992 and 2000 (Drug and Alcohol Services Information System [DASIS], 2003). Also, stereotypical characteristics of heroin abusers (i.e., urban, unemployed, and disadvantaged individuals) have changed with increases of abuse being found at upper and middle socioeconomic levels and in rural and suburban areas; therefore, heroin abuse is no longer limited to low socioeconomic urban setting (Epstein & Gfroerer, 2003). Further, the age of first use has declined with increasing numbers of middle and high school students using (Fields, 2004). It is important to note that the statistics relating to adolescent heroin abuse are likely very conservative because survey respondents may minimize their heroin use due to the stigma associated with its abuse. Finally, heroin abuse statistics tend to lack data relating to adolescents who are not enrolled in school (i.e., students who have dropped out of school), which likely contributes to the underestimation of its use.

For the purposes of this article, the terms heroin abuse will be used to encompass heroin use, abuse, dependence, and addiction. The authors believe that adolescent heroin use may be classified as abuse because of the potential negative consequences (social, legal, educational, psychological, and/or physical impairment) associated with heroin use among young people.

Statistically, heroin abuse among adolescents is not nearly as prevalent as alcohol abuse. While 52 percent of adolescents 12 years and older admitted to having used alcohol in the previous 30 days (Lambie & Smith, 2004), only one percent of all high school students admit to having used heroin (Johnson et al., 2002). Nevertheless, adolescent heroin abuse remains a significant issue for schools. Also noteworthy is the addictive quality of heroin, where approximately half of repeated abusers will become addicted (Doweiko, 2005). The overall prevalence of adolescent heroin abuse may be low (approximately one percent); however, there may be a much higher percentage within certain populations and areas of the country (Johnston et al., 2002).

Most persons who abuse heroin show signs of dysfunctionality at an earlier age (Ray & Ksir, 2004). Given the frequent and consistent contact between school personnel and adolescents in the school,
these school-based professionals are in an excellent position to serve as primary agents in the identification and intervention of adolescent heroin abuse. One school-based professional in particular that can be of help is the professional school counselor (PSC). PSCs are certified/licensed educators who are specialists in human behavior, communication, and relational issues, having received specialized graduate level training in child and adolescent development, therapeutic interventions, and crisis intervention (i.e., student substance abuse). The interactions PSCs have with students and families can offer insight into possible cues to heroin abuse (Lambie & Rokutani, 2002). Therefore, PSCs are in an excellent position to assist these students and their families.

According to the American School Counselor Association (ASCA, 2004a), PSCs are leaders in the identification of “at-risk” students, and coordinate and facilitate appropriate prevention and consultation services to support these students. Additionally, the ASCA National Model (2003) and the ASCA (2004b) Ethical Standards for Schools Counselors advocated that professional school counseling programs and ethical PSCs support the holistic development (academic, vocational/career, personal, and social) of all students. Furthermore, ASCA (2004c) stipulated that PSCs provide both preventive and reactive responsive services to support the needs of all students (including those students with “very” risky and complex behaviors such as addiction). Lastly, according to Sink (2005), central to a PSC role is “facilitating students’ psychological growth, resiliency, and school and life success,” while providing preventative and remediation services to assist students with their “long-term problems” (p. 9).

The purpose of this article is to serve as a resource for PSCs with regards to adolescent heroin abuse. It offers information relating to adolescent heroin abuse that can assist PSCs in making appropriate professional decisions concerning these students. More specifically, this article: (a) introduces the recent trends in adolescent heroin abuse, (b) reviews the potential consequences and warning signs of heroin abuse, and (c) presents school-based consultation as an intervention strategy for supporting these students.

**Recent Trends in Adolescent Heroin Abuse**

Adolescent heroin abuse has seen a significant rise. This recent increase may
have two interdependent sources. The first being that while the supply of heroin to the United States has been fairly consistent; the purity of the drug has continued to increase (Meth, Chalmers, & Bassin, 2000). Specifically, the DEA (The Drug Enforcement Agency, 2003a) reported purity levels were as high as 74% (compared to an average of 7% purity in 1980). As the purity of heroin has increased, so has its potency. Traditionally heroin is “cut,” that is mixed with other chemical solvents (i.e., kerosene, gasoline, and common household chemicals), then sold as if it was pure heroin. This increase in a better “quality” heroin may be both positive and/or negative to the user. The cleaner heroin may be safer because the user is not placing many unknown chemicals into his or her body. However, a potential negative is that if a heroin user takes a higher purity heroin when he or she is accustomed to a lower quality drug, then the risk of overdosing increases.

A second possible contributor to the increased use of heroin is the perception that the drug’s potential harmful consequences have dropped among adolescents (Johnston, et. al., 2002). Traditionally, heroin has been administered intravenously (IV) or via subcutaneous injection (Ray & Ksir, 2004). However, with its increase in purity, users can now smoke and/or snort heroin, the preferred methods of newer users (National Household Survey on Drug Use and Health [NHSDUH], 2003; Rosenker, 2002). Perceived benefits of snorting heroin include a reduced risk of contracting Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Disorder Syndrome (AIDS), hepatitis, and other diseases often contracted through IV use. However, snorting and smoking heroin is highly addictive. In fact, one who snorts heroin is more likely to later “shoot” it (IV administration) (Carnwarth & Smith, 2002). Considering the increase in purity of heroin and its perceived lower risk of use, adolescents are putting themselves in a compromising position when using heroin.

Potential Negative Consequences of Heroin Abuse

The abuse of heroin is associated with numerous potential negative consequences which are divided into the following three categories: physiological, psychological, and legal.

Physiological

Research supports a physiological component in heroin abuse, where heroin abuse may lead to both acute and chronic
physiological complications. An acute problem is that heroin tolerance can develop in less than 10 days and with its short half-life (typically 2-3 hours); withdrawal symptoms (i.e., irritability, restlessness, insomnia, anxiety, depression, nausea, diarrhea, rhinorrhea, and muscle aches) develop (Hopfer, Khuri, & Crowley, 2003). These effects may inhibit an abuser's functioning in his or her everyday living. Additionally, abusers under the influence of heroin may also put themselves and other people at-risk. For example, if abusers drive automobiles while under the influence of heroin, their abilities to operate the vehicles are impaired.

Heroin abuse itself may be lethal. Possibly, the most dangerous acute effect of heroin abuse is overdosing, especially following a period of reduced use (Warner-Smith, Darke, Lynskey, & Hall, 2001). However, overdosing is a complex process likely having more than just physical contributors. Conditional tolerance is a phenomenon where a change in the environment or the ritual of administering the heroin can affect the abuser's tolerance to the drug. Therefore, an abuser may administer a given quantity of heroin in his or her “normal” surroundings and not overdose (OD), then later administer that same amount in a new or different setting and OD. The risk of overdosing carries with it the possibility of severe long-term consequences including brain damage, pneumonia, heart difficulties, and even death (Warner-Smith, et. al., 2001). The reported number of individuals who OD varies throughout the literature based on population characteristics, but consistent findings suggest that chronic heroin abusers will OD at some point. Additionally, most intravenous (IV) heroin abusers share needles, where almost a third of all persons infected with AIDS or HIV are IV drug users (NIDA, 2002).

Psychological

All drugs have psychologically addictive properties. Persons abusing substances have a strong tendency to return to use even after prolonged periods of nonuse, often referred to as psychological dependence. Psychological dependence may be the most powerful factor in addiction and often is present in the absence of physiological dependence. Even after physically withdrawing from heroin, the psychological component is often manifested in a continuous “craving” for the drug (Doweiko, 2005).

Heroin abuse in and of itself may
cause cognitive difficulties for the abuser. Recent research suggested that heroin abusers have poorer short-term and long-term memory, decreased attention spans, poorer information processing ability, and a lowered tenacity for problem solving when compared to a non-heroin using cohort (Darke, Sims, McDonald, & Wickes, 2000). Also, heroin abusers perform lower academically and are less adept socially because of their decreased ability to learn (Petry, Bickel, & Arnett, 1998). Not surprisingly, the cognitive impairment related to heroin abuse reduces the abuser's ability to perceive and anticipate future events. On average, heroin abusers tend to be more hedonistic and less likely to see how their current behaviors will affect them in their future (Petry at al., 1998).

Possibly the most serious psychological concerns with heroin abuse is the strong positive relationship with other concurrent psychiatric disorders (i.e., comorbidity), a condition in which an individual has two or more coexisting psychological disorders. Darke and Ross (1997) found that over half of heroin abusers suffered from anxiety or depressive disorders. Abusers of psychoactive drugs may abuse the substances as a coping strategy attempting to self-medicate in order to manage their psychological and emotional pain. However, self-medication tends to increase the abuser's "highs" and "lows," often exacerbating his or her depression and/or anxiety (Darke & Ross). Further intensifying the potential psychological effects is that heroin abusers are often polysubstance abusers (abuse multiple psychoactive substances), where alcohol and benzodiazepines (anti-anxiety medications) are also being abused (Hopfer et al., 2003).

Legal

Most adolescent heroin abusers will experience a legal consequence. Heroin under the Controlled Substance Act is a schedule one drug (DEA, 2003b). The Controlled Substance Act specifies drug regulations that are covered under federal jurisdiction regardless of the state in which the controlled substance is possessed. Heroin being a schedule one controlled substance means that the federal government considers heroin to have highly addictive properties with no legitimate medical use with possession being illegal (Ray & Ksir, 2004). Adolescents who are involved in heroin abuse are likely to break other laws in addition to possession. As a result, heroin abusers often face legal consequences for committing robbery and
a variety of other nonviolent crimes to support their habit (Dawkins, 1997). Though heroin as a psychoactive drug is relatively cheap (especially in comparison to cocaine), abusers often drain their finances obtaining the substance. For example, an individual addicted to heroin may inject the drug every three to four hours a day for 365 days per year totaling approximately 1,300 injections. Therefore, even at the relatively inexpensive cost of heroin, financial expenditures for abusers can become substantial, often leading them to steal from their place of employment to support their habit (Hammersley & Morrison, 1987).

Warning Signs of Adolescent Substance Abuse

Adolescent drug abuse is a complex interaction of multiple factors such as family structure and relationships, school success, peers, community, genetics, and psychological well-being. For PSCs and other school personnel to support and intervene in student substance abuse, they must have a knowledge base relating to its warning signs. It is important to note that some cues may be strong indictors of substance abuse; however, the presence of one symptom does not necessarily indicate that a student is abusing substances. Therefore, if PSCs observe potential symptoms of substance abuse, they should communicate their perceptions to the student and receive clarification concerning their interpretations before proceeding (Lambie & Sias, 2005). For example, a PSC may observe that a student is exhibiting a pattern of inconsistent academic performance, absenteeism, and moodiness. If these behaviors are atypical for the student, the PSC may be warranted in approaching the student about his or her observations. First, the PSC may simply identify his or her perceptions concerning the changes in behavior. Next, the PSC may ask an open-ended question eliciting the student to discuss his or her current life situation (i.e., How are things going for you?). Nevertheless, having a knowledge base of the symptomology of substance abuse is necessary in supporting adolescents who may be abusing substances.

The literature identifies numerous factors that may be related to adolescent substance abuse. These behavioral cues are not specific to adolescent heroin abuse; but rather to adolescent substance abuse in general. Additionally, these potential indicators may be signs of other kinds of difficulties. Nevertheless, having an understanding of substance abuse symptomology is paramount in intervening as early as
### Table 1. Warning signs of adolescent substance abuse

<table>
<thead>
<tr>
<th>Family Characteristics</th>
<th>Psychological Cues</th>
<th>Low academic motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poor family communication and relationships</td>
<td>• Risk-taking behaviors</td>
<td>• Deterioration in academic performance</td>
</tr>
<tr>
<td>• Family history of substance abuse</td>
<td>• Absence of religion/religiosity/spirituality</td>
<td>• Increased absenteeism and truancy</td>
</tr>
<tr>
<td>• Being raised in a single-parent or blended family</td>
<td>• Low self-esteem</td>
<td>• School disciplinary problems/infractions</td>
</tr>
<tr>
<td>• Family aggression and violence</td>
<td>• Aggressive behavior such as fighting, verbal abuse, and defiance</td>
<td>• Peers who use substances</td>
</tr>
<tr>
<td>• Family history of psychiatric disorders and suicide or suicide attempts</td>
<td>• Engaging in health-compromising behaviors</td>
<td>• Early cigarette use</td>
</tr>
<tr>
<td>• Inappropriate family structure and boundaries</td>
<td>• Isolationism and social withdrawal</td>
<td>• Being drunk in school</td>
</tr>
<tr>
<td>• Poor family nurturance (i.e., not emotionally warm and accepting)</td>
<td>• Being less socially inhibited</td>
<td>• Skipping classes</td>
</tr>
<tr>
<td>• Absence of parental supervision</td>
<td>• Appearing older than one’s peers</td>
<td>• Older friends</td>
</tr>
<tr>
<td>• Access to alcohol and other drugs</td>
<td>• Rebelliousness and nonconformity</td>
<td>• Attendance in alternative school programs</td>
</tr>
<tr>
<td>• Lack of rules for the young person</td>
<td>• Failure to form close interpersonal relationships</td>
<td>• Intense mood changes, irritability, and anger (more than normal adolescent</td>
</tr>
<tr>
<td>• A history of abuse and/or neglect</td>
<td>• Poor coping skills</td>
<td></td>
</tr>
<tr>
<td>• Family appears to have little interest in school and school-related activities (sports, clubs, and parent-teacher-school counselor conferences)</td>
<td>• The presence of a psychological disorder, especially depression, anxiety disorders and Attention Deficit/Hyperactivity Disorder (ADHD)</td>
<td></td>
</tr>
</tbody>
</table>

possible for the student’s benefit. The warning signs of adolescent substance abuse presented in Table 1 are organized by family characteristics, psychological cues, and educational indicators. These observable potential indicators are intended to provide introductory information for PSCs, enabling them to intervene appropriately in cases of suspected substance abuse.

PSCs and other school personnel may begin to identify student substance abuse that might otherwise go unseen by observing, listening, and interacting with their students. It is common for students who are abusing substances to deny their use and be “resistant”; therefore, PSCs need to utilize therapeutic approaches that appropriately address adolescent resistance (for clarifications in strategies for handling adolescent resistance, see Lambie, 2004).

The Consulting Professional School Counselor

The adolescent heroin abuser requires systemic support and intervention, and school-based consultation may be an appropriate professional school counseling strategy. ASCA (2003) identifies consultation services as a foundational component of a comprehensive school counseling program. Collaborative consultation is a method of applying counseling services to a student systemically and indirectly, where the PSC serves as a student advocate (ASCA, 2003; Keys, Green, Lockhart, & Luongo, 2003). The most common form of consultation in schools is of a triadic nature, where a consultant (the PSC) works with a consultee (often a teacher or parent/caregivers) with a concern he or she has relating to a student(s) (Brigman, Mullis, Webb, & White, 2005; Kampwirth, 2003). Once the consultee has collaboratively consulted with the PSC, he or she than implements the agreed upon strategy with the student. It is important to note, that in situations such as a heroin abusing student, multiple consultees may be involved in the process. The inclusion of these multiple consultees may include constituent individuals or teams that may be from within or outside the individual school or district (i.e., parent[s]/caregiver[s], teacher teams, administration, community mental health professionals, and law enforcement professionals). This model of school-based collaborative consultation moves beyond the traditional triadic nature to a quadratic nature where the PSC assumes the role of “coordinating consultant” who directs the efforts of the entire group (for a discussion distinguishing the triadic vs. quadratic nature of consultation, see...
Kampwirth, 2003, pp. 13-15). In either approach, the PSC collaboratively works with all consultees, providing and coordinating information and strategies for the development of a plan to best match the student's needs.

PSCs are professional educators trained in school-based consultation who work to support the holistic development of all students (ASCA, 2003, 2004c). Specific to substance abuse, PSCs have a responsibility to support a drug and alcohol free school (Smaby & Daugherty, 1995). It is probable that the PSC is the only mental health professional with whom adolescents will have contact (Erford, House, & Martin, 2003). Therefore, PSCs who are trained and educated in heroin abuse symptomology are in an excellent position to identify and initiate interventions for these students. Additionally, it is important for PSCs to have a knowledge base of the legal statutes associated with school interventions for drug and alcohol abuse (i.e., the “Confidentiality of Alcohol and Drug Abuse Patient Records” [42 U.S.C. 290 dd-3 and ee-3; 42 CFR Part 2]). For information relating to legal statutes and substance abuse intervention in schools, a reading of Coll (1995), is strongly recommended.

Implications for Professional School Counseling

The problem of heroin abuse among adolescents needs to be addressed in a systemic fashion. Systems theory proposes that a problem exhibited by a single person (i.e., a heroin abusing student) is often not related just to that individual (intrapersonal dysfunctionality), but rather the result of dysfunctionality within his or her family and/or greater community (Lambie, & Rokutani, 2002). In order to support change in a student, the persons within his or her systems need to become a part of the change process. From this perspective, many of the problems exhibited by the adolescent and potential solutions are related to familial functionality. Therefore, systemic interventions and mediation are necessary to support a student who is abusing heroin or any other psychoactive substance.

PSCs should primarily be concerned with three systems when working with adolescent heroin abusers (family, school, and community mental health/substance abuse agencies). Therefore, the following suggestions for PSCs working with adolescent heroin abusers are organized by type (consultation with families, consultation with other school personnel, and consultation with community agencies).
Consultation with Families

When a PSC suspects heroin abuse by a student, family involvement is paramount. As a school-based consultant to the family, the PSC can provide information relating to substance abuse, act as a liaison, offer referral services (i.e., connecting students and their families with the needed resources and services to support change), and contribute school-based support. Ideally, the family will recognize the student's problem. However, it is not uncommon for parents/caregivers to be unaware of their child's substance abuse. Additionally, caregivers may feel threatened in family-school interaction because they feel they are being blamed for the child's problem (White, & Mullis, 1998). Caregivers who had poor experiences in school may also feel threatened by the school climate and be distrustful of school personnel (Cicero & Barton, 2003). Therefore, counselors need to approach the family in a non-confrontational manner, without blaming the caregivers (Lambie, & Rokutani, 2002). The PSCs should present to the caregiver their observations in behavioral terms in an open and non-confrontational style, which avoids evoking resistance (i.e., How is he or she doing at home? How has he or she been spending his or her time?). The focus of the consultation needs to be on facilitating future change, while supporting the success of the student, rather than on past behaviors or experiences.

Consultation with Other School Personnel

To provide systemic support for heroin abusing students, school-based consultation service needs to be offered to all school personnel. A first step in facilitating consultation services is to provide consultees (other school personnel) with information concerning the identified issue (i.e., student heroin abuse). The introductory knowledge base may be supplied through educational training provided by the PSC. This in-service training should incorporate components discussed in this article, including current trends in adolescent heroin abuse, the potential consequences and warning signs of heroin abuse, and services a school may offer to support these students and their families (for further clarification in facilitating school-based workshops and educational programs, see Brigman et al., 2005).

Teachers are the most common consultee for PSCs. Often teachers spend as much or even more time with students than their parents/caregivers, making them potentially very effective school-
based consultees. However, it is not uncommon for teachers to resist consultation services. A teacher may take it personally if an “outsider” tries to infiltrate his or her classroom or he or she may simply become apathetic. Regardless, teachers tend to be wary of PSCs because they do not understand PSCs’ training, roles, and duties (Cicero & Barton, 2003). Therefore, PSCs need to educate teachers and other school personnel about their position and work collaboratively with them, respecting each other’s expertise and view their relationship as a partnership (Lambie, 2005).

Consultation with Community Agencies

Most PSCs do not have the training, licensure/certification, and supervision to provide substance abuse counseling to their students. Currently, the Council for Accreditation of Counseling and Related Educational Program (CACREP; 2001) standards for curriculum and clinical training does not specify course work in substance abuse in the professional school counseling curricula. Heroin abusing adolescents require mental health services (i.e., substance abuse counseling) that are too in-depth for the school environment. Nevertheless, PSCs consistently work with students and their families concerning substance abuse. Therefore, it is critical that practicing PSCs and those in-training increase their personal awareness and knowledge base concerning substance abuse. Offering counseling services that a PSC has not received training in and supervision is unethical practice. This is not to say that PSCs should not support adolescents abusing heroin, but rather understand their competencies, limitations, and appropriate roles.

The appropriate role for a PSC when working with an adolescent who is abusing heroin is to offer school-based consultation and liaison services to the student, facilitating a connection between the adolescent, his or her family, the school, and community agencies that can provide the necessary services. The connection may be initiated by PSCs offering the student and his or her family referral information to other community agencies such as community mental health and substance abuse treatment centers. Research has suggested positive outcomes from school-community agency collaborative relationships (Hobbs & Collison, 1995). Connecting these students and their families with the needed resources and services may be achieved through providing liaison services. Common referrals available in most communities include self-help groups such as Alcoholics Anonymous (AA) and Narcotics...
Anonymous (NA), which are open to individuals experiencing substance abuse problems. Additionally, PSCs may want to be aware of community crisis intervention hotline numbers in case the student and/or his or her family experience an emergency (Edwards, 1998).

**Conclusion**

The abuse of heroin can severely inhibit a student's growth and development. Abuse of heroin carries with it physiological, psychological, educational, and legal risks. All of the aforementioned risks undermine students' chances of achieving a quality education, appropriate psychological and cognitive development, and a healthy life. PSCs are in an excellent position to assist these adolescents based on their consistent interactions with these students and their training, skills, and resources. An effective systemic method of supporting student change within the ASCA National Model (2003) is through school-based collaborative consultation services.

Consultation allows the PSC to support students from multiple dimensions. PSCs need to collaboratively consult with parents/caregivers, families, schools, and the greater community (i.e. community mental health practitioners) in an effort to aid the adolescent abusing heroin. Each person who participates in the student's personal and social world brings a unique and varied perspective to the abusing adolescent's heroin problem. Additionally, this gives the PSC a more holistic conceptualization of the student's substance abuse. The involvement of many individuals to support in the intervention process for the adolescent can greatly amplify the abuser's chances of recovering from his or her heroin abuse, which is reinforced by the proverb, “It takes a village to raise a child.” While the converse also holds true, “It takes a village to fail a child.” Substance abuse is not just an individual's problem, but rather is a collective issue involving an entire community. Therefore, interventions to support the recovery process of an adolescent abusing heroin need the participation of multiple systems (i.e., school, family, mental health agencies, and law enforcement). Through school-based collaborative consultation, the PSC can be a catalyst for both individual and systemic change.

It is not recommended that school-based collaborative consultation be the only intervention employed to support adolescent heroin abusers. It is advocated by the ASCA (2003; 2004c) that PSCs spend eighty percent of their time providing direct services to students, school personnel, and families. Therefore,
PSCs should also facilitate individual and group counseling, the classroom guidance curriculum, and the coordination of other school counseling services as supplements to consultation services. Classroom guidance activities such as psychoeducational groups have been found to be effective drug abuse prevention and remediation strategies in schools (Smaby, & Dougherty, 1995). Adolescent heroin abuse involves interacting factors; therefore, multiple PSCs strategies are necessary to appropriately support these students and their families (i.e., consultation, classroom guidance, individual and group counseling, family education and mediation, referral services, and collaborative school-based education for all school personnel).

References


Duty to Warn and Protect: Not in Texas

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Contrary to the 1976 California Supreme Court decision in the renowned Tarasoff case, the Texas Supreme Court rendered a 1999 opinion (Thapar v. Zeulka) that mental health providers in Texas do not have a duty to warn and protect their clients’ known and intended victims. This decision reflected the intent of the Texas court not to violate existing state confidentiality statutes that permit, but do not require, disclosure of intent to harm to medical or law enforcement personnel only. Other than the reporting of positive HIV results or suspected child abuse, mental health providers in Texas should proceed with caution in revealing confidential information to anyone for any reason, even when the limits of confidentiality are reached.

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The 1976 ruling by the California Supreme Court in the now famous Tarasoff case (Tarasoff v. Regents of the University of California) established a precedent in that state that mental health professionals have an obligation to warn and protect third parties when a client reveals an intent to harm (Corey, Corey, & Callanan., 2007). Although this ruling has jurisdiction only in California, a duty to warn and protect doctrine, as established by Tarasoff, is considered a national standard or mandate by many therapists (Corey, et.al., 2007).

Interestingly, Texas does not adhere to the precedent set by Tarasoff. To the contrary, the opinion in Thapar v. Zezulka, rendered by the Texas Supreme Court in 1999, stipulated that mental health providers do not incur a duty to warn and protect (Dalrymple, 1999; Grinfeld, 1999; Texas Supreme Court, 1999). Specifically, the opinion written for a unanimous court by Justice Craig T. Enoch stated that “we refrain from imposing on mental health professionals a duty to warn third parties of a patient’s threats” (FN1) (Texas Supreme Court, 1999).

Justice Enoch continued with:

The Legislature has chosen to closely guard a patient’s communications with a mental-health professional. In 1979, three years after Tarasoff issued, the Legislature enacted a statute governing the disclosure of communications during the course of mental-health treatment (FN16). The statute classifies communications between mental-health “professional(s)” and their “patient(s)/client(s)” as confidential and prohibits mental-health professionals from disclosing them to third parties unless an exception applies. (FN17) (Texas Supreme Court, 1999).

**Issue of Confidentiality**

The finding in Thapar v. Zezulka is based on the justices’ reluctance to violate various state confidentiality statutes enacted by the Texas Legislature governing mental health professionals. In his opinion, Justice Enoch stated:

...we decline to adopt a duty to warn now because the confidentiality statute governing mental-health professionals in Texas makes it unwise to recognize such common-law duty (FN 14.17) (Texas Supreme Court, 1999).
DUTY TO WARN AND PROTECT: NOT IN TEXAS

Statutes: 1979 Texas Gen. Laws at 514-4(b)(2) and the current Texas Health & Safety Code 611.004(a)(2). The former (1979) Texas Gen. Laws at 514-4(b)(2) states:

(b) Exceptions to the privilege of confidentiality, in other than court proceedings, allowing disclosure of confidential information by a professional, exist only to the following:...

(2) (sic) to medical or law enforcement personnel where the professional determines that there is a probability of imminent physical injury by the patient/client to himself or to others, or where there is a probability of immediate mental or emotional injury to the patient/client…(FN21) (Texas Supreme Court, 1999).

The latter (Texas Health and Safety Code 611.004(a)(2)) states:

A professional may disclose confidential information to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient…(FN22) (Texas Supreme Court, 1999).

Although not mentioned in the above opinion, the Texas Administrative Code, rule 681.41, supports this same position:

A licensee may take reasonable action to inform medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the client to the client or others (Texas Administrative Code, 2006).

Furthermore, the Texas State Board of Examiners of Professional Counselors (2005) Section 681.45(b), Confidentiality, states:

A licensee shall not disclose any communication, record, or identity of a client except as provided in the Health and Safety Code, chapter 611, or other state or federal statutes or rules (Holland, 1996).

In essence, these statutes, in an effort to protect the confidential nature of a professional therapist/client relationship (Dalrymple, 1999), are in close agreement, even referring to each other in circular fashion (Holland, 1996). They are quite specific as to who the professional can notify.
As can be seen, warning intended and identified third party potential victims is not included in any of the above referenced Texas statutes. These statutes do not specifically allow or disallow notification of intended and identified victim third parties by professionals; they simply omit any reference whatsoever to the act of warning these persons. Therefore, the Texas Supreme Court refused to establish a precedent permitting professionals to warn and protect known and intended victims. (The one exception in Texas is the option of reporting positive HIV results to a spouse.)

Accordingly, breaking confidentiality and revealing a client's confidential information to anyone for any reason (other than the reporting of positive HIV results and suspected child abuse), even when the limits of confidentiality are reached, is risky business in Texas. In a closer look at the Texas confidentiality statutes, they state that professionals MAY notify medical and law enforcement but are not required to do so (Dalrymple, 1999). In the Thapar v. Zezulka decision, Justice Enoch makes strong reference to this point and its legal implications by stating:

The confidentiality statute here does not make disclosure of threats mandatory nor does it penalize mental-health professionals for not disclosing threats. And, perhaps most significantly, the statute does not shield mental-health professionals from civil liability for disclosing threats in good faith. On the contrary, mental-health professionals make disclosures at their peril (FN27) (Texas Supreme Court, 1999).

As can be seen, another reason that the Court did not impose a specific duty to warn provision is that there is no protection in state statute if this is the chosen course of action. Justice Enoch further states that if a duty to warn provision had been imposed by the Court, mental health professionals would most likely encounter another dilemma, a classic Catch-22 situation. To quote Justice Enoch:

Thus, if a common-law duty to warn is imposed (by the court), mental-health professionals face a Catch-22. They either disclose a confidential communication that later proves to be an idle threat and incur liability to the patient, or they fail to disclose a confidential communication that later proves to be a truthful threat and incur liability to the victim and the victim’s family. (FN27) (Texas Supreme Court, 1999).
In short, the reluctance of the Court to impose a duty to warn is an attempt to prevent mental health professionals from being placed in an awkward and vulnerable position in which they are not protected by state confidentiality statutes when disclosing client information. In light of existing statutes, there is most certainly a case to be made in Texas that mental health professionals should not violate confidentiality under any circumstances whatsoever, unless reporting positive HIV results and suspected cases of child abuse, both of which are discussed below.

**Texas Statutes v. American Counseling Association Code of Ethics**

The American Counseling Association (ACA) takes a contradictory position on the breaching of confidentiality once its limits are reached. The ACA Code of Ethics (2005), in Section B.2.a. (Danger and Legal Requirements), states that:

> The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm . . . (ACA, 2005).

The ACA position, although not specifying who should be notified, clearly indicates that potential harm to identified others by a client evokes the limits of confidentiality and is to be reported. Accordingly, Texas mental health professionals are encouraged to take note that the ACA position is diametrically opposed to Texas confidentiality statutes which, as discussed above, appear, for the most part, to penalize professionals for breaching confidentiality regardless of the reason or intent. Licensed Professional Counselors and other licensed mental health professionals in Texas should be aware that their allegiance must be to state law or significant penalties may result.

**Reporting of HIV Results and Child Abuse**

Paradoxically, the Texas statutes noted above do not apply to the reporting of positive HIV results or suspected child abuse. The Texas Health and Safety Code is somewhat more lenient regarding disclosure of positive HIV results. Specifically, section 81.050 states that:

> (positive HIV) test results may be released to the health department, the CDC, the physician or healthcare provider who ordered the test, the person tested, or the spouse of the...

This is addressed again in Section 81.103 which indicates that a test result is confidential but may be released to the spouse of the person tested if the person tests positive for AIDS or HIV infection or antibodies to HIV. Melchert & Paterson (1999) note that anyone in Texas is protected from liability when notifying spouses of HIV positive persons. Concomitantly, the ACA 2005 Code of Ethics, in Section B.2.b. (Contagious, Life-Threatening Diseases), states:

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease (ACA, 2005).

Although in basic agreement, the ACA Code is more permissive than Texas statute in reporting results of HIV testing as it permits notification of any third party victim while Texas law only permits notification of spouses. Accordingly, Texas mental health professionals are encouraged to follow Texas mandates, not ACA ethical codes, when reporting HIV results. Interestingly, mental health professionals in Texas are permitted to notify the spouses of their HIV positive clients but cannot warn intended and identified victims of a threat to commit bodily harm.

Regarding the reporting of child abuse in Texas, the Texas Family Code, section 261.101 (a) states:

A person having cause to believe that a child’s physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter (FN 25) (Texas Supreme Court, 1999).

It is important to note in the above wording, that the statute clearly indicates that the person SHALL, not May, report. There is no option in the reporting of suspected child abuse.

Summary

Other than notifying spouses of HIV infected persons, Texas does not incorporate a duty to warn and protect provision in state law allowing mental health providers to notify third party identified and intended victims and will not until the Texas Legislature amends existing confidentiality statutes. In the interim, mental
health practitioners in Texas must recognize that they are vulnerable to civil litigation and should proceed at their own risk if contemplating a breach of confidentiality based on a conscientious need to notify their clients' intended victims. The authors surmise that, in Texas, any civil action brought against a mental health professional warning a third party would cite as its basis the “confidentiality” statutes discussed above which omit any reference to a duty to warn and which do not protect professionals in most circumstances if they disclose confidential information. Counselors and other mental health professionals practicing in Texas may be risking their state licenses; may find their professional reputations tarnished, if not destroyed; and may be found liable for civil damages if the above state statutes and guidelines are not fully understood and incorporated in their professional approaches to client care. Even though Texas practitioners are out of compliance to an extent with ACA ethical codes when following state confidentiality statutes, they have relatively little choice in the matter.

If Texas mental health professionals, as a body, do not agree with existing state laws, they may wish to consider asking their state legislators to amend these statutes to permit therapists to directly warn their clients' identified and intended victims. Revised statutes should also include a provision protecting mental health professionals who warn from civil liability. A concerted approach to achieving this goal by working with an appropriate sub-committee of the Texas Counseling Association and possibly other state mental health licensing boards and organizations is highly encouraged and recommended.

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Culture and Anxiety: A Cross-Cultural Study among College Students

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By measuring interaction among and between anxiety and the independent variables of country of origin, gender, and age, using the State-Trait Anxiety Inventory, 117 international students from Thailand, Taiwan, Japan, and Korea were assessed with regards to how they experience anxiety on a U.S. college campus. Results indicated a high correlation between state and trait anxiety. The results of an ANOVA indicated no significant differences between the state and trait level of anxiety among participants except among Korean Women. Given the results, implications for counseling, advising international students on 2-year and 4-year colleges are discussed.

Introduction

Contemporary social thinkers view anxiety as a unique human emotion that can help, as well as hurt, individuals throughout their lives. Spielberger (1972) defined anxiety as an undesirable emotional state characterized by subjective feelings of stress, apprehension, and worry, and by arousal of the autonomic nervous system. Leary (1982) defined anxiety as a cognitive-affective response characterized by physiological arousal and apprehension regarding a potentially negative outcome that the individual perceives as impending. The concept “anxiety” is also used to refer to a very different

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construct, a complex psychobiological process. This process includes a sequence of cognitive affective, physiological and behavioral events that, according to Holtzman (1976), must be considered together to gain a better understanding of the meaning of anxiety. Spielberger (1972) believed that the concept of anxiety-as-process suggests a theory of anxiety that includes stress, threat, and state and trait anxiety as basic constructs. He also states that, in order to clarify the meaning of the concept of anxiety-as-process, the traditional distinction between fear and anxiety must be examined. He contended that it is generally presumed that fear and anxiety reactions are similar.

Recent literature suggested that culture plays a significant role in how individuals experience and are affected by anxiety. There are a number of cross-cultural studies that highlight these differences (Spielberger, 1966; Spielberger & Diaz-Guerrero, 1976; Sharma, Dang & Spielberger, 1986; Mumford, 1993). Cross-cultural studies provide an opportunity to discern whether findings in research in Western countries are universal. Good and Kleinman (1985) believed that the evidence and results of psychophysiological studies, psychological studies on emotion, and pharmacological research on cross-cultural settings make it clear that anxiety disorders are universal. Even though the phenomenology of these disorders, that constitute the social reality, may vary in quite significant ways from one culture to another, the foundation and essential structure are still the same.

Cross-cultural research on anxiety is most closely associated with the works of Cattell and Scheier (1961) and Spielberger (1966; 1972). These investigators attempted to characterize and to measure anxiety in terms of personality “Traits” and “States” (or responses to psychosocial stressors; however, no one, including Cattell and Spielberger, has looked at cultural differences within the same environment.

**Using the State-Trait Anxiety Inventory in Cross-Cultural Settings**

Any assessment of anxiety must be theoretically grounded with regards to what constitutes anxiety and how anxiety is identified. (Spielberger, 1966). The State-Trait Anxiety Inventory (STAI), one of the more widely used instruments for assessment of anxiety, features these qualities. Spielberger and his colleagues developed this self-report measure by building upon earlier instruments, refining the items to differentiate between enduring
trait anxiety and transitory state anxiety. For Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, (1983), the cognitive-perceptual system was considered to be of primary importance in the assessment of anxiety. In support of using self-report measures to assess anxiety, Holtzman (1976) opined that the self-report inventory is the key method employed for collecting information about one's perceptions of one's life situation, inner feelings, bodily sedation, and reactions to stress.

According to Spielberger (1972), people differ in their vulnerability to different kinds of stress. Therefore, a comprehensive theory of anxiety must include the concept of anxiety as a personality trait. For example, individual differences in A-Trait may be gathered from the frequency and the intensity of A-State reactions over time.

An often-experienced challenge in cross-cultural studies of anxiety is language. Spielberger et al.'s (1983) State-Trait Anxiety Inventory (STAI), based on this “state” and “trait” concept, has been translated into many different languages thus marking it as an ideal instrument for measuring and comparing anxiety cross-culturally. Volume 3 of Cross-Cultural Anxiety, edited by Spielberger and Diaz-Guerrero (1976), reported the research findings from eleven different countries. The investigators all consider anxiety as primarily a transitory emotional state but agree that individual differences in anxiety proneness exist. These tenets provide a unifying conceptual framework for the current researcher.

There are a number of objections to any cross-cultural study and the use of Western-normed instruments. These objections are generally concerned with lack of consideration of the specific cultural norms on the investigator's part. According to Good and Kleinman (1985), cross-cultural studies raise obvious questions of validity. How do we know that the same concept, anxiety, is being measured in the various cultures? Sharma (1977) claimed that in all of the studies involving the STAI and its well-calibrated, translated versions, the mean anxiety scores of cultures other than the U.S. were compared with normative data reported in the Test Manual of the English version STAI. This indicates that cross-cultural comparisons were made before normative data for the new cultures were established. Sharma (1977) continued that a norm based on one culture is likely not to be applicable to another culture. Therefore, one should develop normative data for any culture under study before cross-
cultural comparisons are made. Hence, he claims that all the cross-cultural comparisons of anxiety are not as powerful.

**Method**

**Procedures**

Recent literature (Boehnke, Frindte, Reddy, & Singhal, 1993; Good & Kleinman 1985; Magnusson & Stattin, 1978; Spielberger and Diaz-Guerrero, 1976; Spielberger & Sharma, 1976) suggested that cultures play a significant role in how people perceive, experience and are affected by anxiety. A number of cross-cultural studies have ascertained these differences (Olah, 1995; Ginter, Glanser, & Richmond, 1994; Klonoff & Landrine, 1994; El-Zanhar & Hocevar, 1991). However, this investigation portends to examine cultural differences related to anxiety within the same physical and institutional environment.

Do members of different cultural groups at a college campus experience different levels of anxiety and manifest anxiety differently? In an attempt to discern if and if so, to what extent different cultural groups experience and manifest anxiety differently, a quantitative cross-cultural investigation of international student groups at a college campus was conducted. Specifically, the intent was to ascertain if a significant difference existed among the levels of anxiety in various international cultural groups in an academic environment. The independent variables of gender, age and cultural ethnicity were considered for the purpose of discerning hypotheses and their implications in practice and research in working with international students.

**Instrumentation**

This research utilized the State Trait Anxiety Inventory (STAI) (Form Y-1, State and Form Y-2, Trait), a self-evaluation questionnaire authored by Spielberger et al. (1983). Though available in 20 languages, the English language version of the inventory was used for three reasons: 1) the instrument had not been translated to all the languages that were spoken by the participants in this study; 2) participants were in an English speaking identical environment (same college campus); and, 3) participants were proficient in the use of English as a second language.

The STAI was developed to provide a relatively brief, homogeneous self-report assessment of both state (A-State) and trait (A-Trait) anxiety (Spielberger et al., 1983). The STAI A-Trait scale (Form Y-2,) consists of 20 statements that instructs
individuals to rate how they generally feel (e.g., “I feel that difficulties are pilling up so that I cannot overcome them”; “I take disappointments so keenly that I can’t put them out of my mind”). Subjects respond to each item by rating themselves on the following four-point scale: 1) Almost never; 2) Sometimes; 3) Often; or 4) Almost always. On this instrument, individual items were selected on the basis of the concurrent validity of each item as determined by correlations with two widely accepted inventories, the Taylor Manifest Anxiety Scale (MAS) (1953) and the Cattell and Scheier (1963) IPAT Anxiety Scale.

The A-State scale, Form Y-1, consists of 20 statements (e.g., “I am tense”; ”I feel nervous”) asking individuals to rate how they feel at a particular moment by rating themselves on the following four-point scale: 1) Not at all; 2) Somewhat; 3) Moderately so; or 4) Very much so.

In constructing the STAI A-State scale, the primary qualities measured were tension, apprehension, and nervousness as these feeling, or phenomenological states varied along a continuum of increasing levels of intensity (Spielberger, 1966). Low scores were expected to reflect states of calmness; intermediate scores were designed to indicate moderate levels of tension and apprehensiveness; and high scores were to correspond with intense states of fright and apprehension, approaching panic. Spielberger believes that the STAI has proven to be useful in clinical work as well as in research. He also claimed that the A-Trait scale provides a means for screening patients and normal populations for people who are troubled by neurotic anxiety problems. This scale has also been used as a research tool for choosing subjects who differ in anxiety proneness. In addition, the A-State scale is a sensitive indicator for the transitory anxiety that is experienced by many clients in counseling. This scale has also been used to measure changes in A-State intensity in experimental studies on stress, anxiety, and learning.

This inventory was administered by one of the authors following the procedures as stated by the developers of the STAI. As the STAI is not a timed assessment, the subjects were permitted as much time they needed to complete the forms.

Participants

The STAI and the demographic questionnaire were administered to 117 undergraduate volunteers. Those who wished not to participate had the option of reading their texts or doing homework.
while others were completing the STAI and the demographic questionnaire.

Participants were enrolled in especially designed classes for international students (e.g., American history for international students, English literature for international students, communication 101 for international students and etc.) at a U.S. college campus. Students enrolled in multiple classes were identified to avoid data repetition. Six students failed to provide gender data. Of the 111 who completed all measures, 7 (6.3%) were from Thailand, 48 (43.2%) from Japan, 16 (14.4%) from Korea, and 40 (36.0%) from Taiwan. There were 50 (42.7%) males and 61 (52.1%) females. The average age of participants was 22.7 years (Mean=22.7) with a standard deviation of 3.56 (Standard Deviation=3.56) years.

### Data Analysis

Missing item ratings (less than two for any participant) were replaced with the average rating for the participant. A 2 x 2 x 4 nonorthogonal analysis of covariance (ANCOVA) was performed with between-subjects factors of gender and country of origin, and a within-subjects factor of state and trait anxiety scores. A nonlinear monotonic transformation of age (transformed variable = ln (age - 8)) was entered as the covariate due to severe skew and kurtosis in the original age distribution.

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Table 1

Descriptive statistics for state-trait anxiety scores.
There were no empty cells, and the smallest cell in the analysis contained two participants. Results of the ANCOVA showed near zero effect size for the covariate, so the analysis was repeated using analysis of variance (ANOVA). Table 1 shows the distribution of subjects across the cells with corresponding means and standard deviations.

Results

The standardized regression coefficient for the age covariate in the initial ANCOVA resulted in very small and random adjustments of means (β = .01, t = 0.13, p = .90). We decided thereafter to use an equivalent 2 x 2 x 4 ANOVA, with the factors of gender, state-trait anxiety, and country of origin, for the final analysis. Two interaction effects were significant. The lowest order effect was a significant state-trait anxiety (within-subjects) by country-of-origin (between-subjects) interaction (F(3,103) = 3.45, p < .05, eta-squared = .09). There was also a significant interaction between state-trait anxiety, gender, and country of origin (F(3,103) = 3.97, p < .05, eta-squared = .10).

To probe the lower order interaction, within-subjects effects by country of origin were tested, and between subjects effects for both state anxiety and trait anxiety were tested. Trait anxiety scores were significantly higher than state anxiety scores for participants from Taiwan (F(1,39) = 5.26, p < .05).

For the interaction of state-trait anxiety with both gender and country, within-subjects effects were tested for each cell, and between subjects effects were tested for both trait and state anxiety using two genders by country of origin designs. State anxiety scores were significantly higher than trait anxiety scores (F(1,7) = 14.3, p < .05) for women from Korea.

Discussion

This study attempted to gain insight into how students from different countries experienced anxiety on a U.S. college campus. This investigation measured interactions among and between anxiety and the independent variables of country of origin, gender, and age.

Participants in this study were 117 international students from Thailand, Taiwan, Japan and Korea enrolled in classes designed for international students on an American college campus. The State-Trait Anxiety Inventory (Spielberger, 1983) was used, and each subject evaluated him/herself on how he/she felt at the moment (form Y-1) and how he/she
generally feels (form Y-2) as a person. Results indicate a high correlation between A-State (form Y1) and A-Trait (form Y2). The result of Analysis of Variance (ANOVA) indicates no significant differences between the state and trait level of anxiety among participants except among Korean women.

A literature review suggested the possibility of significant differences among and between respective anxiety levels of students from different countries. However, data in this study did not support these earlier findings. One major difference between this study and other cross-cultural studies is its focus on different cultures within the same environment which may have been a contributing factor resulting in finding no significant difference.

According to Good and Kleinman (1985), cross-cultural studies provide an opportunity to discern if research findings in Western countries are universal. They believed that the evidence and results of psychophysiology, psychological studies on emotion, and pharmacological research on cross-cultural settings make it clear that anxiety disorders are universal. They further claimed that, even though the phenomenology of these disorders—which constitutes the social reality, prevalence, and form of expression—may vary in quite significant ways from one culture to another, the foundation and essential structure is still the same.

Results of previous reliability tests indicated that the State-Trait Anxiety Inventory (STAI), was a reliable instrument for this study. The results of this study agreed with Good and Klienman's findings that anxiety disorder is, indeed, universal. However, different results for Korean women on A-Trait (form Y2) indicate that Koreans experience a higher level of anxiety on a college campus. For Korean women, this increase may be explained by the current economic and political crisis in Korea and the numerous indications that Korean Americans do not enjoy the same level of established minority group recognition at this time as Chinese Americans do, due to the Chinese Americans longevity in the U.S.

The significant difference between the State and Trait forms for Taiwanese may be the result of stronger support from their own well-recognized minority ethnic group (Chinese American) in the U.S. According to some scholars, because Chinese Americans are so prevalent in some U.S. institutions, they may not feel as isolated as some other less-recognized minorities in this culture. However, some
authors suggested that acculturation and adjustment are better facilitated by disassociation from one's own cultural group and association with members of the host culture (Bruner 1956, Rostin & Edleson, 1984).

According to Slavin, Rainer, McCreary and Gowada (1991), “...the simple fact that a group is few in number means that its members more frequently face potential stressors related to being in the minority” (p.158). Also, as Chiu (1971) suggests, Taiwanese may have lower anxiety as a result of having a higher standard of living in the U.S. than in their country of origin.

Since no published anxiety norms for Japanese and Thai students were found, this study did not attempt to explain why there was not a significant difference between form Y1 and Y2 for these populations. For Japanese students, one general explanation may be their familiarity with the host U.S. culture.

In their cross-cultural study, Ben-Zur and Zeidner (1988) reported higher anxiety levels among females than males and concluded that females are more vulnerable to stress and anxiety, regardless of cultural differences. Also, given exposure to similar stresses, women appear more prone than men to manifest stress-related symptoms. According to Ben-Zur and Zeidner (1988), Leventhal suggested that females are more aware of their emotions and better able to evaluate and interpret them.

This study may help 2-year and 4-year college student advisors and counselors to understand that, regardless of differences among human beings, feelings of anxiety seem universal. However, for some reasons, the intensity of anxious feelings can differ from one group to another. For example, students with higher anxiety levels may need easier access to their academic advisors, professors, and counselors to discuss their concerns. These students may also benefit from a mandatory requirement of referral to learning centers on 2-year and 4-year colleges where they can receive more individualized assistance with different subjects. For college counselors and academic advisors it may be more helpful to be more available to students with higher level of anxiety, as students will probably feel less anxious when they can share their concerns with the advisors as soon as possible.

**Limitations of the study**

A number of limitations may have affected the findings of this study. The
total number of participants (N=117) was not an ideal number for the study, and the results might have been different if the total number of participants was higher.

This study was done entirely on one campus. The geographic location of this campus may have affected the study, as well, and results might have differed if the study were done, for example, in a location where there were a large number of Japanese or Thai immigrants. Having a large number of people from an ethnic group may help others from the same group to cope with adjustment problems better and, as a result, experience less anxiety.

Investigators who would like to replicate this study should attend to the above-mentioned limitations. Although random sampling can be appropriately conducted, it may be advisable to include the entire population at all educational levels.

It could also be valuable to involve college campuses in different geographic areas. Including other college campuses would not only increase the number of participants but also eliminate geographical effects on different cultural groups, as noted above. Moreover, including other campuses may add greater diversity among the represented cultural groups.

Because of the problems and limitations of this study, as in all cross-cultural research, a practitioner should avoid stereotyping and generalizing the findings to all individuals from any particular culture. We believe that although individuals are from the same culture, they still differ in their ways of thinking, feeling and behaving. To be effective and helpful, 2-year and 4-year college counselors should try to learn as much as possible about international students' cultural practices, values, and beliefs from the students with whom they are working and should not rely on pre-conceived ideas in these areas.
References


The enneagram (pronounced any-a-gram) is a tool consisting of nine points that depict personality styles. It is a tool that can be integrated into theoretical counseling approaches to better serve the therapeutic relationship and is adaptable to the unique personality of each client. This manuscript includes correlations between the enneagram and psychological precepts such as the diagnostic criteria found within the Diagnostic and Statistical Manual-IV, Ivey's Developmental Counseling theory, and Transactional Analysis theory. To demonstrate the enneagram's compatibility with other counseling theories, each of the nine styles is explained with corresponding theories recommended for each style. A case study and examples are provided to demonstrate effectiveness as a tool to promote awareness in the counseling relationship.

The enneagram, a Greek word for nine (ennea) and figure (grammos) maps nine personality styles of human nature and their interrelationships (Naranjo, 1994). The enneagram consists of three centers called triads, which specify a fundamental psychological orientation and ways individuals make contact with the outer world (Waldberg, 1973). The triads consist of a continuum of positive and negative traits, related to self-image (Feeling triad), thought processes (Thinking triad), and instinctual traits (Doing/Moving triad). According to enneagram theory, each person potentially

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represents all nine styles, with one more naturally expressed than the others. Each individual is disposed inherently to experience and respond to reality in one of the nine styles (Wagner & Walker, 1983). The more familiar style is the home-style and the one from which individuals tend to act from in times of stress. Each style can reveal: (a) individuals' views of the world, (b) the kinds of choices individuals are likely to make, (c) the values they hold, (d) their sources of motivation, (e) how they react to people, and (f) how they respond to stress. By examining what clients value and what is important to them, counselors may get an indication of their preferred enneagram style (Wagner, 1988). Once counselors and clients identify a style, they devote attention to changing patterns of negative traits.

For wholeness, individuals develop the home-style (one of the nine points) of their personalities on the enneagram by balancing the other eight styles, thus having the potential of the nine styles available (Wagner, 1988). For instance, counselors may work from their Helper styles (point two) when involved in therapeutic relationships with clients. At the same time, when appropriate, counselors have access to their Individualist styles (point four) of their personalities to reflect and process clients' stories. Furthermore, counselors can access their Confronter styles (point eight) of their personalities in order to assert therapeutic boundaries with clients for self-care. (See appendix for directions in which each style integrates and disintegrates). Individuals draw from each of the triads and similarly the nine styles, but one fits their specific personalities more than the others.

**Historical Roots of the Enneagram**

The enneagram is based upon a theory that evolved from ancient spiritual traditions going back, perhaps thousands of years. It may have developed in Afghanistan, influencing Islamic thought and have been passed down by oral tradition (Beesing, Nogosek, & O'Leary, 1984). Initially, the enneagram was an oral teaching and is said to have evolved out of Sufism, the mystical sect of Islam, with strong correlations to the Judeo-Christian tradition and Greek philosophy (Riso & Hudson, 1996). The enneagram is part of the oral teaching tradition of Gurdjieff (1973), Ichazo (Palmer, 1988), and Naranjo (1994). However, it was Ouspensky (1957) who influenced its presently revised form. In the 1970s the enneagram was introduced to Western society and was taught, primarily orally,
by a few academicians. The enneagram has increased in popularity as its proponents have promoted its efficacy to the mainstream public through writing and speaking. Despite the enneagram’s apparent spiritual origins, it is not religious and it is not a religion. In fact, a strength of the enneagram is that it transcends doctrinal and dogmatic differences while helping to enlighten a self-knowledge fundamental to all spiritual paths.

Gurdjieff (1973) is credited with indirectly introducing the enneagram to the West, through small study groups in various parts of the world, including Paris, London, and New York. The modern origins of the enneagram are based on two primary sources. Ichazo became acquainted with the enneagram, while studying in Bolivia in the 1960s. In 1970, Naranjo went to Chile and was introduced to the enneagram system by Ichazo. Upon his return to the U.S. he began to teach it to a small group of individuals and is responsible for integrating the enneagram and psychological concepts. From here, the enneagram spread to several American Jesuit priests at Loyola University in Chicago. The Jesuits supposedly used it for their counseling needs. In 1974, while in Canada, Don Richard Riso, who at the time was a Jesuit priest, encountered the enneagram and began a spiritual journey. Others, like Helen Palmer, David Daniels, Sandra Maitri, Suzanne Zuercher, and A.H. Almaas, to name a few have participated in the popularizing of the enneagram to the West.

Empirical Research and the Enneagram

While the enneagram has been elaborated on by experience and intuition since its inception, it has been subjected to little formal, empirical research. The following list summarizes the more notable investigations:

- Wyman (1998) - Measured aspects of personality: core self as indicated by the Myers-Briggs Type Indicator (MBTI) and the defense system as indicated by the enneagram. Recommended an interactive approach to personality typing in therapeutic settings.

- Wagner (1981) - Developed the Enneagram Personality Inventory (EPI), a 135-item measure. In a test-retest analysis, 79% of subjects rated themselves the same type across administrations, with a Cohen's Kappa Coefficient, ranging from .76 to 1.00 for the nine types, demonstrating a satisfactory degree of stability and reliability for the EPI.

- Wagner and Walker (1983) - Compared results on the MBTI, the
Millon Personality Inventories, and the Enneagram Personality Inventory (EPI). Suggested a fit between the enneagram type descriptions and the corresponding configurations on the Millon and Myers-Briggs inventories.

- Riso and Hudson (1999) - Developed the Riso-Hudson Enneagram Type Indicator (RHETI), a 144-item, ipsatively scored, forced-choice inventory of normal personality that measures nine personality types, which correspond to the nine styles of the enneagram (Type 1 = Reformer, Type 2 = Helper, Type 3 = Achiever, Type 4 = Individualist, Type 5 = Investigator, Type 6 = Loyalist, Type 7 = Enthusiast, Type 8 = Challenger, and Type 9 = Peacemaker).

- Newgent, Parr, Newman, & Higgins (2004) computed alpha coefficients that ranged from .56 to .82 on the RHETI and reported an adequate degree of internal consistency, mixed support for construct validity, and strong support for heuristic value.

- Daniels and Price (2000) - Designed the Essential Enneagram Test (EET), a paragraph test based on constructs of the nine enneagram. Computed a Cohen's Kappa of 0.5254 (p<0.0001) for the overall measure.

- Huber (1999) - Investigated correlations between Type 6 drug and alcohol abusers and their MBTI profile. Found common characteristics of the enneagram Type 6 represented certain MBTI profiles.

- Brooks (1998) - In an enneagram study comparing monozygotic and dizygotic twins, found three times as many similar character types among monozygotic twins than among dizygotic twins. This finding provided strong evidence that enneagram personality type is genetically determined.

The enneagram can be a useful tool to help clients develop the observer part of themselves. The enneagram can help a client objectify his or her experience and notice unhealthy patterns before he or she follows through in acting out a behavior. The enneagram can allow the client time to refocus his or her energy toward a more positive characteristic of one of the other styles on the enneagram, which may be more adaptable to his or her present situation.

The purpose of this article is to explain correlations between the enneagram and the psychological precepts on which it is based. Additionally, the enneagram's versatility and compatibility to integrate within other theories that a counselor may use is demonstrated. The words style, space, and type are used synonymously to correspond to the nine-pointed diagram in Figure 1.
The author's experience with the enneagram as a tool for self-discovery, or what Gurdjieff refers to as self-remembering (Nicoll, 1985), has been in the context of counseling relationships. The instrument has helped the author gain insight into the behavioral characteristics of clients, their emotional tendencies, and attitudinal patterns that have inhibited their developmental growth toward a more fulfilling life. The enneagram can be embraced by all genders, different ethnicities, and people with various religious backgrounds without threat to their fundamental beliefs or dogma. Following are descriptions of the nine enneagram styles and the corresponding psychological orientations of each style of the enneagram.

Description of the Enneagram

Point 1 - Perfectionist style

According to Riso and Hudson (1999), persons with the perfectionist-style (point one) desire to be right and good. They want to make the world a better place. Their core fear is being bad or morally unsound. They believe that they are good if they do what is right. The trance of perfectionist-style client is fixating on inadequacies in themselves, others, and the world around them. They are perfectionistic, critical and often obsessive about order and control. Potential DSM correlations are: (a) Obsessive-compulsive disorder, (b) depressive personality disorder, (c) eating disorders, (d) guilt and self-destructive behaviors (Riso & Hudson, 1999).

For the perfectionist-style client, Feminist therapy (Chodorow, 1989) may provide a comparable framework by putting sociopolitical status at the core of the therapeutic process. Feminist therapists emphasize the social and cultural context that contributes to a client's problems. This style of principled idealism of clients' can help develop them into significant advocates for those victimized by the constraints of oppression in society. These clients have high standards, and anger, appropriately channeled, makes them valuable assets in liberating the oppressed. Feminist therapy can serve as a catalyst in developing one-style clients.

Point 2 - Helper style

Clients whose home style fits in the helper-style (point two) of the enneagram desire affection and love. These clients fear being undeserving of the love of others. They naturally give of themselves more than any of the other enneagram styles. At their extreme they can help others to the point that their sense of self-worth suffers. They do not feel accepted and loved by
others when they are not needed. The trance or negative pattern of the type two is to over-focus attention on other people's needs. They want to be needed, and their identity is dependent on this. Possible correlations for the severely distressed type twos are: (a) histrionic personality disorder, (b) somatization, (c) eating disorders, and (d) coercive sexual behaviors (Riso & Hudson, 1996).

Adlerian approaches may serve effectively for working with clients having a helper style. With a strong view toward educating clients, Adler (1958) posited new ways for clients to understand themselves, offering a modified cognitive map that challenges a client's personal logic. Adlerian therapy can assist clients in acquiring a sense of equality with others, and dispelling the feeling that they are unlovable if they are not in a helping role.

**Point 3 - Performer style**

Clients who fit the enneagram performer-style (point three) desire to be valued for what they do (Riso & Hudson, 1999). These clients are productive and value being efficient. Under stress they have a tendency to become performers and focus on success by drawing attention to themselves as a way of being valued. The trance of performer style persons is to over-focus attention on tasks and goals. They are often overachievers and believe that worth is tied into what is done. DSM-IV (1994) correlations for the severely fixated type three clients are: (a) narcissistic personality disorder, (b) hypertension, (c) depression, (d) rage, (e) vindictiveness, and (f) psychopathic behavior (Riso & Hudson, 1999).

The type of counseling theory that may work best with the performer-style client is Cognitive Behavioral Therapy (CBT) (Beck, 1976). Clients with a highly driven competitiveness have a strong tendency to escalate desires into irrational dogmatic shoulds, demands, and commands. This theory focuses on the restructuring of thoughts and irrational beliefs to change a person's dysfunctional personality. CBT can help the type three client to recognize that emotional problems stem from irrational beliefs and to acquire strategies for disputing these self-defeating beliefs.

**Point 4 - Individualist style**

The individualist-style (point four) client desires authenticity, and wants to be special and unique. This client struggles with a fear of lost identity and issues of abandonment. To the individualist-style client, life may seem to be a perpetual
search for answers to the question, “Who am I?” Life is an artistic endeavor for this client, who is led predominantly by his or her feelings. The trance of this client is over focusing on what is missing, which can manifest as envy for what others have. In efforts to be important and significant, these clients may become self-absorbed to the extent of over-identifying with feelings and idealistic views of self. Psychological correlations consist of: (a) severe depression, (b) narcissistic personality disorder, (c) avoidant personality disorder, (d) crimes of passion, and (e) suicide (Riso & Hudson, 1999).

Person-centered therapy may be effective with the individualist-style client who is self-conscious, reserved, and sensitive, and who may feel defective from a lack of mirroring and validation as a child. Person-centered therapy is nondirective and is based on the assumption that the client has the potential for understanding himself or herself. This will encourage this client to look within and discover inner resources as opposed to looking externally for other “I-dentities” (Wolinsky, 1994).

Because of a tendency to find comfort by replaying childhood dramas, type four clients also may find Narrative therapy (White, 1993) a helpful option to re-script their past and move out of woundedness. Nondirective, person-centered counselors avoid sharing a great deal about themselves and by focusing on the client they can help heal abandonment issues that four-style clients may have suffered, while validating them as a unique individuals.

**Point 5 - Observer style**

Clients who fit in the observer-style (point five) desire to be competent, adequate, and proficient. They want to know and understand what life is about. Their fear is to be found lacking and not knowing, which they would interpret as being inadequate. The trance of the observer-style is over focusing on detachment and thus falling into inertia. They see themselves as looking up to others as experts while they are playing catch up, and they may become focused on specializing in a subject or task. Potential pathologies are: (a) schizotypal and avoidant personality disorders, (b) psychotic breaks, (c) dissociation, and (d) depression (Riso & Hudson, 1999). Psychoanalytic therapy (Freud, 1952) may suit the observer-style client by providing the often detached client with concepts in regard to his or her desire for understanding.
**Point 6 - Loyalist style**

According to Riso and Hudson (1999) the loyalist-style (point six) client desires certainty, stability, and security. This client is loyal and faithful, especially to authorities; yet he or she tends to question and doubt to the point of fear and rigidity. In an effort to gain a sense of certainty, this person may fall into polarized thinking and a rigid belief system to create the illusion of security in life. The trance of the six-style is focusing on negative future consequences. They tend to do what is expected of them because of a fear of the consequences of not being good enough and feeling insecure. In extreme cases these individuals can deteriorate into: (a) paranoia, (b) dependent and borderline personality disorders, (c) dissociative disorders, (d) passive-aggressive behaviors, and (e) anxiety attacks (Riso & Hudson, 1999).

Existential therapy (May, 1983) is recommended for loyalist-style clients who are often cautious and indecisive. The purpose of this kind of therapy is not to cure but to help clients become more aware so that they will no longer choose to be in victim roles. This style of therapy will help type six clients learn to trust themselves and to develop an inner certainty and courage to take more responsibility, while not giving their power away to outer authorities. Counselors working from an Existential approach endeavor to promote awareness, self-responsibility, and creating one’s identity as part of the therapeutic process, which coincides with the transformational path of this style of client.

**Point 7 - Dilettante style**

The dilettante-style (point seven) clients desire to be happy and satisfied. They have a fear of feeling the existential pain of ordinary life and being trapped in that. They believe that, if they are getting their needs met by what they want, then they will feel satisfied, and feelings of pain will be diminished. The trance of the dilettante-style client is over focusing on the bright side of life without considering the negative possibilities to the point of denial. This can lead to a deterioration of escapism and an indulgence of pleasurable pursuits to avoid pain. According to Riso and Hudson (1999) worst-case scenarios may lead to: (a) manic-depressive disorders, (b) borderline conditions, (c) histrionic personality disorder, (d) obsessive-compulsive disorders, and (e) substance abuse.

For these optimistic clients (point seven), systems therapy (Bowen, 1978) provides a framework that may work best.
A Family Systems perspective focuses on relationships within a functioning unit. By working with a system, like a family, clients may develop their inner observers to witness their effect on the functioning system. This can help them not to overextend. With the insight these clients have on the functioning system, they become responsible and reliable for how they are affecting the overall system.

**Point 8 - Controller style**

The controller-style (point eight) clients have a strong desire to protect themselves from hostile forces in the world. They manifest power and autonomy and have a confrontive and controlling style. They fear that if they are not in control, they may be harmed or taken advantage of. The trance of the controller-style is focused on taking control to the detriment of others. Intimacy is a challenge for these clients, as they believe that they have to be strong in order to avoid showing weakness. In a state of pathology these clients may suffer from: (a) antisocial personality disorder, (b) sadistic behavior, (c) paranoia, and (d) social isolation (Riso & Hudson, 1999).

For the controller-style client, Reality Therapy (Glasser, 2000) focuses on what clients can control in their present situations. The reality therapist does not tolerate complaining, blaming or criticizing. Reality Therapy is focused on the present situation, responsibility for what is going on and the choice to change the situation. Such engaging techniques of reality therapy maintain momentum for type eight clients who want things to be concise, to the point, and focused on behavior. This style of client respects the confrontive counselor and is willing to trust the counselor with this approach to therapy.

**Point 9 - Peacemaker style**

Client who fits in the peacemaker-style (point nine) have strong desires for peace and harmony. They are often called the mediator types because of a tendency to conform rather than become disruptive. This can deteriorate into self-neglect in order to be amiable with the agenda of others. The trance of peacemaker-style clients is over focusing on the agendas of others, while denying their own. Their fear is a loss of connection and inner harmony. Extreme denial for these clients can lead to: (a) dissociative disorders, (b) dependent and schizoid disorders, (c) depression, and (d) severe depersonalization (Riso & Hudson, 1999).

Peacemaker-style clients are self-
effacing and willing to accommodate the views of others to maintain peace. Behavioral therapy with its themes of action orientation, cognition, and responsibility accommodates the self-forgetting vice of the nine-style client. In order to help persons who manifest this style formulate goals that are specific and unambiguous, these nine-style clients are encouraged to focus on proactive behavior according to their needs, while avoiding passive-aggressive tactics and sacrificing themselves to maintain harmony with others.

The enneagram process is called integration when a person's home-style moves toward another corresponding point on the enneagram to integrate and achieve balance. In situations of stress and duress a person's home-style will have a tendency to move toward another corresponding number, which is called disintegration. Disintegration is the result of an unconscious habit of behaving that each person becomes fixated on. For instance, in situations of distress John may have learned to become angry in order to obtain what he wants. Although this behavior may have achieved positive results when John was a child, it no longer serves an efficacious purpose but has become an unconscious habit in behavior. John is said to be in a trance and fixated on this particular style of behaving which is no longer effective. Each style on the enneagram has its own point of integration and disintegration, which can help the counselor develop a treatment plan and goals. An example of how this works in the counselor-client relationship is demonstrated in the following case study. (See Figure 1 for integration and disintegration directions on the enneagram).

**Enneagram Theory: Ego, Personality, Essence**

The enneagram can help promote self-knowledge and facilitate individuals empathizing with the experiences of others. Interpretation of the instrument normalizes human experience without pathology, thereby contributing to empowerment. A foremost teacher of the enneagram, Helen Palmer (1988), said: “One of the enneagram's problems is that it's very good. If you can type yourself and the people who are important in your life, a lot of information is immediately available about the way that you and another are likely to get along” (p. 6).

A person's style may change several times, until he or she recognizes a consistent personality pattern that has developed as a strategy for living. According to Riso
(1990), in determining type a person tends to pick the desirable rather than the actual personality type. There is also a tendency to make an identification based on a single trait of one of the styles instead of taking all the traits into consideration. Like any system, use of the enneagram can degenerate into stereotyping. However, taken to a deeper level, the enneagram can help develop a person's observer-self, which can replace a blind subjectivity with a more accurate objectivity in personal relationships.

In the tradition of spirituality and the
teacher/disciple motif, the enneagram helps create the framework to see others as mirrors and as personal beings that are also growing and developing on their own path. This contributes to tolerance and patience in human interactions. Thus, the enneagram can become a tool in healing relationships, effectively interacting with colleagues at work, parenting children, and providing a framework to understand meanings of experience.

Riso (1990) and Riso and Hudson (1996; 1999) correlated much of their work on the enneagram from a psychological perspective. Developmentally, psychologists have suggested that how we function is due in part to how needs were met in childhood (Riso & Hudson, 1996). The ego provides a frame of reference for the individual to give meaning to his or her experience (Helson & Roberts, 1994). Personality develops as a strategic defense of unmet needs and thus serves the individual as a coping mechanism.

Unique to each of the nine styles on the enneagram is a primary fear, which is compensated for by a basic desire (see Figure 1). The personality develops out of this compensation. Essence is our true self and essential nature with which we are born. To clarify this distinction, essence is what babies are born with, and personality is what they acquire throughout life (e.g. views and opinions) (Ouspensky, 1957). To the extent that a person lives out of his or her fears, he or she becomes stuck in his or her ego’s fixation according to one of the nine personality styles. To become aware of this fixation is to have access to our essence and to no longer be seduced by the trance of ego (Richo, 1999). Riso and Hudson (1999) make a distinction with this analogy:

Our personality is like a cast that protects a broken arm. The more extreme the original injuries the more extensive the cast has to be. Of course, the cast is necessary so that the limb can heal. But if we never take the cast off, it severely limits the use of the limb and makes further growth impossible (p. 34).

All people have unmet needs for which personalities have compensated. The enneagram can help bring awareness to these reactive tendencies that may be hindering their potential while allowing growth toward greater liberation emotionally and spiritually.

According to the concepts of Transactional Analysis theory (Berne, 1961), injunctions are messages given out of the pain of the client's parents and
undevelopment (Goulding, 1997). The basic unconscious messages that children receive to some degree are: Don't take risks-- It is not all right to be functional (i.e., point one, the Perfectionist-style); Don't be-- It is not all right to be confident and to be autonomous (i.e., point two, the Helper-style); Don't succeed-- It is not all right to have your own feelings and identity (i.e., point three, the Performer-style); Don't be a child-- It is not all right to be too happy or excited (i.e., point four, the Individualist-style); Don't grow-- It is not all right to become competent (i.e., point five, the Observer-style); Don't be yourself-- It is not all right to be comfortable or trust in yourself (i.e., point six, the Loyalist-style); Don't belong-- It is not all right to depend on anyone or to have needs (i.e., point seven, the Dilettante-style); Don't be close-- It is not all right to trust anyone (i.e., point eight, the Controller-style); Don't be important-- It's not all right to assert yourself (i.e., point nine, the Peacemaker-style) (Goulding & Goulding, 1997). One message tends to centrally correspond to each style. This is a helpful model to show how a fixation or trance can develop from early childhood experiences and messages and how the personality begins to form in order to protect and compensate for the apparent deficiency.

Counseling Implications

An advantage of the enneagram for counselors working with clients is its versatility in meeting clients at an appropriate developmental level. The enneagram is valuable in aiding the counselor to conceptualize a client's situation and his or her potential for responding to the situation. For instance, if a counselor sees a female client who has come in for a substance abuse problem and it becomes evident that the client is fixated in the helper-style (point four) aspect of her personality, the counselor can use his or her knowledge of the enneagram to help the client. A clue for the therapist may be that the client had been a nurse for 22 years and had recently retired. This suggests that, to some extent, she may have gained her self-worth by being needed by others (helper-style). Essentially this client would deny her own needs to respond to the needs of others and thereby gain a sense of worth for herself in this process. After more exploration this client might discover that for her to have been needy would have been a sign of weakness and thus shameful in her estimation.

Because the helper-style (point four) is in the feeling triad, this client has a tendency to over express her feelings. The underlying core feeling behind the intense
concern for self-image is shame and guilt. By continuing to work with this client, the therapist may notice a strong front that the client presents for emotional protection. It is obvious how this could be problematic in this client's personal relationships. The client may become confrontational and defensive (clue: in disintegration the helper-style moves toward the controller-style) when asked for more information, as if she had been backed into a corner and her environment was becoming unsafe and threatening to her. Her rigid posture and dualistic attitudes toward her drinking and her quitting suggested that she had a strong correlation also to the perfectionist-style (point one) to complement her home-style of point two (helper-style). It is common for a person's home-style to also draw more heavily from the characteristics of its neighboring styles on the enneagram. This is often called a person's wing style. Her intense self-forgetting that had gone on for years and had been exacerbated by her profession as a nurse was the cause of her dysfunctional coping of her drinking problem and she was in need of integration.

The integration direction for the helper-style (point two) is to move toward the positive characteristics of the individualist-style (point four). In this client's case this meant accepting and celebrating her uniqueness. For this client, withdrawing for the purpose of self-care in order to reconnect with her needs was appropriate. This helped her to identify goals to work on while working on her substance abuse problem. The harder task will be helping this client become aware that she has severely limited herself by being unyielding and inflexible in only one aspect of her personality, primarily the helper-style (point two). To some extent she has been a prisoner to this particular perspective in how she relates to herself, others, and the world around her. To the extent that she can relinquish the false safety she feels from her home-style (point two) and allow herself access to the other styles on the enneagram by integrating them into her personality, she will gain new awareness and have new choices to reshape her life and the direction in which she wants to grow. The enneagram helped the therapist conceptualize this client's situation and verify hunches that proved to be the underlying causes of many of her presenting issues, including her drinking. The nine styles, their trances, and characteristics can do that for the counselor-supported client.

Corresponding to Allen Ivey's Developmental Counseling Theory (1993) the enneagram can serve as a tool of
varying understanding according to the cognitive level of the client. For instance, clients with sensorimotor perspectives focus on the elements of their immediate experience. Their cognitions are somewhat disorganized, and they may be embedded in an emotional here-and-now experience. The enneagram may serve to aid these clients to organize their experiences because the experiences tend to be random and disorganized. The enneagram, with the counselor's guidance can show these clients their particular fixations (one of the nine styles), and as a result, clients can gain objectivity on their situations. These clients may perceive the enneagram as a systematic theory that can be applied to their situations. In the above example of the nurse, the insight of the enneagram could have diminished the threat of her sharing with the counselor and would have acted as a buffer for the client and counselor while a rapport was being established.

Clients coming from the concrete-operational perspective are more concrete and detailed about their situations. These clients are often more cognitive and detached as they describe their situations and feelings. Because it is difficult for these clients to reflect on their emotions, the enneagram can aid them to see patterns of thoughts, feelings, and behaviors by providing a concrete diagram and concrete characteristics of each style. These clients may perceive the enneagram as a helpful tool to which they can relate and not just another attempt to categorize them. From this perspective, the nurse client may have been amenable to the enneagram as a tool to help her discover more cognitive ways of expressing herself and her situation, while formulating a cognitive re-mapping of how she viewed her situation and what she wanted to work on.

The formal-operational perspective occurs when clients are more abstract in their thinking and are able to talk about their situations from different perspectives. These clients are able to recognize patterns in thought and behavior that may be troublesome. The enneagram can help them develop their observer-selves in order to gain more objective views of themselves, events, and feelings. These individuals may perceive the enneagram as an approach to describe and help them in personal growth. At this cognitive level, the enneagram is dynamic and versatile in its approach for developmental growth. From this perspective the substance-abuse client would have gained depth and a multi-dimensional aspect of her behavior and how it was becoming dysfunctional.
for her, as well as alternative healthy possibilities. By aiding in the development of her observer self, the enneagram could help challenge her personal logic of how she saw herself and the beliefs that motivated her behavior.

_Dialectic-systemic_ clients have better developed observer selves and can talk about their situations from multiple perspectives. At this stage of development, they are able to challenge themselves while reflecting on multiple perspectives from their environment and feelings. These clients' perceptions of the enneagram may be one of a multi-leveled system of thought. They can see themselves in all of the nine styles, dynamically interacting from one to another, depending on the situation. They would also be able to recognize that they each have one style, which is most comfortable, and another style to which they can move when under stress and, perhaps, even another when they are feeling secure. To these clients the enneagram is more than a categorical diagram; it is a map of personal potential for spiritual growth.

With guidance from the counselor, the aforementioned substance-abuse client could learn the valuable tool of stepping outside of herself to observe her behavioral response to her situation. The more she learns about the nine styles, the more she will be able to recognize the aspects within her own personality and get in touch with each style. She becomes free to choose which style to move to when she needs those characteristics, as she becomes aware of her tendency to fixate on one particular style.

Understanding clients' perceptions may help the counselor to be more insightful about clients' past experiences, present circumstances, and future prognoses, as well as how to present the enneagram as a tool that is most appropriate for a specific client's healing and growth. This knowledge can also help counselors develop relevant treatment plans and choose which theories may be more applicable to clients' personalities. Understanding the interrelatedness of the nine enneagram styles with clients' personality styles may help counselors have a clearer understanding of their clients.

**Limitations**

Though personality typologies have existed for years (Riso & Hudson, 1996), one limitation of the enneagram is that it could be viewed as just another way to label and stereotype clients. For those who compare it to only other personality type indicators, it is merely that, a labeling system.
Another limitation is its complex nature. Clients who do not have a higher cognitive level of functioning and a desire for self-discovery may have difficulty grasping its concepts. Also, clients with DSM (1994), Axis II disorders may not be able to embrace the concepts of the enneagram; nonetheless, it can be a helpful tool for the counselor in determining which counseling theory to use with clients. The value of the enneagram is that it can be used as a conceptualizing tool for the therapist to form a hypothesis concerning clients' situations, even if clients choose not to embrace the enneagram. The enneagram is not a substitute for rapport and relationship with clients. Without a strong therapeutic relationship between counselor and client, introducing the enneagram is not recommended, because clients could misunderstand the counselor's intent. The enneagram is an interpersonal tool to aid clients in their relationships, therefore, clients must be ready to be empowered and do self-work with the support of a counselor.

Though the enneagram may appear to be simple in its application, it can yield powerful insights for clients. As with any tool that is self-revealing, there are positive and negative insights to which clients may become aware. Clients must have a strong enough ego to integrate the wisdom they discover about themselves. “As you become more aware of your fixations, you do have to deal with the fallout—the unconscious material that comes up—through good psychological work” (Schwartz, 1995, p. 401).

Another limitation is the lack of empirical research to this point. There are mostly books written about the enneagram, which tend to speak favorably about the enneagram's effectiveness with reference to case studies. Most of the proof is experiential in nature and difficult to measure. Wilber (2000), who espouses an integral model of human growth and development, calls the enneagram a horizontal approach to growth. Horizontal tools can help explain the diversity of individuals at various vertical levels of development, but they are not tools to help a person developmentally graduate from one vertical level to another (Wilber, 2000). Last, there are limited cross-cultural studies to suggest the effectiveness of the enneagram in cultures other than that of the West. In spite of the lack of cross cultural research, it is interesting to note that the primary enneagram teachers in the West also lecture and teach the enneagram internationally as well.
Conclusion: The Enneagram Difference

People create their lives by the quality of choices they make. As personality is developed, attention becomes preoccupied to enable a person to cope in spite of earlier and often traumatic circumstances, thus losing a certain ability to respond from an authentic-self. Attention and the shifting of awareness is the key to transformational change. Palmer (1988) propagated the oral tradition of the enneagram, that focuses on the development of the inner observer as a way to be objectively aware of a person’s experience. To transcend a fixation (trance) is to observe patterns through the enneagram tool and realize the limitations of over utilizing one style and remembering that individuals have choices to expand awareness of how they may respond to a situation. The goal of all the nine styles is to move from a place of self-forgetting to self-remembering. In self-remembering, individuals are able to shift attention and energy toward the development of the positive traits of each of the nine styles. This is the result of awareness, which leads to the freedom to change behavior and responses to enable individuals toward a fuller potential.

While increased self awareness cannot guarantee liberation from problematic patterns of behavior, the enneagram can help clients determine right action for themselves in a given situation. “The enneagram is comprehensive and can act as a framework for other typologies, even though it cannot be reduced to any one single psychological explanation” (Riso & Hudson, 1996, p. 432).

Examination of the nine styles of the enneagram reveals that personalities are often self-deceiving and inhibiting rather than liberating. The enneagram can give clients the power to change while observing these patterns. To the extent that individuals review the information of the enneagram, they will experience a new recognition of themselves and their relationship to those around them.

More counselors may benefit from incorporating the enneagram as a tool for conceptualizing clients and their issues while developing the therapeutic relationship and aiding interested clients in their growth. No matter their enneagram style, people share in the full spectrum and experience of human potential. By using the enneagram, a new level of human potential can emerge to expunge the old paradigms of ignorance and fear.
References


