Teaching Advocacy and Social Justice in Supervision

Presenters (Alphabetical Order)

Loretta J. Bradley, PhD
Paul Whitfield Horn Professor
Texas Tech University

Bret Hendricks, EdD
Associate Professor
Texas Tech University

Wendy Killam, PhD
Associate Professor
Stephen F. Austin State University

Nicole Noble, MEd
Doctoral Student
Texas Tech University

Douglas R. Kabell, MA
Doctoral Candidate
Texas Tech University

Valeria Smith, MEd

TCA Conference
November 15, 2012
Teaching Advocacy and Social Justice in Supervision

Welcome and Introduction

Social Justice

Advocacy

Counselor Supervision

Counselor Supervision: Roles

Importance of Advocacy Role

- Multicultural Circle
- ARD Meeting
- Older Adult

Discussion

References


**Advocacy Competency Domains**

**ADVOCACY COMPETENCIES:** Lewis, Arnold, House & Toporek, 2003

**Client/Student Empowerment**
- An advocacy orientation involves not only systems change interventions but also the implementation of empowerment strategies in direct counseling.
- Advocacy-oriented counselors recognize the impact of social, political, economic, and cultural factors on human development.
- They also help their clients and students understand their own lives in context.
  This lays the groundwork for self-advocacy.

  **Empowerment Counselor Competencies**
  In direct interventions, the counselor is able to:
  1. Identify strengths and resources of clients and students.
  2. Identify the social, political, economic, and cultural factors that affect the client/student.
  3. Recognize the signs indicating that an individual's behaviors and concerns reflect responses to systemic or internalized oppression.
  4. At an appropriate development level, help the individual identify the external barriers that affect his or her development.
  5. Train students and clients in self-advocacy skills.
  6. Help students and clients develop self-advocacy action plans.
  7. Assist students and clients in carrying out action plans.

**Client/Student Advocacy**
- When counselors become aware of external factors that act as barriers to an individual's development, they may choose to respond through advocacy.
- The client/student advocate role is especially significant when individuals or vulnerable groups lack access to needed services.

  **Client/Student Advocacy Counselor Competencies**
  In environmental interventions on behalf of clients and students, the counselor is able to:
  8. Negotiate relevant services and education systems on behalf of clients and students.
  9. Help clients and students gain access to needed resources.
  10. Identify barriers to the well-being of individuals and vulnerable groups.
  11. Develop an initial plan of action for confronting these barriers.
  12. Identify potential allies for confronting the barriers.
  13. Carry out the plan of action.

**Community Collaboration**
- Their ongoing work with people gives counselors a unique awareness of recurring themes. Counselors are often among the first to become aware of specific difficulties in the environment.
- Advocacy-oriented counselors often choose to respond to such challenges by alerting existing organizations that are already working for change and that might have an interest in the issue at hand.
- In these situations, the counselor's primary role is as an ally. Counselors can also be helpful to organizations by making available to them our particular skills: interpersonal relations, communications, training, and research.
Community Collaboration Counselor Competencies
14. Identify environmental factors that impinge upon students’ and clients’ development.
15. Alert community or school groups with common concerns related to the issue.
16. Develop alliances with groups working for change.
17. Use effective listening skills to gain understanding of the group’s goals.
18. Identify the strengths and resources that the group members bring to the process of systemic change.
19. Communicate recognition of and respect for these strengths and resources.
20. Identify and offer the skills that the counselor can bring to the collaboration.
21. Assess the effect of counselor’s interaction with the community.

Systems Advocacy
- When counselors identify systemic factors that act as barriers to their students’ or clients’ development, they often wish that they could change the environment and prevent some of the problems that they see every day.
- Regardless of the specific target of change, the processes for altering the status quo have common qualities. Change is a process that requires vision, persistence, leadership, collaboration, systems analysis, and strong data. In many situations, a counselor is the right person to take leadership.

Systems Advocacy Counselor Competencies
In exerting systems-change leadership at the school or community level, the advocacy-oriented counselor is able to:
22. Identify environmental factors impinging on students’ or clients’ development
23. Provide and interpret data to show the urgency for change.
24. In collaboration with other stakeholders, develop a vision to guide change.
25. Analyze the sources of political power and social influence within the system.
27. Develop a plan for dealing with probable responses to change.
28. Recognize and deal with resistance.
29. Assess the effect of counselor’s advocacy efforts on the system and constituents.

Public Information
- Across settings, specialties, and theoretical perspectives, professional counselors share knowledge of human development and expertise in communication.
- These qualities make it possible for advocacy-oriented counselors to awaken the general public to macro-systemic issues regarding human dignity

Public Information Counselor Competencies
In informing the public about the role of environmental factors in human development, the advocacy-oriented counselor is able to:
30. Recognize the impact of oppression and other barriers to healthy development.
31. Identify environmental factors that are protective of healthy development.
32. Prepare written and multi-media materials that provide clear explanations of the role of specific environmental factors in human development.
33. Communicate information in ways that are ethical and appropriate for the target population.
34. Disseminate information through a variety of media.
35. Identify and collaborate with other professionals who are involved in disseminating public information.
36. Assess the influence of public information efforts undertaken by the counselor.

Social/Political Advocacy
- Counselors regularly act as change agents in the systems that affect their own students and clients most directly. This experience often leads toward the recognition that some of the concerns they have addressed affected people in a much larger arena.
- When this happens, counselors use their skills to carry out social/political advocacy.

Social/Political Advocacy Counselor Competencies
In influencing public policy in a large, public arena, the advocacy-oriented counselor is able to:
37. Distinguish those problems that can best be resolved through social/political action.
38. Identify the appropriate mechanisms and avenues for addressing these problems.
39. Seek out and join with potential allies.
40. Support existing alliances for change.
41. With allies, prepare convincing data and rationales for change.
42. With allies, lobby legislators and other policy makers.
43. Maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals.
Overview of Counseling Supervision

LORETTA J. BRADLEY, NICHOLAS LADANY, BRET HENDRICKS, PEGGY P. WHITING, and KATIE M. RHODE

Counselor supervision is arguably the primary way in which educators facilitate or inhibit counselor competence (Ladany & Inman, in press). Supervision comes in many shapes and sizes and reflects many of the chapters in this book (e.g., individual supervision, group supervision, supervision of family counseling, etc.). The most common form of supervision is individual supervision and it is here where we start with a definition. Ladany and Inman broadly define individual supervision as a dyadic activity whereby the supervisor facilitates the provision of feedback to the supervisee, which is based on the interpersonal communication between both members of the dyad and can pertain to the work in supervision, the supervisee, the supervisee’s clients, or the supervisor. (Ladany & Inman, in press)

We can expand this definition to encompass all types of supervision in the following manner: Counselor supervision is a didactic and interpersonal activity whereby the supervisor facilitates the provision of feedback to one or more supervisees. This feedback can pertain to the work in supervision, the supervisee(s), the supervisees’ clients, or the supervisor, and can positively or negatively influence supervisee counselor competence and client outcome.

This definition obviates the problems with other definitions of supervision that typically only address individual supervision of individual counseling, leaving other valuable forms of supervision such as peer and group supervision unaddressed. Moreover, it addresses the interrelated types of supervision traditionally referred to as administrative supervision.
(e.g., supervisor helps the supervisee function effectively as a part of the organization with the overall intent to help the organization run smoothly and efficiently) and clinical supervision (e.g., supervisor assists with supervisee-related and client-related issues).

With this definition in hand, we spend the remaining part of this chapter attending to aspects of being a supervisor that sets the stage for the book. These aspects include: a brief history of counselor supervision, supervisor qualifications, supervisor skills and attributes, and purposes of counselor supervision.

A Brief History of Counselor Supervision

Supervision can be traced back to the field of social work in the late 1800s (Munson, 2002). Charity Organization Societies, as it was called, retained staff members who supervised apprentice workers. The format typically consisted of supervisors, each of whom supervised multiple supervisees occasionally through individual, and later group, conferences. Freud, in 1902, set the stage for supervision, whereby the analyst was analyzed (Goodyear & Guzzardo, 2000) and in 1925, supervision first became a required aspect of training (Kugler, 1995). In the middle of the twentieth century, theories of supervision were largely modeled after theories of psychotherapy (e.g., Ekstein & Wallerstein, 1958) and it wasn’t until the 1980s when supervision-based models emerged and supervision was seen as a distinct subfield within counseling (Bernard, 2005). It was also during the 1980s when research on supervision process and outcome began to burgeon (Ladany & Inman, in press). Since that time, empirical studies have been published at a moderate rate of about 12 per year, and the fields most linked with the theoretical and empirical work in supervision have been counselor education, counseling psychology, and social work.

Supervisor Qualifications

The necessary academic preparation and background experiences of counselor supervisors have been investigated by Borders (2005); Eriksen, Ellison, and Throckmorton (2008); McAdams and Foster (2007); Richardson and Bradley (1986); Thompson (2004); and previously by Riccio (1961, 1966), and the Association for Counselor Education and Supervision (ACES) survey (1969). Additionally, ACES has developed standards for supervisors (1993). Results from these studies indicate that the majority of supervisors in field settings (i.e., agencies, state departments, and schools) have gained a significant level of education beyond the master’s degree. Despite these high levels of educational attainment, the alarming fact remains that only
a token number of supervisors, regardless of work setting, have received specific preparation for supervision.

A reasonable assumption is that many counselor supervisors achieved their supervisory positions on the basis of educational level, tenure, and successful counseling experiences. It would also be realistic to expect that such professionals are well connected politically within their organizations to attain positions of authority and power. However, counseling experience and an accumulation of academic credits must be viewed as insufficient qualifications, by themselves, for supervisors of counselors. This is especially the case with supervisors who attained their positions because they were well connected with dominant power structure within the organization. Preparation in supervision methodology must become an entrance criterion if supervision practice is to be validated (Barnes, 2004; Hazler & Kottler, 2005; Holloway & Neufeldt, 1995; McWhirter & McWhirter, 2007; Neufeldt, 1999, 2007).

Skills and Attributes

The literature on supervisory job functions generates some information about the necessary personality attributes of a supervisor. The supervisor must be a serious, committed professional who has chosen counseling and supervision as a long-term career (Bernard & Goodyear, 2009). This assumption implies that the supervisor is energetic and ambitious, but not in an egotistical or opportunistic manner. Instead, the supervisor is committed to and ambitious about developing and maintaining accountable helping services.

The supervisor must possess the skills of empathy, respect, genuineness, supportive-confrontation, and immediacy (Blocher, 1983; Juhnke, Kelly, & Cooper, 2008). In addition, other descriptions of the good supervisor included concern for the growth and well-being of the supervisee (Bernard, 1992; Estrada, 2005; Mueller & Kell, 1972; Norcross & Beutler, 2008), as well as the welfare of the client (Bernard, 2005; McWhirter & McWhirter, 2007). Other positive supervisor characteristics included integrity, courage, sense of humor, capacity for intimacy, sense of time, openness to self-inspection (Ellis & Robbins, 1993), responsibility (Borders & Brown, 2005; Holloway & Neufeldt, 1995) and a nonthreatening, nonauthoritarian approach to supervision (Geldard & Geldard, 2008; Pearson, 2006). Supervisors should also possess the capacity to be flexible, tolerant, and open to various styles and levels of learning (Borders, 2005).

In short, supervisors should themselves be able to demonstrate the conditions and characteristics they expect of their supervisees. This means that they become living examples of all those qualities, skills, and behaviors.
that they consider important for others (Bradley, Lewis, Hendricks, & Crews, 2008).

The essential criteria for selection of supervisors include an expectation of competence and success in a broad range of helping activities. In addition to such professionally demonstrable qualities, a supervisor should possess confidence and professional assurance. A hesitant, unsure supervisor cannot offer the kind of leadership that is needed in supervisory positions. This is particularly true in agencies and schools where counselors are subordinate to other administrators. The supervisor needs to be confident and strong when working with those who have administrative power over counselors, as well as when grappling with the difficult decisions that arise in supervision.

A supervisor should command both the professional and the personal respect of colleagues and associates in the work environment. Professional respect is, in part, founded on competence and ability, first as a good counselor and then as a capable supervisor. Personal respect relates to whether the supervisor is accepted as a person by her or his associates based upon integrity and ethical indices that are reflected through professional behavior.

Finally, the supervisor must be highly committed to protecting the welfare of others, including the ability and willingness to serve as an advocate for counselors and their clients. All individuals need support, and counselors as a group suffer from a lack of professional affirmation. A supervisee needs to feel that the supervisor believes in her or his potential to become a more effective practitioner.

To summarize, the supervisor is a well-prepared individual who has entered the supervisory position after attaining a high degree of training, experience, and wisdom as a practitioner with specialized knowledge of supervision in counseling. The supervisor is respected as a person of exemplary character and is regarded as a mentor from whom other counselors can learn. The supervisor is an advocate for counselors and is dedicated to her or his personal and professional development.

** Purposes of Counselor Supervision **

What are the purposes of supervision? There are obvious functions, to be sure, but also subtle ones as well. Statements of purpose are often overlapping, but they are extremely important because they register intent and set direction.

Counselor supervision has three main purposes:

1. Facilitation of counselor professional and personal development
2. Promotion of counselor competencies
3. Promotion of accountable counseling services and programs
Singularly and collectively, these purposes provide a rationale for the work of supervisors (Borders, 2005; Bradley, 1989; Bradley & Ladany, 2001).

Facilitation of Counselor Personal and Professional Development

The first purpose of supervision is a dual one: to facilitate the personal and professional development of counselors. The supervisor acts in the role of mentor and advocate, as well as teacher and consultant. Concurrently, supervisors must pursue professional and personal continuing education on a regular and on-going basis (Ethical Guidelines for Counseling Supervisors; ACES, 2003) to insure that they have the necessary resources and skills to provide supervisees with relevant training. In order for supervisors to monitor the counseling performance of supervisees, supervisors must themselves be aware of current trends and techniques of counseling.

Assuming agreement that facilitation of counselors’ personal development should be a purpose of supervision, the next questions we need to ask are how much and what kind of emphasis should be placed on personal development. Answers to these questions are a matter for debate, but the following guidelines may be helpful in arriving at a partial resolution.

1. The foremost purposes of counselor supervision are facilitating professional development, increasing competencies, and promoting accountability in counseling.
2. Supervision should offer the supervisee an optimal opportunity for self-initiated personal development and encourage the supervisee to take advantage of the opportunity.
3. Supervisory interventions into the counselor’s personal development should be undertaken typically when psychological distress is obviously and deleteriously affecting the counselor’s performance. “Facilitation” of personal development is, however, a continuing supervisory effort.
4. The counselor’s personal and professional development is interrelated. Damage to, or facilitation of, one of these concepts has a reciprocal effect on the other. Furthermore, facilitating personal development can be construed as contributing indirectly to all purposes of supervision.

Professional development, an interrelated part of the dual purpose of supervision, is a concept that must be clearly defined if the supervisor is to functionalize its intent. In a broad sense, professional development encompasses all that makes the counselor a professional, including increasing and improving competencies. In the context of this presentation, however, a more narrow definition is used, since competency improvement is
designated as a separate supervisory purpose. Professional development, as defined here, refers to four tasks that have been adapted from concepts of Becker and Carper (1956); Bernard (2005); Green, Shilts, and Bacigalupo (2001); Hart and Prince (1970); and Ellis (2006).

1. The counselor must accept the name and image of the profession as part of her or his self-concept. This task causes problems for counselors because their preparation may lead to a wide variety of positions, each with a different job or professional title (e.g., child/adult development specialist, counseling psychologist, group facilitator, human development counselor, mental health counselor, family therapist, human resource specialist, or school counselor).

2. One must have a commitment to, and a clear perception of, the professional role and function. Counselors do not typically enter positions where their role and function have already been established. In fact, establishing this operational base is one of the most important and difficult tasks of the newly employed counselor. Occasionally, situational conditions can be so restrictive that the environment is unfit for good professional practice. A frequently slighted facet of the counselor’s role and function is support of the profession and contribution to its growth and strength. Counselors are in dire need of professional affirmation however; ironically, the only way to receive this affirmation is to produce it! Participation in local, state, and national professional associations is a start.

3. The counselor must be committed to the goals of the institution in which counseling services are performed while ensuring that the goals do not contradict effective counseling practice. This commitment additionally includes the counselor’s influence on establishment or alteration of institutional goals.

4. The counselor will recognize and appreciate the significance of the profession for individuals, groups, institutions, and society as a whole. A true profession exists to meet the needs of society, and professional accountability begins with recognition of these needs, an understanding of how the profession meets them, and an assessment of the profession’s impact.

Promote Counselor Competence

The second purpose of supervision, to increase counselor competencies, incorporates helping the counselor acquire, improve, and refine the skills required by the counselor’s role and function. Counselor competence has been defined as consisting of three subconstructs: knowledge, self-awareness, and
skills (Ladany & Inman, in press). Knowledge pertains to an understanding of the theoretical and empirical work related to counseling clients. Of course, knowledge alone is insufficient to work effectively with clients. Self-awareness refers to the ability to self-reflect on how the counselor is influencing counseling process and outcome, as well as a self-examination of how one’s biases may be influencing counseling process and outcome. For example, counselors must work toward overcoming oppressive beliefs they possess based on their societal and cultural indoctrination. Finally, with greater knowledge, and enhanced self-awareness, counselors must be able to demonstrate skills in working with clients. Skills can be framed along four levels: (1) nonverbal behaviors; (2) response modes (e.g., helping skills); (3) covert processes (e.g., internal thoughts and feelings); and (4) therapeutic strategies and techniques (Ladany, Walker, Pate-Carolan, & Gray Evans, 2008). In all, the supervisor’s role is to facilitate the development of counselor competence attending—often simultaneously—to all the aforementioned areas. No easy task!

**Promotion of Accountability**

To say that the helping professions, and particularly counseling, are presently in an “age of accountability” would be an understatement. Accountability is, and should be, demanded by the public. The consequences of not being able to satisfy public expectations could be disastrous for helping professionals. To ignore the public’s need would be irresponsible, but these forces should not be the motivation for helping services and programs to respond to the need of demonstrating accountability. Such forces from outside the profession may serve as a cue to raise serious questions about effectiveness, but the motivation for demonstrating accountability must come from within. A profession emerges in response to the needs of a society and exists for the purpose of meeting those needs. Accountability is the profession’s index of validity and evidence that the profession is meeting society’s needs. The profession’s obligation, not society’s, is to establish accountability.

As a term, *accountability* has been given many definitions (Corey, Corey, & Callanan, 2007; Gysbers, 2008; Jenkins, 2006; Koerin & Miller, 1995; Sanchez-Huckles & Jones, 2005; Sexton, 1998). The core concept relates to accomplishment of the purposes and goals a person or institution has contracted or promised to accomplish. Glass (1972) compared this core element of meaning to “the simple economic relationship of vendor and buyer” (p. 636). The public is the buyer of helping services and counselors are the vendors. An accountable relationship between these two parties would involve:

1. Complete disclosure concerning the service being sold.
2. Testing of the effectiveness of the service.
3. Redress if the service is found by the public to be ineffective or falsely advertised.
According to this vendor–buyer paradigm, counselors are accountable to their employers: the public. Counselors must openly and honestly explain their functions and what their services can do. Counselors must test and evaluate their services and share the findings with the public. Lastly, counselors must be responsible for the consequences (good and bad) of their work and make adjustments when their work is ineffective.

Counselor supervision is a means for promoting accountability in services, programs, and relationships between helping services and the public. Supervised assistance to an individual counselor improves that person's accountability, while supervision applied to a staff of counselors involved in program development, management, and evaluation is a route to program accountability. In both cases, a special set of skills—a technical expertise—is needed by the supervisor if accountability is to be achieved.

Conclusion

Counselor supervision has been presented as a professional specialty with a methodology requiring highly developed skills. Successful counseling experience is a necessary but insufficient prerequisite for supervision and should be supplemented with advanced preparation in supervisory methods. The importance of supervision to the future of help-giving services should again be stressed. Counselor supervision is an indispensable component of counselor preparation programs. Coupled with the supervisee's self-developmental process, counselor supervision is a key to accountable helping services and attainment of the supervisee's professional potential. It is not an exaggeration to say that counselor supervision can be one of the most instrumental factors affecting future development of the helping professions. The remainder of this book will attempt to show you how all of this can be done!

References


Dad Just Fell Again: Out of AA and into Grief

Peggy P. Whiting and Loretta J. Bradley

Peter, 84, falls, and the staff at the assisted-living facility realizes that he is drunk. In short order, Peter is enrolled in a substance abuse program. Peter's drinking is connected to grief over the loss of his wife of sixty years. Peggy Whiting uses narrative reconstruction, an approach that encourages a grieving individual to author a healing story about the past relationship, his new identity without the deceased, and the meaning of life as it unfolds in the future. Whiting relies on her mentor, Loretta Bradley, to sort out how her feelings toward her own father readily transfer to Peter. “My total lack of objectivity with my own father kept us apart from assisting each other in our grief. I discovered that I have a strong sense of protection toward others older than me.”
This is the case of an older male whose issue of grief might not have surfaced except for the curiosity of a professional who knew through experience that the presenting concern is rarely the whole picture. This client came to me after a precipitating event of a fall led the staff at a nursing care facility to seek an evaluation for drinking. This case, like most, had layers of issues to confront that had to be prioritized as his treatment evolved. Several professionals had seen this man before his grief came to the forefront as a concern for counseling. I was the grief therapist, and I consulted with my dear colleague and mentor, Loretta Bradley. Here is the story of Peter.

Peter Martin is an 84-year-old Caucasian man who has been living in an assisted-living facility for the past four years. Peter, a retired Episcopal clergy, has all the graces of a Southern gentleman. He has lived in small, rural communities in the South his whole life except for a few years right after college when he took a summer job as a police reporter near Boston. Peter speaks with great pride and affection about his heritage as a well-educated, middle-class family man. He talks with a pronounced cough every few sentences. He apologizes, while struggling to catch his breath, and explains that he has been diagnosed with cardiopulmonary disease with fluid buildup in his heart and a periodic need for oxygen. Peter is mobile with the aid of a walker. He immediately tells others, including me, that his walker was originally his beloved wife’s and he uses it as a memorial to her. While this gentleman has some memory issues associated with his age, he has no cognitive impairment or diagnosed dementia.

Peter was married for sixty years to Mary Catherine, who died four years ago after a long illness during which Peter was her caregiver. He speaks of her with great admiration and love. His description of their partnership brings both a smile and a tear to his face. Peter is quick to recall how they met when he was working his first job as a police reporter in a small office where Mary Catherine was the office assistant. Peter corrects me if I call her “Mary” instead of “Mary Catherine.” He liked her double name and says it is important I know her as the Southern beauty queen she was. Peter says, “Mary Catherine thought she was marrying a police reporter but stayed with me when I heard the call to minister . . . that was the kind of love we had.” Peter and Mary Catherine had moved out of their home into a residential living environment that provides varying levels of care. They shared an apartment on the grounds of the same assisted-care building where Peter now resides alone.

Peter readily talks about his own parents as being the role models for his marriage with Mary Catherine. He speaks of their relationship as “remarkable” and “inspiring” and calls himself fortunate for growing up in a stable and nurturing home with no problems such as alcoholism. “My wife and I had that same kind of thing.”

They had one daughter and two sons, all of whom live relatively close by. The daughter, Dianne, is the designated contact for Peter and has his legal power of attorney. Dianne handles all the business affairs and details of Peter’s life—money, health care insurance policies, and routine necessities. Peter is grateful for her help yet doesn’t call this a close relationship. Dianne worked quickly with the nursing facility after Peter’s fall to arrange intervention related to his alcohol use. Dianne, however, did not provide
any history to the addiction treatment team and seemed to just want the problem handled without need for her continued involvement.

Peter’s middle child, Dave, is married and father to three young boys. These grandchildren are a source of delight for Peter. Peter is also close to his daughter-in-law. Dave brings various family members for weekly visits that are a highlight in Peter’s week.

Peter describes his youngest son, Robert, as “irresponsible” and gives examples of how Robert has provided him with “an extra stash of booze” over the past few years. Robert has never married, and Peter has bailed him out many times when his son quit a job or mismanaged money. Peter has had very limited contact with Robert since his fall. None of Peter’s children is reported as having a history of alcohol or other drug abuse.

**Alcohol History.** Peter was diagnosed some twenty years ago with alcoholism. It is difficult to get an accurate picture because Peter seems to “forget” the story. He reports that his drinking never adversely affected his job but was something his wife preferred him not to do. It is also difficult to know exactly when he started drinking again.

I do know that his assisted-living facility has a “social hour” each afternoon during which residents may have two drinks of alcohol of their choice. The nursing home had allowed Peter to participate, although it came to light later that they were aware of his previous diagnosis and treatment for alcoholism. His drinking became a concern about a year ago, when Peter fell and was found to be intoxicated. The staff, concerned about liability, reacted and called a local substance abuse program. Peter felt punished by the facility’s social worker, who required that he must have a “companion” with him when he was outside his room. Peter describes these companions as the “police patrol.”

Peter has stopped drinking for almost a year now and participates in an outpatient program for substance abuse with an addictions specialist, forty years his junior. The specialist noticed that the deaths of his wife and best friend occurred around the same time as Peter “remembers” his drinking starting again. Peter had not made this connection. The addiction specialist functions as Peter’s advocate and educated the staff about setting realistic limits to protect Peter as he sustains sobriety.

As his recovery became solidified, the addiction specialist referred Peter to me for specialized counseling around his grief over the deaths of his best friend and his wife. I was identified as a counselor with expertise and credentials for grief education and counseling. Given that I hold a license as a professional counselor, I was an endorsed provider of care for Peter and was paid for service as a consultant to his addiction treatment. Medicare was billed as usual for the individual counseling sessions, and I was paid by the treatment center. This arrangement is an example of the collaboration that is possible between service care providers. Peter continued biweekly sessions with the addiction specialist and met with me for grief counseling on alternate weeks.

**Conceptualization**

My initial goal was to assess the grief experiences, first around his wife and then his friend. I wanted to hear the story of the relationships he had with individuals and how he has integrated their deaths. I wanted to “bear witness” to his construction
of his own identity in relationship to them and now in life without them. I wanted to know if his family and friends and living setting were providing opportunities to grieve.

So often the grief of older persons is undervalued, unrecognized, and unsupported. Without a community that legitimizes grief and allows opportunities for sharing of grief, reconciliation is less likely and the bereaved are left with greater physical and psychological vulnerability. I wondered if drinking was triggered by grief as a means of coping. I am aware of the impact of unresolved grief on physical and emotional health. Especially in the elderly, grief can be fatal, and this particular individual already had serious health concerns. I was concerned about the toll of two significant losses so close to each other. The use of altering substances during grief usually signals that the individual is feeling a need to self-sooth by numbing. This pattern can lead to suppressed or prolonged grief, two categories of complications in the “normal” grieving process.

I chose a narrative reconstruction orientation to help Peter. This contemporary intervention has the theoretical premise that healing occurs as a grieving individual re-creates his personal narrative in an empowering way to design a resilient future. The client must author a story of meaning about the past relationship with the deceased, his present identity without the deceased, and the meaning of life as it unfolds in the future. Narrative practices use arts techniques such as writing, photography, and music to encourage expressions of grief. The counselor is an intuitive collaborator and listener who guides the narrative reconstruction process toward a story of survivorship. Narrative reconstruction of this sort can move an older client toward a review of life that is experienced as having integrity as opposed to despair.

**Process**

I met with Peter for grief counseling biweekly for six months, a total of twelve sessions, although we initially contracted for only eight sessions. Our sessions took place in a conference area in his assisted-living facility. This location was a bit unusual although helpful with the transportation issue, given he no longer drives, and it did provide for confidentiality. The social worker and other staff welcomed my visits. The tone of the caregivers surrounding Peter seemed to soften with his demonstrated sobriety. The addiction specialist advocated for more social opportunities with other residents and outside visitors. We all attended a treatment planning conference to coordinate our efforts.

**Session 1.** I began with the usual introductions. Peter was already familiar with counseling process and its limits of confidentiality. He seemed eager to work with me but a bit confused about how our role would be distinguished from that of the addiction specialist.

I was direct about the addiction specialist’s hunch that his return to drinking might be linked to his losses. Peter had not himself made this connection, so I spent much of this session drawing out the time sequence of these events.
Therapist: I understand you lost both your beloved wife and your trusted best friend around the same time. I would like to hear about both of these important people. Let’s start with Mary Catherine.

Peter: She was my love, my rock. I could not imagine my life being worth very much without her by my side. She had been sick for a while and I had been taking care of her. We sold our home and moved into assisted living because she couldn’t get around very much any more and the house was too much for us to manage. We were in an apartment on the grounds here and pretty much did everything for ourselves. The kids helped out with errands, doctors’ appointments, and house cleaning. I didn’t expect her to die.

Therapist: So even through her illness, the two of you remained fairly independent and you thought you were settling into a new but longer-term living situation.

Peter: Yes. We hated to give up our home. I left my church that I had started and that was really hard. But we were together and the new place was comfortable and we had everything we needed. She just died one random day. Nobody expected it that day. I could tell she wasn’t breathing and I called for help. They came right away but it was too late. I was shocked and don’t remember a lot of the next few days.

Therapist: Tell me what you remember.

Peter: My daughter came in and kind of took over. I wasn’t asked much about the plans for the funeral or anything. I don’t know if I could have gotten it all together or not, but I sure wanted to be asked. I just tagged along and went where I was told.

Therapist: What would you have done differently if you had been asked?

Peter: I might have written something and had it read. You know I was a reporter for years and I like to write. Mary Catherine liked my writings, too.

Therapist: I wonder if you would be willing to write now what you might have written then. Could you have it ready the next time we meet? And maybe you could also write about what she meant to you. I would like to know this, too.

Sessions 2 and 3. Peter brought a folder of his writings from the years of his marriage. Some were in pristine condition, typed and printed on parchment paper. Other writings were worn, hand scribbled on scraps of paper and napkins stained with food. He proudly presented them: “Here is what she meant to me . . . take them all.” I asked him to choose one to read that he thought captured her the most. I sat quietly as he rummaged to find his selection.

Peter: A Southern beauty says she will marry me. How could I be this blessed? I feel chosen and unworthy. I feel greater than I was before. I feel humble yet proud. I am not easy yet she finds me to be enough for her life.
Therapist: This is very sacred . . . these memories and this marriage. Would you consider creating something with all these writings? Like putting them together in some way that you might keep and eventually pass on in your family?

Peter: Who would care about this? About us?

Therapist: Well, you tell me who might. Just think about it.

Peter had not written anything for the second session that he might have said at her funeral, but I prompted him and he had it for the third session. His eulogy was about her life, their marriage, and raising children. He wrote about her patience with his visits to spend time with his best friend. The two men spent time together without their families at a mountain cabin, where they fished and smoked cigars.

Therapist: What, if anything, would you like to do with what you have written?

Peter: Well . . . I could put it on the first page of that collection you wanted me to make . . . you know of the other writings.

Therapist: So, can I take that as a decision to create a sort of memory book?

Peter: Well, it feels like a silly thing for an old man to do, but if you think it might be good, I will.

Peter is very much a pleaser and usually complied. His voice was poetry and short stories. I wanted to use this creative outlet as a means of assisting Peter with reconstructing his narrative.

Sessions 4–6. Peter asked me to dispose of three empty, one-ounce bottles of vodka.

Peter: Could you throw these away for me? They will put me on all kinds of restrictions if the staff sees these.

Therapist: How long have you had these? What happened to the alcohol in them?

Peter: Don’t you panic, too. I drank these, of course, but a long time ago, right after Mary Catherine died. I kept them as my funeral bottles.

Therapist: So these are memorabilia. What do they indicate to you?

Peter: That I wasn’t doing very well. I hadn’t had anything to drink except for two times in twenty years. You know she was the one who got me to stop all my drinking before. I did it for her really. I loved her that much.

Therapist: So when she died unexpectedly, you reached back to something you had stopped largely because of her influence. What were you feeling that you were trying to soothe by drinking?

Peter: Emptiness. Heartache. I was lost and didn’t know how to cope.

I did report this session and delivered the bottles to the addictions specialist after talking with Peter about the need for this. I decided with their consultation to let the treatment center staff handle any follow-up regarding the empty bottles. I did not see my role as one to check any possibility of current alcohol use. Neither did I want to generate suspicion with the staff at his residential center. They had grown to trust Peter and had responded by lifting his previous restrictions around outings and visitation.
I saw photos of their wedding, their children and grandchildren, their home, Peter’s ordination into the ministry. I followed the prompts Peter gave us about the story of Mary Catherine’s significance to him. I began to redirect our work around the issue of what Peter thought his life would be like now.

Therapist: Peter, I feel honored to go inside your life with Mary Catherine. You have lived out a love story and you described some hard times of ill health, little money, and concern about your drinking. How is your life different since her death?

Peter: Nothing is the same. I had to move from our apartment into this one room on this floor with all these strangers. I can’t remember any of their names. Mary Catherine would have known all their names and everything about their families. She always did all that social stuff in my ministry. I’m not good at that. She was natural.

Therapist: So everything seemed to get smaller . . . your living space and your social connections.

Peter: Everything . . . I’m ready to go. The love story is over.

Therapist: Well, it seems that particular part of the story is gone, but the bigger story doesn’t end yet. That’s why it might be important to create another part of the story that could go on even when you are gone. You seem close to your grandchildren and your story is a part of their story. Isn’t that one of the reasons people write about their lives?

I believe narrative reconstruction is critical to grief reconciliation. In the sixth session, Peter told me about all the losses he experiences without Mary Catherine. My questions had elicited much reminiscence, and Peter seemed slower in his conversations and more resistant to my suggestion of an alternate ending to his love story. I slowed down our reconstruction work to accommodate his timing and to honor what had been true and important to him for sixty years. I used my best reflective skills to follow Peter’s lead in communicating his myriad losses since her death.

Peter: Maybe you are too young to get this but I spent my whole day around her . . . my eating, my sleeping, the chores, the conversations, my prayer life, our times with the family, our friends. When I was sick, she pampered me. When she was sick, I could feel useful when I took care of her. I knew what she liked without asking. I knew what subjects to stay away from in our conversation!

Session 7. This session had to be rescheduled on two occasions because Peter caught pneumonia and was in critical condition for several weeks, including a four-day hospitalization. I sent get-well cards and an anniversary card—Peter had told me how special occasions involving Mary Catherine were unrecognized since her death. As his health improved, we met for a short session to discuss whether we would continue our work. We had initially committed to eight sessions. Peter wanted to continue, and we extended our contract for five more sessions.
**Sessions 8-10.** Peter left urgent-sounding telephone messages for me, and yet when I contacted him there was no emergency. Peter said he was afraid I was not coming back. I reassured him that we would continue until we both agreed the work was done. The goal of these three meetings was to continue the story beyond Mary Catherine’s death. However, several issues arose that required my attention. Peter was labored in his speech because of difficulty breathing. The staff reported that he lacked the stamina to write very much. Additionally, his sleeping had increased and his social outlets had decreased. The social worker stated that his daughter thought it would be best to discontinue counseling. This was in conflict with Peter’s wishes. I discussed this with him, and he stated emphatically that he wanted to continue. I asked if he would mind if I talked with his daughter, and he gave me permission.

I invited Dianne to join our next meeting. I spent much of our time describing what our counseling had been about in the preceding weeks. Dianne voiced concern that her father was “needlessly being dragged through the past,” but Peter spoke up, insisting that this was not the case. I explained what I see as the benefits of telling one’s story in grief. This seemed important to do, not only to gain Dianne’s endorsement of her father’s counseling but also because she has been living the loss of her mother. Peter showed Dianne his folder, and she was amazed that he had written so much about her mother over the years. She asked him if she could take the folder and he replied “Yes.”

During the next few weeks, Dianne kept the writings and I continued to have sessions with Peter. He did not have the stamina to work actively on assignments outside of our sessions. He did say that he thought the residents would get a lot out of sharing the stories of their lives. I decided to follow through and the staff encouraged Peter to begin such a group. We talked about how he might lead the group. I saw an excitement in Peter that I had not previously seen. His functioning improved over the next few weeks.

**Sessions 11 and 12.** Peter came to these sessions with his folder of writings. He reported that Dianne encouraged him to put them together to pass on to his grandchildren. He wished that she had asked for them for herself. Peter said, “She learned avoidance from me.” We outlined an advertisement for participation in a resident support group.

Peter: I guess I can still minister even though I don’t have a church of my own and even though Mary Catherine isn’t here to remind me of people’s names.

Therapist: Yes . . . you are alive and you still have something to do. For our last session, would you be willing to write a story about what your years with Mary Catherine still mean? You could write about how her death has been important to your understanding of why grieving people need community.

Peter agreed to ask someone to help type as he dictated. Our closing session was spent listening to this writing. Here is an excerpt:

*Mary Catherine gave me much of my life for most of it. Then, she suddenly died and all the lights went out. I forgot about my call to the ministry. I had already*
retired, so being away from the church responsibilities made it easy to forget this mission in my life. I knew people need others in times of great grief. Mary Catherine and I had been called a thousand times to sit with families in times of tragedy and loss. She just kept me focused. Now I realize I have been given a chance to keep this going. I didn't think it would be here. I certainly didn't want it to be without her. But it is and here I am.

Outcome

I felt mostly pleased about our work with Peter. I think he will stay sober and continue to reconcile his grief. Three indicators of grief reconciliation are Peter’s investment in reconstructing new meaning while incorporating what is lost, his movement from isolation in his grief to reach out to others, and his self-report of feeling renewed interest in living beyond his loss. The addiction specialist confirmed Peter’s commitment to sobriety.

I experienced some surprises throughout the therapy sessions that I processed with Loretta in peer consultation. I did not expect the interruptions associated with Peter’s health. The empty bottles of vodka threw me for a loop. I hadn’t planned to include any of his children, given their resistance to family counseling. I was pleasantly surprised when Peter started a support group for other residents. Maybe I should have foreseen these things. A look back makes the unfolding process seem much more obvious than it did during our counseling.

Reflections

In hindsight, I might have initiated more family involvement besides Dianne’s session with us. Peter could probably have benefited from feeling my advocacy in his family. He repeatedly said that he felt neglected by his children. Family counseling in bereavement situations can provide safe opportunities for multiple narratives of meaning. Family interventions can bridge the separation that is common in grief. Also, I did not work with Peter on the death of his best friend. This was left largely unaddressed.

The most interesting learning for me as a therapist came from seeing Peter’s strong attachment to me and subsequent dependency. My presence with him, the regularity and reliability of our visits, was more important to Peter than either of us realized. As a counselor some twenty-five years younger than Peter, I experienced some urges to take care of him in ways I might do with my own parents. Peter interacted with me in a fatherly way. I kept myself aware of how transference and countertransference might be affecting my work. I repeatedly discussed this with Loretta, and she helped a lot with this.

I am in mid-life, with the predictable evaluation of my own relationships and life events. My own father was a minister who lost his beloved wife early in life. I observed how my personal response to him after the death of my mother was so much different from the professional response I offered to Peter. My total lack of objectivity with my own father kept us from assisting each other in our grief. I caught a glimpse of my own family through Peter and Dianne. Somehow I was able to offer more grace as I looked inward at the meaning of my father’s death a few years ago. I
discovered that I have a strong sense of protection toward others who are older than I am. I’m also having to confront my own vulnerability about aging and death.

**Suggested Readings**


**Biographical Statement**

Peggy P. Whiting, Ed.D., is a professor in the Department of Counselor Education at North Carolina Central University. She is a licensed professional counselor and a nationally certified thanatologist with specializations in grief education and grief counseling. Peggy has maintained a private practice for twenty years while teaching in counseling programs at both Vanderbilt and Winthrop Universities. She is the author or co-author of more than 100 articles, presentations, videotapes, and manuals focused on loss. She is the 1998 recipient of the Distinguished Service Award given by the South Carolina Counseling Association for prolonged accomplishment in counseling. You can reach Peggy at pwhiting@nccu.edu.

Loretta J. Bradley, Ph.D., is Paul Whitfield Horn Professor and Coordinator of Counselor Education at Texas Tech University. She is a licensed professional counselor supervisor and a licensed marriage and family therapist and supervisor. Loretta is past president of both the American Counseling Association and the Association for Counselor Education and Supervision. She has authored or co-authored seven books and more than 150 articles and presentations. Loretta is featured in the book, *Legends and Legacies*, edited by J. West, C. J. Osborn, and D. L. Bubenzer (Philadelphia: Brunner-Routledge, 2003), as one of the top twenty-five counselors who have made significant contributions to the counseling profession from 1952 to 2001. You can reach Loretta at loretta.bradley@ttu.edu.
Counselor Supervision: Roles

- Advocacy
- Teaching
- Evaluation

- Consultation
- Counseling