# Caring and the Ethic of Caring: Exploring the Connection and Importance in the Counseling Relationship

By

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## Table of Contents

## Abstract

The *Occupational Outlook Handbook* (U.S. Department of Labor, 2012) reports that there are approximately 653,000 counselors in the United States. These counselors are expected to maintain high ethical standards and core counseling components such as genuineness, unconditional positive regard, empathy, and caring. An area of counseling competency that is often overlooked, both in the literature and in counselor education, is caring and the ethic of caring. Researchers (Buber, 1923/1996; Gilligan, 1982; Heidegger, 1927/1962; Held, 2006; Noddings, 1984, 2003; Remley & Herlihy, 2010) defined caring as recognizing the needs of another individual and then meeting those needs in such a way that a connection is maintained with the individual. When thinking about caring and its many facets, it is difficult to think about caring without remembering the medical profession, education (Noddings, 1984, 2003), social work (Freedberg, 1993), rehabilitation (MacLeod & McPherson, 2007), physical therapy (Greenfield, 2006), psychology (Batson, 1990; Craig, 1987), psychiatry (Stiver, 1986), and counseling (Halstead, Wagner, Vivero, & Ferkol, 2002). This caring is based on natural caring. However, when natural caring is not enough, the ethic of caring takes over in the caring-one meaning that it is at this point that the caring-one recognizes an obligation to care. The ethic of care is defined as the obligation to care whereby the caring-one summons up a feeling of "I must do something" such that the caring-one not only sees the reality of the cared-for as a real possibility but also actively responds to the cared-for (Noddings, 1984, 2003). Caring and the ethic of care are a natural link to enhance successful counseling and most individuals would classify counseling as a caring profession. However, following a literature review, it became readily apparent that a paucity of

research has explored caring and the ethic of caring of Licensed Professional Counselors (LPC). Thus, this qualitative study explores the connection and importance of caring and the ethic of caring in the counseling relationship. Twelve counselors who are LPCs and have practiced for a minimum of one year participated in the study.

Six research questions were developed. A number of themes were identified for each of the six research questions which examined the concept of caring, the importance of the role of caring in counseling, ways caring is manifested within the counseling relationship, how LPCs maintain a caring professional presence under certain difficult circumstance, and the circumstances under which LPCs found caring for clients might lead to ethical dilemmas. A thematic strand analysis identified the following five themes: the therapeutic relationship, therapeutically helping clients, contours of care, ethical elements of care, and primary components of care. A preliminary definition of caring for the profession of counseling is also offered. Recommendations for additional research and professional practice are provided.

# Chapter I

## Introduction

The *Occupational Outlook Handbook* (U.S. Department of Labor, 2012) reports that there are approximately 653,000 counselors in the United States. From the total of 653,000 counselors, 156,300 are mental health and marriage and family counselors; 281,400 are school and career counselors; 129,800 are rehabilitation counselors; and 85,500 are substance abuse and behavioral disorder counselors. These counselors impact approximately 10 million individuals (Olfson & Marcus, 2010). Over the next 10 years the U.S. Department of Labor predicts that the total number of counselors needed to provide services will increase by 26 percent, which translates into more than 825,000 counselors. This overall career growth rate for counselors is expected to be a faster growth rate than the average growth rate (14 percent) for all occupations (U.S. Department of Labor, 2012).

Given the large number of practicing counselors, the rapid rate of projected growth, and the large number of clients seen for counseling, counselors have a tremendous task. Moreover, they are expected to be competent in their area of expertise and effective in their counseling practice. Further, they are expected to maintain high ethical standards and core counseling components such as genuineness, unconditional positive regard, empathy, and caring. One area of competency which includes the realm of ethics that is often overlooked, both in the literature and in counselor education, is caring and the ethic of caring.

With regard to caring, this term was originally associated with the medical profession. That is, it was expected that the physician or nurse was not only concerned

but also cared about the patient. Suffice it to say that patients would likely avoid a physician or nurse who was void of caring. Researchers (Hanson & Randall, 2007; Levinson, 1997; Vincent, Young, & Phillips, 1994; Wilkie, 2003) have also concluded that patients are also less likely to sue physicians who are caring. Thus, the medical profession practices from a caring perspective. This perspective provides a way for clients and their families to achieve maximum well-being and caring, while simultaneously fostering within the counseling profession a thorough understanding of caring and how it can enhance the quality of services and counseling outcomes between the caregiver and care receiver (Benner & Wrubel, 1989; Knowlden, 1998; Watson, 1988).

In addition to caring advocated by the medical profession, caring is an important component of other professions. Some of these professions include education (Noddings, 1984, 2003), social work (Freedberg, 1993), rehabilitation (McPherson & MacLeod, 2007), physical therapy (Greenfield, 2006), psychiatry (Stiver, 1986), and psychology (Batson, 1990; Craig, 1987). Though somewhat devoid in the literature, counseling is another profession in which caring would be considered an important component. As with medicine, a client would likely say that he/she would not want to be counseled by a counselor who does not possess caring.

Noddings (1984, 2003) and Tronto (1993) defined *caring* as seeing the needs of another individual and then meeting those needs in such a way that a connection is maintained with the individual. Defining caring thusly makes this component of counseling an essential ingredient of counseling. Furthermore, the ethic of caring is defined as an obligation to care whereby the caring-one summons up a feeling of "I must

do something" such that the caring-one not only sees the reality of the cared-for as a real possibility, but also actively responds to the cared-for (Noddings, 1984, 2003). Within the realm of counseling, the ethic of caring is based on the moral principles of autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity as described by Kitchener (1984), especially the component of nonmaleficence.

Counselors are knowledgeable about the counseling relationship, including Rogers's core conditions and counseling ethics. Perhaps one reason for this is curricular components required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). This CACREP requirement has been supported in the research. Researchers concluded that the counseling relationship is a salient counseling ingredient that in turn is a positive contribution to successful counseling outcomes (Day, 2008; Laughton-Brown, 2010; Tannen & Daniels, 2010). Additional impetus for its importance has been provided by several studies conducted on Rogers' core conditions: congruence, unconditional positive regard, and accurate empathy. According to Watson (2007), these conditions are essential to counseling outcomes. Similarly, counseling ethics is a well-researched phenomenon that is of paramount importance to counseling outcomes (Corey, Corey, & Callanan, 2011; Remley & Herlihy, 2010).

Even though caring and the ethic of caring has been largely overlooked in the counseling research, caring and the ethic of care are a natural link to enhance successful counseling. The *Oxford Dictionaries Online* (2012) defines *caring profession* as "a job that involves looking after other people, such as nursing, teaching, or social work." Given this definition, most individuals would classify counseling as a caring profession.

Caring and the ethic of caring are also both considered highly relationship

oriented (Buber, 1923/1996; Gilligan, 1982; Heidegger, 1927/1962; Held, 2006; Noddings, 1984, 2003; Remley & Herlihy, 2010). Likewise, counseling by its very nature is also relationship oriented, and accordingly, the connection between the counselor and the client is referred to as the counseling relationship (Day, 2008; Laughton-Brown, 2010; Tannen & Daniels, 2010). Given this natural connection between counseling, caring, and the ethic of caring, additional research needs to be conducted in this area.

**Statement of the Problem**

Although a natural connection between counseling, caring, and the ethic of caring seems to exist, there is a paucity of research in the counseling literature in regard to caring and the ethic of caring in counseling. Specifically, the researcher found only three articles that connected caring with counseling. Thus, caring and the ethic of caring are aspects of counseling that have been largely ignored in the counseling literature (Halstead, Wagner, Vivero, & Ferkol, 2002). This omission is perplexing because caring is such an essential component of counseling.

Rogers's core conditions of congruence, unconditional positive regard, and empathy may be viewed by some counselors as showing that they care in the counseling relationship; and they may well be a part of the concept of caring. Even aspects of the moral principles of autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity may be considered traits of caring in counseling. However, according to Knowlden (1998) caring encompasses a broader frame of professional motivation. Professional caring has been defined as a form of interpersonal communication whereby one applies the content and principles of a specific knowledge area (e.g., counseling) within the

context of a professional relationship for the purpose of rendering a service designed to improve the human condition (Knowlden, 1998).

While caring alone is not sufficient to ensure effective counseling practice, several researchers suggest that there are clear benefits when clinically competent professionals integrate caring into their practice (Benner & Wrubel, 1989; Freedberg, 1993; Noddings, 1984, 2003; Peloquin, 1993; Roach, 1987; Swanson, 1993; Watson, 1988). In their report, Tresolini and The Pew-Fetzer Task Force (1994) strongly advocated for relationship-centered care. Specifically, they state that relationship-centered caring is the foundation of therapeutic activity, and that relationships are not only critical to the care provided by practitioners but are also a source of satisfaction and positive outcomes for clients and practitioners.

**Purpose and Significance of the Study**

The purpose of this study was to fill a void in the literature by exploring the view of caring and the ethic of caring exhibited by Licensed Professional Counselors (LPC). Further, this study explored the ethical dilemmas that counselors may face in regard to their caring for their clients. Unlike previous studies that used counseling students as participants (Halstead et al., 2002; Hwang, 2008), this study only included as participants, counselors who had practiced as LPCs for a minimum of one year.

Secondly, this study was designed to increase the knowledge base of caring in the counseling arena. Only a paucity of research had been conducted previously in regard to caring in counseling (Halstead et al., 2002; Hwang, 2008; Skovholt, 2005). Thusly, this study was designed to add a new dimension to the counseling literature by focusing on the ethic of caring in counseling.

The results of this study is important to counselor education programs in that it will identify the importance of caring which in turn should increase the knowledge base of salient components needed in the education of successful counselor training. Given the importance of caring in counseling, counselor education programs might want to consider a course in caring and/or implementing the topic in one of the required counseling courses.

**Research Questions**

This study is designed to answer the following questions:

1. What concepts do Licensed Professional Counselors believe about caring?
2. What concepts do Licensed Professional Counselors believe about the importance of caring in counseling?
3. How do Licensed Professional Counselors perceive the role of caring in the counseling relationship?
4. How do Licensed Professional Counselors conceptualize ways that caring is manifested within the counseling relationship?
5. How do Licensed Professional Counselors maintain a caring professional presence when they find it difficult to do so under difficult circumstances?
6. Under what circumstances have Licensed Professional Counselors found that caring for clients might lead to ethical dilemmas?

**Delimitations**

The following delimitations provide the boundaries for this study. The sample population for this study was LPCs who reside in the Southwestern United States. Thus the cultural norms and beliefs related to caring and the ethic of caring of the participants

may be specific to the region. Another delimitation of the study arises from the data collection method; that is, it was primarily based on personal interviews. Unlike quantitative research, which involves a large number of participants, the results of this study were based on the in-depth perspectives of a small group of participants. In contrast, quantitative research usually has a greater number of participants with more generalizability. However, the purpose of this study was not to generalize, but to learn about caring and the practice of ethical caring as perceived by LPCs. While every attempt was made to include a diverse group of participants, participation in the study was strictly voluntary and depended upon those LPCs who volunteered.

**Limitations of the Study**

The geographic location of the participants in this study may pose a limitation. Participants were LPCs who reside in the Southwest region of the United States. By virtue of the geographic region, the cultural norms and beliefs related to caring and the ethic of caring of the participants may be germane to the region. Thus this population may not be representative of LPCs living in other areas of the United States. Therefore, the results of this study may not be transferrable to the total population of LPCs.

Another limitation of the study may result from the opportunities that LPCs had to participate. Since, as in many professions, professional counselors are busy counseling with clients throughout the day and because of their demanding schedule, a large number of counselors declined the opportunity to participate in this study. Further, their busy schedule was the impetus for some counselors to withdraw from the study.

A further limitation of the study was that it was based on interviews of LPCs. No observations of the counselors conducting counseling sessions with clients were

conducted. Therefore, the data collected was based on what the counselor stated and was not verified through observations.

**Definition of Terms**

*Autonomy*: The fostering of self-determination in the client by the counselors.

*Beneficence*: The counselor doing good by providing a service that benefits society.

*Caring*: Seeing the needs of another individual and then meeting those needs in such a way that a connection is maintained with the individual (Noddings, 1984, 2003; Tronto, 1993).

*Congruence*: The counselor being freely and deeply themselves with their actual experience accurately represented by their awareness of themselves (Corey, 2013; Day, 2008; Hill, 2007; Prochaska & Norcross, 2010).

*Core counseling conditions*: Rogers's (1957) three primary conditions that are necessary and sufficient for therapy to be successful. Those three conditions are congruence, unconditional positive regard, and accurate empathy (Day, 2008; Kensit, 2000; Lazarus, 2007; Samstag, 2007; Watson, 2007).

*Counseling Relationship*: The quality, personal relationship between the counselor and the client that allows the counselor and client to function as a team with goals.

*Empathy*: The counselor accurately sensing the less obvious feelings that the client is experiencing as if these feelings are the counselor's own and then reflecting these feelings back to the client (Corey, 2013; Day, 2008; Hill, 2007; Kensit, 2000; Prochaska & Norcross, 2010).

*Ethic of caring*: An obligation to care whereby the caring-one summons up a feeling of "I must do something" such that the caring-one not only sees the reality of the cared-for as a real possibility, but also actively responds to the cared-for (Noddings, 1984, 2003).

*Ethics*: Acceptable or good practice according to agreed upon rules or standards of practice, conduct or actions in relation to others established by a profession (Cottone & Tarvydas, 2007; Levy, 1972).

*Fidelity*: Fulfilling a responsibility of trust with the client in the counseling relationship.

*Grounded theory*: An approach to theory development that involves deriving constructs and laws directly from the immediate data that the researcher has collected rather than drawing on an existing theory (Gall, Gall, & Borg, 2007).

*Informed consent*: Provides sufficient information to a client or potential client about the counseling relationship and process so that he or she can make an informed decision before undertaking the counseling relationship (ACA, 2005).

*Justice*: The counselor's commitment to fairness in professional relationships.

*Nonmaleficence*: The counselor doing no harm to the client even inadvertently.

*Participants*: Participants will be Licensed Professional Counselors, who have been fully licensed for 1 year, have practiced as a Licensed Professional Counselor for 1 year, and have not had any complaints filed against them with the Licensure Board.

*Principle ethics:* Agreed-upon assumptions or beliefs about the ideals shared by members of the helping professions (Remley & Herlihy, 2010).

*Professional caring*: A form of interpersonal communication whereby one applies

the content and principles of a specific knowledge area (e.g., counseling) within the context of a professional relationship for the purpose of rendering a service designed to improve the human condition (Knowlden, 1998).

*Unconditional positive regard*: The therapist communicating a deep, genuine caring for the client neither being judgmental nor evaluative of the client or the client's feelings, thoughts, or behaviors (Day, 2008).

*Veracity*: Veracity means truth. It involves truthfulness to the client. It also addresses the counselor's obligation to deal honestly with the client and others with whom they relate professionally.

# Chapter II

## Review of the Literature

The review of literature is divided into four subsections. These subsections are: the counseling relationship, ethics, caring, and the ethic of caring.

### The Counseling Relationship

Counseling by it very nature is relationship oriented and is therefore rooted in an interpersonal relationship. More than 70 years ago Rogers (1942) identified the therapeutic relationship as a salient feature of counseling. In fact, Rogers was clear in stating that a working relationship must be established if counseling is to be successful. Other researchers have posited that the counseling relationship is a significant contributor to positive therapeutic outcomes (Day, 2008; Laughton-Brown, 2010; Tannen & Daniels, 2010). Horvath and Bedi (2002) concluded that across various types of psychotherapy at least 12 percent of the therapeutic outcome is due to the counseling relationship. Since the counseling relationship is based on trust and the ability of the counselor to communicate effectively with the client, these elements are essential. Further, actively listening to the client is also a crucial element of the counseling relationship (Davis, Foley, Crigger, & Brannigan, 2008). An important feature of the counseling relationship is that it is developed between the client and the counselor when the counselor is completely present with the client. That is, the counselor must fully and completely meet the client as the client truly exists as a person (Knox & Cooper, 2010).

This counseling relationship is also known as the therapeutic alliance, the working alliance, or the helping alliance (Day, 2008; Stiles, Shapiro, & Elliot, 1986). This relational alliance is a quality, personal relationship between the counselor and the client

that allows the counselor and client to function as a team with goals. Likewise, it is the positive, affective aspect of the same relationship that allows the client to feel valued and liked. Research indicates that the client's judgment of the alliance is a greater predictor of the counseling outcome than the therapist's judgment of that same alliance (Horvath & Symonds, 1991). That is, the client's perception of a warm, accepting relationship is more important than the counselor's perception of that same relationship.

The counseling relationship is unique in that it is as a one-way relationship. Its purpose is to resolve a concern and/or foster a personal growth of the client (Moss & Glowiak, 2013). The goal of the counselor–client relationship consists of four basic goal areas: changes in behavior and lifestyle, increased awareness or insight and understanding, relief from suffering, or changes in thoughts and self perceptions (Brammer & MacDonald, 1996). Thus, an important aspect of the therapeutic relationship is enabling the client to grow in a direction that the client chooses. This begins with the building of a foundation of mutual trust that enables the client to explore his/her presenting issues.

Seligman (2004) posits that the therapeutic relationship consists of the following characteristics:

- A safe and protective environment
- Collaboration between client and the counselor
- A shared feeling of warmth, caring, affirmation, and respect
- Clients identifying with their counselors and perhaps even using them as role models
- Agreement on goals and procedures between the counselor and client with sessions structured so as to clearly move toward accomplishment of these goals

- Client and counselor viewing themselves as participating together in a venture that appears likely to succeed

It is the counselor's responsibility to begin establishing the therapeutic relationship with the client as quickly as possible. Without this critical relationship being established by the counselor, it appears unlikely that the needs of the client will be met. Furthermore, it appears likely that the client would terminate the counseling process prematurely due to an issue with the therapeutic relationship (Green, 2006).

Researchers (Corey, 2013; Day, 2008; Farber, 2007; Hill, 2007; Kensit, 2000; Lazarus, 2007; Prochaska & Norcross, 2010; Samstag, 2007; Watson, 2007), however, have found that there are several essential elements that make the relationship more favorable, thus allowing for greater client growth in counseling. Some of those elements include Carl Rogers's core conditions. In the next section these conditions will be examined to a greater extent.

**Core Counseling Conditions**

According to Rogers (1957), three primary conditions are necessary and sufficient for therapy to be successful. Those three facilitative conditions are congruence, unconditional positive regard, and accurate empathy (Day, 2008; Farber, 2007; Kensit, 2000; Lazarus, 2007; Samstag, 2007; Watson, 2007). Consequently, the three primary counseling conditions are referred to as the core conditions. Sometimes they are labeled merely as *the conditions* (Day, 2008). While these three conditions, especially Rogers's sufficiency assertion, are sometimes contested and debated, they remain highly influential for successful counseling (Corey, 2013; Day, 2008; Farber, 2007; Hill, 2007; Kensit, 2000; Lazarus, 2007; Prochaska & Norcross, 2010; Watson, 2007).

**Congruence.** Congruence, according to Rogers (1957), is "the opposite of presenting a façade" (p. 97). Within the counseling relationship, the counselor is to be freely and deeply themselves with their actual experience accurately represented by their awareness of themselves (Corey, 2013; Day, 2008; Hill, 2007; Prochaska & Norcross, 2010). Congruence implies that therapists are real, genuine, integrated, and authentic. Both their inner experience and outer expression of that experience is a match, and within the counseling relationship, counselors are able to openly express their feelings, thoughts, reactions, and attitudes with their clients (Corey, 2013); this means that congruent counselors are honest, transparent and open during their interactions with clients. Rogers believed that only when the counselor provides the reality that is within her or him can the client successfully seek the reality in him or her (Moss & Glowiak, 2013).

Being congruent, the counselor then serves as a model for the client. The congruent counselor models for the client an individual that is struggling toward greater realness. Thus the counselor might express anger, frustration, liking, attraction, concern, boredom, annoyance, as well as a whole range of other feelings to the client in the counseling relationship. However, this does not mean that the counselor would impulsively share all of his or her reactions. Such self-disclosure needs to be appropriate, well timed, and have a clear therapeutic reason for the self-disclosure.

An issue that counselors may have with being congruent and genuine is that they sometimes try too hard to be genuine and congruent. Sharing a reaction just because the counselor thinks that it might be good for the client might even make the counselor incongruent especially if the counselor is not genuinely moved at the time to do so. It would also be incongruent for a counselor who either dislikes or disapproves of a client

to feign acceptance. Nevertheless such a counselor would discover a way to congruently maintain a caring professional presence even under these circumstances.

Being congruent does not mean that only a fully self-actualized counselor can be effective. No counselor is ever completely and totally genuine and congruent all of the time. Congruence exists on a continuum rather than on all-or-nothing basis (Corey, 2013). Congruence is really more about caring than about being congruent all of the time.

**Unconditional positive regard.** The second core condition is a caring attitude of unconditional positive regard. Through unconditional positive regard, the therapist communicates a deep, genuine caring for the client. The counselor is neither judgmental nor evaluative of the client or the client's feelings, thoughts, or behaviors. Thusly, the counselor does not judge the client's feelings, thoughts, or behaviors as either good or bad. This is in contrast to clients who are usually accustomed to conditional acceptance such as: "I'll love you if…"; "I'll accept you when…"; "No son/daughter of mine would…" (Day, 2008). Rather the congruent counselor portrays an attitude of "I'll accept you as you are."

This acceptance translates into the counselor recognizing that clients have the right to have their own beliefs and feelings. Counselors communicate acceptance of their clients through their behaviors and through their caring attitude towards their clients. However, the counselor's caring must be nonpossessive. This means that the counselor's caring cannot emanate from her/his own need to be liked and appreciated. Counselors value and warmly accept clients without placing any conditions on their acceptance.

Further, counselors desire that their clients know that they value them as they are,

and therefore the counselor desires that clients know they are free to have feelings and experiences without the risk of losing their counselor's acceptance. This acceptance, however, is never to be considered approval of all behavior. Overt behavior of any kind need not be approved of nor accepted by the counselor (Corey, 2013; Day, 2008; Moss & Glowiak, 2013).

**Accurate empathy.** Accurate empathy is the third core condition that Rogers (1957) believed to be necessary and sufficient for therapy. It is through empathy that the client feels the counselor's acceptance. When the counselor effectively communicates accurate empathy, the client feels understood. It can also provide the client with a sense of safety thus allowing them to oftentimes begin exploring difficult issues (Moss & Glowiak, 2013).

Empathy enables the counselor to sense the client's feelings as if these feelings are the counselor's own without the counselor becoming lost in the feelings of the client and without the counselor's own anger, fear, or confusion becoming part of the experience (Corey, 2013; Day, 2008; Hill, 2007; Kensit, 2000; Moss & Glowiak, 2013; Prochaska & Norcross, 2010). Empathy also involves understanding the client's thoughts and struggles from the client's point of view, the ability to see completely through the client's eyes and to adopt the client's frame of reference. Empathy means entering into the client's private world and being sensitive, moment-by-moment, to the felt meanings of the client (Elliott, Bohart, Watson, & Greenberg, 2011).

Accurate empathy extends beyond the recognition of obvious feelings and includes a sense of the less obvious feelings that the client is experiencing (Corey, 2013). Part of empathy is the counselor's ability to reflect the feelings of clients. In doing so,

the counselor attempts to sense the client's subjective experience, especially in the here and now; this is achieved through focused, responsive attention to the client's thoughts and feelings (Day, 2008). The aim of empathy is to encourage clients to "get closer" to themselves, to feel deeply and intensely, and to recognize and resolve the incongruence that exists within themselves.

Empathy then is a very deep and subjective understanding of the client. By tuning into their own feelings that are similar to the client's feelings, counselors are able to share the client's subjective world. Nevertheless, counselors must remain separate from the client even as they experience the client's world. Consequently through the use of empathy, the counselor can comprehend the client's private world as the client sees and feels it (Corey, 2013).

In summary, Rogers viewed the core counseling conditions as a value set that counselors hold deeply, both personally and professionally. Likewise, counselors' adherence to values embraced by ethical codes and standards define their identity and empower them to achieve positive therapeutic outcomes. Ethics will be considered in the next section.

**Ethics**

Ethics and ethical standards are vitally important to the success of counseling and the counseling profession. Ethics involves human conduct and moral decision-making (Remley & Herlihy, 2010). Mental health professionals defined ethics as standards of conduct or actions in relation to others (Levy, 1972). Cottone and Tarvydas (2007) defined ethics as "acceptable or good practice according to agreed-upon rules or standards of practice established by a profession" (p. 4). While there are a number of

differences among the ethics codes of the various professional organizations, Koocher and Keith-Spiegel (2008) describe a number of similar themes. These include (a) promoting consumer welfare, (b) practicing within one's competence, (c) doing no harm, (d) maintaining client confidentiality and privacy, (e) being ethically responsible, (f) not exploiting clients, and (g) striving for aspirational practice. However, when it involves counseling, ethics refers to the conduct of counselors and the counseling profession that is judged as good or right. Such ethics are codified and become the ethical standards to which counselors and the counseling profession are expected to adhere to professionally (Remley & Herlihy, 2010).

**Principle ethics.** One of the most fundamental aspects of ethics that counselors base their practice upon is principle ethics. The foundation upon which principle ethics is placed is moral principles, those agree-upon assumptions of beliefs about ideals that are shared by all counseling professionals (Corey et al., 2011; Meara, Schmidt, & Day, 1996; Remley & Herlihy, 2010). Building on the work of Kitchener (1984) and others, Meara and colleagues (1996) identified and described six moral principles that form the foundation of functioning at the highest level as a professional. Those six moral principles are: autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity.

Autonomy involves the fostering of self-determination. Accordingly, counselors respect the rights of clients to choose their own directions, act in accordance with their own beliefs, and control their own lives. Counselors also work to decrease client dependency and foster independent decision making by the client.

Nonmaleficence means do no harm to the client. This principle was first identified by Hippocrates, and thus, it has long been established in the medical

profession. It obligates counselors to avoid actions that risk hurting clients, even inadvertently.

Beneficence, the opposite of nonmaleficence, means to do good. Counselors not only have the obligation to do no harm to the client, they also have the higher obligation to provide a service that benefits society. Thusly, counselors actively do good, are helpful, and work to promote mental health and wellness of their clients.

Justice refers to the counselor's commitment to fairness in professional relationships. Justice demands equality, which has implications for nondiscrimination and equitable treatment of all clients. Therefore, counselors' actions and decisions must be fair to all concerned.

Fidelity involves fulfilling a responsibility of trust with the client in the counseling relationship. Thusly, counselors strive to be faithful to the promises they make, such as maintaining confidentiality to the limits of confidentiality.

Veracity means truth. It involves truthfulness to the client. It also addresses the counselor's obligation to deal honestly with the client and others with whom they relate professionally (Corey et al., 2011; Kitchener, 1984; Meara et al., 1996; Remley & Herlihy, 2010).

**Ethical perspectives.** While various codes of ethics exist for counselors (e.g., the American Counseling Association *Code of Ethics*), counselors can view and interpret their codes of ethics from a number of perspectives. These various perspectives usually take opposing positions on what it means to be and act ethically. Having some familiarity with these various ethical perspectives will perhaps aid in understanding how various counselors can have completely different understandings of the same codes of

ethics.

One perspective on ethics is ethical absolutism versus ethical relativism. Counselors who view ethics from the absolutist perspective believe that there are absolute moral standards that are universal in nature; that is, these moral standards are not dependent upon an individual's beliefs or cultural values. Rather, universal moral standards apply to all persons, at all times, in all situations. Thus, these standards exist before a situation arises, and it exists independently of whether or not the individual believes in them. On the other hand, ethical relativists take the position that if the members of a culture believe an action is morally right then it is morally right to perform that act in that culture. Therefore, ethical relativists do not believe that there are any moral standards that can be universally applied absolutely to all individuals, at all times, in all situations (Freeman, 2002; Remley & Herlihy, 2010).

Another ethical perspective is utilitarianism versus deontology, also known as consequential and nonconsequential ethics. Utilitarianism argues that individuals should choose the act that will do the greatest good for the greatest number; that is, an act is evaluated on the consequences it has. By contrast, deontologists believe that an action is justified by its being inherently right, not by its consequences. In other words, what makes an action right is the principle that guides it. Deontology is the ethical philosophy that underlies much of the reasoning that counselors use in determining professional ethical behavior.

A third ethical perspective that counselors could use in viewing ethics is egoism and altruism. Egoism describes the actions that are taken out of self-interest, whereas altruism describes the actions that are taken to benefit others (Freeman, 2002; Remley &

Herlihy, 2010). Most counselors consider themselves altruist when it involves counseling. Indeed, one of the most influential ethical values of counselors is "do no harm."

A fourth perspective is virtue ethics. Virtue ethics considers the question of what character traits or personalities constitute the basis for right actions. Virtue ethicists, therefore, believe that moral choices cannot be made by rules. Rather, what is needed instead is good judgment (Remley & Herlihy, 2010).

Another ethical perspective is mandatory ethics versus aspirational ethics. Mandatory ethics involves operating ethically at such a level that only the minimal standards of the ethics codes are met. Counselors who operate as mandatory ethicists comply only with the basic "must" and "must nots" of the codes. They meet the letter of the code, but not the spirit of the ethical standards. Juxtaposed to this is aspirational ethics which involves the highest standards of conduct to which counselors can aspire. Aspirational ethicists understand not only the spirit behind the code, but also the moral principles upon which it rests. Such individuals look both outwardly to the established standards and inwardly to themselves and ask whether what they are doing is best for their clients (Corey et al., 2011; Remley & Herlihy, 2010).

One final ethical perspective from which counselors might choose to view ethics is that of the relational perspective or the ethic of care. After discussing what constitutes care, the ethic of care will be discussed in greater detail below.

**Caring**

According to Noddings (1984, 2003) and Tronto (1993), *caring* is defined as seeing the needs of another individual and then meeting those needs in such a way that a

connection is maintained with the individual. Given this definition, a distinction needs to be made in regard to caring; that distinction involves the difference between caring *for* and caring *about*. Caring *about* operates at a personal level and assumes a relationship between the caring-one and the cared-for. It occurs in the context of practices and relationships involving the cared-for (Hollway, 2006). Tronto (1993) makes this distinction in regard to caring *about* when she states: "Caring about involves the recognition in the first place that care is necessary. It involves noting the existence of a need and making an assessment that this need should be met" (p. 106).

On the other hand, caring *for* involves the actual practice of caring which includes the work and task of caring, and does not necessarily relate to caring *about* (Hollway, 2006). In other words, an individual may provide care *for* another individual and yet care nothing *about* the other individual. Tronto (1993) refers to this as *taking care of*. This involves assuming some responsibility for the identified need and determining how to respond to it. Also included in this aspect of caring is *care-giving*, i.e., the direct meeting of needs for care. It involves the direct physical work, and almost always requires that the care-giver come in contact with the object of care. In this study, the term *caring* is utilized in the relational caring *about* sense.

Although a relationship between caring and counseling outcome seems obvious (Stiver, 1986), there is a paucity of articles and research on caring in the counseling literature. The concept of caring began with the work of such philosophers as Buber (1923/1996), Heidegger (1927/1962), and especially Mayeroff (1971). Buber, in his classic work *I and Thou*, examined the experience and mutuality that exists in the meeting of two individuals. Heidegger posited that caring was a universal phenomenon,

and that as such, it influences the ways in which individuals think, feel, and behave in relation to one another.

According to Buber (1923/1996), individuals can form two types of relationships with the world, an I-It relationship and an I-You relationship. In the I-It relationship the individual interacts partially, conditionally, not with his/her whole being. It is characterized by projectedness, subordination, and I-centeredness. Additionally, the I-It relationship sees other individuals only as objects separate from self.

In contrast, the I-You relationship is characterized by immediacy, reciprocity, and fullness of engagement. The I-You relationship is a mutual relationship. It requires full engagement with the other individual, thus penetrating the object-status of the It. The I-You relationship embraces the wholeness of the other individual moving beyond the motives and experiences of the object world entering into a relationship with the other individual, not standing apart from it. The *I* speaks to the other individual rather than about the other individual.

Buber does acknowledge that the full mutuality of the I-You relationship is intermittent. While the I-You relationship potentially always exists, it does not always exist in actuality. Individuals tend to move in and out of the I-You relationship with other individuals because full mutuality is difficult to maintain continuously.

Nevertheless, in order to maintain the I-You relationship, Buber posits that the individual, the *I*, needs to be fully and completely present with the other individual, the *You*. To be fully present stands in contrast to objectification. Presence also signifies a connection to the other individual, a touching of two individuals at the level of existential being. Presence also involves personal authenticity. To be present to another individual

is to be willing to present oneself authentically to the other individual and to be open to receiving the authentic presence of the other individual in return.

Buber additionally maintains that the *I* needs to accept and affirm the other individual as she/he is at the moment as well as have a willingness and capacity to see the other individual as his/her best self. Furthermore, the *I* is willing to look beyond the present difficulties and limitations of the other individual in order to help that individual. For Buber, these conditions are necessary in order to maintain the I-You relationship.

Mayeroff (1971) in his seminal book, *On Caring*, states that to care for an individual, in the most significant sense, means helping that individual grow and actualize (Halstead et al., 2002; Noddings, 1984, 2003). For Mayeroff, caring is a process, a way of relating to an individual so that development occurs for that individual. According to Mayeroff, the major eight ingredients of caring involve (a) knowing the individual, (b) alternating rhythms, (c) patience, namely, participating with the individual in such a way that we give completely of ourselves, (d) honesty, (e) trust, (f) humility, (g) hope, and (h) courage (Mayeroff, 1971; Rundqvist, Sivonen, & Delmar, 2011; Wilkes & Wallis, 1998).

Mayeroff asserts that caring requires knowledge of the other individual's needs and limitations as well as knowledge of what is conducive of her/his growth. Good intentions are insufficient to guarantee a caring response. Furthermore, caring requires self-knowledge of one's own limitations. Caring also is expressed in purposeful patterns of action and inaction called alternating rhythms. In other words, determining from past actions whether the individual has been helped or not, the caring-one then either maintains those actions or changing them to better help the individual in the future.

According to Mayeroff, patience is another aspect of caring. Patience is not waiting around for something to happen, rather it is participating with the cared-for in such a way that the caring-one gives fully of themselves. Growth cannot be forced upon the cared-for. The cared-for must be allowed to grow in her/his own time and way.

Caring additionally involves honesty. That is, caring requires being true to yourself while also being truthful in seeing the other individual as she/he really is and not as the caring-one would like the cared-for to be. Thus the caring-one responds to the cared-for as the cared-for is in order to assist in the cared-for's growth. Trust involves trusting the cared-for's capacity to grow as well as trusting one's own capacity to care. At the same time the caring-one must be willing to learn from the cared-for. This requires humility on the part of the caring-one. Each cared-for individual is different, new, and unique along with his or her situation. Therefore, caring must be learned anew. It is not simply a repetition of past caring. Caring also requires hope. Hope is the expression of a bountiful present that is alive with a sense of that which is possible. Finally Mayeroff contends that both courage and trust are needed in order to be able to go into the unknown with the individual for whom we care. By following the lead of the cared-for, the caring-one does not know where it will lead. Therefore, trust and courage are not only needed in order to follow, but are also interdependent (Mayeroff, 1971; Rundqvist, Sivonen, & Delmar, 2011; Wilkes & Wallis, 1998).

Tronto (1993) posits that caring not only connotes some kind of engagement, but that it also carries with it two additional aspects. First, caring implies a reaching out to something other than the self. Secondly, caring implicitly suggests some kind of action. That is, caring involves seeing the needs of others and then meeting those needs in such a

way that a connection is maintained with the individuals; this makes caring primarily relational in nature. Caring as relational is the way that Gilligan (1982) and Noddings (1984, 2003) viewed caring. Both Gilligan and Noddings approached the concept of caring from the feminist perspective, although Noddings (1984, 2003) uses the term feminine rather than feminist.

Gilligan (1982) was a developmental psychologist, who originally worked with Kohlberg during the development of his model of moral development. Within time, Gilligan became frustrated when women consistently scored lower then men on Kohlberg's model of moral development. When women were evaluated according to the masculine models of personality theory and developmental psychology, they were consistently found to be lacking in moral development (Stiver, 1986). Through her own research, Gilligan sought to explain the apparent differences in the moral decision making processes between men and women. What Gilligan discovered was that women only scored lower when compared with data gathered on the all male samples collected by Kohlberg. Gilligan concluded that Kohlberg's model failed to recognize the unique qualities of female development and experience.

In examining the female experience of morality, Gilligan determined that most women base their moral decision making on how it affects their relationships with other individuals; that is, much of their moral decision making is organized around issues of responsibility for other people within the context of investment in relationships (Gilligan, 1982; Stiver, 1986; Wilkes & Wallis, 1998). Thus, women tend to construct moral problems as problems of care and responsibility in relationships rather than as problems of rights and rules. Women's judgments, therefore, are usually tied to feelings of

empathy and compassion. They are concerned with the resolution of real as opposed to hypothetical dilemmas. Therefore, they have a proclivity to reconstruct hypothetical dilemmas in terms of real situations and to request or to supply missing information about the nature of the people and the places where they live. In doing so, they shift their judgment away from the hierarchical ordering of principles and the formal procedures of decision making to feeling an obligation to exercise care and avoid hurting others (Gilligan, 1982). For most women, the relationship and maintaining the relationship is the most important thing with regard to moral decision making. Therefore, caring is really an activity of the relationship. It is about seeing the needs of others, responding to those needs, and sustaining the web of connection with individuals so that no one is left alone (Gilligan, 1982).

Following in her predecessors' footsteps, Noddings (1984) further developed the relational concept of caring by providing a more phenomenological account of what is involved in activities of care. Through her book, *Caring* (1984), Noddings examined the virtues of close attention to the feelings and needs of others, and the identification with another's reality as being central to caring (Held, 2006).

Utilizing some of the same conceptual framework as Buber (1923/1996), Noddings focused on how two individuals related to one another during an encounter (Bergman, 2004; Huffman & Brubaker, 2009). Noddings (1984, 2003) designated the individuals as the "one-caring" and the "cared-for." She posited that within the relationship between the one-caring and the cared-for exists all the necessary elements for caring. For the one-caring, this consists of apprehension, confirmation, disposability, motivational displacement, non-rule bound behavior, and receptivity/engrossment. For

the cared-for, the only essential element in the caring relationship is responsiveness (Bergman, 2004; Huffman & Brubaker, 2009).

Nodding posits that caring is based on the natural caring that is received through a relationship with at least one adult who has learned how to care by having been cared for. This might involve what the adult did, how the adult took care of us, and once basic needs were met, how the adult cared about us. These experiences are both physical and emotional (MacLeod & McPherson, 2007). When such caring occurs in the lives of individuals, the result is that they then have a memory of caring and being cared for. It is through this caring process that individuals learn how to spontaneously care for those they love (Bergman, 2004; Noddings, 1984, 2003).

In order for caring to occur, engrossment and motivational displacement are essential. Engrossment means that the cared-for's situation takes over the conscience of the one-caring, even if only for a moment, which in turn leads to motivational displacement. Through motivational displacement, the one-caring temporarily joins with the cared-for in order to respond to the needs of the cared-for. In order for this to occur, the caring-one must pay close attention to the feelings, needs, desires, and thoughts of the cared-for, and possess a skill to understand the situation from the cared-for perspective (Held, 2006). For the caring response, however, to be completed effectively, concerted thinking, both with and on behalf of the cared-for, will often be necessary (Bergman, 2004; Noddings, 1984, 2003).

While the caring-one acts in behalf of the cared-for's interests, the caring-one also cares for himselg or herself. Without the maintenance of their own capabilities, they will not be able to continue to engage in caring. For Noddings, care is an attitude and an ideal

manifested in activities of care in concrete situations. However, an individual cannot be caring to the point of selflessness; for if this occurs, the individual will lack self-respect. The individual who participates in an admirable practice of care will not only respect him or herself, but will also foster mutual respect and mutual sensitivity (Held, 2006).

From these early philosophical beginnings, the concept of caring has been the focus of research for such professions as education (Noddings, 1984, 2003), social work (Freedberg, 1993), rehabilitation (MacLeod & McPherson, 2007), physical therapy (Greenfield, 2006), psychiatry (Stiver, 1986), psychology (Batson, 1990; Craig, 1987), counseling (Halstead et al., 2002; Skovholt, 2005), medicine (Brezis, 2009), and to the greatest magnitude, nursing (Craig, 1987; Huffman & Brubaker, 2009; Maggs, 1996; Rundqvist et al., 2011; Schwerin, 2004; Sitzman, 2007; Wilkes & Wallis, 1998; Woodward, 1997). From this extensive research, caring has evolved to mean different things, thus receiving a wide range of interpretations (Sitzman, 2007).

Caring involves concern, empathy, and consideration for the needs and values of others. This may be demonstrated through such things as understanding the other person's perspective, advocating for the needs of others, communicating effectively with the other person both verbally and nonverbally, embracing the other person's emotional and psychological needs, and attending to the cared-for's needs. Individuals also show that they care by not only respecting others, but also considering the cared-for as unique and of value (Greenfield, 2005). Caring includes feelings of compassion, competence, confidence, commitment, and comportment, that is, essentially caring from the heart (Rundqvist, et al. 2011). Caring requires mutuality and the cultivation of ways of achieving this in the various contexts of interdependence. It also requires a substantial

capacity for being sensitive to the feelings of others as well (Held, 2006).

**Ethic of Caring**

From the concept of caring as outlined earlier, the ethic of caring developed. Essentially the ethic of caring is based on the recognition that individuals exist in relationship and connection with one another (Held, 2006; Remley & Herlihy, 2010). It is for this reason that the ethic of caring is also known as relational ethics. This differs from other ethical theories (e.g., ethical absolutism versus ethical relativism, utilitarianism versus deontology, and egoism versus altruism) in that these ethical theories focus on the question of what constitutes ethical action. Relational ethics also differs from Aristotelian virtue ethics in that virtue ethics focuses on what constitutes ethical character (Held, 2006; Remley & Herlihy, 2010). Relational ethicists do not disagree with principle ethicists; it is just that their focus is different. The ethic of care is a practice rather than a set of rules or principles (Tronto, 1993). Relational ethicists view moral actions as those that empower individuals, promote social justice, and ensure that all people are cared for and nurtured to develop their potentials (Remley & Herlihy, 2010; Vasquez, 2008).

Noddings (1984, 2003) distinguished caring from ethical caring in concluding that sometimes natural caring is not enough for engrossment and motivational displacement to occur. When that happens, then the caring-one needs to summon up what she refers to as the "I must." For the caring-one, there is an arousal feeling of "I must do something." It is at this point that the caring-one recognizes an obligation to care. For Nodding, only when the caring-one sees the reality of the cared-for as a real possibility does the caring-one genuinely care (Noddings, 1984, 2003).

Noddings (1984, 2003) does acknowledge that even if an individual feels the initial "I must," that feeling may be rejected immediately by shifting from "I must do something" to "Something must be done", thus allowing the individual to avoid taking any personal action. However, if the individual chooses not to act on behalf of the needs of the other, than the individual indicates that they do not care. Noddings (1984, 2003) concludes that caring requires individuals to respond to the initial "I must" with an act of commitment either by committing an overt act on behalf of the cared-for or to at least thinking about what might be done. It is this "I must" that Noddings refers to as ethical caring.

According to Noddings (2002), we recognize an obligation to care because we value the relatedness of natural caring. Noddings (2002) concludes:

> When we care, we must employ reasoning to decide what to do and how best to do it… But reason is not what motivates us. It is feeling with and for the other that motivates us in natural caring. In ethical caring, that feeling is subdued, and so it must be augmented by a feeling for our own ethical selves (p. 14).

Noddings (2003) defines this ethical self as "an active relationship between my actual self and a vision of my ideal self as one-caring and cared-for" (p. 49). This ethical self is born of the recognition of relatedness. Nodding (2003) further states,

> As I care for others and am cared for by them, I become able to care for myself. The characteristic "I must" arises in connection with this other in me, this ideal self, and I respond to it. It is this caring that sustains me when caring for the other fails, and it is this caring that enables me to surpass my actual uncaring self in the direction of caring" (pp. 49-50).

Thus, the ethical self is based upon an ideal self that is developed in congruence with the best remembrance of caring and being cared-for.

Ethical caring requires an effort that is not needed in natural caring (Noddings, 2003). While Noddings believes like Kant that ethics evolves out of duty and not out of

love, Noddings also believes that an ethic built on caring strives to maintain a caring attitude that is dependent upon, but not superior to, natural caring. Ethical caring then is committing to obey the "I must" even at its weakest and most fleeting, rather than rejecting it. When this is done, the individual is operating under the best picture of him or herself caring and being cared for (Noddings, 2003).

An ethic of caring also reflects a cumulative knowledge of human relationships. It evolves around the central insight that self and others are interdependent (Gilligan, 1982; Held, 2006). This then effects how we make ethical choices. It is no longer just between right and wrong, ethical absolutism versus ethical relativism, utilitarianism versus deontology, or egoism versus altruism. It is about the responsibility to care for both self and others. That responsibility and interdependence frees the individual from the conventional constraints and gives a whole new meaning to the injunction do no harm. Caring and the ethic of care actually frees individuals from the paralyzing injunction not to hurt others to an injunction to act responsively toward self and others and thus to sustain connections (Gilligan, 1982).

According to Held (2006), ethical caring is about cultivating relationships, responding to need, and demonstrating sensitivity to individuals. By this virtue, the ethic of caring builds on the experiences that all individuals share, although they may not be aware of its embedded values and implications. Thus the ethic of caring attends especially to relationships between individuals, evaluating each relationship and valuing the relationships of care. It does not assume that every relationship has been entered into by equal individuals. Rather it appreciates well the relationships that have been entered into between individuals of unequal power (Held, 2006).

In summary, the research conducted on caring and the ethic of caring indicates that caring is based on the natural caring that is received through a relationship with at least one adult who has learned how to care by having been cared for. Because of this natural caring, the caring-one is able to see the needs of another individual with a desire to meet those needs in such a way that a connection is maintained with the other individual. However, sometimes this natural caring is not enough to generate a desire to meet the needs of the other individual. When that happens, the ethic of caring takes over in the caring-one. The ethic of care is the obligation to care whereby the caring-one summons up a feeling of "I must do something" such that the caring-one not only sees the reality of the cared-for as a real possibility, but also actively responds to the cared-for.

# Chapter III

## Methodology

While caring is often assumed to be a prominent characteristic of counselors, a paucity of research exists on the subject. Therefore, this study was designed to explore the concept of caring and the ethic of caring among LPCs. In addition, this study examined the connection, importance, role, and manifestation of caring and the ethic of caring in the counseling relationship. Furthermore, ethical dilemmas that caring for clients may create for LPCs were investigated. Since so little research had been conducted in regard to caring and the ethic of caring among counselors, this study was based on the phenomenological perspective of LPCs.

In this section, the research methodology for this study is reported. This information is organized into the following sections: grounded theory, research questions, rationale, research design, context of the study, data sources, participant selection, ethical considerations, data collection methods, data management plan, data analysis, research ethical considerations, and criterion for goodness.

### Grounded Theory

The theory upon which this study was based was grounded theory. Grounded theory began with the publication of *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). Glaser and Strauss were looking for an alternative to the research practice of testing hypotheses to prove existing theories. These researchers developed a way to foster new theories from collected data. According to Glesne (2011), Glaser and Strauss proposed an inductive strategy, whereby the researcher discovers concepts and hypotheses through constant comparative analysis. Glaser and Strauss also advocated

theory generation through inquiry calling the results grounded theory. "Grounded theorists argue that theories should be developed from the data collected in the field. Unlike quantitative researchers, grounded theorists neither test existing theory nor try to fit their data into preconceived concepts" (Heppner & Heppner, 2004, p. 148). In doing this, Glaser and Strauss (1967) began to direct research away from a few theories that were based on the conclusions of a limited number of famous theorists, and steer it toward theories that were grounded in real data. Grounded theory is widely used in many different disciplines using qualitative research, including education, counseling, and nursing (Johnson & Christensen, 2007). The goal of grounded theory is the construction of a theory by inductively deriving concepts generated directly from the data collected in the study. Thus, the emerging theory is grounded in the data. Strauss and Corbin (1990) wrote, "One does not begin with a theory, then prove it. Rather, one begins with an area of study, and what is relevant to that area is allowed to emerge" (p. 23).

According to Heppner and Heppner (2004) "The hallmark of grounded theory research is constant comparative method" (p. 150). The constant comparative method was used throughout this study. There are various ways to conduct a constant comparative analysis, "Since this is an inductive and intuitive process, there are no simple procedures or techniques for this kind of analysis" (Taylor & Bogdan, 1998, p. 156).

**Research Questions**

Using LPCs as participants, this study examined the concept of caring, the ethic of caring, and how caring and the ethic of caring might lead to ethical dilemmas. Accordingly, the following research questions were utilized during this study:

1. What concepts do Licensed Professional Counselors believe about caring?
2. What concepts do Licensed Professional Counselors believe about the importance of caring in counseling?
3. How do Licensed Professional Counselors perceive the role of caring in the counseling relationship?
4. How do Licensed Professional Counselors conceptualize ways that caring is manifested within the counseling relationship?
5. How do Licensed Professional Counselors maintain a caring professional presence when they find it difficult to do so under difficult circumstances?
6. Under what circumstances have Licensed Professional Counselors found that caring for clients might lead to ethical dilemmas?

**Rationale**

The qualitative paradigm was selected for this study because qualitative research examines the meaning behind various actions, events, and individuals (Denzin & Lincoln, 2005). Qualitative research lends itself to providing researchers an understanding of the perceptions of others and to explore what meanings individuals give to things in their lives (Berg, 2001). This study focused on gaining a better understanding of LPCs' conceptualization of caring and the ethic of caring in the counseling relationship.

Interviews of LPCs were conducted for the purpose of gaining additional insight concerning how they understood caring and the ethic of caring in the counseling relationship. Taylor and Bogdan (1998) wrote that in-depth interviewing is especially well suited when the research interests are relatively clear and well defined. They also concluded that research interests in qualitative research are usually broad and open-

ended. Thus, this design allowed the researcher to fully understand caring and the ethic of caring in the counseling relationship from the perspective of practicing LPCs.

There are advantages and disadvantages in conducting in-depth interviews, as reported by Taylor and Bogdan (1998), who wrote:

> It is also important to point out the limitations of interviewing. First, individuals say and do different things in different situations. Since the interview is a particular kind of situation, you cannot assume that what an individual says during an interview is what that individual believes or will say or do in other situations. (p. 91)

Another disadvantage is in the time it takes to conduct in-depth interviews. However, despite the disadvantages, there is a great advantage of this design because the flexibility of the interview allows the interviewer to follow the interviewee in the direction that particular experiences might lead.

**Research Design**

In order to understand the phenomenon of caring and the ethic of caring in the counseling relationship from the participant's frame of reference, a qualitative research paradigm was implemented for the study. The benefit of using a qualitative design is that the researcher is able to obtain thick, rich descriptions of phenomenon that have not been widely studied previously (Gall et al., 2007; Glesne, 2011). Further, qualitative design openly explores a phenomenon without imposing preconceived assumptions on the phenomenon being studied. Also, participants are able to elaborate however they see fit and are not limited to the specific questions that would be asked in a quantitative design; thus allowing the gathering of germane information related to the counselor's experiences, beliefs, attitudes, and perceptions (Gay, Mills, & Airasian, 2006). The flexibility of the qualitative design allows for additional probing about the participants'

answers; in turn, this flexibility allows the researcher to follow the experiences and meanings given by counselors without attempting to control the context or environment (Gay et al., 2006). Finally, this design allows the researcher to obtain examples from the counselors' experiences.

**Context of the Study**

Interviews for this study were conducted in the offices of LPCs residing in the Southwest United States. Taylor and Bogdan (1998) recommended creating an atmosphere for the participants in which the participants are likely to talk freely, and to try spending time with the individuals "on their own turf" as the individuals go about their day-to-day lives. Therefore, the offices of the LPCs were selected as the sites for the interviews because the LPCs most likely felt safe and comfortable in this environment. Being comfortable and feeling safe in the setting where the interviews occurred enabled the counselors to respond fully and completely to the research questions, thus making for more in-depth and honestly transparent results from the interviews possible. The offices of the LPCs were also secure, private settings because this is where the LPCs usually conduct their counseling sessions.

**Data Sources**

Several sources for data gathering were used in conducting this study. The primary source was the individual interviews. Another major source was the published literature. The final source was the researcher's observations within the context of the qualitative study.

The final source of data collection was in the form of observations during the interviews. This is an important aspect of the data collection because it allows for

identification of any discrepancy between what a participant is saying and what he or she may be feeling as indicated by body language. One potential risk factor in this type of observation is that it may not always account for personal habits or quirks of the individual.

Participants were presented research questions during individual interviews. The answers were recorded, and follow-up questions were asked when clarification was needed. The literature review provided background information to better understand caring and the ethic of caring as the participants conceptualized this phenomenon.

The participants were selected on the basis of both convenience sampling and purposive sampling. Convenience sampling relies on the availability of subjects. One issue with convenience sampling is that a researcher may be interested in studying the characteristics or processes that the readily available sample cannot provide. The benefit of this type of sampling is that it can provide information on research questions quickly.

Purposive sampling utilizes a small sample that meets specific criteria established to best answer the qualitative research questions; this differs from quantitative research where the primary goal is to represent the general population (Silverman, 2001). Because qualitative researchers use a small number of participants, it is more likely that bias could occur. According to Berg (2001):

> When developing a purposive (judgmental sampling) sample, researchers use their special knowledge or expertise about some group to select subjects who represent this population. In some instances, purposive samples are selected after field investigations on some group in order to ensure that certain types of individuals or individuals displaying certain attributes are included in the study. Despite some serious limitations (for instance, the lack of wide generalizability), purposive samples are occasionally used by researchers. (p. 36)

All participants for this study were selected on a voluntary basis. Taylor and

Bogdan (1998) wrote the following about selecting participants:

> Although all individuals have one good story to tell, their own, some individuals have better stories and make better research partners for the purpose of constructing a life history. Obviously, it is essential that an individual have the time to devote to the interviewing. Another important consideration is individuals' willingness and ability to talk about experiences and articulate feelings. Individuals simply do not have equal ability to provide detailed accounts of what they have been through and what they feel about it. (p. 94)

In accordance with *The Belmont Report* (1978) on the selection of human subjects, all precautions were taken in order to ensure that individual and social justice was maintained while selecting participants. Individual justice requires that all researchers exhibit fairness while selecting participants. In order to conform to social justice principles, the above listed criteria and preferences guided the procedure for selecting participants.

**Participant Selection**

Twelve participants were selected for this study. The rational influencing choosing 12 participants evolved from reviewing five qualitative research studies and averaging the number of participants that other researchers had chosen for their studies. The following research studies were reviewed: Counselors' conceptualization of caring in the counseling relationship by Halstead et al. (2002) included 13 participants. Caring in nursing: Investigating the meaning of caring from the perspective of cancer patients in Beijing, China by Lui, Mok, & Wong (2006) utilized 20 participants. Practices for caring in nursing: Brazilian research groups by Erdman et al. (2011) had 12 participants. Caring, competence and professional identities in medical education by MacLeod (2011) consisted of 7 participants. Municipal night nurses' experience of the meaning of caring by Gustafsson, Asp, & Fagerberg (2009) interviewed 7 participants. These five studies

provided a mean of 12 participants.

Participants were selected according to the following criteria:

- Participants were Licensed Professional Counselors. LPCs were selected because this group of counselors had not been previously studied in regard to caring and the ethic of caring. In the only other study conducted utilizing this topic, Halstead et al. (2002) used master's-level counseling interns as participants.
- Participants were fully licensed as an LPC for a minimum of 1 year. Being fully licensed as an LPC for a minimum of one year provided the participants with enough counseling experience whereby their view of caring is likely to be different from master's-level counselors who are initially beginning their career as counselors and thus lack the experience that LPCs fully licensed for a minimum of one year will have as counselors.
- Participants had practiced as Licensed Professional Counselors for minimum of 1 year. Some individuals have and maintain their LPC licenses but do not, or have not for a number of years, practiced as LPCs for various reasons. These individuals would have had different experiences and conceptualizations of caring and the ethic of caring then do LPCs who are practicing as counselors. This study therefore focused on the experiences of those individuals who are practicing counselors.
- Participants did not have any complaints filed against them with the Licensure Board. This study in part examined the ethics of counselors via the ethic of caring and ethical dilemmas that counselors might experience because of their caring for clients in the counseling relationship and their desire to fulfill the ethic of caring

for their clients. LPCs who have had complaints filed against them have had their ethics challenged.

**Ethical Considerations**

Steps were taken to avoid any sense of ethical impropriety. All proper applications and information were submitted to the Human Research Protection Program (HRPP) at Texas Tech University, and research did not proceed until approval by the HRPP had been received. All participants were given complete information to assure full knowledge of the objectives of the study was understood.

Each participant was required to read and sign a consent form (see Appendix B). All research was conducted on a voluntary basis. There were no consequences for those who did not choose to participate or who decided to withdraw during the study; this was explained to the participants.

All guidelines presented by the HRPP at Texas Tech University regarding informed consent were adhered to. The informed consent form that was used for this research study is located in Appendix B. This form contains information required by HRPP such as informing the participants of the purpose of the study, what is required from the participants, warning of any potential risks, explanation of how confidentiality will be handled, as well as the rights of the participants. The anonymity of each participant was protected at all times throughout the research and in the written submission of the data and results.

**Data Collection Methods**

Data was collected using semi-structured, in-depth interviews. Interviews were

conducted because it allowed for appropriate data for this type of study. Interviewing provides a useful means of access particularly when investigators are interested in understanding the perceptions of participants or learning how participants attach certain meaning to phenomena (Taylor & Bogdan, 1998). Qualitative interviewing allows a researcher to enter into the inner world of another individual and to gain an understanding of that individual's perspective (Patton, 1987).

The interview questions that were asked of each participant were the following:

1. What is your concept of caring?
2. What makes caring important in counseling?
3. What is the role of caring in the counseling relationship?
4. How is caring manifested within the counseling relationship?
5. How do you maintain a caring professional presence when you find it difficult to do so under certain circumstances?
6. What are some ways that caring for your clients might lead to ethical dilemmas?

The above questions were designed by examining the research questions and formulating interview questions that would best provide needed data to answer the proposed research questions. Following his research analysis, Berg (2004) posited the following about the content of interview questions, "The researcher must take into consideration the central aims and focuses of their studies" (p. 85). The order of the interview questions have been established in a sequence that will help the participants respond in a natural sequential order.

The interviews were all conducted at the convenience of the participants, thereby,

allowing the interviews to occur when the participants' schedules permitted. The locations of the interviews were the offices of each individual LPC. The offices of the LPCs were selected as the sites for the interviews because the LPCs likely felt the safest and the most comfortable in this environment. These offices were also secure, private settings because this is where the LPCs usually conduct their counseling sessions. The entire interview process – introductions, reading and signing of the informed consent, completion of the short demographic information sheet, and the interview itself – took approximately 30 minutes. The actual interview ranged in completion time from 16 to 26 minutes in length, with most of the interviews being about 20 minutes.

**Individual interviews.** Qualitative studies typically rely on the use of interviews as the primary source of data collection (Rossman & Rallis, 2003). There are three types of interviews: the unstructured or informal conversational interview, the semi-structured interview, and the structured or standardized open-ended interviews (Gall et al., 2007; Glesne, 2011). Unstructured interviews do not follow a detailed interview guide, however, they do lead the participants to the desired information in a more conversational manner. Structured or standardized interviews are the least in-depth and contain predetermined questions worded the same for each participant. This type of interview tends to provide for less flexibility and spontaneity than the other types. The interviews that will be used in this study will be the semi-structured interview. This type of interview uses the structure of preset open-ended interview questions, while simultaneously maintaining flexibility to veer into different areas that the participants deem relevant to this study.

In qualitative research, it is important to develop and maintain rapport with the

participants so that they will be comfortable throughout the interview process. Being comfortable with the researcher allows the participants to more freely and openly respond to the interview questions. Researchers (Taylor & Bogdon, 1998) noted certain attributes that make for a good interviewer, and in some instances, many of these same attributes can be found in a successful counselor. One attribute is the ability to look ahead and anticipate how to present one's self to the participant. Another attribute is a natural curiosity to learn what the participant has to say and avoiding persuading the participant to focus on how to view a particular issue. Attentive listening and patient probing are also attributes of a good counselor, attributes that are also useful in the role of interviewer. These skills include using attentive listening skills such as eye contact and nodding, using gentle probes such as "tell me more about . . ." and "I'm wondering about . . ." to help the participants further explain themselves, and being cognizant of mannerisms. Being aware of the differentiation of power between the interviewee and interviewer is also important, as well as, appropriate attire worn to the interview. Such attire should be appropriate for the interview situation. Beginning the interview with a brief informal conversation is another means for building rapport.

During the interviews, participants were observed; these observations by the researcher allowed for identification of any discrepancy between what participant was saying and what he or she may have been feeling as indicated by body language. One potential risk factor in this type of observation is that it may not always account for personal habits or quirks of the individual.

**Data Management Plan**

Researchers (Richards & Richards, 1987) suggested that the use of computers is

beneficial to manage data as well as analyze data. According to Richards and Richards (1987), computers easily offer assistance in the management of complex data. Computers also can be used in the discovery and management of unrecognized ideas and concepts, and the construction and exploration of explanatory links between the data and emergent ideas, to make fabrics of argument and understanding around them. Richards and Richards (1987) stated that these processes involve the recognition of categories in the data, generation of ideas about them, and exploration of meanings in the data. Because the categories and meanings are found in the text or data record, this process demands data management methods that support insight and discovery, encourage recognition and development of categories, and store them and their links with data. The computer program used to store and analyze data for this study was NVivo 10, which has been widely used in qualitative research for many years.

The time frame designated for the management of the data was to conduct interviews with the participants upon approval of the study by the HRPP of Texas Tech University. The recruitment process and interviews took approximately five weeks. The data gathered from participants consisted of individual in-depth interviews that were digitally recorded. These recordings were then transcribed. Each participant was then sent his or her transcription for checking by the individual. The participants were given two weeks to review her or his interview transcription and to make any changes and/or additions. Once that process was completed, the data were added to the computer program. Once the data had been added, it was reviewed line-by-line and initial coding was conducted. Upon reading of the text, a code was assigned to areas of significance; these codes helped in text reduction and locating of data. It also assisted in the

development of potential themes. "Codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled" (Miles & Huberman, 1994, p. 56). The coding was beneficial in organizing and later finding particular sets of data: "The organizing part will entail some system for categorizing the various chunks, so the researcher can quickly find, pull out and cluster the segments relating to a particular research question, hypothesis, construct, or theme (Miles & Huberman, 1994, p. 57). A codebook was developed and maintained in order to help organize these codes. All codes had a name and a description of each code as well as some sections of text to serve as examples. The codebook was developed using the NVivo 10 software. The codebook allowed for ease of understanding when reviewing the codes throughout the analysis process. The codebook was refined as analysis continued.

With each theme that emerged, memos were made to organize the themes that were later used in the actual writing of the findings. The program was also used to write initial memos about the emergent themes. Johnson and Christenson (2007) summarized the purpose of memos as:

> Memos are reflective notes that researchers write to themselves about what they are learning from their data. The content of memos can include notes about anything, including thoughts on emerging concepts, themes or patterns found in the data, the need for further data collection, a comparison that needs to be made in the data, and virtually anything else . . . Memoing is an important tool to use during a research project to record insights gained reflecting on data. Because qualitative data analysis is an interpretative process, it is important that you keep track of your ideas. (p. 501)

Reviewing coding and memos were a great asset. Analytic files were kept in order to assist in the organization of thoughts (Lofland, Snow, Anderson, & Lofland, 2005). This assisted in the management of individuals and places, ideas concerning introductions, and conclusions. It also directed the organization of memos written about

the data. These files changed and grew as the research project continued.

This process was very detailed and time consuming; therefore, two months were allowed for the process of data collecting and management. Extra time was also allowed in the event the participants had scheduling problems and to accommodate any unforeseen issues that developed in the participants' personal lives.

All of the data management previously mentioned was a benefit in working with the collected data when the full analysis phase was entered. As mentioned earlier, the amount of data collected was vast, and the computer program assisted greatly in managing the data throughout the analysis phase. The final analysis phase took approximately two month. The analysis of the data, memos, coding, and individual quotes from the text were used in order to write the findings and results of this study. The computer program was useful in organizing each of these sections, which in turn allowed easy retrieval of the components necessary to write the remainder of the dissertation. Writing the final sections of the dissertation took approximately three months; this time frame allowed for unforeseen events that occurred and delayed the process. Upon completion of the dissertation, the data collected by digital recording were destroyed in order to protect the privacy and confidentiality of the participants.

**Data Analysis**

Qualitative researchers tend to agree that data analysis begins during the collection process and should not wait until all the data have been collected (Glesne, 2011; Rossman & Rallis, 2003; Stake, 2000). According to Glasne (2011), concurrent data analysis helps shape the study. Emerging themes from this early analysis can alert the researcher to questions not previously considered that could be asked in subsequent

interviews. Early and ongoing analysis not only keeps data from becoming too unwieldy and overwhelming to the researcher, but also brings order, structure, and meaning to the mass of collected data (Rossman & Rallis, 2003).

One method of organizing the data involves creating analytic files to separate data by data type, person, emerging themes, or quotations (Glesne, 2011). This particular method helps the researcher find information more easily, begin coding schemes that will carry on throughout the analysis, and help the researcher with condensation of data (Rossman & Rallis, 2003). During and after organizing data, steps were taken to become more familiar with the data. This involved transcribing the interviews and reading them numerous times to gain an overall understanding about the information (Agar, 1996). Wertz (2005) suggests searching the data for collective perspectives across participants, moving from part to part and part to whole. Differences in experiences will also be noted in order to better understand what has been collected (Hays & Wood, 2011).

Categories and themes, with categories describing explicit information and themes describing more implicit processes, will be generated during the process of becoming familiar with the data (Rossman & Rallis, 2003). Some of the categories and themes will be inductive, thus meaning they emerge through analysis and are preconceived (Ellingson, 2011; Glesne, 2011; Patton, 2002). Other themes and categories may be deductive, stemming from the related literature and parameters of the study (Rossman & Rallis, 2003). During this process, statements that exemplify significant answers to the research questions were noted, written down, and categorized.

Once initial categories and themes were generated, coding of the data began, with additional categories and themes being added as required. Some statements had multiple

codes because they involved more than one category or theme. Codes also changed as new insights are gained over time. The process of coding occurred multiple times since themes and categories naturally changed as additional thoughts on caring were encountered. Broad codes were utilized at the beginning of the study followed by more specific subcoding as the coding process proceeded.

After the data had been coded, data analysis interpretation commenced. It was during this process that synthesis occurred, meaning was attributed, essence was brought forth, and possible explanations were advanced (Cresswell, 2007; Rossman & Rallis, 2003). According to Rossman and Rallis (2003), interpretation is where the phenomenon is described in terms of thought, ideas, and experience. Interpretation also included searching for alternative meaning and understanding of the concept being researched.

Finally, categories and themes from the coding and analysis were condensed into major themes. These major themes were then be used to write a description of caring and a description of what the participants experienced in regard to caring and the ethic of caring. Such themes were used to answer the research questions.

**Research Ethical Considerations**

The *ACA Code of Ethics* (2005) mandates that counselors obtain and maintain the informed consent of all participants. This consent is to inform the participants of the perceived benefits and risks of the study as well as to inform them of their right to participate voluntarily or withdraw at any time. The informed consent also advises the participants of the anonymity and confidentiality. Maintaining anonymity and confidentiality of the participants is of utmost importance. For that reason, pseudonyms were used for each of the participants, and each participant was allowed to choose the

pseudonym they desired. All of the participants except two chose their own pseudonyms. Pseudonyms not chosen by the two participants were randomly chosen by the researcher to protect the identity of these two participants.

Finally, accountability and accuracy are extremely important in qualitative research. To maintain the highest amount of accuracy possible, member checks and an audit trail were utilized. In order to minimize bias, a researcher journal was also used to reflect on the process.

**Criteria for Goodness**

In quantitative research, reliability, validity, and generalizability help determine the quality and rigor of the study (Patton, 2002). On the other hand, the goal of qualitative research is to gain a thorough understanding of a phenomenon while maintaining the highest possible level of quality. In order to achieve this, qualitative research, therefore, focuses on trustworthiness.

Lincoln and Guba (1985) in discussing trustworthiness at length give four conditions for a study to be trustworthy: credibility, transferability, dependability, and confirmability. Credibility addresses how credible findings and interpretations appear. Strategies that were used to establish credibility in this study included triangulation, peer debriefing, and member checks. Triangulation requires multiple informants, sources of data, or theories be used to ensure that fuller and varied picture of the phenomenon is gathered. Twelve interviews, observations, and a researcher's journal were used to aid credibility. Peer debriefing involves using someone not involved in the study that can explore the process with the researcher and help foster awareness. A peer knowledgeable in qualitative research and the field of counseling will be utilized as a peer debriefer to

provide input. Member checks were preformed by each of the participants to make sure their comments were perceived accurately and to provide a summary of their information, which is helpful during data analysis. Transcripts of their interviews were sent to each participant to obtain their feedback and to allow for revisions or additions.

The second condition of trustworthiness is transferability. Transferability refers to the degree to which the results in the study can be applied to similar populations in other contexts. Transferability was enhanced in this study through the use of thick descriptions of the participants, environments, processes, and assumptions guiding the study that provide a detailed database of information that can be used by others to determine whether the findings could transfer to their own contexts. Following Shenton's (2004) suggestions, information on the participants were included. Also included is detailed information on data collection methods, number and length of interviews, and time period of data collection. In essence, enough information has been provided in this study through thick description that the reader can decide if the information transfers, or is applicable to their situation.

Dependability, that is, demonstrating that the findings are consistent, is the third criterion for trustworthiness. In order to meet this requirement, substantial detail about research design and implementation, the process of data collection, and a reflection of the research process was included. This, according to Shenton (2004), allows the reader to understand the process, and if desired to replicate it in future studies. Further strategies that address dependability are triangulation of data and sources and the use of analytic files and an audit trail. The audit trail is used during and after the data interpretation process to serve as justification for how conclusions came about. Interview transcripts

were continuously matched up to interpretations made in the results section to increase dependability.

The fourth and final construct is confirmability, the degree to which the results come from the participants and not the researcher's bias. Lincoln and Guba (1985), in addressing this construct, seek objectivity by asking if another individual can confirm the results of the study. That is, would an objective third party, such as an informed reader or critical friend, be able to see the logic of inferences made by the researcher? What Lincoln and Guba assert by approaching confirmability in this way is to say that the interpretive nature of the inquiry can be made somewhat transparent to others, thus increasing the strength of the assertions. Like Lincoln and Guba, Marshall and Rossman (2010) propose several strategies that the qualitative researcher can build into the study in order to limit bias in interpretation. Among them is the use of a research partner or a critical friend who thoughtfully and gently questions the researcher's analysis. In this study a colleague who, by profession, is an historian and professor with qualitative research experience was used in this capacity. This research partner reviewed the analysis, interpretations, and assumptions in order to bring objectivity and critical mindfulness to the study.

# Chapter IV

# Results

## Organization

In this chapter the results from the study will be reported. This chapter is focused on the following subsections: Statement of the problem, Description of Participants, Analysis of Data, Research Questions 1-6, and Summary.

## Restatement of the Problem

Although a natural connection between counseling, caring, and the ethic of caring seems to exist, there is a paucity of research in the counseling literature in regard to caring and the ethic of caring in counseling. Specifically, the researcher found only three articles involving counselors as care agents. Caring and the ethic of caring are aspects of counseling that have been largely ignored in the counseling literature (Halstead et al., 2002). This omission is perplexing because caring is an important component of counseling.

While caring alone is not sufficient to ensure effective counseling practice, several researchers suggest that there are clear benefits when clinically competent professionals integrate caring into their practice (Benner & Wrubel, 1989; Freedberg, 1993; Noddings, 1984, 2003; Peloquin, 1993; Roach, 1987; Swanson, 1993; Watson, 1988). In their report, Tresolini and The Pew-Fetzer Task Force (1994) strongly advocated for relationship-centered care. Specifically, they stated that relationship-centered caring is the foundation of therapeutic activity, and that relationships are not only critical to the care provided by practitioners but are also a source of satisfaction and positive outcomes for clients and practitioners.

**Description of Participants**

In this section, each of the participants with their demographic information will be introduced. To maintain confidentiality, the information will be presented utilizing the pseudonyms that most of the participants chose for themselves.

**Mariposa.** Mariposa is a Caucasian female. She is 66-70 years of age with a Master's degree. She has been fully licensed for 14 years and has practiced as an LPC the entire 14 years. Her primary counseling theory-base is Cognitive Behavioral Therapy (CBT).

**Delilah**. Delilah is a Caucasian female. She is 56-60 years of age and has a Master's degree. She has been fully licensed as an LPC for 13 years and has practiced as an LPC all 13 of those years. Her primary theory base in counseling is CBT.

**Tara**. Tara is a 66-70 year old white female. She has a PhD degree and has been a fully licensed LPC for 13 years. She has practiced as an LPC for 13 years as well. Her primary counseling theory is systems theory.

**RSST**. RSST is a Caucasian male 56-60 years of age. He has a Master's degree and has been fully licensed for 13 years. He has also practiced as an LPC for 13 years. His primary counseling theories are CBT and Reality.

**Laynie**. Laynie is a 66-70 year old white female. She has a Master's degree and has been both fully licensed and practicing as a LPC for 10 years. Her primary theory-base when conducting counseling is CBT.

**Barney**. Barney is a 56-60 year old Caucasian male with a Master's degree. He has been fully licensed and has practiced as a LPC for 20 years. The counseling theory he uses primarily when counseling is Rational Emotive Behavioral Therapy (REBT).

**Sigmund**. Sigmund is a white male. He is 66-70 years of age and has a PhD degree. He has been fully licensed as a LPC for 17 years. He has also practiced as a LPC for 17 years. Sigmund identified his primary counseling theories as CBT and Object Relations.

**Kathleen**. Kathleen is a Caucasian female, 46-50 years of age. She has a PhD degree and has been fully licensed as an LPC for 10 years. Kathleen has also continually practiced counseling as a fully licensed LPC for 10 years. Her primary theory-base in counseling is Integrative.

**Susan**. Susan is a 46-50 year old Caucasian female with a Master's degree. She has been fully licensed for 10 years and has been counseling as a LPC for 10 years. Susan self-identified her primary counseling theory-base as Integrative.

**Mya**. Mya is a Caucasian male. He is 51-55 years of age. He has a Master's degree and has been fully licensed as a LPC for 10 years. Mya has also practiced continually as a fully licensed LPC for 10 years. He identified his primary counseling theories as Integrative and Family Systems.

**Pancho**. Pancho is a Hispanic male between the ages of 61 and 65. He has a Master's degree and has been fully licensed as a LPC for 30 years. However, he has practiced continuously as a fully licensed LPC for 29 years. His self-identified primary counseling theory-base is Cognitive Restructuring.

**Carla**. Carla is a 56-60 year old Anglo female with a Master's degree. She has been fully licensed for 23 years, but has practiced continually for 21 years. Carla identified her primary theories when counseling as Client Centered/Ellis and Reality Therapy.

## Analysis of Data

### Research Question 1

What concepts do Licensed Professional Counselors believe about caring?

**A natural ability to care.** The first theme to emerge was a natural ability to care. This theme encompasses the idea that counselors have the innate capacity to care for their clients. It appears to be something that counselors are born with and not something that they learned along the way, especially when they entered graduate school to start studying to be a counselor. At the very least this natural ability to care is based on the natural caring that is received through a relationship with at least one adult who has learned how to care by having been cared for (Noddings, 1984, 2003). This might involve what the adult did, how the adult took care of us, and once basic needs were met, how the adult cared about us. These experiences are both physical and emotional (MacLeod & McPherson, 2007). When such caring occurs in the lives of individuals the result is that they then have a memory of caring and being cared for. It is through this caring process that individuals learn how to spontaneously care for others (Bergman, 2004; Noddings, 1984, 2003).

Barney posited this in regard to counselors' natural ability to care: "I don't think you could be a good counselor without caring." Although Tara expressed this idea as well, she also saw it as something that emanates from the counselor rather than the counselor needing to voice it. In other words, clients can instinctively tell that the counselor is a caring person.

> **Tara**: For me, if you're a caring, compassionate person, it's an energy that radiates so that people can perceive it when they're in your presence. It's that awareness of "Oh, she cares." So I think it's something that comes through nonverbally and by someone's presence more so than my saying, "Oh, I care so

much."

Laynie voiced somewhat the same thought. "It's hard for me to imagine a successful, a really good therapist, being able to be a good therapist and really not care." She also used spiritual terminology to express her idea.

> **Laynie**: Well I think, from my perspective, mine comes from who is God and what does he expect me to do in the world perspective. And He expects me to care about other human beings, and has put it inside me to care about other human beings.

Kathleen specifically stated that caring is "a natural trait that someone has;" that "they didn't start caring when they got into graduate school and started to become counselors." This is the way that Kathleen conveyed this idea in her own words.

> **Kathleen**: I think that most really good counselors, they didn't start caring when they got into graduate school and started to become counselors. I think it's an innate personality trait, that caring for other individuals that is a natural trait that someone has that allows them to be a good counselor. But I think it's something that someone always had or not had. I don't think that it's teachable in a classroom.

Pancho, on the other hand, said that for him caring was "to be kind to people." However, when RSST was asked about his concept of caring, he viewed this natural ability to care more in therapeutic terms.

> **RSST**: Caring is having concern about the wellbeing, the welfare, of the client. How well are they doing in the phases of their life, the areas of their life: the world of work, the world of home? How are they doing emotionally? How are they doing cognitively?

For Susan it was "I guess, just kind of loving people." Carla, on the other hand, saw caring as the cornerstone of counseling itself. This is the way that Carla stated it in her own words.

> **Carla**: Caring is the cornerstone for what we do in a helping profession. I felt like that when I was a teacher. And I always told myself that when I stopped

> caring about the student, I needed to leave that occupation. You can be an awesome teacher and impart wisdom, but if you don't have rapport and relationship with the person that you're teaching or that you're caring for, then I think that you deplete the interaction immensely. I've done that twice in my career where I could feel myself just say, "Oh, my gosh, do I have to do this again," and I thought it's time for me to leave. It's time for me to do something different or to take a break. I wouldn't have the personal reward and meaning in the job that I do if I didn't have genuine caring and positive regard for others. I wouldn't get any satisfaction out of being here and doing what I do and I'm not sure that I would be very effective. From the student or client side if they didn't feel that you had their best interest or care, that you cared genuinely about them as a human being and an individual, I don't think that would go very far. I've never had a lack of caring so I don't know what that would look like or feel like. I think when you get to that place as a professional, it's time to go sell cars or whatever, you know. That has to be the cornerstone of why we all go into a profession of teaching or counseling or social work. It has to be because we care about other people. I would assume that would be true but I've never met anyone that's gone into those professions that didn't. So that might be an assumption. Maybe there are plenty of people that can just do the mask and do the role-play and not really genuinely care. But that's not my experience.

**The therapeutic relationship.** A second theme that developed was the therapeutic relationship. Like Carl Rogers (1957) some of the participants believe that the therapeutic or counseling relationship is a salient and important aspect of caring. These participants believe that the counselor truly cares about the client through their therapeutic relationship with the client. They also believe that it is through this relationship that caring takes place in counseling. Sigmund was emphatic in this regard.

> **Sigmund**: Counseling is about the relationship. That's where I come from. That's my theoretical base that I add the other theories to, but I really do believe change comes from the context of the caring relationship that's developed between the counselor and the client.

Tara noted the numerous studies that were conducted across all counseling theories and how all these studies found that the most important variable was the personal relationship between the therapist and the client. She then commented that this must be very important and that she tries to develop therapeutic relationships with all of her

clients.

> **Tara**: I was thinking of something else too. Oh, one of the things they found in many meta-analytical studies on effectiveness comparing numerous approaches – marriage and family, psychology, RET, LPC, psychoanalytic, etc. – they found that the most important variable which crosses all the fields of study is the personal relationship between the therapist and the client. So it's the personal qualities of the counselor more so than the field. Which I find fascinating. So I think that's important. I try to build that relationship with my clients, if I can. It doesn't always happen. I can build that relationship with most of my clients. For me part of that is listening, and also using humor when I can, because I think humor often helps us kind of laugh with ourselves. Instead of making the problem bigger and bigger, it can make it more manageable. Some people don't like comic relief, and so they don't appreciate it.

As Tara also noted in her response, listening is important in developing that therapeutic relationship. According to Davis et al. (2008), actively listening to the client is a crucial element of the counseling relationship. Tara stated, "For me caring is listening to what people have to say, trying to understand their point of view and their worldview, and then working within this with my skills."

Pancho likewise mentioned listening in his definition of caring. While defining caring, Pancho stated, "My concept of caring is…to listen to them [i.e., clients]." Similarly, Mariposa included listening as part of her conceptualization of caring. As she spoke about caring in counseling trying to explain what caring means to her, Mariposa invoked spiritual language in her definition.

> **Mariposa**: I believe everyone that comes to me is important and deserves to be heard and valued and cared about. You know, that I have compassion toward them and that they are valuable. I listen to them. I try to help them to see the best in them. I'm always trying to help people see the good in them. Because I believe when you see good in you, you're seeing God or the Holy Spirit in you, the love in you, and that that's the place that feels good. You know, to feel separate from God can't feel any good.

Tara also spoke about a modification she made to a particular counseling technique that she believed was a caring adaptation for the client and a way of

maintaining the counseling relationship with the client.

> **Tara**: Oh, I know something else. As I was training in EMDR, Eye Movement Desensitization & Retraining – when clients participate they're supposed to relive the experience. I've modified it because people who have been abused, especially sexually abused, don't want to relive the abuse that they've gone through. So I modify it – they fly above their life and then pick up the trauma and destroy it. And so it is imagery which can heal a lot of trauma for people without them having to relive it. But I call it imagery, not EMDR. And for me, that's a very caring adaptation.

An important feature of the counseling relationship is that it is developed between the client and the counselor when the counselor is completely present with the client (Knox & Cooper, 2010). Delilah echoed this when she defined her concept of caring.

> **Delilah**: Caring is really being with your client in the moment. Kind of just, nothing else matters. Just you and your client. Just whatever is going on in that moment. You're not thinking about what you're going to be having for dinner or all the other stuff that you have to do. Just really paying attention, and just really trying to understanding what that client is saying.

**Rogers's core conditions.** Another theme that emerged from this research question on caring is Rogers's core conditions. According to Rogers (1957), three primary conditions are necessary and sufficient for therapy to be successful. Those three facilitative conditions are congruence, unconditional positive regard, and accurate empathy (Day, 2008; Kensit, 2000; Lazarus, 2007; Samstag, 2007; Watson, 2007). Consequently, the three primary counseling conditions are referred to as the core conditions.

These core conditions were identified by several of the LPCs as their concept, or at least part of their definition, of caring as a counselor. One, Carla, identified Carl Rogers's Client Centered Therapy as her concept of caring, stating, "My basic concept of caring is very student centered, or client centered." However, Carla went on to identify genuine caring and positive regard as part of her definition of caring.

> **Carla**: Caring is the cornerstone for what we do in a helping profession. I felt like that when I was a teacher. And I always told myself that when I stopped caring about the student, I needed to leave that occupation. You can be an awesome teacher and impart wisdom, but if you don't have rapport and relationship with the person that you're teaching or that you're caring for then I think that you deplete the interaction immensely. I've done that twice in my career where I could feel myself just say, "Oh, my gosh, do I have to do this again," and I thought, "It's time for me to leave. It's time for me to do something different or to take a break." I wouldn't have the personal reward and meaning in the job that I do if I didn't have genuine caring and positive regard for others. I wouldn't get any satisfaction out of being here and doing what I do and I'm not sure that I would be very effective. From the student or client side if they didn't feel that you had their best interest or care, that you cared genuinely about them as a human being and an individual, I don't think that would go very far. I've never had a lack of caring so I don't know what that would look like or feel like. I think when you get to that place as a professional it's time to go sell cars or whatever. You know, that has to be the cornerstone of why we all go into a profession of teaching or counseling or social work. It has to be because we care about other people. I would assume that would be true, but I've never met anyone that's gone into those professions that didn't. So that might be an assumption. Maybe there are plenty of people that can just do the mask and do the role-play and not really genuinely care. But that's not my experience.

Delilah utilized such Rogerian words as empathy and genuine, along with summarization of meaning and content as part of her definition of caring.

> **Delilah**: It's to be empathetic, sympathetic towards other people, clients, when you're in counseling. To really be as Rogers put it, genuine. I like his words of caring. Just really be open and honest. Yeah, beyond the words; summarizing meaning and content.

While Kathleen defined her concept of caring thusly, "It's having compassionate concern for another person." Mariposa also included the word *compassion* as part of her concept of caring. She stated, "I believe everyone that comes to me is important and deserves to be heard and valued and cared about, you know. That I have compassion toward them and that they are valuable." Mariposa went on to further clarify her understanding of caring through the use of the terms *cold* and *warm*. In regard to the term *warm*, Mariposa saw it more as maternal and in maternalistic terms. She explained

her idea in great detail.

> **Mariposa**: I've heard of cold therapists, you know. They're kind of cold and keep their professional distance, and maybe that's good for some people, I don't know, but it's just not who I am. I could never pull it off, you know. I can't imagine being cold and distant. For me it's about being warm. Being maternal really. Gentle. Inviting them to be gentle with themselves, more accepting of themselves. Imploring more feminine energies than masculine energies. You know, the feminine…the masculine energies – the doing, forcing, making things happen, kind of energy, and the feminine energies are the allowing, accepting, surrendering, being grateful, kind of energies. And I try to move them toward more of the feminine energies because I believe those energies endure. They're easier on a person. You know, to accept what is. You can have a desire for something different in the future; you can have intent for something different, but what is, is and there're no reason to struggle against it because it is. I don't know. I kind of believe like the Chinese when they say, "Know the masculine, but keep to the feminine." I think that's what helps women live longer, you know. Not pushing and struggling against everything. So mainly I guess really my approach is pretty maternal. It's like, you know, moms give a lot of unconditional love, unconditional positive regard. And it's usually the dad that sets the standards. And, you know, I find a lot of people have a real lack of ever having any one in their lives who really, completely accepted them just as they are. So I try and give them that.

Pancho was another LPC who used the words empathy and compassion as part of how he viewed caring. Pancho defined his concept of caring in part this way, "My concept of caring is…to be empathetic, to be compassionate." Susan also believes that empathy is a part of caring along with empowerment.

> **Susan**: Caring is being able to have like empathy, I guess, for people where they're coming from… so that you empower them and not enable them. I think caring is caring about someone enough to empower them, to show accurate empathy for their situation.

**Therapeutically meeting the needs of the client.** Caring according to those LPCs who espoused this concept of caring involves meeting the needs of the clients therapeutically. They believe that being able to achieve the goals that clients came to counseling for through the therapeutic process is the best way for counselors to care. It is

through the meeting of the clients' needs therapeutically that the counselor cares.

For Carla, it is placing the welfare of clients first, guiding them through the counseling process, helping them identify their agenda and journey, and then meeting the clients' needs as best she can.

> **Carla**: I genuinely put the welfare of the student as my focus. I help guide them in discovering what the best path for them would be. I don't have an agenda other than working with students to help them identify what their agenda, what their journey, looks like, and to meet those needs as best I can.

Laynie emphasized the fact that helping the client is part of caring for her. So for Laynie, it is all about the helping, helping the client get to the place in their life where the client wants to be. To let us know just how vitally important helping clients meet their needs therapeutically is for her, Laynie stated "I need to be doing something that's a little more direct as far as helping, caring helping, and so I need to be doing something that affects a person emotionally in some way."

> **Laynie**: How can I help them and if I didn't care or wouldn't care about helping them, so helping them is part of the caring, how can I help them get where they want to be in the future more than where have they been, where do you want to be, how can I help you get there. To walk alongside them, so to speak, and not to guide but to maybe get some resources that they wouldn't necessarily have, either things they haven't thought of or books they haven't read if they're readers, whatever. Just to be there to offer what I can. So I need to be doing something that's a little more direct as far as helping, caring helping, and so I need to be doing something that affects a person emotionally in some way. I might be helping them physically, but it would need to be something that touched them deeper than selling them shoes or giving them pizza.

While Mya also stressed that caring for him was meeting the needs of the client therapeutically, he also wanted to make sure that the client didn't become dependent upon him as a counselor. To underscore this point, he added that the counselor was only one person in the life of the client and that there were many other individuals who are able to help the client as well. He concluded that the client was quite capable of living

the rest of her or his life without needing him to do everything for the client. Here is how Mya put it in his own words.

> **Mya**: My concept, as a counselor, of caring would be trying to assess the needs of my client, and trying to help them to discover how to meet those needs apart from me. The proverb would be instead of giving them a fish I would rather teach them how to fish. That would be caring for me. It's a little bit subjective from one counselor to another, you know, about what their ideal of caring is, but I think the key is if you're willing to realize you're not the only person in that person's life and be content and just doing your part. I'm the counselor. I'm not the caseworker. I'm not the ad litem. I'm not the attorney. I'm not the judge. I'm not Social Services. I am one person. I am the counselor. And I will do my part in that person's life. And I will trust that they can live the rest of their life, you know, without needing me to do everything for them.

RSST stated in similar words and ways that his concept of caring was to help meet the needs of his clients therapeutically in counseling. He saw the knowledge, skills, and abilities that he had as counselor as the unique caring contribution he could make to his clients. Here is how RSST described caring.

> **RSST**: And the caring comes in with the idea that wherever it's hurting or causing problems wanting to move them to a place where the pain, the discomfort, is removed or the problem is solved. And the caring involves getting them to that point, the completion of treatment. Whereas, I don't love my clients, but I certainly care about their welfare and how well they do. So caring is helping the client in the counseling relationship to get them to a better place. I think when a client comes in they're hurting. Something's not right. That's why they came. And caring means that I don't judge or criticize the things that aren't working or the things they're doing wrong. Caring is being able to step back and say, "Let's figure out what it would take for you to be well, for you to feel good." And then to focus on how do you get that person there with the feelings that you want this person to get better. You care about whether or not they get better or not because you want them to get to that in point where life is better for them.

Likewise Sigmund's definition included helping the client discover what is blocking the client from living the kind of life the client wants to live. Therefore, by helping the client "succeed in their journey through counseling," Sigmund believes he is caring for the client.

> **Sigmund**: My concept of caring is to discover what issues, what is going on with a person, assuming it's my client, that is keeping them from living the kind of life they would like to. And I want to try to determine what is it that is holding them back from them experiencing the kind of life they would like to live. And so my desire is to help them move from a place that's keeping them from living the kind of life they want to, to a place where they can live the kind of life that they would like to be living. So the caring is wanting them to be able to fulfill what they would like to do. It is to help them succeed in their journey through counseling.

Susan, as well as Kathleen, defined caring as taking care of and helping the client therapeutically, nevertheless within therapeutic boundaries. Susan described it thusly, "Caring involves taking care of things as much as, you know, like their emotional needs, their physical needs, within reason, not like overdoing it, but, you know, doing it adequately, I guess." While Kathleen stated it much more succinctly, "Caring is wanting to help that person."

For Barney it was not only about therapeutically meeting the need of the client, it was also about enriching the client's environment is some way. Barney stated, "So my philosophy of caring is…to hopefully enrich somebody's environment in some way." Whereas Pancho's concept of caring involved helping the client in an ethically acceptable manner while still helping the client therapeutically.

> **Pancho**: My concept of caring is…to help people in different forms and fashions, you know. Not to give them all your money or, you know, your car or things like that, but to try to help in some form or fashion. If you can't physically or monetarily, maybe referring them to agencies that might be able to provide some assistance; again, you know, in different forms or fashions.

One of the ways that Tara was able to meet the needs of many of her clients is with a therapy dog. Here is how Tara stated that information, "I have a little therapy dog too. A lot of people really enjoy having a therapy dog." Accordingly, in having a therapy dog, Tara is meeting the needs of many of her clients.

**Nonmaleficence.** A fifth theme that developed in regard to LPCs' concept of

caring was nonmaleficence. Nonmaleficence means do no harm to the client. This principle was first identified by Hippocrates and thus it has long been established in the medical profession. It obligates counselors to avoid actions that risk hurting clients, even inadvertently (Corey et al., 2011; Kitchener, 1984; Meara et. al, 1996; Remley & Herlihy, 2010). This is the concept of care that Barney espoused when asked about his concept of care in the counseling relationship.

> **Barney**: My concept of care is a very holistic model. So I think we're all part of this big fabric called humanity, we're all threads in this big fabric called humanity, and we're all very, very similar. So my caring model actually goes back to a fundamental, do unto others as they would do unto you. I want to care for people as I would like to be care for. So my philosophy of caring is, first of all, not to do any harm.

**Research Question 2**

What concepts do Licensed Professional Counselors believe about the importance of caring in counseling?

**Helps develop the therapeutic relationship.** The literature indicates that the therapeutic relationship is a quality, personal relationship between the counselor and the client that allows the counselor and client to function as a team with goals. Likewise, it is the positive, affective aspect of the same relationship that allows the client to feel valued and liked. Research indicates that the client's judgment of the alliance is a greater predictor of the counseling outcome than the therapist's judgment of that same alliance (Horvath & Symonds, 1991). That is, the client's perception of a warm, accepting relationship is more important than the counselor's perception of that same relationship.

This being the case, then developing that relationship in such a way that the client perceives the therapeutic relationship as warm and accepting is very important to the counselor. Many of the LPCs interviewed believe that this is accomplished through

caring. Thus caring becomes vitally important in counseling. Laynie even stated that without caring the counselor would not be able to develop the needed therapeutic alliance. What form of caring the counselor might utilize in counseling might vary, but without caring, clients would not allow you to work with them for very long in counseling.

> **Laynie**: I think it would be very difficult to form any kind of a therapeutic relationship with someone if they could detect that you did not care about them. If you don't care, they're going to know it and they're not going to let you work with them, not for very long. It may be that your caring has to be less personal, more generic caring, but it has to be caring from one human being to another. Some people are easier to care about than others are. They're easier to like, they're easier to connect with, but you have to want to. They will know if you want to. I think really probably that when I said some people are easier to like than others, the ones that you don't make a quick connection with, people you would not like in personal life, you still can care enough for on a therapeutic level. That's sort of the generic caring that I'm talking about. I care about you generically as a human being, as somebody God put here, as somebody who has worth in some place, someway, somehow. Maybe it's your personality that I just don't connect with; or maybe it's just that you're somebody who I would never like to be around. But, I can care enough for you to make enough of a connection to have a therapeutic relationship. And the personal would be most people I would personally connection with. And I would personally develop a caring relationship, a caring therapeutic relationship, more on a personal level because of the ease of connection with them.

Susan likewise noted the importance of caring in helping to develop the therapeutic relationship with clients. That caring for Susan is developed through Rogers's care conditions of empathy and understanding. These core conditions then brings about the necessary therapeutic relationship with the client.

> **Susan**: The thing that makes it important in counseling is that I think being able to relate to people from where they're coming from, giving some kind of like true empathy and understanding towards their circumstance, and giving them appropriate responses, like touch, care, concern. It's important to counseling because, I think that, if you don't have caring, you're not going to have a very therapeutic relationship with your client.

According to Carla, individuals want to feel cared for within the counseling relationship. When the client feels like they are being cared for and about by the counselor, this helps develop the therapeutic relationship. Clients can also feel, sense, and know when they are being cared for and about by the counselor and when they are not.

> **Carla**: I think other people, your clients, students will respond if they feel like you are being genuine and you genuinely have their best interest at heart, and that you are genuinely concerned and caring about them as an individual and as a person. Caring must be meeting the person where they are and allowing them to have their thoughts, feelings and experiences without judgment and without my inflicting my agenda on them. But I think it's an affect and it comes across in verbal and nonverbal communication, and all the ways we show and demonstrate that we care about the other person. I think Rogers called this "Unconditional Positive Regard" where a therapist or counselor has a genuine support and acceptance.

For Delilah and Tara, developing that therapeutic relationship also involves listening to the client and what the client is really saying. Listening for them not only develops the therapeutic relationship it also shows the client that you care about them, that they are important.

> **Delilah**: I have a client, just as an example, who we met for the first time, and he looked at me at the end and he said, "[Delilah], you really cared about me and I haven't had that in so long." He said, "You didn't fall asleep on me." And I went, "What!" He said, "Yeah, my previous counselor used to fell asleep." Oh, no! It's really attending. And for this particular client I just really listened. Oh, what are those counseling terms where you feedback, you know, do the meaning behind the words. I did a lot of that, because he was in a bad place. I wanted to make sure that I understood where he was coming from. Reflection of meaning. Reflection of feelings. So kind of back to the Rogerian concepts. It makes the client feel like they are important, like they matter, that their words, their feelings matter.
>
> **Tara**: I think people come to counseling because they want someone to listen to them, and to help them. If you don't care about them, I don't know that you can be very helpful. You could probably do it on a computer.

**Caring about another individual.** Almost all of the participants mentioned caring about another individual as an important part of counseling. This is done in such a way that the client knows that you care about him or her. This caring in counseling is accomplished through the therapeutic relationship. It is through that relationship that the client knows that he or she is cared about.

> **Barney**: Well, I think you have to actually in counseling not necessarily become involved in the other person but you have to care as to what happens to that individual. They're bringing to you something in their life in some way that's causing them stress in some way. And the caring aspect to me would be helping to sort of soothe that. Kind of, if we go back to the nursing model, it's taking care of possibly the wound that they may have, showing them a different way to deal with that issue, or a different way to look at that issue so that it's not so stressful for them.

Carla believes it is essential that counselors care about other individuals. She also believes counselors need to be genuinely concerned about their clients and their situation.

> **Carla**: I think it is essential that professionals in the counseling profession have the ability to care about another person. I think other people, your clients, students will respond if they feel like you are being genuine and you genuinely have their best interest at heart. And that you are genuinely concerned and caring about them as an individual and as a person.

The importance of caring in counseling for Delilah lies in the fact that it is sometimes only in counseling that clients receive care and feel cared about. "I have a client, just as an example," Delilah said, "who we met for the first time, and he looked at me at the end and he said, '[Delilah], you really cared about me.'"

Kathleen believes that the caring in counseling is important because counselors need to have concern for other people. That is why, according to Kathleen, most individuals become counselors. "Because if you don't care," Kathleen stated, "first of all, this is absolutely the wrong profession for you. Caring is the basis of why most people become counselors, I believe, because they have a concern for other people."

Laynie emphasized this point as well. However, she did so in terms of the caring being less personal in counseling and more generic. Nevertheless, for Laynie the caring still has to be from one human being (i.e., the counselor) to another human being (i.e., the client). She also stated that the client will readily know if the counselor has a desire to care for them.

> **Laynie**: I think it would be very difficult to form any kind of a therapeutic relationship with someone if they could detect that you did not care about them. If you don't care, they're going to know it and they're not going to let you work with them, not for very long. It may be that your caring has to be less personal, more generic caring, but it has to be caring from one human being to another. Some people are easier to care about than others are. They're easier to like, they're easier to connect with, but you have to want to. They will know if you want to.

The reason it is so important to care about a client, according to Mariposa is because if the counselor does not care about the client, the client will not be able to help the client find/be "their best self." That, for Mariposa, is the most important thing that the counselor can do for the client in counseling.

> **Mariposa**: How can we help a person find their best self, be their best self, take responsibility for who they are, for their thoughts and actions if we don't care about them. To me it's just core. It's just completely the most important thing.

Mya viewed the importance of caring for the client in terms of helping the client as well. However, unlike Mariposa who spoke in terms of *best self* for the client, Mya spoke of such help for the client in terms of *right direction* for the client.

> **Mya**: The concept of counseling is based on helping someone to get through an issue. And if I don't care about my client then I don't think I'm going to lead them in the right direction or help them discover the right direction.

Caring about the client for Pancho means winning the confidence of the client. This for Pancho is important because by doing so the client is more willing to open up and be truthful with the counselor. Moreover the client will then be willing to work with

the counselor.

> **Pancho**: One of the things that makes caring important in counseling is so that you can win the confidence of the client, otherwise the client might not open up to you or be as truthful or maybe, you know, might not want to work with you. So I think that's important.

For RSST caring about the client means "having a buy-in with the client." It is much more than just being mechanical and rote in regard to dealing with the client as if the counselor is merely checking off a list of steps. It is about caring about that client enough that the counselor is willing to "hang in there" with the client until the client has reached emotional and mental health.

> **RSST**: Well, you know caring involves having a buy-in with your client. If a client comes and all you're doing is collecting the check then you're very methodical, I think. It's like, here's step "A" to get you to step "B", now go and do that. It's connected to that end result about whether you are there that week but it's that you're there until you get to that point of mental or emotional health. Caring is hanging in there with them.

**Important part of change.** Both Mariposa and Sigmund stated that caring is an important aspect of counseling because it is part of change within the client. Sigmund goes so far as to posit that without caring in counseling, he is not sure that change will occur. Although in the end he does concede it might be theoretically possible to not care and the client be help, but for him that has no appeal.

> **Sigmund**: To me, it's the core of counseling. I can be a good technician. I can work through techniques or theories without caring, but I personally am not sure change will occur. It's, I think, theoretically possible for change to occur, but I do believe with all my heart that it's the caring that is the foundation of the change. Therefore, my choice of theory isn't as critical to me as maybe some because I would lean probably toward Carl Rogers' view that, you know, a human being in the room who cares, is empathetic, demonstrates unconditional positive regard, is therapeutic. It may not be completely therapeutic, but it's the foundation and the substance of change, in my view. It's the most important ingredient of counseling. So you can go through the process of counseling, but if you don't care it's probably not going to help the person; it's not going to help them succeed in counseling, without caring. I guess it's theoretically possible to not care and to

> present the theories or the techniques and them be helped but that has no appeal to me.

Mariposa also stated that she did not think that counselors could be change agents if they are not caring. Here is how Mariposa put this concept of caring being an important part of change in counseling.

> **Mariposa**: I think it's an important part of change. First we need to be accepted for who we are – completely, unconditionally accepted – that you're important, you're valuable, you're in this universe, you have a right to be here, and I value you. I don't think we can be agents for change if we don't care.

**Creates a drive to help individuals.** For Kathleen and RSST caring is important in counseling because it creates a drive in the counselor to help individuals. This drive is the motivation and desire to help the client throughout the counseling process. Caring, for Kathleen and RSST, is what assists the counselor in moving forward with the client until the goal of the client is achieved and the end is reached. According to Kathleen, "Caring is a drive that you have to assist this person through whatever it is that they're dealing with. It's kind of the premise of counseling itself." RSST, on the other hand, viewed it from this perspective.

> **RSST**: Caring is seeing it out to the end. And without that you don't have the drive, I think. You wouldn't have the drive to really invest into the wellbeing of the client. You may not have the motivation to really look at what's going to work, and when it doesn't work, what else would you do to make it work; to hear the depth of the client's life, those morbid factors, or those enhancement factors that enrich or hurt their lives and their behavior patterns. Otherwise it's just like a checklist. Because you have that buy-in is… This isn't, it's a job but it has an end product, and you care about that end product because it's humanity. You know, it's a living, breathing person, and all the people who are surrounding them. It's not like I'm going to pack up something, put it on the shelf, and hope that someone will buy it. It's not an object that is emotionless; this is a person with emotion, that has feelings themselves.

**Research Question 3**

How do Licensed Professional Counselors perceive the role of caring in the counseling

relationship?

**Foundation of counseling.** Caring is the basis upon which counseling rests. Without the client's perception of the counselor being a genuinely caring individual, clients may not be as willing to open up to the counselor and share themselves with the counselor. Clients are not going to trust the counselor enough to open up to the counselor. Without that caring foundation in counseling, Tara views counseling as being purely mechanical in nature. A caring foundation provides the compassion that is so critical in counseling. Here is how Tara stated these thoughts in her own words, "I think it has to be the foundation for the counseling relationship – if you don't care, you probably are just being more mechanical as a counselor. I think being a compassionate counselor is essential."

While counseling skills are important in counseling, Carla believes a foundation of caring is even more important. If counselors are not genuinely caring and base their counseling in caring, so much would be lost in counseling and so little would probably get done in counseling (at least as Carla views counseling). Therefore, caring and a foundation of caring are vital ingredients.

> **Carla**: I think it's a foundation. I believe that you can have really great skills as a counselor or therapist but if you don't, if you are not perceived as being authentic and genuine and caring about that person, it doesn't matter what skills you have, I believe they're not going to trust. They're not going to be vulnerable. They're not going to open up. They're not going to let you into their inner circle. And without that trust and that caring – and I think that trust and caring go hand-in-hand – I don't think anybody would trust you if they didn't sense that you genuinely cared about them. Obviously there are varying levels of caring about another person, my level of caring with my children or my spouse is a deeper more enmeshed caring than I would experience with a friend or a client/student. If you don't have caring – and I would hate to see someone just being a caring person and have no skills and call that therapy or counseling – but I think you can have really great skills, but if that person doesn't feel like that you genuinely care about them, and care about their feelings, and care about their thoughts, then I

> think all the skills in the world are going to fall flat. Showing that you genuinely care about the welfare, safety, development, and growth for that person, they do not find the value in themselves. I think you have to have a foundation of caring, you know. And that's very client centered, I know, but it is true. That's authentically who I am. So I've never done anything differently in my counseling experiences. But I just, I cannot imagine, especially in this environment where you have students that are developing their sense of who they are and their value in the world and not having someone who is a counselor not caring about them. They're (college students) a pretty non-trusting breed. And they're pretty suspecting of anything or anyone trying to manipulate them, or coerce them into something. So if they don't perceive that I genuinely care about them and have their best interest at heart, it doesn't matter what I say, they're not going to follow through. They're not going to change behavior. They're not going to gain insight. They're just going to walk away like "Another stupid person tried to talk me into doing something."

Sigmund views counseling in much the same way as Carla. He too believes that without caring serving as a solid foundation in counseling "change is not going to happen as readily." In fact, Sigmund lays so much significance on caring in counseling that he describes it through the term *powerful*. Here is now Sigmund stated his view of caring in counseling and its foundational role.

> **Sigmund**: It's the central role. It's, from my view of counseling, if it doesn't occur, change is going to be thwarted, or not thwarted but, it's just not going to happen as readily. The power of someone…another human being feeling cared for by someone else is, I think, more powerful than we even know. So to me it's so central to the change in counseling.

Mariposa described the foundational role of caring in counseling like children who are unable to flourish and flower without care and love. Similarly Mariposa believes that clients cannot flourish and flower within the counseling relationship without that foundation of care beneath it all.

> **Mariposa**: It's the foundation beneath it all. It has to be present, I believe. Well, just like with children. Children cannot flower and be all they can be without love and caring. I don't believe they could. So I kind of view it as an essential part of helping a person find their best self.

**To help the client.** While caring is vitally important in counseling, the role of caring in counseling for Barney, Delilah, Mya, Pancho, RSST, and Laynie is to help the client. Clients come to counseling because they have issues affecting their lives that they want changed. Helping the client in counseling to achieve that change is the reason that counselors care in counseling and thus the role of caring in counseling.

Some individuals who come to counseling may have done some horrendous acts for which they are seeking counseling. While counselors cannot and do not condone their actions, counselors can and must "appreciate them and their situation." Counselors also need to care enough that they want to help that client change their situation and life. Here is how Barney described it and illustrated his thinking:

> **Barney**: I think that has to do somewhat in the counseling relationship with the follow-through, what's going to happen to this individual. It's not just that we see them for five sessions or six sessions and then they're on their way. I think there has to be an assessment, a follow-up, to find out if they did implement something that you suggested in counseling, and if it did work for them in their life. Otherwise how would you know that it works? So in the counseling relationship I think you have to like the individual to some extent or you have to like or appreciate the situation that they're in. You don't necessarily have to like them as an individual, but you have to appreciate them and their situation. I worked for a period of time in the prison system and the inmates that would come in with the various issues. (It was a maximum-security psychiatric prison.) These people have in some cases done horrendous acts, but you, as a counselor, have to sort of divorce that, because that particular thing may be causing them incredible stress. And you have to care for that. But not necessarily condone what they did as a behavior. So it's more along the lines of this is a human being. I appreciate the fact that they're [a] human being. I'm appreciative of that because I'm a human being, and we share some similar qualities. And I'm in a position where I am supposedly to guide them in a certain way. And that has a lot to do with caring for them. It's sort of like here at (said the name of the place). I was in a meeting one day and they were talking about appreciating diversity. And a member of the group who happen to be an attorney said, "No, we do not appreciate and support diversity here, all diversity." And that was sort of striking for me to hear that from somebody. And they said that there are people here…that in their cultures it's perfectly okay to throw acid in someone's face. It's perfectly okay or acceptable to set somebody on fire. And they said, "No! We don't appreciate that

> diversity. No! We don't honor that. And no! We don't accept it." And I thought, "Well, that's very good. That's sort of a divorce. They can see the person but they're not going to go full range." For example, in the prison system, "Oh, I can completely understand what you did to that other person. No I don't! I don't understand that. But I can appreciate the fact that you have an issue with it now. And maybe we can get past it." And I think that has to do with caring.

For Delilah and RSST, caring needs to be combined with the ability to help the client through the counseling process. The counselor needs to know where they are going and how to get there, all within a caring environment. And in that process caring means not allowing the client to "slide, rationalize, justify away things that need to be addressed," or letting them "get by with stuff that has not been helpful." Thus, the role of caring in counseling sometimes means confronting the client. Delilah and RSST stated it thusly in their own words:

> **Delilah**: I think it's part of our role. You can care all you want, but I think you've got to also have skills in counseling. You've got to be able to understand where you're going, what you're doing. Kind of making sure it all fits together in a caring environment.

> **RSST**: The role of caring is seeing that end point. Where're we trying to get? What's that final step or what's that final product going to look like when we're done? And being able to work with that person to get there, caring enough not to let them slide, rationalize, justify away things that need to be addressed. So, caring is that full investment that you say, "I care about you getting here enough that I can't let you get by with stuff that has not been helpful to you, or that has been damaging." So, sometimes it's a little bit of that confrontation that's involved; and being able to do that in a constructive way, that you don't lose your client, or hurt your client. It's kind of like a mix maybe of parenting, guidance counselor, pastor, something, you know. I think kind of like all those things mixed together.

Mya noted that in helping the client in counseling, the role of caring in counseling is to maintain the client's autonomy and not to enable them. It is also not to make them dependent upon the counselor. As counselors we are to care enough about the client to help the client discover their own solutions to their own issues.

> **Mya**: I think the role of caring is to not become an enabler and to, again, help the

> client discover how to help themselves. I think my role as the counselor is not to become an enabler. So in other words, to make sure I hold true to the idea of helping them discover the solutions.

For Pancho, the role of caring in the counseling relationship is also about helping the client. However, he was quick to add that we, as counselors, must maintain appropriate ethical boundaries in the process of helping the client.

> **Pancho**: I would think that if you want to have success, and help that person, then we have to show empathy. We have to show that we care. Of course there's always the limits, you know. So you want to be careful that you don't go beyond that, those limits, those boundaries. But do show care; do show concern in wanting to help that person.

In order to help the client, Laynie sees the role of caring in counseling as making that connection with the client. It is then at that point that the client is "more willing to work with you or delve into themselves more freely." Without that connection, the counselor might not be able to help the client with the issue for which they came to counseling.

> **Laynie**: The first role of caring is to make a connection with them so you can have that therapeutic relationship. Beyond that, I think the caring in and of itself develops that relationship to where the person, the client, will talk more freely with you, open up, be more willing to work with you or delve into themselves more freely because they connect with a caring spirit in you.

**To show care.** The final theme to emerge in regard to LPCs' perception of the role of caring in the counseling relationship was to show care. In other words, the role of caring in the counseling relationship was to show that the counselor cares about the client. This theme emerged through such statements as "you need to demonstrate that you do care," "to show that we care," and "to show appropriate care." However, the counselors expanded the concept by explaining their thinking on this particular concept. Kathleen stated, "That kind of goes back to Rogerian; that you need to demonstrate that you do care; that there is concern on your behalf; that there is an authenticity of caring for

that person and what's in their best interest."

Pancho also utilized the Rogerian term of empathy as a way for the counselor to show care to the client. Pancho, however, quickly added that it was vitally important for the counselor to maintain ethical standards in the process. Furthermore, Pancho stressed that it was important for the counselor to show the client care.

> **Pancho**: I would think that if you want to have success, and help that person, then we have to show empathy. We have to show that we care. Of course there's always the limits, you know. So you want to be careful that you don't go beyond that, those limits, those boundaries. But do show care; do show concern in wanting to help that person.

Susan stressed why it is so important for counselors to show care to clients. The "why" is because clients are bearing their hearts and souls to the counselor. Susan explained it this way.

> **Susan**: I think that the role is that like in any given relationship, especially one that is based where people are bearing their heart and soul, if you're able to show appropriate care to a client they're more likely to trust you, they're more likely to open up to you, and they're more likely to disclose information to you that they might not otherwise because they feel like you genuinely are interested in them as a person and are interested in their circumstances and how to help their hearts heal.

**Research Question 4**

How do Licensed Professional Counselors conceptualize ways that caring is manifested within the counseling relationship?

**Through communication.** The first, and major, theme that emerged from the data was communication. Most of the LPCs emphasized that it was through communication and the process of communication that the counselor manifested caring the most. How that communication manifested caring to the client happened in many and various ways for the participants. However, two subthemes emerged from the theme of

communication. Those two subthemes are verbal and nonverbal. While several of the counselors talked about how verbal communication plays a part in manifesting care to the client, the vast majority of the LPCs indicated that the nonverbal aspect of communication plays an even greater role in manifesting care to the client than did verbal communication. In other words, for the participants interviewed, counselors show their clients that they care through the nonverbal communication rather than the words they say. Nevertheless, the first subtheme to be discussed will be the verbal aspect of communication.

***Verbal.*** Verbal as the word implies is the words that we say. For some of the LPCs it is the verbal aspect of communication, or the words that they say to the client, that demonstrate caring to the client the most. For these LPCs, it is not so much what they say, but that they say something to the client that conveys to the client that they as the counselor care about them as a client. Kathleen illustrated this point as, "It's a lot of expression. But also in what I say to them. I have said many times, 'I'm sorry you're going through that. I'm sorry that you're dealing with that.' That kind of thing." Mariposa also provided an example of how she might communicate to a client that she cares about them verbally.

> **Mariposa**: Sometimes I find myself saying, "Oh, Honey, that must be so hard for you." Calling them a term of endearment. (laughs) I don't know. Just because I want them to know that they matter, their feelings matter, and that someone sees their suffering and wants it to stop, and wants to help them through it.

Like Kathleen and Mariposa, Barney provided an example of how he might verbally communicate care to a client. However, unlike Kathleen and Mariposa, Barney provided an extensive illustration. The following is how Barney expressed the idea that counselors need to verbally communicate to their clients that counselors care for the

client, and the extended illustration that he provided.

> **Barney**: If you have a notion in the counseling relationship that you are understanding what someone is telling you and they as the client validate that then across that medium there, whatever that may be, that thing that, it's hard to explain, they understand that you understand. And that's caring. You show that in a number of ways. Number one you, you say, "Yes, I understand. Yes, I can understand what you're talking about. Yes, I see." In the prison system, I would start out the session introducing myself. "Hello." In the prison system you are Mr. (states real name). You're not (states real name). So, you know, you are Mr. (states real name). So, "Hello. I am Mr. (states real name) and I am here to help you today with any issues that you may have. You've been referred to me by the lead psychologist on the unit and they feel that you would benefit from discussing your issues with someone. So I'm here to listen to your issues and to hopefully try to help you get past anything that may be causing you discomfort. I'm not going to judge you. I'm here to listen to you. And if we can get to some points that you want to work on and hopefully get past, we can try to set a goal and do that. But I'm not here to judge you for what you've done that's already being done by the State of Texas."

While Sigmund did not provide any examples of how he might verbally communicate his care to clients, he did emphasis the importance of verbally expressing care to clients.

> **Sigmund**: To me it's manifested several ways. Of course there is all the verbals and that is the communication that I, through my words, am very interested in you and who you are, where you're coming from, what's caused problems in your past, what's causing problems in the present, and the communication that you are important.

For Carla and Pancho the exact words or even giving examples of what they might verbalize to a client was not important. What was important was the fact that they believe that some form of verbal communication expressing their care for the client was communicated to the client. Pancho succinctly stated it this way: "I think a couple of ways. One would be verbalizing in a way, uh, expressing verbally." Carla on the other hand had a more expanded description about the subject.

> **Carla**: I think it's a lot of verbal clues that demonstrate caring. I think sometimes we do need things like reflection, clarification, and additive empathy

> to reassure the client that we have understood their thoughts and feelings and to encourage them to move forward. And some of those things that we use to show that we are engaged and that we are authentically listening to what they are saying. That goes a long way to showing that you care, and that you're interested in a person. And I think that students, clients, will respond to that. Reflection and added empathy reassures them that I am partnering with them in their sharing and that I understand those feelings that you're having. I can understand where that comes from and to give reassurance that what they are feeling and experiencing is a normal part of being human and that they are not going crazy and that they are not some weird person.

***Nonverbal.*** Nonverbal communication is usually understood as the sending of messages and information to another individual without the use of words. This information and messages can be communicated through such things as gestures and touch, by body language or posture, by facial expression, eye contact, voice quality, rate, pitch, volume, rhythm, intonation, and stress. It is through all of these things and even more that the vast majority of the LPCs interviewed believe that counselors convey and manifest caring the most to the client. As Carla stated, "You can say the words but most of us believe the nonverbal communications over the verbal."

According to Barney, it is the nonverbal behaviors that show clients the extent to which the counselor cares. Nonverbal behavior can demonstrate that you are fully engaged with the client and that you care about the client. Nonverbal behavior can also indicate to the client that the counselor is neither interested in nor cares about the client and the issue for which the client came for counseling. Below is Barney's description:

> **Barney**: The other way is your nonverbal behavior toward the client. If you're open and accepting to the client, if you're really there in the moment with the client, I think that shows them you care. It would be, for example, if you're asking me these questions (turns toward typewriter and starts to simulate typing) and I'm over here doing something else am I fully engaged with you? Am I fully interested in what you're saying? Probably not. I'm into something else. It doesn't mean that I can't multitask or anything like that, but I'm not fully engaged with you. I think you know it. I think you feel it.

Carla spoke not only of nonverbal clues, but she also spoke extensively about how

those nonverbal clues demonstrate to the client that the counselor genuinely cares about the client. What follows is Carla's statement on the matter of caring.

> **Carla**: I think it's a lot of nonverbal clues that demonstrate caring. It is the eye contact, the tone, the words we choose, the physical posture and focus of our attention that people will believe. It is all those things that we use in communication that will demonstrate that you "see" that person. You know, "I see you", "I hear you", "I'm understanding you", "I'm empathic with you". You can say the words but most of us believe the nonverbal communications over the verbal. Some non-verbal cues like eye contact, touching, posture, and facial expressions. In this environment, if I have a student that I am working with, that's experiencing a lot of emotional experiences, I might touch their hand and let them know it is okay. I might move the box of Kleenex toward them, just some small ways to let them know that "I'm here with you and it is OK". I want them to know that this is a safe place an accepting place for them to share. I want them to know that I'm in partnership with you as you are going through this experience. Lean forward and having direct eye contact are other ways that I get involved with the student. I don't know. Just all those things that I learned in the books. But mainly it's eye contact and it's responding in an acknowledging way that I heard what you said and I understand what you mean; and I understand what you are experiencing. The Lord knows there have been times when their experiences are so painful and they cry, I cry; we just all cry. (Laughs) I shut the door. I don't have distractions. I'm not doing anything else except dedicating my focus and my time to that student, or to that client. Those would be some of the nonverbal kinds of things that I do regularly with students.

Laynie likewise spoke extensively about nonverbal communication and what that all involves. All of these nonverbal communications show the client that the counselor cares about the client and what the client is saying.

> **Laynie**: I think it's manifested in every way that a person can communicate. It's manifested in body language mostly. It's manifested in, if you don't count facial expressions as body language in general, then facial expressions, tone of voice, the words that are chosen in response or in explanation; in just every way that you can connect with somebody in communication that's how you would show caring. It would come out in all those ways. I think facial expression: being open, smiling, in white Anglo Saxon groups, you're more than likely going to have eye contact, not so much with some other groups. And, voice: in your vocal tones, something mild but not uninterested; that's, I don't know exactly how to define that, but something that is not a harsh tone; something that sounds, to you at least and to others evidently, if you've gotten old enough to learn to communicate, you found out how to talk to them in a tone of voice that does not put them off. Body

> language: more open then closed, more leaning forward then leaning back, although I spend quite a bit of my time with my feet out in front of me and kind of laying back in my chair. It conveys comfort with the other person that we're just talking, and we're comfortable with one another. But if it is an intense conversation, I may be up bending forward a little bit. It just depends on the body language of the other person. And if they're very stiff, I'm going to be stiff to mirror them.

While Mariposa also addressed nonverbal communication as a way of showing clients that the counselor cares about the client, that nonverbal communication begins the very first time the counselor meets the client and then extends on into the counseling session. In other words, Mariposa addressed nonverbal communication throughout the counseling process.

> **Mariposa**: I think when you first meet a person and you shake their hand or look into their eyes, be kind to them, polite to them. If they're trying to open up, you give them looks of encouragement, to let them know this is a safe place. You're not going to be judged here. You're valued. You're safe. I care about you. I want to help you. It manifests in lots of little ways. If they're crying, I offer them a tissue.

Like Mariposa, Delilah spoke about nonverbal communication throughout the counseling process. In doing so, she also included how such nonverbal communication shows her clients how much she cares for them as a counselor, especially those clients with AIDS and HIV. According to Delilah this means a lot to her clients, particularly those with AIDS and HIV.

> **Delilah**: It's manifested from the very first time you meet the client. Are you warm? Do you shake their hand? I work a lot with people with AIDS and HIV and most people shun people with AIDS and HIV. I'm immediately sticking out my hand and I'm there. Okay, I'm not afraid. I'm not going to, "Oo, I'm not going to touch you." And that for some reason, just sets the stage that I care about them and who they are. That I'm not afraid, I'm not going to, you know, catch some horrible disease because I shook their hand. I do the same thing for all of my clients. Now I don't do the huggy/feely thing. But I do shake their hand. At least know that they are welcome in my office and in my life. Making them feel that they are my only client. At least for the moment. That they are important.

Pancho and Sigmund included nonverbal communication when responding to how LPCs manifest caring within the counseling relationship. Pancho said, "I think [caring is manifested] a couple of ways…. One would be through nominal behavior – focusing, listening, maintaining eye contact, I think, would be some form of manifesting caring in counseling." While Sigmund stated, "To me it's manifested several ways. One is through body language, eye contact, mannerism, voice tone, some of the nonverbal."

Kathleen and Mya mentioned other aspects of nonverbal communication not previously stated by the other LPCs. Kathleen mentioned warmth, while both Kathleen and Mya included some form of the word *attend* in their responses. When asked as to how LPCs manifested caring in the counseling relationship, Kathleen responded as, "Displaying warmth. Being attentive to what their needs are." While Mya had this to say, "I think that an astute counselor pays attention to their client."

**Through the therapeutic relationship.** Another way that LPCs conceptualize that caring is manifested within counseling is through the therapeutic relationship. Under this theme the LPC's believe that counseling is about the therapeutic relationship. It is then through this relationship and everything that the counselor does through the counseling relationship that shows the client that the counselor cares about the client. Delilah perhaps said it best in explaining this theme: "I think the whole counseling session establishes the role of caring." Here is how she explained how caring is manifested through the counseling relationship.

> **Delilah**: And so I think it starts from the very beginning. And, you know, about introducing yourself, going through the whole confidentiality and rights. I think that sends a message of care because you're trying to protect the client, and you. And I think the whole counseling session establishes the role of caring.

In order to make a connection with clients so that the counselor can provide the needed assistance to the client, Kathleen surmises that the counselor needs to display caring. That caring is displayed then through the counseling relationship and all that is involved in that relationship with the client.

> **Kathleen**: The assistance that you give them or guide them through all shows caring. And the significance in the relationship is that without that you are just…for that to be absent, you don't have the connection, you don't have the rapport. You don't have the relationship that is one of someone trying to assist another. I see it that in order for me to connect with my client I have to display to them that I care; that I care that they're there at all; that I care there is a problem in their life that they're trying to deal with, and that I'm here to help them through that. And to show them that I care is displaying warmth, displaying concern. A lot of the Rogerian is part of that – empathy, being congruent. I can't not be present in the moment for them because I think that shows. If I'm not in the moment with them, if I'm off thinking about other things and not about that I care about this person or their problems, I think people can pick up on that. And then they know, you know, that I'm not just playing caring, and I think that the relationship would suffer, the therapy itself would suffer, the treatment would suffer, and the results would suffer.

For Mya, caring through the counseling relationship manifests itself particularly in the counselor helping the client to examine and explore the client's specific issue, especially if the client is avoiding that issue or has framed it in a way that is inaccurate. Thus the caring involves discerning the client's issue and then helping the client address that issue without enabling the client.

> **Mya**: When issues present themselves, and they don't always come in a real clear way with bells and whistles, but when opportunities present themselves, I think the counselor has to be willing to address it, and the way it would manifest itself is in helping the client to turn and look at the issue particularly if they've been avoiding it or if they've reframed it in a way that's not accurate. So caring would manifest itself in catching those issues and helping the client to turn and address them. Sometimes clients will also attempt to move you in the direction of trying to enable them. I've had clients tell me, "If you cared about me, you would just do X, Y, Z." And when they say things like that, I have to remember that counseling is not a popularity contest. And in a caring way, I'm just not dictating to them the rules of counseling. I really am trying to explain to them how it is

> caring to, you know, help them to see what their needs are. And sometimes I'll use, antidotal stories about how, I'll use a little self-disclosure, not a lot, but when it's appropriate maybe something I went through as a child, my first job, how it empowered me to buy a car, something, you know. That would be an example of helping the client appreciate something that they don't see as being caring. And I think another way that I show them I care is I'm not afraid to explain to them the concept of counseling and how it works. I'll give you a for instance. I had a client who'd been in many abusive relationships. And I explained to her that developing the ability to stand on her own two feet, and to have her own identity was important. And at first she didn't understand that. She wanted to know why I didn't think she shouldn't be having a pimp for a boyfriend. And so I said, "Well, you know, if you develop a sense of who you are, and if you develop a sense of empowerment through gaining employment and having your own apartment in your name, then it may seem painful at first but the benefit of that is that you become more in charge of your own life and making your own decisions." Again, the client doesn't see that is helpful. But with time, uh, and, and, and work on both of our parts we, we'll hopefully move in that direction of the client beginning to understand that is helping them. And feeling good is not always what therapy is about. In fact, that's one of the things in therapy that I tell clients. Therapy does not mean I make you feel good. It means we move in a direction of addressing mistruths. And sometimes it'll be painful; sometimes, in the long run, it'll be helpful. Sometimes, for instance, if I say to a client, "For you to get your child back from Child Protective Services, you're going to have to get a job." And they may say to me, "I don't like work." (laughs) And so we begin the process of, you know, talking about that, and try to get them to understand how that is, somewhere in there's a way they can begin to appreciate this reality.

Throughout the counseling relationship, from beginning to end, caring is involved and is a part of that relationship. It may appear to look different throughout the counseling process and various phases, but caring is definitely always there throughout the counseling relationship.

> **RSST**: I think absolutely it starts in the beginning where you develop that rapport, that relationship, with the client, that connection, that "Okay, you and I are in this together and we're going to work together on this." And then the next, you know, phase of the caring is challenging those discordant thoughts, and those things that have not been working. And being able to hang in there, not getting discouraged, or not be offended, or not, you know, letting the client hurt you so that you give up. But to hang in there and get through that phase and to stick with them while you implement those, and of course since I come from cognitive-behavioral, those changes in thinking and behaving long enough to see them to start to develop more of that pattern that they can work with. And then just that last stretch,

> hanging in there until the very end when you say, "Wow! You're doing so good and things are working. Off you go." So it's a commitment from, but it looks like, and it starts with…I think that it definitely got differences in all those phases.

Susan wholeheartedly agreed with RSST. She too echoed the same idea that from beginning to end, caring is involved in and is a part of the counseling relationship throughout the counseling relationship.

> **Susan**: I think it starts kind of with informed consent when you kind of give them the, limits of confidentiality, and you're able to set that up and allow them to understand there's certain times that you have to care for them, maybe more than they will want you to. So that if they disclose something that is a reportable event for you to keep them safe or to keep someone else safe, sometimes, you have to breach confidentiality for that reason. I think that it also then, through the therapeutic relationship, helps you build rapport, helps you build trust, and then you're able to give them genuine empathy throughout the counseling process. And when you're able to do that, it just makes the therapeutic relationship solid and it creates an environment where people can really feel like they can trust you. And then it also makes closure easier because they're able to feel heard and cared for, and, have resolution and closure, and then move on with their lives with a positive experience. I work a lot with traumatized children so when you create appropriate boundaries you're able to show them that caring about them includes certain boundaries like not just talking to people any way they want, you know. They can't just come in here and call me, you know, expletives and it be okay. They have to know, because if trust is part of caring, which I believe it is because you have to really trust someone to be able to know that they care about you if I have to breach confidentiality because they disclose something, then they're going to know that I am breaching it as I'm doing it, and before, and the stage is set before that so they won't feel betrayed, or hurt, or anything if that happens. But boundaries are a very good way to teach appropriate interaction. And so if you start out by having boundaries and appropriate interactions than they're going to really learn what caring looks like in an appropriate manner with an adult, or with another person, or something like that.

Tara believes that caring is manifested through the counseling relationship itself by helping clients address "their situation as quickly and efficiently as possible." Thus helping the client to achieve wellness in his or her life shows the client that the counselor cares for the client.

> **Tara**: By listening carefully, and by doing what I can to help them with their situation as quickly and efficiently as possible. My professional training as an

> MFT (Marriage and Family Therapist) honed my skills to evaluate system dynamics, individually and also in larger systems. I am also skilled as a brief therapist. Usually we try to figure out why they've come to counseling and what they want from counseling, and then what's going on, and what's getting in their way of becoming what they want to become. Then we do some problem solving on what might be some options for them. Then they get to choose whether they are going to do them or not. I usually help them with some ideas because a lot of people are stuck and they just can't figure out what they need to do. So I try to use some common sense and practical approaches that are going to fit in their worldview.

**Research Question 5**

How do Licensed Professional Counselors maintain a caring professional presence when they find it difficult to do so under difficult circumstances?

**Through self-care.** One way that LPCs maintain a caring professional presence is through self-care. Some of the participants stressed the importance of taking care of themselves so that they can be their best in the counseling session. This self-care took on many different forms for each of the LPCs identifying this theme. However, they all thought that it was necessary for the counselor to do what the counselor believed benefited her or him the most in order to help them maintain a caring professional presence when counseling a client.

For Mariposa, this involves caring for herself first. While this involves many different things, it is all about maintaining balance in her life. Through balance in her life, she is able to maintain a connection to her clients. This connection is based on a belief that a "kinship" exists between all humans because we are all human. Thus for Mariposa "it's a natural thing for me to care." Below is the way Mariposa summarized this concept:

> **Mariposa**: One of the ways I maintain my caring is by trying to maintain my own balance. You know. Taking care of myself. I don't feel like we can care for anybody else if we don't first care for ourselves, you know. How can you have generosity of spirit if you're not giving the good to yourself? So one thing I do is,

> I don't see too many people. I don't do well when I try to see too many people in a day. I get over stimulated. I have trouble sleeping. I'm a really sensitive soul. So I take care of myself, first so that I'll have that generosity of spirit. And I have this belief where I believe I am you, you are me, we are one. Everything you have in you, I have the seed of in me. And so, I have a kinship with you because we're human, you know. So it's a rare thing for me not to like a client. I mean, it really is. I mean, there's been a few, but mostly I just really… It's a natural thing for me to care. One time I had one client come to me who was just harsh with me. She goes "What's wrong with you? Why aren't you taking notes?" (laughs) I said, "Well, we're not taught to take notes." (laughs) And she was like, "Well, that doesn't sound very professional." She was very judgmental of me, which kind of put me on the defensive. And you know, then I found she was manipulative with me too. She tried to manipulate me to doing something in her family to extricate her stepdaughter from her life basically. So that was difficult for me to find a loving feeling for her (laughs). You know what I'm saying. But that's a rare thing. Generally people come; I can look at them and see the sweetness of their spirit, and want to help, just want to help. It's mainly about staying in balance. And giving myself all the good, because that gives me a generosity of spirit so that I can, you know, radiate more love.

For Mya, that self-care involves wellness and the wellness model. He focuses on that concept of self-care and stressed that it is important for counselors to not only be aware of the wellness model but also to follow it. He provided an example of what might happen to a counselor who does not provide themselves with enough self-care or follow the wellness model.

> **Mya**: I think certainly you have to be aware of what mental wellness is. You have to remember that when you look at a wellness model you cannot overwork yourself and become stressed out to the point that you're trying to explain to a client things that are going to be frustrating or hurtful to them. In other words, if I'm tired and wore down and a client seems to be going over the same problem and not getting it, it may be a real problem if I raise my voice at them, you know, and was to say something like, "Can't you get into your head?" That's not going to be helpful. And so, I think being aware of how not to get overstressed, how to take the time to do the research for whatever it is I'm working on with that client, and you have to keep that balance. And that, if you looked at a wellness model, encompasses a lot of stuff. Am I getting enough sleep? Am I getting enough time to relax? Am I getting enough time to address my spiritual needs? Am I getting enough time for all my existential needs, my exercise? If I'm doing all that, then I'm going to be fully in the present when I'm sitting here with a client and I'm not going to be popping off or shorting their time, those kind of things

that's going to hurt them.

Likewise, Tara also focuses extensively on self-care in order for her to be her best in sessions. Tara explained exactly what self-care looks like for her in her life.

> **Tara**: I try to be at my best in sessions. This takes a lot of self-care. I meditate and exercise in the morning, or when needed. I eat well, and rest well – including a nap, if needed. I try to not schedule too many sessions in a day. I try to send out sufficient compassionate energy that their negative energy does not drain me. I practice Buddhist equanimity. I find sessions difficult especially if people are angry and they're in my office being angry at each other. I'll ask them to please take a time out. If they don't and then they get back into arguing and do it over and over – those are trying circumstances. At times I'll suggest that they can do that at home. It's that we're not making any progress in counseling because they're sitting there yelling at each other, using insulting language. And as a counselor there's no room to be able to help them if they're going to continue that kind of behavior. So it's a matter of self-care at that point. They can find another therapist, or they can argue at home. Those are difficult circumstances. I usually get about one a year. If they are going to continue to be like that, I don't want to work with them any more. That's different from being tired or not feeling on top of it, because those are my responsibility. The arguing is their problem. If I can't do well as a counselor, because they won't give me time and space and working room, then I can't really help them. That's different then if I feel tired. If I'm feeling tired, I do what I need to do to feel better. After I have lunch I like to take a little nap – just be lazy for a while. I've also started beginning to work later so I don't start until about 11:00 am. Then I stop work about 6:00 pm. I used to work until 7:00. I meditate, do yoga and Tai-Chi, kickboxing, listen to music, garden, and have many friends. I do things that make my life satisfying. My children & grandchildren are the biggest joy in my life! However, they live in DC, California, and Florida – so we have to work hard to stay close! One of my friends said that she thinks I embrace Life!

Susan described what she does in regard to self-care when she might be tired, have a headache, or just not feeling very well so that she can maintain her caring professional presence during counseling sessions.

> **Susan**: If I'm tired, I just try to get up and walk around in-between sessions, drink some coffee. It just doesn't seem fair to me, to the client to not do that, you know. If it's something I did like stayed up too late or didn't get enough sleep, that's not the client's fault. And so I tried to get out and walk around sometimes. If it's a child, I can take them and walk around the complex that we all have fresh air and we're a little chilly, cause it's kind of chilly outside, and then come back in, and, you know, it's all better. But when that happens I try to be proactive, and

> be aware that these issues are at hand. If I'm so tired, or if I have such a headache or I don't feel well, I try to plan it enough ahead of time to where I can reschedule the session for maybe 30 minutes later or to a completely different day. Sometimes it works out they reschedule, and I don't even have to. So, you just have to be proactive about that kind of stuff.

**By focusing on the client.** Another way that some of the LPCs maintain their professional presence under difficult circumstances is by focusing on the client. By focusing on the client, the counselor no longer focuses on any personal issues the counselor might be experiencing during the session. This is critical in that the client is the most important individual in the counseling room at the time and not the counselor. It is the client and the client's issues that are the total focus of attention during the session and not any personal issue that the counselor might have. Perhaps Pancho summarized this best when he said, "I try to think of the client's need, and not necessarily my need. I'm here for the client, not for me."

In order for Delilah to maintain a caring professional presence when she finds it difficult to do so under certain circumstance, she repositions herself in her chair so that she can better focus on the client. Occasionally she even changes places with the client. While this may make the client somewhat uncomfortable, it does give her a different perspective and focus on the client.

> **Delilah**: I think I do it a lot by body language. I make sure I rearrange myself in the chair, maybe lean forward a little bit so I can pay attention to what they're saying. And so that way I can get myself in the mode of being a counselor. And so that way I can pay attention to what they are saying, reflect what they are saying, and it keeps on going. So, you know, uncross my legs, and I'll ask them a question, and just really talk to them. I've done this with a couple of clients. Ever once in a while, when I find myself in that position, I'll ask to trade places. I'll say, "Okay, you sit here, and I'll sit there." And it really makes me, and of course it makes them uncomfortable, because they are now in the position of authority. But it also makes me understand what they're feeling. So just getting up and changing positions helps.

One of the things that Kathleen does in order to focus on the client is what she calls *rallying*. While Kathleen explained in great detail what rallying means, in essence rallying means setting aside whatever is on the mind of the counselor during counseling sessions so that the counselor can put all of her or his attention and focus on the client. Here is how Kathleen explained rallying in her own words beginning with how she focused on one client in particular.

> **Kathleen**: I've had a client that I found it difficult with, for some circumstances about his issues. But I actually did care. Not just about him but about his whole family. And I knew that the best treatment I could give overall to, not just him, but the other people in his life was to help him. There were some things revealed, um, I didn't display just consistent acceptance of behaviors. But I displayed acceptance of the person. Another thing I do and this isn't just in counseling but in different aspects of life, my friends and I call it rallying; but sometimes you have to rally. Sometimes you don't…there's other things going on and it's difficult to be present. But I rally to it. And we…everybody does that for different things. I mean, not everything you do in life is something that you want to do or on that day you may have something else going on that is preoccupying your mind. But to rally to something means you pick yourself up for it and you put yourself in that mind space. I've walked in my private practice and thought, "Okay, you know, this next hour I'm rallying; I'm in this moment and everything else…" I mean, it's a mental process that I do for a couple minutes. Okay everything else in my mind is going on this other side, on the back burner and I'm rallying for the moment. In my mind I place whatever's in the forefront that may impede showing caring or being present in the moment, uh, I do like just, in my mind, I actually kind of box it up and set it on a shelf and I know in an hour I'll get that box out. Or if I got three clients lined up, I've got three hours. That box is going to sit there, and that's fine. But I box it up and put it on a shelf. So it's a mental exercise where I kind of think it through, and sometimes I even see it a little bit. Okay that's going into the box. I got to set that aside. I got to rally for this moment. So I show that caring professional presence by putting the client first and whatever I had pressing, the headache, you know. I've certainly done counseling with bronchitis, you know. And I haven't felt well, but I just kind of set that aside. And actually it makes me feel better too. Because you can kind of physically, or if you do it mentally, kind of physically say, "These physical ailments I'm setting aside and I'm doing this."

While Pancho doesn't call it "rallying" like Kathleen, he does describe it somewhat the same way. That is, he talks about putting things out of his mind so that he

can focus entirely on the client. Or as Pancho concluded, "I try to think of the client's need, and not necessarily my need." Here is what Pancho stated:

> **Pancho**: I've done this long enough that, you know, I'm here for the client, not for me. So if the client is showing resistance, then to me it's that they're probably not ready to continue. Or if it's mandated like say by the court, then I try to keep that in mind that the reason this person might be resisting is because they really don't want to be here. So I try to find a way to express that, you know. "I know you don't want to be here, but you have to be here. So let's make the best of it so that, you know, you can fulfill that obligation." I try to keep the client upfront in my mind that it's "I'm here for them." I'm getting paid to do that work. So even though it's difficult, I keep reminding myself this is the reason I'm here for. So I try to focus on the client in trying to help them. There have been times when I'm really tired. I mean, so tired that if I was a shut my eyes for a second I'd probably fall asleep. But I keep reminding myself, you got to listen, you know, you got to remember things so when you document, you're able to document the right information, the correct information. So it's a matter of just forcing myself to keep doing it. And then also remind myself that maybe I need to go to bed a little earlier so I get some rest so that I won't be so sleepy. But that's what I try to do. I try to keep the client's focus upfront. If you are my client, I would try to remember that you're here for a reason. If you're paying me or if I'm working for someone, I'm getting paid by them to provide this service. So I want to focus on you, and do the best I can. Even though you're tired, it's personal, but I try, again, to put that in the back of my mind. Not to be thinking about it because I think, the more you think about it, the more focused it can become on the person and then interfere with, you know, your task at hand. And I think one of the things about counseling is listen carefully to what the client is saying so you're able to conceptualize, you know, do the conceptualization and then provide a good treatment plan. Again those are my reasons for wanting to do it.

Laynie described how she deals with difficulties in communication, annoying/irritating clients, and boring clients. In all of these difficult situations and circumstances, Laynie basically focuses on the client. She believes by doing so she shows the client that she cares. Here now is how Laynie specifically described handling these particular situations.

> **Laynie**: I'm thinking of certain difficult circumstances that I've had in counseling and that's when you go back to that I care about helping you, I care about getting you what you're here for. And it may be that one thing that I will do if the circumstance becomes difficult, it may be that the reason it's difficult is

> communication. So I will simply take it back. I'll back us up to some earlier point where we agreed. I'm always looking for a point of agreement. Because if I can find that point of agreement than they, I assume, consider that, I care enough about you and you getting what you need in our relationship, our therapeutic relationship, to find something we agreed about. Now, let's look at some divergent ideas, some different perspectives. Occasionally I'll get someone that just annoys me. Really, except for a couple of clients here and there, and that doesn't happen very often, that irritate me, that annoy me, and that's very rare. The other, the worst, are the ones that for me, and there are not very many of those, but there are more that bore me than annoy me. And for me the bore me people are generally children; not young, young children, but kids that don't really have much have much of an idea why they're there, and they don't really have anything to talk to you about and they're not really interested to be there, that kind of thing. I'm kind of looking at the clock going, "Wow! This is taking a really long time." But when I do that, I go. "Wait a minute! Maybe they're bored with me too." You know. Let's figure this out; let's do something different. But then I taught school for 29 years. I learned, do something different. I also maintain a caring presence by being friendly, being welcoming, being open to hearing what they say and what they say is okay with me. Whatever they want to believe, it's okay with me if they believe that and because that's true I think it makes them feel safe to say what they have to say or to say more. Because even if I disagree with them, it's going to be in sort of a safe way like it doesn't matter. Everybody has an opinion, and opinions are like noses everybody's got one, so mine's not any more important than anybody else's. And when clients irritate me I pretty much do the same thing. I set that aside because my irritation's not important. And I just set it aside and say, "You know, you're not here about you. I'm not here about me. And they're paying me for a service. And my service is to be helpful and help them figure out a solution or a direction to go to make their life different than it is."

When certain counseling circumstances become difficult for Susan, she maintains her caring professional presence by focusing on the client and not the behavior of the client. She then deals with the behaviors of the clients while still caring for the client. Susan describes how she does this.

> **Susan**: What I do, like I said, I primarily work with kids, is I remind myself that this is a child that has experienced hurt, has experienced difficulties, and that it's more the behaviors that I probably don't like than the actual person. And so to separate out the behaviors from the person makes it so that I'm able to really still care about the person and not like their behavior. And then deal with the behavior while still caring for the person. I think I may have just said that twice but basically kind of separating out the things I don't like which typically is the

behavior, but still able to care about them as a person, a human being.

**Through the therapeutic process.** A third way that LPCs maintain their professional presence when it is difficult to do so under certain circumstances is through the therapeutic process. Through the therapeutic process and working within that process, the counselors are able to get through any difficulties that they might be having with the client while maintaining a caring attitude toward the client. The therapeutic process then is what they rely upon and even fall back upon when difficulties in counseling arise. For Delilah, it is reliance upon a "very loose CBT" structure that allows the caring to take place with clients with which she may be struggling.

> **Delilah**: One of my clients, it's like pulling teeth, you know, to get them to say anything beyond, "Oh, how are you today?" And so I start out the morning and go, "How am I going to spend 50 minutes with this client (laughs). But, you know, given the right setting, given the right, reflection, given the right… I tend to be somewhat more structured, and so I do a lot more structure. A lot of it's CBT. Very loose CBT. About how people think about things, about how we behave and how that impacts our lives. And so I do ask a lot, "Well, how are you feeling at that time?" "What were you thinking?" Not "what were you thinking", but (chuckling) "what were you doing at that time?" And "how did your thinking impact what you did?" But once I get that structure going, then the caring kind of kicks in. Oh, I really do care about how he feels about that.

Sigmund noted that it is easier to care for a client, even during difficult situation, through the therapeutic process. This is because the client came to him for counseling and is willing to pay him to help them change something. Sigmund further stated that it is also easier to confront a client who is being difficult through the therapeutic process.

> **Sigmund**: You know, I think, to answer that question I think of my professional relationship with a client versus a personal relationship with someone who I just have met outside the counseling room who may be obnoxious or difficult to be around. And, I think, I want to be congruent with both, but I think when I'm in the counseling room I'm more aware that this person's here and willing to pay me to help them change something. And so because I believe that caring is the way that that happens it's easier. It's easier because we're in the context. They're coming for a reason. They want to change something and caring is essential for that. Someone outside the counseling room in that relationship, they're not in

> relationship with me for change. They would be in relationship with me for various reasons. I still want to be congruent in that I demonstrate care to them. It just may be more difficult when I get strong resistance, or maybe even disrespect or something like that. I'd love to be able to say I would still care for them, but I, because I'm a human being I would realize, there would be part of me that would want to go, mmm, forget it. Blow you off. However, if that same obnoxious, difficult person came into my office, it would be different because they have somehow made contact with me and told me that they want to come in to change something. They're dissatisfied with something in their life and they want to come in and sit down with me and discuss their being not satisfied with what's going on in their life and they want to change it. That's the assumption I make when they're talking. Therefore, if I'm meeting resistance or obnoxiousness, if that's a word, or they're being disrespectful I will interpret that for them in the therapeutic setting that that doesn't match what you're here for. "You communicated that you want to change something, and yet I'm experiencing your disrespect. I'm experiencing your obnoxious behavior. What are we going to do? This isn't working." And so, in the context of the therapeutic setting I am able to interpret what that person is doing in our relationship. Outside of the therapeutic setting, they haven't asked me to do that. There are relationships I have outside the therapeutic setting, and that would be close friends, that I would use some of the same techniques with, but I would only use them because I know that that's what in our relationship they want. They want to know how they're coming across. It's not counseling outside the counseling room. It's deepening a relationship. And I guess one of the things I've learned the most is that even though I'm not a client's friend, the same techniques and ways of communicating healthy relationships work outside the counseling room too. It's just that most people outside the counseling room don't want that.

**By maintaining justice.** A fourth theme that emerged when the participants were queried as to how they maintained a professional, caring presence under certain difficult circumstances was that they do so by maintaining justice. Justice refers to the counselor's commitment to fairness in professional relationships. Justice demands equality, which has implications for nondiscrimination and equitable treatment of all clients. Therefore, counselors' actions and decisions must be fair to all concerned. The following is Barney's description about maintaining justice as a means of maintaining a caring professional presence.

> **Barney**: Let's see. I think that goes back to my original premise: I don't really have the notion of judging someone because it's, again, all part of the human

> condition. If we put the human condition in a big bowl, and we could pull out, you know, horrendous acts, and we could also pull out great acts of courage. You know some people have come to counseling because they can't handle great acts of courage. They have survivor guilt, for example, if you're working with the veteran population. They've done great things, but they didn't go through it unscathed. So I can't judge the fact that they've been in war. I can't judge the fact that they've committed a crime. I think you have to be open and honest about that in the counseling setting. That's been my view for many, many years. You never know what's going to come through the door. But if you already have preconceived notions that you're going to judge someone by the way they look, or the way they act, or what they've done, then I think you've already biased the setting.

RSST shows that he cares and maintains a caring professional presence by maintaining justice with sex offenders as a Licensed Sex Offender Treatment Provider and with students and parents as a Licensed Professional Counselor. While vastly different, sex offenders, students, and parents may lack genuine care for various reasons. Consequently, RSST may be the only one in the counseling relationship who retains a caring attitude in that relationship. He does so by reminding himself who the real clients are and why it is so important to care about them. He also sustains his caring through numerous consultations with colleagues and other professionals. RSST thoroughly explained it this way.

> **RSST**: Two general thoughts come to mind, like I'm thinking clients, where does that happen? Being a Licensed Sex Offender Treatment Provider I know that I'm working with a high-level of sociopathology in there. And I know enough about sociopaths that when it comes to caring, I'm probably the only one in that relationship who's truly got a level of caring but my caring goes caring towards the safety of society. But I also care, I really care that these guys and these ladies become good people, you know, and don't do those same deviant acts again. And sometimes they'll challenge me; sometimes they'll be pains in the ass. They'll defy; they will manipulate. And I'm also thinking like in the school business, you know, you get worked over. You get worked over by either kids or parents, who, you know, they just… It's all talk and no follow-through and that's very, very frustrating, because the kid is the one who suffers. And you do have a tendency to go, "Well, great! I can't help you" because your parents, you know, "Well, I can't fix this! You…"; that kind of thing. It's not as difficult for me, just because, I think, because the number of years, 10+ years that I've done Sex Offender

> Treatment. And I've got a philosophy, I've got a true philosophy about what I do. And there're times when I have to step back and reconnect with that and think it through, and remember what I'm doing. But, you know, my philosophy is based on a Christian belief that I'm not the judge, there's only One; thank goodness it's not my responsibility. My job is to help these folks fine a way to repent or to be as good as they can be, so that when the judgment does come, they're in pretty good shape; they're in better shape than they were. So, with that, and that is my belief system, it's not hard for me to care. Because it also goes back to, I truly believe that we are all literally children related to each other anyway. There's going to come a time when we will look at each other and go, "Oh, now I remember. We were all family once before. I wonder, how did I do for you when we were trying to work through things?" So, that kind of drives me as well.
>
> Going back to sex offenders, sometimes I just will have to step back and do consultation with the other therapist in the business. Sometimes I need to, for lack of a better word, meditate on it. I need to step back and let my emotions drain off, those negative emotions that get in the way of my sense of caring. And then, I have to process through and say, "Okay, this isn't about you personally. This is about you working with somebody who's…you don't understand everything. So you may be just the one that they're just taking things out on; and the system is hard, so, you know. Your job: protect society and get them to a really good place. So think about this and step back." And over the years I've gotten so much better at that. I also do the same thing with children and parents. It looks slightly different, because I don't have the same level of consultative companions that I can work with or professionals that I can work with. The colleagues that I would consult with here, there is a difference between the counseling world and the administrative world. So I will go and talk with the administrators, and they don't have the same viewpoint. But, one of the things I find is that when they state their viewpoint it's real easy for me to reconnect with, "Oh, I know what my job is now because it's not that." I'm not trying to be a hard ass or something like that. I've worked in this population for as long as I've done like with Sex Offender Treatment. And, you know, there are times when I have to go back and read up on poverty, and I have to be reminded of where our families are and where these kids come from and the things that affect them. So, yeah, sometimes it's an intentional, "you've got to remember this stuff."

Carla also explains in detail how she maintains a caring presence by maintaining justice when dealing with individuals who come to counseling but have no desire to change anything in their lives and so provide strong resistance to the counseling. She also describes maintaining justice through caring when she taught GED classes to incarcerated individuals as difficult as that was due to the nature of these individuals.

**Carla**: Two things pop into my head and let me just share those experiences with you and see if this answers the question. I was working with a student not long ago that was very resistant to any insight. His stance was "I'm perfect. Everything's perfect. I'm not going to change anything. You're not going to tell me anything. I'm not going to do anything different." When I asked what his actual grade on the last exam was, and it was not a passing grade, I used confrontation about the statement "Everything is perfect" when it really is not. I asked him what he would be willing to change in order to have a more successful outcome and he was emphatic that there was nothing he needed to do differently. After several attempts at reframing and redirecting, he held fast to his behaviors. I get a little frustrated when students (clients) are clinging so tight to their behaviors but hopefully they will gain insight through their experiences. I had a client my first year in private practice, a female, older lady married to a very wealthy, prominent man and she came for counseling. We worked on some of her issues but she was adamant that she was not going to make any changes. I confronted the conflict of wanting things to be different but her unwillingness to change any of her behaviors and she agreed that she was not willing to make any changes in her behaviors, attitudes or choices. After about the third session, I confronted her about that contradiction, "You're coming here and you have all these things, but you're not willing, you don't want to change anything to be happy, or to make any changes." And she said, "That's right! I'm not going to make any changes. I'm just coming here to talk to you." And so I dealt with that for a time or two more, and then I told her I didn't feel like I was being of help to her. (Laughs) You just get that wall, and that resistance, and they're not going to let you break down that façade, or that denial barrier, or whatever it is that's protecting them. And in some cases I just back off and I leave that shell on until they decide that the shell is keeping them from growing or being happy. The pain has to be more than the fear of change. If they're not miserable enough to change then they may not change. So that would be the one: when it's a really resistant client, kind of arrogant attitude thing of "I'm just here to spend your time." (Laughs). That's kind of hard for me because I don't typically have that kind of resistance. The other situation that comes into mind, and I wasn't in a counseling, therapeutic environment, but I was working at (named a particular place) teaching GED classes. There you have to have this persona of distance, of being removed, and an attitude of "you're not going to manipulate me". You have to have a kind of façade. And very self-aware, and very environmentally-aware, but at the same time show that you really genuinely care about them as human beings. So that was kind of hard because you are void of some of those social skills that we use every day as we interact with people. You have to stay very distant and very literal and very professional. And so those are the two situations I struggle with. When I was in graduate school, one of the first things that I remember having an impact on me was being in a class and, I'm not even sure, maybe it was (named a specific professor) class, but it was a self-inventory type question, "What type of client would you be, would be most difficult for you to work with?" And at that point it was an abuser – elderly, spouse, or child. And I still have a really difficult

> time being compassionate, or having a caring or positive regard for those issues even though intellectually I've come to understand some of the dynamics of all of that but I still would find working with that clientele to be very difficult for me. I just never put myself in that circumstance and I would probably have to refer that client to another resource. So… Maybe self-preservation from that direction. (Laughs).

**Research Question 6**

Under what circumstances have Licensed Professional Counselors found that caring for clients might lead to ethical dilemmas?

The participants identified numerous and various circumstances that caring for clients might lead to ethical dilemmas. These circumstances have been classified under three identifiable themes: (a) maintaining appropriate boundaries, (b) autonomy issues, and (c) countertransference issues. These themes are discussed in greater detail below.

**Maintaining appropriate boundaries.** The first theme to develop under this research question was maintaining appropriate boundaries. A boundary in counseling can be conceptualized as a frame around the counseling relationship that defines a set of roles for the participants in that relationship (Remley & Herlihy, 2010). That framework for LPCs is created by codes of ethics (e.g., *ACA Code of Ethics,* 2005). Such framework and the codes of ethics that create them are vitally important for counselors. Maintaining appropriate boundaries within the counseling relationship is also an important issue for LPCs. Maintaining appropriate boundaries, however, can sometimes be a difficult thing to do. Caring for clients might, if the counselor is not careful, lead to ethical dilemmas for the counselor. When asked the above research question, most of the participants provided illustrations about how not maintaining appropriate boundaries while caring for clients might lead to ethical dilemmas. Barney provided two specific illustrations in regard to caring for clients while still maintaining appropriate ethical boundaries.

> **Barney**: Well, I can give you the perfect example. Early on in counseling, I had a lady come in the counseling setting, and she found herself in the situation where she was going to have a baby. She really didn't have very good support from her family. She didn't have any support from the man that was involved in the relationship. And so she had come to counseling to work on how to get through this situation because she was not going to have an abortion; she is going to have this child, and she was going to do the best that she could. And so we talked about that, and then on into the counseling she said to me "I want to ask you something. Would you show up at the delivery and hold my hand at the delivery? Would you be there for me at the delivery?" Well, the big ethical flags really flew at that moment, right? So I talked that over with my wife, and I did a lot of soul-searching about that. And I thought, "Yes, I can do that. As another human being, I can do that." I made sure to let her know that I would be happy to do that for her and stand in and hold her hand while she goes through that process. But after that process, we would have no further contact. That would be the end of our therapeutic sessions together. She said she understood completely. The time came. I got the phone call. I went to (named the hospital). I stood right there, held her hand, looked her in the face the whole time. She delivered that baby. I said, "Congratulations." She said, "Thank you for being here." That's the rest of it. That's the end of the story. Caring for your clients can go too far, you know. I can't feed the world. I can't clothe the world. I can do what I do, but it's really, really easy to fall into that. That's really a tough question. That's really a tough question. Would I loan my clients money? No! Have I ever loaned a student money that I've seen here at (named a specific place)? Yes! A student came in and asked me one day, "I need 80 bucks to buy a book or I'm going to have to drop out of college. I get paid next week. I can bring it in next week." I said, "Fine." I gave him 80 bucks. I said, "Go buy your book." I fully expected never to see the student again. The student showed up the next week and said, "Thank you, Mr. (said name). I really appreciate that." I don't know. I guess you have to judge it. The way then that the codes of ethics and ethical decision-making models would play into all of this as a counselor is whether or not what you were actually doing in your behavior was fulfilling your need as opposed to the client's need. And I think if you're careful not to get on a slippery slope about fulfilling your own needs as opposed to the client's needs I think you're on pretty safe ground. If you head down that road, however, I think that's a reason a of lot therapists and clients have gotten themselves into big trouble; especially those clients and therapist who work together, male and female, who are dealing with some very, very intimate issues of their sexuality or their nature that way. I think that's where you'd have to be really, really careful.

Kathleen not only provided a specific illustration when she cared about a client while maintaining appropriated boundaries, she also spoke of various other ways of maintaining appropriate boundaries while caring for clients.

> **Kathleen**: Well, I think at this stage that I, that I've been doing it for so long it's not really an issue. But I think that at the beginning, and I think this for all new counselors too, that there is a boundary that you have to display in order to keep any type of transference and countertransference from happening. The caring has to remain within a professional boundary, that is, your caring and concern is limited to the professional limits. But I think, I'm really good about that because I really lay that out from the beginning with clients that our relationship is a professional one. And professionally I'm concerned, I care about it, but because I set up the limits of after hour, you know. This is your hour. I let them know because I live (said where she lived) that if I see you at the mall I won't come over and say hello. You're welcome to say hello to me. But the boundary of confidentiality, I think, although I'm not revealing anything to run over to a client in the mall, and, you know, people can ask, "Hey! How do you know that client?" So they know where the limits are, that I care about them professionally. So you have to set the boundaries. And I think that in order to do that for a new counselor is more difficult. When you've been doing it for so long, I think you're so used to it, you know. I had a client, and I have my clients call me (said name), and I had a client say, "Oh, I feel like I know you so well." Well, she knows nothing about me. But she said, "Can I call you (said first name)?" And I said, "Oh, I would just like to keep this professional. Please call me (said last name). And I think she had kind of almost reached where, I think she felt so comfortable, which was good, but I had to continue that that boundary was right there. So, to set it, you know.

Similarly Laynie provided an example of being put into the middle of a family situation because she cared about her clients and why it is so important to maintain appropriate boundaries with clients. Laynie further explained how she went about maintaining that boundary.

> **Laynie**: When you want to step in and help in the areas that you haven't been asked to help in. Situations where you have divorced parents and children, and you would like to help one with the other, you have an opinion about how this aught to be. I had one that really was a problem to me. And it was that I probably should never have taken half this group on as clients. A husband and wife had cut off their relationship with her parents because of a, in my opinion, miniscule problem that they had with them and would not allow them to see their grandchildren, over pictures to be taken at Christmas. It was just nothing, nothing, nothing. And they hadn't seen them in three years when they came to me the first time. And it was very difficult for me to not,… I knew those people, I didn't know them personally on a separate level, but I knew them on a separate level. I knew who they were. I could have worked in that situation. And the grandparents that they had broken off from also became my clients, with the

> agreement of the first couple. "Yeah, you need to work with them. They're…" And there wasn't really, I couldn't find really anything wrong with the grandparents. Anyways, I think, probably for me, my greatest temptation to do something unethical is when I allow myself to get personally involved, personally, emotionally involved in the situation. I had to tell myself that these people didn't ask me to solve their problem. In fact, (quick chuckle) I have to remind myself the first people that came to me probably just wanted to hear somebody go, "Yes, you're right. Those grandparents are horrible people. Stay away from them!" And they never did hear that from me. But, any time that I've personally been tempted to step over the line, it is always been in helping too much in the situation where I have become emotionally involved. When that happens I step back then. I just say, "You can't do that. (Laughs) There's rules against that." "You just don't do that." So I fall back on the ethical codes and the "that's not your job" message that I tell myself. The "sorry, your job is not to fix their lives the way you think they ought be fixed. Your job is to help them in whatever way they came to you for help." And it's not always satisfying sometimes.

Mariposa tries from the very beginning of the counseling relationship with her clients to establish ethical boundaries with her clients. She also attempts to very clearly communicate that this is a professional relationship. Should clients want Mariposa to do something or to go beyond her ethical boundaries, she tries to explain in a very caring, loving manner her ethical constraints and boundaries as a counselor.

> **Mariposa**: Well, I've had clients who wanted me to go to their birthday, 60th birthday, (laughs) or something. Or, you know, do things out of the context of this relationship, which I'm not, you know, comfortable with. I, you know, don't want to hurt anybody's feelings, but I try to make it clear from the outset that this is a professional relationship. I feel like my caring is manifested in the hour that I get with them, you know. It's a matter of, for that hour extending myself, even if I'm tired, with a headache or whatever, like you said before. It's the will to love, you know. It's not an emotion, which waxes and wanes; it's will to love. Do you have the will to give your best for this hour? You know. That's what I do and then as far as their expectations and all, the best I can do with that is just talk to them, you know. Communicate well what my ethical constraints are. And try to help them see it and understand it, you know. I mean, just recently, I had a male client tell me that he was sexually (laughs) fanaticizing about me. Well that was really uncomfortable for me (laughs). But I tried, you know, to still maintain, you know, "I care for you, but you understand that this is professional relationship," you know. I said, "This flatters me, but the truth is, now you're very vulnerable, you're going through a divorce, you don't have contact with many females and

> this would be a natural thing to feel, but it's not, um, it's nothing to be afraid of, it shouldn't interfere with our therapeutic relationship…" I don't know. I just tried to talk nice and normalize his experience so he wouldn't feel foolish, but still help him. He said, "Oh, I know nothing's going to happen." I said, "Yes, I know you know that." So, that's how it went.

Sometimes as counselors it is difficult to maintain appropriate boundaries. Because counselors usually do care about their clients, they occasionally want to cross those boundaries and help their clients beyond the therapeutic relationship. Mya illustrates this point. He also discusses what counselors need to do should they find that they have crossed ethical boundaries.

> **Mya**: Sometimes clients have needs that are right there in that moment when they, for instance, do not have a home to stay in that night. Or they do not have food in their stomach right then, and they haven't had it for 24 hours. And a lot of times a client may be sitting on your couch and they're going to leave your office and they're telling you they're getting back with their boyfriend or their girlfriend who's been, for whatever reason, that person's abusive or something. And you have to be very clear about what your boundaries are so that you don't get into a situation where you're running around calling people, trying to stirring people up, and say, "We need to monitor where that client's going," you know, and breaking… Now where I have gotten into a situation – and I have pretty good boundaries – where I've gotten into a situation where I kind of broke a rule one time. And it wasn't a bad one, and by no means is it something reportable or anything like that. But I remember there was a client who really just had very poor social skills and he had a girlfriend and they had a child. And they've been walking to work every day. They weren't getting a paycheck until tomorrow, the next day. And as I was seeing them, they were telling me about all of their financial problems, and we were working on their budget. And sort of a Maslow's hierarchy of needs approach to an issue. And I kept hearing the man's stomach grumble. He was hungry. And when I asked him about it he said, "Well, we haven't eaten since yesterday, but we get paid tomorrow." He didn't ask me for a thing. And I thought to myself, "You know I've got to see 25, 30 clients this week. I can't be buying lunch for every one of them." And when the session was over, and the man and his girlfriend were walking out, I just felt compelled to go give him $10 to get lunch. And it was just an immediate need. And I went out there. And as soon as I did I thought, "What kind of door am I opening right now, you know, for that client to start asking me for money." But I just felt compelled, and I handed him $10 and I said, "You guys go get something to eat." And he said, "Thank you." And I was lucky. He never asked me for another dime. But that could have opened up an ethical door where he could have said, "Can you

> help me with rent? Can you help me with this?" The thing I have found about ethical dilemmas is the reason they're a dilemma is because there's no easy answer. And so what I have found is if I do something like that I like to immediately document it, and after I document it, I will go talk to another counselor about it. And just make sure, you know, that I didn't cross a line, or do something that has compromised me. Or if it has compromised me, I need to instantly make the covert overt and get it out there, document it, talk about it, and take corrective action.

Pancho, like Mya, talked about boundary crossings. He also illustrated what might happen if the counselor does cross established boundaries without carefully considering the situation.

> **Pancho**: I think some ways that caring for the client might lead to ethical dilemmas could be not realizing or recognizing limitations and boundaries. For example, if a client is mandated by the justice system to come to counseling but then that client also has an eating disorder and I'm not trained in that area to handle eating disorders but I try to do it then that might create some ethical issues there in overstepping those boundaries. To do the work that I do in the evenings I have to have another license, a license by the State of Texas certifying that I'm trained to do that kind of work. So if I were to encounter an issue like that then I would have to refer that person to someone that has that expertise rather than try to do it myself because, you know, this is a mandate by the State. So that's the way I see it. I think if you overstep the boundaries then sometimes that can create ethical issues. Some of the people that I work with in the evenings have difficulty with transportation, you know. So sometimes they'll ask me about, you know, catching a ride, or things like this. And I seriously have to think about that because you don't want to get caught in a situation where you have a client with you, and you're transporting that client and something could happen. You could get blamed for that or get sued, or whatever. So I tell them, you know, ask some other people in the group; see if they can give you a ride, or prearrange for this, you know. Sometimes they have to come to group by bus. And the groups are in the evenings. So by the time they get out the buses aren't working. So I tell them, you know, make rearrangements with somebody to be picked up so it doesn't increase the probability of putting ourselves in a compromising situation that might create an ethical issue. The codes of ethics play into my decision of how to handle the situation because then you could, you know,… Playing that dual role of trying to be a friend as well as a therapist could come in and create an ethical issue there. So you have to be… That's why I say I have to think about it real closely. When it comes to meeting the needs of client, it doesn't necessarily mean that I have to be the one to actually provide those needs. I can meet as many of those needs possibly through referrals or references rather than, you know, me physically or actually doing that. So in my head I think that's the better way to see

things that can prevent ethical issues and still stay within boundaries, and still be within reason of trying to help the client to the best of your ability.

Similarly RSST discusses the consequences of not maintaining appropriate boundaries with clients. On occasion, not maintaining appropriate boundaries may even have dire consequences – not only for the counselor, but for society as well – all because the counselor cared too much about the client.

> **RSST**: If you don't set your boundaries of what care…like your question about what is caring in the therapeutic sense, you've got to have a definition? I think you got to know it's too easy to get over involved, over caring, to where you lose that professional therapeutic analysis, ability to analyze what's going on. You get caught up in their pain. You get caught up in their suffering. You get caught up in their drama and dilemma. And you lose perspective and you're no longer effective. And that's real easy. That's real easy, especially when you're talking to children, because children have a child's perspective about what's goes on. And it's way too easy to say, "Oh, these damn parents. If they were just better parents." But you don't really know. And you can make some really serious mistakes. And with sex offenders, every year I make sure I go to a victim panel. I listen to the victims, because I don't want to lose perspective on, you know, getting wrapped up in the abuse that they suffer from the legal system and lawyers and cops and all that kind of stuff and what they're put through because it does require perspective. It's too easy to take sides and you make bad decisions when you do that. Couples counseling can really get you into trouble because it's so quick to take sides, if you're not good at what you do. So I think in our profession that caring is to be limited to that professional: What's your goal? Where's the end point that you're going? And there's just going to be a lot of stuff that you don't deal with; you can't deal with. But if you help them fix certain things, then they'll be able to fix that other stuff. And you've got to give them that right and that responsibility to do that. So, consultation's huge, I think, in our profession. If you're not consulting with people and getting squared, and I'll give you an example. I've been treating a young man who is bipolar, fetal alcohol, ADHD, developmentally delayed. His mom is a crack-head, abandoned all the children, a family adopted them, and they've been raising him. And he got caught with child pornography so he came under my treatment. He's been with me for a year and a half. He's attended a group every week and I've done individual sessions every week with this guy. And trying to work with him on…and we've like gone through some rough times because he got caught up in a very manipulative situation by a minor girl. And so there were certain goals he had to attain. One was not to hang around 14- to 16-year-old girls. And the other was to get a job, because he needed a purpose in life. He can barely read, so he needs to have a reason to function because otherwise he would cut, and smear

> blood. He would take it out on his family, and he would be depressive and all that. And I kept working with him, and working with him. And he's going to turn 18 in two weeks. And if he didn't complete sex offender treatment, he's going to register as an adult for the rest of his life. So, he didn't stop hanging around little girls. And I know part of it is developmental and his emotional level, but he's an adult. And the legal side of it says if you do get caught up sexually with a minor, you know, it's an offense. In my mind I can't guarantee he won't do that because he hasn't quit, and he's had several sexual encounters with a minor. And so it was hard, but I had to write the letter, that I just delivered today, that said, "I will not release him from Sex Offender Treatment." He did not graduate. And that means that I'm the one who made the decision that he's probably going to register as an adult [sex offender] the rest of his life. It's tough! It's tough! But I had to consult and I had to pull in all the documentation that I had. I had to look at the polygraphs. I had to make a decision on who's my client, and in S.O. treatment society is my client first, because I'm protecting them from deviant behavior. And then he's my second client. And so I had to make a decision, and that was hard! That was really, really hard. So… Because I like him. See, and that's where it gets wishy-washy if you, if you like them and you think, "I would hate to do this to him or this would be so devastating on him," but I don't get the luxury of that. I have to make a decision based on my client. That was a tough one! That was a really tough one! And that's where if you don't work hard at making wise decisions about this whole thing about caring, I could've made a wrong decision. So what if I'd released him? And he felt free to do whatever. And he goes out and victimizes another minor. That's wrong! So there's like a fresh example of how easy it is to lose perspective if you don't get some strong concept of where the caring goes and where it doesn't, if that makes sense? Back to the first question which is a really good question because I hadn't really thought about it. I've been doing it action wise but to actually formalize the thought in my mind. So what would be the therapeutic boundaries that would define caring in a relationship? And it comes back to the client, you know. When you work with clients and the goals they set and the process of getting there, that's, I think, within the boundaries you allow that caring or you have that caring to be to get there to be good.

Sigmund and Susan discussed the importance of maintaining appropriate boundaries and the struggle that counselors might feel if they do not do so.

> **Sigmund**: I guess I could see if we develop a caring relationship and I really liked this person, and enjoyed being with them, and they revealed something that is stated in my informed consent and I would have to break confidentiality like they were sexually abusing their friend's daughter, or something like that, that would create lots of disruption inside me. That wouldn't keep me from reporting him but I would feel the hesitation, I would feel the conflict. I would say, "I know this person, they're a good person, but this child's at risk." So it would create conflict

within me. Therefore, it would create an ethical… It's not really an ethical dilemma because I'm not going to not report that, but it would be more difficult. So if they revealed something that requires me, especially if it moves over into a gray area something like, they said they know someone who is abusing a child. It could get real messy, and sticky, and… I would need at that point some consultation, and some supervision of what would,... "Well, what do you think I would need to do here?" And things like that. I'm not sure if this answers that question, but I have currently been seeing a client long-term and this client is a male client who is just likable. And I feel the pull of we could be friends outside the counseling relationship. And so if we didn't have the counseling relationship, I think we probably could be friends outside the counseling relationship. But that's not ethical. That's not going to happen. So, from time to time he'll be leaving and say, "See you, my friend." So I haven't sat down with him and said, "You're not my friend." But I think he feels cared for to the place where he would like a friend who cares for him. And he has to pay me to do that. And so I'm not sure how many friends he has outside the counseling relationship who actually care for him.

**Susan**: I guess we have so many like multiple roles that we have to play. I'm thinking of like my CPS clients and stuff like that…where we have to do visitation and we have to do this. Like they'll invite me to ballgames and things, and I'll always say, "Oh, darn it, I have something planned that day. I'm sorry I can't go." I don't know that I've ever felt that feeling like I need to do something, by the time I think about it and I think about the ramifications of it. I do everything that I'm supposed to do and then trust that the other people involved will do. Like if they're having trouble in school or something, the most I would do would say, "Well, if you're having trouble in school, and the school counselor, you know, wants to staff with me, you know, have your mom sign a release." Or I'll talk to the mom and say, "Sign a release and the school counselor and I can chitchat about it." But I don't really run into those situations very often because I have very strong boundaries with stuff like that. I can't even think of a situation… Oh, I have a perfect example! I recently had a child that transitioned out of my care into the care of another counselor because she went from all of this horrible back stuff to this new phase of adoption counseling. And the foster parents wanted to take her to another counselor because I was kind of a reminder of the past. And so she transitioned to a new counselor and, they forgot to invite me to the adoption. And all the people at CPS are like, "You need to go! You need to go!" Well, I told them if they wanted me to come they needed to make sure I knew. And so, they were like "but you need to go." And I'm like it's counterintuitive of me to put my needs before the needs of one of my clients, even my former clients. So I'm not going to go unless they call and personally invite me. That was a ground rule I laid with them. So I did kind of struggle with that, because I really wanted to go, but I thought, "No, it's counterintuitive. Something is not right in my gut about this." So I didn't go because I felt it was, you know, they simply forgot to invite me because I ran into them in the grocery store. But

> it's one of those situations where you have to always put the needs of your clients above your need unless they're threatening you or something. So it would probably go back to the boundaries. And if I ever have any question as to whether I'm leaning in the wrong direction, then I'll talk to (said a person's name). Or if I'm down talking to one of my other therapist friends, (said person's name), than I'll talk to (said person's name). Typically, you know, it's like the ethical decision making process. You consult with other people if you're not able to figure out exactly if it is one of those gray areas. So I guess that would be what I would do.

Tara tells how she maintains appropriate boundaries with her clients. She admits that by maintaining appropriate boundaries some clients may perceive it as uncaring. Nevertheless, it is necessary for counselors to maintain those boundaries with clients.

> **Tara**: Sometimes a man might want a hug or something, but I avoid that, and I just explain to them that's not something women counselors do. And if people want to call me like in the middle of the night I just turn my phone off. They can call me during the daytime or they can call 911. It may be perceived as uncaring because there are some people, especially clients with Borderline issues that would want to call at midnight and at 2:00 in the morning. So if I don't answer the phone, they probably see it as uncaring. For me it's a boundary issue. To me caring is when we're in the office and talking.

**Autonomy issues.** A second theme that came from this research question was autonomy issues. Autonomy involves the fostering of self-determination. Accordingly, counselors respect the rights of clients to choose their own directions, act in accordance with their own beliefs, and control their own lives. Counselors also work to decrease client dependency and foster independent decision making by the client. If the counselor cares too much about the client, the very opposite could happen. Rather than fostering self-determination and decreasing dependency, the counselor could make the client dependent upon the counselor because of the counselor's caring. Thus, the client depends upon the counselor to help the client meet their everyday needs and to help make everyday decisions. Therefore, it is important for the counselor to help the client stay autonomous even while caring about the client.

Delilah points out the difficulty that some counselors have in wanting to offer the client help when the counselor should allow the client to do things for themselves. However, Delilah also stipulates that when counselors do help clients beyond the normal counseling relationship, the counselor needs to be aware of their motivation for doing so. On the other hand, Delilah is aware that counselors do need to sometimes advocate for specific groups of clients.

> **Delilah**: Sometimes I care too much. I find myself wanting to offer to help more than I should. I'm very much a rehab counselor, working with people with disabilities. And I'm so use to arranging services. And so I find myself wondering, "Well, you know, if you have that problem, why don't I call so-and-so. So I have a hard time with that. And that can cause ethical dilemmas. In those situations I shut my mouth and think about it for a minute, and go "Is this going to be helpful for my client." And sometimes it works and sometimes it doesn't. You know, sometimes they need resources. And sometimes they do need resources in this city that I know of, and I can put them in contact with different resources that they need, either for jobs or housing or finances or food or, you know, whatever they might need. I can do that because I know people in the town. But I have to be aware of my motivations to doing that. I have to understand where I'm coming from in doing that. Is it to impress them? Is it doing to make me feel more important that I am, you know, that I can help. Kind of going outside the counseling bounds. But because of the population that I work with, and my degree, that's what I was always taught as a rehab counselor. I wasn't just a counselor. So I work with everybody. And so I just have to be real careful in why I'm doing what I'm doing, because I understand that some people don't need that help, or they can get that help on their own. And that's important for them to do that, you know, for them to be responsible. I've been a rehab counselor since the '70's, and that was a tough time for people with disabilities. And I have advocated for people with disabilities my whole life. That's what I do. I see that as one of my roles. But it's hard in the counseling setting. How much do you advocate for, and how much do you let them be responsible for. I think caring is part of advocacy. I think advocacy comes out of caring because if you didn't care for your clients you wouldn't do anything. You'd just sit here for 45-, 50-minutes and you'd go, "Okay, see you next week." But I think advocacy is more than that. I think it's making life better for a group of people who typically in the past is not able to access the services. I can't tell you what the bus system here in (named city) is. It stinks (chuckles) for people with disabilities. And so I was on a board to help change that. And we did change a lot of things. So that was, you know, that was a good thing. But I think it comes out of caring for the population that you work with, and for your clients. But you can't take

> over for the client. By taking over it would be kind of hurting the client because then they would become dependent upon you. You wouldn't be teaching them anything. And I know there is a big difference between teaching and counseling and it gets muddy some times.

Like Delilah, Barney advises counselors to check their motivation for why they are doing something for a client. Is the counselor fulfilling her/his own needs or the needs of the client? If the counselor is fulfilling the counselor's needs rather than the client's needs, then the counselor is not allowing the client to be autonomous. At that point the counselor could find himself or herself in an ethical dilemma.

> **Barney**: The way that the codes of ethics and ethical decision-making models would play into your actions as a counselor is whether or not what you were actually doing in your behavior was fulfilling your need as opposed to the clients need. And I think if you're careful not to get on a slippery slope about fulfilling your own needs as opposed to the client's needs I think you're on pretty safe ground. If you head down that road, however, I think that's a reason a lot therapists and clients have gotten themselves into big trouble; especially those clients and therapist who work together, male and female, who are dealing with some very, very intimate issues of their sexuality or their nature that way. I think that's where you'd have to be really, really careful.

Maintaining the client's autonomy does not necessarily mean doing nothing for the client as Susan points out. Susan makes the fine distinction in regard to autonomy that she tries to lead the client in meeting the client's needs without doing it for them. Taking over and doing everything for the client denies the client their autonomy.

> **Susan**: I keep a list of community resources here in my office and if someone needs, you know, food, clothing, or shelter, I know the shelters in town and I refer them to them. I have pulled up on my computer the different addresses for like the Medicaid office and things like that. So, that way I can give them addresses to. I even print out bus schedules for them if they don't have, you know, a ride. I kind of try to help lead them in that way without doing it for them, because if I do it for them, then they'll never learn how to do it for themselves. But I do help, I do show them how to, you know, let them know the resources that are available, tell them that if they have questions they can go to the library, which happens to be just down the street, and they can pull up more information about it.

Kathleen stated that the role of the counselor is to offer counseling. Anything beyond that is the responsibility of the client and for Kathleen that is where the responsibility falls. One example that Kathleen offered was that of a book. If the counselor suggests a particular book for the client to read, it is the responsibility of the client to get the book, not the counselor's responsibility. However, Kathleen does state that it is the responsibility of the counselor to do any kind of research the counselor may need to provide the best counseling possible. That is where the counselor's responsibility lies beyond providing counseling.

> **Kathleen**: I think that the something that we do to help is offer counseling. I think that is the thing that we do. I put a lot of the responsibility for doing on them because that's where that belongs. My job is really not to do for them, it's to provide them with counseling. Some of that is inside. Some of that is listening. Some of that is clarifying what they're looking at. Some of that is helping with, you know, a certain diagnosis so that they have an understanding of what's going on. Some of it is referring them to physicians. But I often have them do their own research. I don't do that for them. You know, if I say, "This is a really good book. I'd really like you to read that. I think it would give you more insight on how you're feeling and what you're going through." I don't go get the book for them. I have them do that. And I think that's empowering to them. But as far as what I do for them is counseling. Now on my own, after like an initial counseling session, if I see some characteristic traits that I think I need to look into further I do research for myself in order to be able to provide them better services. But what I do for them is counseling.

Carla in answering this question spoke of several issues involving autonomy giving specific examples with each one.

> **Carla**: Well, when you work for example, in this environment at (said place of work), and my job is to help students be successful at (said where). But sometimes (said location) is not the appropriate environment for a student. So the ethical dilemma comes in, am I here to serve the student's best interest or (this certain place) best interest, my employer's best interest. The legal dilemma of "who is the client?" Your employer or the individual? It is not as cut and dry as embezzling money or something. But, morally and ethically there is a division that I've had a couple of incidences where I've had to make that determination. Ethically and morally, I go with what's best for the student. I don't tell them what

> to do but I can give them information about other alternatives or options instead of "keep beating your head against a wall here", (laughs), kinds of things. I can see where there will be places when, where you might work where you have a worker's obligation to the employer and that may, hopefully not often, but that may conflict with your moral and ethical centeredness for that student, or that client. I can see in other environments that that could really become a dilemma for people. When I first started this job, my door did not have a window in it. And I insist that my doors always have a window. I want anyone to be able to walk by and see anything that's going on in my office. My boss, kind of thought that I was being a little extreme but it was for my protection and for the student's protection so there would never be any reason to question what was happening behind a closed door. That was another situation where I had to take care of myself and my clients over the standard of the employer. I don't know if that was a legal or an ethical dilemma but that was important to me. Often in this environment, I will hug a student but I always do that outside in that lobby area. (Laughs). I'm kind of a "mom" and "grandmom" type, and sometimes, when we finish talking together, the student and I will walk out together and I give them a hug out in the lobby in front of everybody, you know. If I were in a more therapeutic environment, I would probably never hug a client but working with students and I build a rapport with them so that they know I care about them and that I am here for them lends itself to giving hugs from time to time and letting them know that I am so very proud of who they are and what they are accomplishing. So there are some things that I do that are just…me. I just have to make sure that I'm taking care of myself ethically and that I'm not putting myself in any kind compromising situations or circumstances. There have been gray lines, in this particular job, where it's a "need to know" kind of environment. When I first started working I was the first LPC – well, I was the first LPC that had been in any of this kind of environment before – and so it was difficult when I would explain to my boss that I needed information regarding students be kept confidential when she wanted to see my files, or that I needed my appointments to be private. At first the attitude was "I'm the boss. You can tell me. I'm your boss". It took a little bit of educating I guess, informing, drawing a line and saying, "This is what I will and this is what I will not be able to do." Working confidentiality out when you work in a team environment like that was a challenge. So those are some of the things just in this workplace that I've had to kind of think about, and plan for, and make accommodations with, or whatever.

**Countertransference issues.** Countertransference is defined as any projections by counselors that distort the way they perceive and react to a client. Countertransference occurs when there is inappropriate affect, when counselors respond in highly defensive ways, or when they lose their objectivity in a relationship because

their own conflicts are triggered. In other words, the counselor's reaction to the client is intensified by the counselor's own experience (Corey et al., 2011). Barney, Kathleen, and Susan contend that sometimes perhaps caring in the counseling relationship can actually be a form of countertransference rather than true caring. Therefore, counselors need to closely examine whether their caring is true caring or whether it is really countertransference, thus creating an ethical dilemma. If it is countertransference, than the counselor needs to deal with their countertransference issue through supervision, consultation, or personal therapy. Here is how Barney addressed caring as a possible countertransference issue, "It would have a lot to do with transference and countertransference going on in the session. How would you denote caring as opposed to countertransference, for example? I'm caring. No, that's countertransference. You know? What's going on there?"

Kathleen spoke too of countertransference issues that counselors, especially new counselors, might have at the beginning of their counseling careers due to their caring for their clients.

> **Kathleen**: Well, I think at this stage that I've been doing it for so long it's not really an issue. But I think that at the beginning, and I think this for all new counselors too, that there is a boundary that you have to display in order to keep any type of transference and countertransference from happening. The caring has to remain within a professional boundary, that is, your caring and concern is limited to the professional limits.

Likewise Susan addressed countertransference as an ethical issue that counselors might encounter if they care too much for their clients. Here is how Susan spoke about that situation.

> **Susan**: If you get over involved or if you too close relate to maybe their circumstances, and you're not able to deal with whatever your countertransference with that client is, that could cause some ethical problems. If

> they remind you of someone you dislike, then you might not care enough. If they remind you of somebody that you deeply care for, maybe have experienced loss with, you may care a little too much and put stuff on them that isn't appropriate. And those instances if you're not able to overcome that very quickly, then I would say refer as long as you haven't been seeing them for like two years. Otherwise, go to therapy and work on it for yourself because, you know, as long as you deal with your countertransference that shouldn't happen too often. I guess. I just deal with it.

**Summary**

The results of the research offered insight into the perceptions of Licensed Professional Counselors regarding caring and the ethic of caring in the counseling relationship. This chapter (Chapter 4) presented information from the in-depth individual interviews of each of the Licensed Professional Counselors. It also included the insight of the researcher after the interviews were transcribed and their thoughts placed into specific themes. The results identified several themes about the concept of caring such as a natural ability to care, the therapeutic relationship, Rogers's core conditions, therapeutically meeting the needs of the client, and nonmaleficence. In regard to the importance of caring in counseling, the themes identified were: (a) that caring helps develop the therapeutic relationship, (b) counseling necessitates caring about another individual, (c) caring is an important part of creating change within the client, and finally (d) caring creates a drive to help individuals. The themes identified for the role of caring were: (a) caring is the foundation of counseling, (b) caring motivates counselors to help the client, and (c) to show that care that counselors naturally possess to their clients. The themes in regard to how caring is manifested were through communication and through the therapeutic relationship. Two subthemes under communication also emerged: verbal and nonverbal. As to how LPCs maintain a professional presence under certain difficult circumstances, four themes were identified: (a) through self-care, (b) by focusing on the

client, (c) through the therapeutic process, and (d) by maintaining justice. Finally the themes identified for the circumstances under which LPCs found that caring for clients might lead to ethical dilemmas were: maintaining appropriate boundaries, autonomy issues, and countertransference issues. In the next chapter, a discussion of the findings will be presented as well as implications and potential future research.

# Chapter V

## Discussion

In this chapter, the results of the research are summarized. Additionally, thematic strands generated from the research questions themes are discussed. This chapter also includes a discussion of implications for theory and practice including four recommendations for practice. Finally, various avenues for future research are presented.

### Summary

This study was conducted to ascertain the perceptions of Licensed Professional Counselors (LPCs) of caring, its important role and manifestation in the counseling relationship, its role in LPCs maintaining a caring professional presence, and its role in ethical dilemmas that caring for clients might create for counselors. Based on the literature review, the following six research questions emerged. What concepts do Licensed Professional Counselors believe about caring? What concepts do Licensed Professional Counselors believe about the importance of caring in counseling? How do Licensed Professional Counselors perceive the role of caring in the counseling relationship? How do Licensed Professional Counselors conceptualize ways that caring is manifested within the counseling relationship? How do Licensed Professional Counselors maintain a caring professional presence when they find it difficult to do so under difficult circumstances? Under what circumstances have Licensed Professional Counselors found that caring for clients might lead to ethical dilemmas?

In order to answer the aforementioned research questions, the participants were 12 volunteers: Licensed Professional Counselors who had been fully licensed as LPCs for a minimum of one year, had practiced as LPCs for a minimum of one year, and had never

had any complaints filled against them with the Licensure Board. The participants were seven females and four males, ranging in age from 46 to 70 years. Eleven of the participants were of European decent, and one participant was Hispanic. They have been fully licensed as LPCs for 10 to 30 years, with a mean licensure time of 15.1 years. Their experience as counselors ranged from 10 to 29 years, with a mean experience level of 14.8 years. In terms of education, there were three participants with PhD degrees and nine participants with Master's degrees. All of the participants reside in the Southwest region of the United States.

A brief summary of the various themes that emerged from each of the research questions is provided in the following paragraphs. In regard to LPCs' concepts of caring, five themes emerged. The first theme was a natural ability to care. This theme encompasses the idea that counselors have the innate capacity to care for their clients. The second theme under concepts of caring was the therapeutic relationship. This theme emphasizes the idea that it is through the therapeutic relationship the counselor shows the client just how much the counselor truly cares about him or her and that it is through this relationship that caring occurs in counseling. The third theme was Rogers's core conditions of genuineness, congruence, unconditional positive regard, and accurate empathy. The fourth theme to emerge was therapeutically meeting the needs of the client. This theme emphasizes that achieving the goals for which clients sought counseling is the best way for counselors to care. The final theme is nonmaleficence. *Nonmaleficence* means do no harm to the client, and it obligates counselors to avoid actions that risk hurting clients, even inadvertently (Corey et al., 2011; Kitchener, 1984; Meara et al., 1996; Remley & Herlihy, 2010).

With regard to the LPCs' concepts about the importance of caring in counseling, four themes emerged. The first concept was that caring helps develop the therapeutic relationship. The literature indicates that the therapeutic relationship is a quality, personal relationship between the counselor and the client that allows the counselor and client to function as a team with a focus on goals. Likewise, it is the positive, affective aspect of the same relationship that allows the client to feel valued and liked (Horvath & Symonds, 1991). Under this first theme, many of the LPCs in this study believe that this therapeutic relationship is developed through caring. The second theme to emerge involved caring about another individual whereby this occurs in such a way that the client knows that the counselor cares about him or her. The third theme was that caring is an important part of change. This theme encompasses the concept that caring is part of the change process within the client. Without care, some counselors believe that change might not occur within the client. The final theme was that caring creates a drive to help individuals. This drive is the motivation and desire to help the client throughout the counseling process.

Regarding the counselors' perceptions of the role of caring in the counseling relationship, three themes emerged. Caring as the foundation of counseling was the first theme. This theme emphasizes that caring is the foundation upon which all aspects of counseling is based. In the second theme, the role of caring is to help the client. Clients come to counseling because they have issues affecting their lives, issues that they want changed. Helping the client in counseling to achieve that change is the reason that counselors care in counseling. Finally, the role of caring is to show care to the clients. According to this theme the role of caring in the counseling relationship is to convey that

the counselor genuinely cares for the client.

From the data collected on, how caring is manifested within the counseling relationship, two major themes and two subthemes emerged. First, caring is manifested through communication. It was through communication and the process of communication that the counselors reported that they most frequently manifested caring. Further, two subthemes emerged from the theme of communication – verbal and nonverbal communication. While several of the counselors talked about how verbal communication plays a part in manifesting care to the client, 67 percent of the LPCs indicated that the nonverbal aspect of communication plays an even greater role in manifesting care to the client than did verbal communication. The final way that caring is manifested is through the therapeutic relationship. Specifically this includes everything that the counselor exhibits throughout the counseling relationship, and it likewise includes the ways in which the counselor shows the client that the counselor cares about him or her.

With regard to maintaining a caring professional presence, four themes were identified. The first way that counselors maintain a caring professional presence is through self-care. This theme examined the many different methods that counselors used to take care of themselves so that they can be "their best" in the counseling session. The next method by which counselors maintain a caring presence is by focusing on the client. By focusing on the client, the counselor no longer focuses on any personal issues the counselor might be experiencing during the session; this is critical in that the client is the most important individual in the counseling room at the time and not the counselor. The third theme that developed was that counselors maintain a caring presence throughout the

therapeutic process. Through the therapeutic process and working within that process, counselors are able to get through any difficulties that they might be having with the client while simultaneously maintaining a caring attitude toward the client. Finally, counselors maintain a caring professional presence by maintaining justice. Justice demands equality, which has implications for nondiscrimination and equitable treatment of all clients. Accordingly, the counselor's actions and decisions must be fair to all clients.

The final research question examined the circumstances under which LPCs find caring for their clients might lead to ethical dilemmas. From this research question, three themes emerged. The first was maintaining appropriate boundaries. *Maintaining appropriate boundaries* means the counselor establishes ethical relationships with clients and does not allow clients to move her or him beyond that relationship. Caring for clients might, if the counselor is not careful, lead to ethical dilemmas for the counselor because if the counselor cares too much about clients, the counselor can inappropriately cross those established boundaries. The second theme to emerge was autonomy issues. *Autonomy* means that counselors seek to decrease client dependency and foster independent decision-making by the client. If the counselor cares too much about the client, the counselor could create dependence upon himself or herself to such a degree that the client must come to the counselor for help with decisions that the client could make for herself or himself. Accordingly, it is important for the counselor to help the client stay autonomous even while caring for the client. The final theme was countertransference issues. Countertransference is the redirection of a counselor's feelings toward a client. Therefore, counselors need to closely examine whether their

caring is true caring or whether it is really countertransference, thus creating the potential for an ethical dilemma.

Caring can be a complex phenomenon. It can become even more complex when it involves counselors caring for their clients. It can even cause ethical dilemmas for counselors if they are not cautious and care too much about their clients. For example, counselors might give money to their clients for food, give them rides home after evening group sessions, or say clients are able to take care of their children that were taken away from them by Child Protective Services when the clients are not ready or able to appropriately care for their children. In summary, using the aforementioned research questions as foci, this study's purpose was to examine the phenomenon of caring among LPCs, how LPCs appropriately care for their clients, and what ethical dilemmas LPCs might encounter if they care too much about their clients.

**Thematic Strands**

From the themes that emerged from the six research questions, several thematic strands developed. *Thematic strands* are themes that emerge from within the various themes that had previously emerged. Thematic strands, accordingly, represent a higher level of thematic analysis of the data. The thematic strands are: the therapeutic relationship, therapeutically helping clients, contours of care, ethical elements of care, and primary components of care

**The therapeutic relationship.** The first thematic strand to emerge was *the therapeutic relationship*. Whether it was the concept of caring, the importance of caring, how caring is manifested in the counseling relationship, or how a caring professional's presence is maintained under challenging circumstances, the therapeutic relationship was

continually mentioned. This attests to the importance and significance of the therapeutic relationship in counseling. Additionally, it attests to the significance and importance of caring within that relationship.

More than 70 years ago, Rogers (1942) identified the counseling relationship as a salient feature of counseling. In fact, Rogers was clear in stating that a working relationship must be established if counseling is to be successful. Similarly, other researchers have posited that the counseling relationship is a significant contributor to positive therapeutic outcomes (Day, 2008; Laughton-Brown, 2010; Tannen & Daniels, 2010). Horvath and Bedi (2002) concluded that considering various types of psychotherapy, at least 12 percent of the therapeutic outcome is the result of the counseling relationship.

Based on the important and critical nature of the counseling relationship, caring and establishing caring in the counseling relationship are critically important. That is why some of the participants defined caring as the therapeutic relationship itself. It is through this relationship that the counselor's caring takes place in counseling between the counselor and the client. It is also through this relationship that the counselor cares about the client.

Counselors also believe that caring helps develop the counseling relationship, which is critically important for the counselor inasmuch as the therapeutic relationship plays such a vital role in counseling. Counselors also verbalized that for some of them it is through the therapeutic process that they maintain a caring professional presence when difficulties might arise in the counseling session. In other words, when difficulties arise in the counseling session, whether it is due to the client or personal issues with the

counselor, these counselors rely heavily upon the therapeutic counseling process to get them through those challenges.

In summary, the participants viewed caring as the therapeutic relationship. Caring was also conceptualized as helping to develop the therapeutic relationship. Caring, for these LPCs, is maintained through the therapeutic process. Finally, it is through the therapeutic process that LPCs maintain a caring professional presence when they find it difficult to do so under challenging circumstances.

Counseling is about caring. Thus, caring is integrally connected to the therapeutic relationship. Everything LPCs do within the counseling relationship and even the relationship itself involves caring about the client. As one participant stated it, "I think the whole counseling session establishes the role of caring."

**Therapeutically helping clients.** Another thematic strand that emerged was therapeutically helping clients. Clients come to counseling with problems and issues that are affecting them, their lives, and sometimes their families. Caring, in counseling, involves meeting the counseling needs (i.e., goals) of the clients. Some clients come to counseling because they have done some atrocious acts. Even though counselors cannot excuse such actions, counselors need to care about those clients so that they are able to help the clients change their situation. This is the reason that many individuals seek counseling and the primary purpose for counseling's existence.

Additionally, caring about the client creates a drive in the counselor to help the client. Caring is the phenomenon that motivates the counselor and enhances a desire within the counselor to help the client achieve his or her counseling goals. Caring keeps the counselor moving forward with the client through the sometimes long and

challenging counseling process.

Furthermore, caring in counseling includes helping the client. In helping the client, the counselor assists the client through the counseling process so that the client may achieve the goals for which he or she sought counseling. Thus, the counselor guides the client in a certain way, understanding throughout the counseling process where they are going and what they as counselors are doing. What aids the counselor in this process is the particular counseling theory ascribed to by the counselor. This theory informs and guides the counselor in facilitating the achievement of the client's goals. It also enables the counselor to care enough about the client not to allow the client to "slide, rationalize, [or] justify away things that need to be addressed" as one participant stated. Rather, caring about the client means helping the client discover how to help themselves achieve their counseling goals.

Caring also involves maintaining justice for all clients. That is, treating all clients, regardless of their situation in life, with equity, fairness, and nondiscrimination. Treating clients fairly and equally in counseling is one method of demonstrating to the client that the counselor cares about the client. Further, it denotes that regardless of their situation in life, the counselor will help clients meet their needs; specifically, the counselor will not refuse to see clients because of their circumstances.

In summary, caring in counseling involves helping clients therapeutically meet their counseling needs. Furthermore, caring creates a drive within counselors to help their clients. Additionally, caring empowers counselors to help their clients through the counseling process so that the clients are able to achieve their counseling goals. Lastly, counselors maintain justice for all of their clients.

**Contours of care.** *Contours of care* address the various avenues and aspects of care. It embraces such concepts as the natural ability to care, caring about another individual, showing care, Rogers's core conditions of genuineness, congruence, empathy, and unconditional positive regard, focusing on the client, verbal and nonverbal communication, and self-care.

While caring in counseling may vary with counselors, it all starts with a natural ability to care. Caring about another individual and that individual's hurts, needs, and mental issues that are causing that individual distress in their life seems to be an innate quality within counselors that attracted them to counseling and becoming a counselor. Thus counselors are ready, willing, and able to show care to clients when clients come to counseling. How counselors show care to clients is through Carl Rogers's core conditions of congruence, genuineness, unconditional positive regard, and empathy.

Care is also exhibited to clients through the communication process. While verbal communication understandably plays a central role in the manifestation of caring to the client, participants were more adamant and focused on the nonverbal aspect of communication in demonstrating care to the clients. As one participant stated, "You can say the words but most of us believe the nonverbal communications over the verbal." This is congruent with the research on nonverbal communication which indicates that 55 percent of nonverbal communication is physiological, such as gestures, facial expressions, or movements and 38 percent is vocal, such as tone and vocal expression or quality, while only seven percent of all communication is through words (Devlin & Green, 2000).

Counselors are also very cognizant of self-care as one of the contours of care.

Counselors reported that it is very important for them to take care of themselves so that they may provide their best counseling services when they are in a counseling session with a client. This included, but was not limited to, getting plenty of sleep at night, utilizing mental wellness and meditation, exercising, eating well, not seeing too many clients each day, listening to music, gardening, and enjoying friends.

Although counselors have a number of contours of care at their disposal to utilize in the counseling process, counselors all seem to have a natural ability to care. Therefore, they instinctively care about other individuals, particularly their clients. In addition, counselors demonstrate care to their clients through genuineness, congruence, unconditional positive regard, and empathy. Counselors also manifest care by focusing all of their attention on the client through the use of verbal and nonverbal communication. Finally, to make sure that counselors remain the caring individuals that they naturally are, they focus some of that care on themselves. While the contours of care appear to be vastly different in form, together they create this dynamic flow with each and every one of the contours necessary for counseling to be the caring profession that it is.

**Ethical elements of care.** The fourth thematic strand that developed from the themes previously stated was ethical elements of care. A counselor's own personal ethics and codes of ethics (e.g., the *ACA Code of Ethics*) empower counselors to be ethical. Therefore counselors want to practice nonmaleficence with all of their clients by seeking to avoid actions that risk hurting clients, even inadvertently (Corey et al., 2011; Kitchener, 1984; Meara et al., 1996; Remley & Herlihy, 2010). Clearly, nonmaleficence is one way of caring for clients.

As counselors care for their clients, they simultaneously want to maintain appropriate boundaries with their clients. Boundaries are like a frame around the counseling relationship defining a set of rules and roles for the counselor and the clients. To practice sound ethics, it is important for counselors to maintain appropriate boundaries with the client. If counselors are not cautious they can care too much for their clients and cross ethical boundaries, even unintentionally. Counselors need to help clients understand from the very beginning of the counseling relationship that these boundaries are really a way for counselors to care for clients. If clients want counselors to violate clearly established boundaries, counselors clearly communicate to clients in a caring manner exactly what the boundaries are for the counseling relationship. In doing this, counselors are really communicating and demonstrating to the client how much the counselor cares about the client and the counseling relationship.

Caring also means avoiding autonomy issues with clients. Clients must be able to make their own decisions and remain autonomous. Thus caring for clients entails fostering self-determination for clients. Counselors respect the rights of clients to choose their own direction, act in accordance with their own beliefs, and control their own lives. If the counselor cares too much about the client, the very opposite could happen. Rather than fostering self-determination and decreasing dependency, the counselor could cause the client to be dependent on the counselor because of the counselor's caring. Thus, the client becomes dependent on the counselor to help the client meet their everyday needs. Therefore, it is important for the counselor to help the client stay autonomous even while simultaneously caring for the client.

Additionally, counselors need to carefully consider whether their caring for a

client is true caring or countertransference. Countertransference is the redirection of a counselor's feelings toward a client. Often counselors who distort the way they perceive and react to a client are having countertransference issues. Countertransference occurs when there is inappropriate affect, when counselors respond in highly defensive ways, or when they lose their objectivity in a relationship because their own conflicts are triggered. In other words, the counselor's reaction to the client is intensified by the counselor's own experience (Corey et al., 2011).

Caring can occasionally masquerade as countertransference. Consequently, counselors need to determine whether what they are doing is really caring about the client instead of having countertransference issues with the client, which in turn can create ethical issues for the counselor. In order to help counselors make the best determination in regard to this situation, it would be wise for the counselor to consult with a colleague.

Although clients may not always recognize it, caring necessitates counselors remaining ethical at all times with all clients. Clients will occasionally misinterpret being ethical as being uncaring. However, being ethical really means that the counselor is extremely caring toward the client and does not want to hurt, harm, or endanger the client in any way. In caring, the counselor simultaneously practices nonmaleficence. The caring counselor, furthermore, maintains appropriate boundaries with the client, which is in the best interest of the client and which allows the client to be autonomous from the counselor. Further, the caring counselor examines her or his caring for evidence of countertransference in order for that ethical issue to remain a nonissue.

**Primary components of care.** The final thematic strand was primary components of care. These primary components consist of caring as the foundation of

counseling and caring as an important part of change. Many of the participants (67%) identified caring as the foundation of counseling. For them, it is on the base of caring that all of counseling rests. This means that the client needs to perceive the counselor as genuinely caring. When the client has that perception, then the client is more willing to be "open" with the counselor and share his or her internal concerns and feelings with the counselor.

A few of the participants ($n = 2$) also viewed caring as an important part of therapeutic change. These LPCs believe that it is part of the change process within the client. Though theoretically possible, some LPCs believe that without the counselor caring about the client, the client might never change, thus leaving the client with the same issues and problems in their lives for which they sought counseling.

Thus, caring is the cornerstone for counseling. It is that ingredient that counseling builds upon and rises from. Further, caring is an integral part of the change process within the client. Without care, some LPCs believe that change within the client will not occur, and accordingly, caring is a primary component of counseling.

**Compatibility of the Research Results with the Literature**

**Convergence with the literature.** A careful analysis of the data from this study indicates that this research is consistent and compatible with the way caring has been conceptualized in the caring and counseling literature. For example, in the caring literature, Noddings (1984, 2003) discussed the natural ability to care. Noddings posited that caring is based on the natural caring that is received through a relationship with at least one adult who has learned how to care by having been cared for. She further states that it is through this caring process that individuals learn how to spontaneously care.

Additionally, the caring literature (Bergman, 2004; Noddings, 1984, 2003) contains information about motivational displacement and how the one-caring temporarily joins with the cared-for in order to respond to the needs of the cared-for. In order for this to occur, the caring-one must pay close attention to the feelings, needs, desires, and thoughts of the cared-for, and possess the skill to understand the situation from the perspective of the cared-for (Held, 2006). The caring literature also discusses self-care stating that while the caring-one acts in behalf of the cared-for's interests, the caring-one also cares for himself or herself. Without the maintenance of their own capabilities, they will not be able to continue to engage in caring (Held, 2006). Borrowing from counseling and other literature, the caring literature refers to empathy, emotional needs, attending to the cared-for's needs, understanding their perspective, and the cared-for as unique and of value. The caring literature also covers communication, both verbal and nonverbal. According to the counseling literature, caring involves concern, empathy, and consideration for the needs and values of others. This may be demonstrated through such things as understanding the other person's perspective, advocating for the needs of others, communicating effectively with the other person both verbally and nonverbally, embracing the other person's emotional and psychological needs, and attending to the cared-for's needs. Individuals also show that they care not only by respecting others but also by considering the cared-for as unique and of value (Greenfield, 2006). Based on this information it can be determined that all of the items cited in the caring literature were cited by the participants in this study and in the identified research themes.

Research themes not included in the caring literature were included in the counseling and ethics literature. This includes such themes as those involving the

therapeutic or counseling relationship and Rogers's core conditions. The counseling relationship is a salient feature of counseling (Rogers, 1942). In fact, Rogers clearly stated that a working relationship must be established if counseling is to be successful. Rogers (1957) also posited that congruence, unconditional positive regard, and accurate empathy were necessary for therapy to be successful (Day, 2008; Kensit, 2000; Lazarus, 2007; Samstag, 2007; Watson, 2007). These three primary counseling conditions are often referred to simply as the core conditions. Thus, the research data in this study that emphasize the therapeutic relationship and Rogers's core conditions are congruent with the literature.

Research participants in this study identified such ethical issues as autonomy, nonmaleficence, and justice. This research data is compatible with the research by Kitchener (1984) and Meara et al. (1996), which identified and described the moral principles of autonomy, nonmaleficence, and justice, while the *ACA Code of Ethics* (2005) sets forth appropriate boundaries for counselors. Simultaneously, Corey et al. (2011) discussed countertransference issues.

The anticipated results of this study were expected to be significantly different from the literature reviewed, the anticipated difference being attributable to the data being collected from a different professional group. However, the current outcome was to be expected in that a large body of research had been previously conducted on caring across a number of professions such as education (Noddings, 1984, 2003), social work (Freedberg, 1993), rehabilitation (MacLeod & McPherson, 2007), physical therapy (Greenfield, 2006), psychiatry (Stiver, 1986), psychology (Batson, 1990; Craig, 1987), medicine (Brezis, 2009), and to the greatest magnitude, nursing (Craig, 1987; Huffman &

Brubaker, 2009; Maggs, 1996; Rundqvist et al., 2011; Schwerin, 2004; Sitzman, 2007; Wilkes & Wallis, 1998; Woodward, 1997).

**Divergence from the literature.** The unique contribution of this research study is the thematic strands identified. Based on the literature reviewed, no studies were found that collectively identified the various elements of care, although several studies individually identified elements of care. This present study is a study that begins to bring these elements together collectively as components of care in counseling. Additionally, this research study developed the various contours of care: the natural ability of counselors to care, the importance of counselors to care about another individual and to display that care by focusing on the client, the importance of verbal and nonverbal communication in counseling as an element of care, Rogers's core conditions, and the importance of self-care. This present study has the potential to advance therapeutically helping clients as caring in counseling. The ethical elements of nonmaleficence, maintaining appropriate boundaries, autonomy, countertransference, and confrontation were collectively identified as caring as well as the primary components of care, namely the results from this study suggest that caring is an important part of counseling and that caring is the foundation of counseling.

This research study provides another unique contribution by postulating a preliminary definition of caring for the profession of counseling. This definition is developed from and is based on the thematic strands that emerged. Accordingly, *caring* is defined as the foundation of counseling upon which the contours of care that establish and maintain the therapeutic relationship arise so that counselors can therapeutically help clients change while still maintaining the ethical elements of care.

## Implications of the Results

**Theoretical implications.** Research participants in this study identified caring as the foundation of counseling. Identifying caring as such would make caring a universal component to most counseling theories; however, c*aring* does vary with theories. For psychoanalytic theories, *caring* may not be highly significant; while for such theories as cognitive theories, *caring* may only be slightly more significant. Nevertheless, caring is a part of these theories. On the other hand, while caring may not be specifically addressed in all of the other theories, it seems to be nonetheless implied (Corey, 2013; Day, 2008; Remley & Herlihy, 2010). Therefore, caring appears to be universal to most counseling theories.

Additionally, the research reported herein connected caring to the counseling elements of the therapeutic relationship, the various contours of care, therapeutically helping clients, ethical elements of care, and the importance of caring in the change process for clients. All of these counseling elements are a significant part of all counseling theories. Even though the caring contour of Rogers's core conditions (genuineness, empathy, congruence, and unconditional positive regard) is specific to Client-centered Therapy developed by Rogers (1951), these core conditions have also evolved into standard counseling aims for virtually all theories. Therefore, the data collected in this research study has significant implications for all of the counseling theories because it applies to all of the counseling theories. In other words, regardless of the theory implemented by the counselor in counseling sessions, she or he can apply and implement the research themes identified during this research study to that theory.

Another implication for theory is the development of a theory of caring in

counseling. From the body of research conducted on caring, the ethic of caring was developed (Gilligan, 1982; Remley & Herlihy, 2010). As further research is conducted on caring and the ethic of caring, a theory of caring in counseling may one day be developed.

**Research implications.** The purpose of this study was to explore the views of caring and the ethic of caring exhibited by Licensed Professional Counselors (LPCs). Further, this study explored the ethical dilemmas that counselors may face in regard to their caring for their clients. While this study accomplished its purpose, several avenues for further research on caring and the ethic of caring are suggested. First, given the limited scope of this study, additional studies with LPCs or their equivalents need to be conducted in other parts of the country in order to further develop the body of literature on caring and the ethic of caring in the counseling arena.

Another area where further study needs to be conducted is in the area of diversification. Thus far much of the emphasis has been on Anglo Americans. More people of color in counseling need to be specifically identified for qualitative study in the area of caring and the ethic of caring. These studies could provide data for examining any differences and similarities that might exist.

A third aspect of caring that needs further inquiry is advocacy and its connection to caring and the ethic of caring. While there appears to be a natural connection between caring and the ethic of caring in counseling, especially with counseling's emphasis upon the *ACA Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2002), thus far no known study in the counseling literature has been conducted with regard to advocacy and its connection to caring and the ethic of caring. Even in this study, only one participant

mentioned this topic.

Additionally, a more in-depth inquiry is also needed to focus on the ethic of caring within the realm of counseling. This study briefly and preliminarily examined this particular area of caring by exploring the ethical dilemmas that caring for clients might create for counselors. Additional inquiry is needed in this area to seek a better understanding of the concepts counselors hold with regard to the ethic of caring.

Another avenue for further inquiry would be how clients experience caring in counseling. Thus far, caring has been only explored from the perspective of the counselor or counselor education student. Based on the literature review, no studies were fund that focused on caring from the perspective of the client and how the client experiences caring in counseling.

Additionally, research regarding the distinction between countertransference and caring is recommended. In the study reported herein, participants alluded to the fact that such a distinction and difference exists between the two but did not clarify that distinction. Inasmuch as such a distinction does exist between caring and countertransference, understanding the differences between the two might prove invaluable to counselors.

Given that caring and the ethic of caring appear to be a relatively new focus of study within counseling, there certainly are more avenues for further inquiry. A few of the ways that caring in counseling can be explored have been suggested. Perhaps many more studies will be conducted in regard to caring and the ethic of caring so that this area is expanded within counseling and counselor preparation.

**Practice implications.** This research study focused specifically on how LPCs care

and manifest that care within their counseling practice. In doing so, this research study begins to help counselors comprehend exactly how they manifest care within their own practice. While most counselors are naturally caring, this study helps counselors suitably utilize care within the therapeutic relationship. Accordingly, counselors will be able to increase the manifestation of that care within their own counseling practice. This study also enables counselors to care and to display that care to their clients even under challenging counseling circumstances, so that clients will feel cared for even during those conditions. Additionally, understanding how practicing LPCs exhibit appropriate care in counseling will assist counseling students and beginning counselors to properly care about clients as these novice counselors learn to be counselors. Consequently, in the next section, four recommendations are made for counselors and Counselor Educators regarding caring and the ethic of caring.

**Recommendations**

In this section, four recommendations are made for counselors and Counselor Educators. The first recommendation is to increase counselor awareness of her or his caring and the incorporation of the contours of care into the therapeutic relationship. The second recommendation is to increase counselor integration of caring into their professional identify and counseling core values. A third recommendation is to increase counselor and client awareness that confrontation in counseling is really genuine caring. The last recommendation is to increase Counselor Educator awareness that nonverbal communication is a significant part of demonstrating care to clients and that greater use of videoed counseling sessions is needed to show and provide feedback on students' nonverbal communication as a means of increasing this form of caring. Those recommendations are

discussed in the following paragraphs.

**Recommendation 1: Increase counselor awareness of her or his caring and the incorporation of the contours of care into the therapeutic relationship.**

Researchers (Bergman, 2004; Halstead et al., 2002; MacLeod & McPherson, 2007; Noddings, 1984, 2003) and the data collected in this study have indicated that counselors have a natural ability to care; that is, they are naturally caring individuals. This is perhaps one of the reasons that they gravitate to counseling. The data in this research indicate that counselors display caring appropriately in counseling sessions with their clients. However, counselors are not always aware of their caring, nor are they always aware of how they display that caring within the therapeutic relationship. Third, they may not be aware of how their caring and display of caring relates to or impacts the therapeutic relationship. Thus, it would be in the best interest of the counseling community to increase counselor awareness of her or his caring and how the various contours of care relate to the therapeutic relationship by facilitating that awareness. Therefore, I recommend that counselors increase their awareness of their caring and that they incorporate the contours of care into the therapeutic relationship.

In addition to a natural ability to care, the data from this research study suggest that it would be beneficial to both counselors and clients to have an increased understanding of the contours of care and their relationship to the therapeutic relationship. The contours of care are: Rogers's core conditions, caring about another individual, showing care, focusing on the client, and verbal and nonverbal communication. Collectively, these contours of care facilitate and aid not only in the establishment of the therapeutic relationship but also maintaining that relationship through the concept of care. Although counselors and

counseling students are well aware of each of the individual elements that constitute the contours of care and practice them in their counseling sessions, they may not be conscious of them as caring components.

Counseling is not mechanistic. That is, the counselor does not come in and check off a list of steps accomplished with and by the client. One participant addressed this phenomenon as, "here's step 'A' to get you to step 'B', now go and do that." Nor is counseling a product that the counselor sets on a shelf for someone (i.e., the client) to come along and buy, as was stated by another participant in this study. Counseling is about caring. Sometimes, it is only in counseling that clients receive care and feel cared about. Counseling is about winning the confidence of the client so that the client is more willing to share her or his inner thoughts and feelings, be truthful with the counselor, and more willing to work on his or her issues with the counselor. Therefore, it is important for counselors to demonstrate to their clients that they care; that there is concern on the counselor's behalf; that there is an authenticity of caring for the client and that the counselor seeks to maintain what is in the best interest of the client.

Nonverbal communication is another way that counselors demonstrate to the client that the counselor cares about the client and his or her issues or problems. Researchers (Demir, 2011; Devlin & Green, 2000; Foley & Gentile, 2010) indicated that a greater percentage of all communication is nonverbal rather than verbal. The data from this current research study additionally indicated that nonverbal communication demonstrates caring to a greater extent than does verbal communication. This nonverbal communication included focusing on the client rather than the counselor's own personal issues at the time.

Thus, through the various aspects and contours of care, counselors let their clients know that they as counselors care about them as clients and care about their problems and issues that they bring into counseling. Knowing and understanding these contours of care would then in turn strengthen the counselor and the counseling relationship with the client. Accordingly, I recommend that counselors learn the contours of care, increase their understanding of these contours and incorporate the various contours into their therapeutic relationship.

**Recommendation 2: Increase counselor integration of caring into their professional identify and core counseling values.**

Gibson, Dollarhide, and Moss (2010) defined *counselor professional identity* as the integration of professional training with professional attributes in the context of a professional community. Accordingly, they identified three themes from which professional identity derives: self-labeling as a professional, integration of skills and attitudes as a professional, and a perception of context in a professional community. Additionally, Remley and Herlihy (2010) included the following as elements of professional identity: the ability to explain the philosophy that underlies the activities of their professional group as well as the services their profession renders to clients, the ability to describe the training programs that prepare them to practice their profession along with their qualifications and the credentials they possess, the ability to articulate the similarities and differences between members of their own profession and other similar groups, feeling significant pride in being a member of their profession, and finally, the ability to communicate this special sense of belonging to those with whom they interact.

While numerous items have been identified and included in professional identity,

caring could also be included. Counselors first of all are naturally caring individuals. Many individuals also see counseling as a caring profession. Suffice it to say that many individuals would not like counselors whom they perceive as uncaring. Accordingly, it would be beneficial to the counseling profession for counselors to increasingly integrate caring into their professional identity and to include caring when speaking about the counseling profession.

Furthermore, counselors embrace such core counseling values as autonomy, nonmaleficence, beneficence, fidelity, veracity, and justice. Most counselors would also consider genuineness, empathy, congruence, and unconditional positive regard as core counseling values. As this research study seems to suggest, care could also be considered a core counseling value.

While care embraces many of the above values, as seen in this study, the study also indicates that caring contains other aspects than just these core values. The concept of caring in counseling includes such characteristics as the therapeutic relationship, its development and maintenance, communication in counseling, particularly nonverbal communication, therapeutically helping the client, maintaining appropriate boundaries, countertransference issues, and even confrontation. Thus, caring within counseling embraces many elements of counseling that greatly benefit the client. Given this diverse yet integral aspect of caring in counseling, the concept of care could and should be included as a very important element of the core counseling values that counselors embrace within counseling. Accordingly, I recommend that counselors increasingly integrate the concept of care and caring into their professional identity and core counseling values.

**Recommendation 3: Increase counselor and client awareness that confrontation**

**in counseling is really genuine caring.**

Confrontation is a counseling practice typically used by counselors to point out client incongruencies, to focus attention on other ways clients might perceive themselves or their circumstances, or to influence clients to take actions. It is sometimes regarded as a way of challenging blind spots or to mobilize resources clients are not yet using. Additionally, confrontation is sometimes used as a means of helping clients realize their goals in counseling (Strong & Zeman, 2010).

A few ($n$ = 3) of the participants in this study mentioned the use of confrontation in regard to caring. Each one viewed confrontation as a way of showing a client that the counselor cared about the client. One participant indicated that caring means not allowing the client to "slide, rationalize, justify away things that need to be addressed," or letting them "get by with stuff that has not been helpful." For another participant, caring through the counseling relationship manifests itself particularly in the counselor helping the client to examine and explore the client's specific issue especially if the client is avoiding that issue or has framed it in a way that is inaccurate. Thus, caring involves discerning the client's issue and then helping the client address that issue without enabling the client. Finally, Sigmund voiced the idea that caring and maintaining a caring presence for the counselor may mean confronting the client.

> If I'm meeting resistance or obnoxiousness, if that's a word, or they're being disrespectful, I will interpret that for them in the therapeutic setting that that doesn't match what you're here for. "You communicated that you want to change something, and yet I'm experiencing your disrespect. I'm experiencing your obnoxious behavior. What are we going to do? This isn't working." And so, in the context of the therapeutic setting I am able to interpret what that person is doing in our relationship.

Thus, it is important to increase counselor and client awareness that confrontation in

counseling is really genuine caring. Confrontation then is not meant to be hurtful or mean, nor does it signify that the counselor does not care about the client, although the client might interpret confrontation as not caring. In fact a client might say to the counselor, "If you cared about me, you would just do X, Y, Z," as one participant mentioned in his interview. That same participant, however, went on to rightly say, "In a caring way, I'm just not dictating to them the rules of counseling. I really am trying to explain to them how it is caring to help them to see what their needs are."

Helping counselors understand that confrontation is actually genuinely caring for the client might dissuade any feelings of guilt or fear the counselor might have over confronting the client. Increasing client awareness of confrontation as genuine caring might assist in alleviating any defense mechanisms the client may have in regard to confrontation. Therefore, increasing counselor and client awareness that confrontation in counseling is genuine caring would be beneficial to both counselors and clients.

**Recommendation 4: Increase Counselor Educator awareness that nonverbal communication is a significant part of demonstrating care to clients and that greater use of videoed counseling sessions are needed to show and provide feedback on students' nonverbal communication as a means of increasing this form of caring.**

The importance of nonverbal communication cannot be underestimated. Research indicates that between 55 and 65 percent of all communication is nonverbal. Concurrently, the same research states that less than 40 percent comes from verbal communication (Demir, 2011; Devlin & Green, 2000; Foley & Gentile, 2010). Given this high importance of nonverbal communication, more emphasis needs to be placed on the various aspects of nonverbal communication and the messages that are being relayed

to other individuals through nonverbal communication.

During this study on caring, participants ($n$ = 8) identified nonverbal communication as a salient feature of demonstrating care to the client. This leads to the conclusion that counselors need to have a greater awareness of this aspect of counseling, an awareness that begins with the training of counselors. Counselor Educators need increased awareness that nonverbal communication is a significant part of demonstrating care to clients. They also need to be encouraged to make greater use of videoed counseling sessions to show and provide feedback on students' nonverbal communication as a means of increasing this form of caring.

As counselors are being trained, the increased use of videoed training sessions, both simulated and real, will provide greater feedback to the students. This feedback should not only include how students could improve their counseling skills but also how they could improve nonverbal communication toward the client to reflect a more caring attitude. Videoed training sessions will also illustrate to the students their nonverbal communication skills toward the client. Sometimes what we think we are displaying through our nonverbal communication to others is not what we are actually displaying. Videoed sessions would show the student the nonverbal communication actually displayed to the client as opposed to what the students thought they were displaying. Thus, through videoed training sessions, students could learn to display more congruent, caring nonverbal communication toward their clients. This in turn could increase the counselor's therapeutic relationship with the client as clients can ascertain if the counselor is a caring individual. One of those ways to provide this communication is through the nonverbal communication of the counselor, and therefore, the counselor

needs to be as congruent and caring with her or his nonverbal communication as possible.

**Conclusion**

The previous chapters consisted of an introduction, review of the relevant literature, the methodology implemented in this study, and a presentation and analysis of the data.

Chapter I serves as an introduction to the topic of caring and the ethic of caring. It also gives a statement of the problem, which is that a paucity of research exists even though there is a natural connection between caring, the ethic of caring and counseling. This chapter establishes the purpose and significance of this study, which is to fill a void in the literature and increase the knowledge base. Additionally, Chapter I contains the research questions used for this study, the limitation and delimitations of the study and a list of definitions.

Chapter II presents an in-depth examination of the literature relevant to this study. This review of the literature covers such topics as the counseling relationship and Rogers's core counseling conditions. Furthermore, the chapter includes a review of the counseling ethics literature including principle ethics and ethical perspectives. Chapter II examines the literature on caring and concludes with the literature exploring the ethic of caring.

Chapter III provides an exploration of the methodology used to efficiently answer the research questions. This study was based on *grounded theory*, which is an inductive strategy used to discover concepts through a constant comparative analysis. Grounded theory is also used when little or no research has been previously conducted on the chosen topic allowing the examination of meaning supporting various events experienced

by individuals. Further, grounded theory allows themes to emerge thus grounding new theory in the data collected.

Chapter IV contains the presentation of the analyzed data. Themes were allowed to emerge from data collected on each of the six research questions. These themes were then discussed following each of the research questions.

In Chapter V, the final chapter in this dissertation, a summary of the themes presented in Chapter IV was presented first. Following the summary, a discussion of the analysis of the themes was presented as thematic strands. Additionally, compatibility of the research results with the literature was discussed. Implications for theory, research, and practice were then presented along with four recommendations. Finally, six avenues for further inquiry were presented in this concluding chapter.

In conclusion, concepts of caring and the ethic of care were explored with 12 LPCs serving as participants. Themes were identified for each of the six research questions, and from those themes, strands were identified. Those strands are the therapeutic relationship, contours of care, therapeutically helping clients, ethical elements of care, and primary components of care. Finally, a preliminary definition of caring in counseling was offered based on the thematic strands.

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## Appendix A

### Email Script Asking for Participation in the Study

Dear Counselor,

My name is Douglas Kabell and I am a doctoral candidate in Counselor Education at Texas Tech University. I am currently recruiting Licensed Professional Counselors (LPCs) to participate in my dissertation study. To be a participant, you must:

- be a fully licensed LPC for a minimum of one year,
- have practiced as an LPC for a minimum of one year, and
- have not had any complaints files against you with the Licensure Board.

In this study, I am exploring caring and the ethic of caring. I will also be exploring its connection, importance, and role in counseling, ways that it is evident, how it is maintained in counseling under difficult situations, and how caring might lead to ethical issues.

Participation in this study will involve one interview 45-60 minutes in length with the slight possibility of a second interview being required of about 30 minutes. Meetings will be scheduled at a time convenient to you, including nights or weekends. Interviews will be audiotaped to ensure accuracy and completeness of information. Research participation is completely voluntary and confidential and great care will be taken to maintain your anonymity in the final study report. At your request and upon completion of the study, you will be emailed the findings of the study or a copy of the study should you desire to receive this information.

This research has been approved by the Texas Tech Institutional Review Board. This board protects the rights of people who participate in research. You may contact them with your questions at 806-742-2064. You can also mail your questions to the Human Research Protection Program, Office of the Vice President for Research, Texas Tech University, Lubbock, TX 79409. The study is being supervised by Dr. Loretta Bradley in the Texas Tech University College of Education. She can be reached at 806-742-1997 x 263, loretta.bradley@ttu.edu, or COE Box 41071, Lubbock, TX 79409-1071.

If you are interested in participating or have questions about the study or participation, please contact Douglas Kabell at douglas.kabell@ttu.edu or 940-636-7433.

Thank you for your consideration,
Douglas R. Kabell, MDiv, M.A., LPC Intern
Counselor Education Doctoral Candidate
Chi Sigma Iota Chapter President
College of Education | Texas Tech University
Lubbock, Texas 79409
Email: douglas.kabell@ttu.edu

# Appendix B

## Informed Consent

**What is this project studying?**

This research project is studying caring and the ethic of caring. It will explore its connection, importance, and role in counseling, ways that it is evident in counseling, how it is maintained under difficult situations, and how caring might lead to ethical issues within the counseling relationship.

**What would I do if I participate?**

You will be asked to participate in one interview with the possibility of a second interview. During the interview you will be asked about your understanding of caring, its connection, importance, and role in counseling, ways that it is evident, how it is maintained in counseling under difficult situations, and how caring might lead to ethical issues. These interviews will be audiotaped to ensure completeness and accuracy of information.

**Can I quit if I become uncomfortable?**

Yes, absolutely. Dr. Loretta Bradley and the Protection Board have reviewed the questions and think you can answer them comfortably. However, you can stop answering the questions at any time. You can leave any time you wish. Participating is your choice.

**How long will participation take?**

The interview will take about 45-60 minutes. Should a second interview be required, it will take about 30 minutes.

**How are you protecting privacy?**

Every effort will be made by the researcher to preserve your confidentiality including the following:

- You will choose a pseudonym that will be used throughout the study. Notes, interview transcriptions, and any other identifying participant information will be de-identified with this pseudonym and kept on a password protected computer in the personal possession of the researcher. Electronic audio files will be completely deleted after they are transcribed.
- Your place of employment will not be identified.
- Each participant will get a transcribed copy of his or her interview and the opportunity to add to the information or choose for specific statements to be deleted from the study.
- Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include incidents of abuse, suicide risk, and professional conduct that has harmed or is likely to harm a client.

**How will I benefit from participating?**

Upon completion of the study, you will be emailed the findings of the study or a copy of the study should you desire to receive this information.

**If I have some questions about this study, who can I ask?**

- The study is being chaired by Dr. Loretta Bradley from the Counselor Education program at Texas Tech University. If you have questions, you can call her at 806-742-1997 x263 or email loretta.bradley@ttu.edu.
- TTU also has a Board that protects the rights of people who participate in research. You can ask them questions at 806-742-2064. You can also mail your questions to the Human Research Protection Program, Office of the Vice President for Research, Texas Tech University, Lubbock, Texas 79409.

Signature _____ Date _____

Printed Name: _____

This consent form is valid from November 30, 2012 to October 31, 2013.

## Appendix C

## Demographic Information Form

Chosen Pseudonym:

Age Range (circle one): 20-25 26-30 31-35 36-40 41-45

46-50 51-55 56-60 61-65 66-70 70+

Gender:

Ethnicity:

Highest degree obtained:

How long have you been a fully licensed LPC?

How many years have you continually practiced counseling as a fully licensed LPC?

Have you ever had any complaint filed against you with the Licensure Board?

What is your primary theory-base when conducting counseling?

# Appendix D

## Interview Protocol

Following the signing of the informed consent, and the counselor filling out the Demographic Information Form the following questions will be asked with gentle probing and follow-up questions as required:

- What is your concept of caring?
- What makes caring important in counseling?
- What is the role of caring in the counseling relationship?
- How is caring manifested within the counseling relationship?
- How do you maintain a caring professional presence when you find it difficult to do so under certain circumstances?
- What are some ways that caring for your clients might lead to ethical dilemmas?

# Appendix E

TEXAS TECH UNIVERSITY
Vice President *for* Research

December 5, 2012

Loretta Bradley
Ed Psychology & Leadership
Mail Stop: 1071

Regarding: 503671 Caring and the Ethic of Caring: Exploring the Connection and Importance in the Counseling Relationship

Dr. Loretta Bradley:

The Texas Tech University Protection of Human Subjects Committee has approved your proposal referenced above. The approval is effective from November 30, 2012 to October 31, 2013. This expiration date must appear on all of your consent documents.

We will remind you of the pending expiration approximately eight weeks before October 31, 2013 and to update information about the project. If you request an extension, the proposal on file and the information you provide will be routed for continuing review.

Sincerely,

Rosemary Cogan

Rosemary Cogan, Ph.D., ABPP
Protection of Human Subjects Committee

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