THE HEART OF HUMAN RESOURCE DEVELOPMENT:

COUNSELING COMPETENCIES

By:

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The Importance of Counseling in HRD

While the quality movement has attempted to reverse several hundred years of increasing
the distance between worker and customer, as well as worker and the complete product, the
successes and advances in the HRD field have tended to reduce the one ingredient that seems to
be necessary-- caring human interaction! The increased sophistication and emergence of human
resource development as a major component of organizational life in the last twenty-five years
has helped in the sustainable development of people and their organizations. But success has
brought increased specialization, professionalization, and commercialization.

Colleagues of ours make distinctions between the “fields” of HRM, HRD, OB, OD, OT,
MD, CD, PD, and T/D (i.e., human resource management, human resource development,
organizational behavior, organizational development, organizational transformation,
management development, career development, professional development, and training and
development, respectively). This provides fodder for academic debate and disaggregates the
HRM function’s activities. Professionalization has resulted in increasing rituals and “tests”
through which a person must pass to enter one of these specialties. Commercialization, aided by
downsizing of internal staff and the frenetic demand for “bottom-line” evidence of the
contribution of HRD, has resulted in the multiplicative growth of consulting and training
companies. Since they provide their services “by the hour or by the day,” the inevitable push
toward standardization and efficiency of delivery has resulted in a rush toward packaging of
training notebooks, course outlines, trainer training, performance improvement systems, etc. etc.
and, now, of course, we have succeeded in eliminating people and human interaction from these
processes because you can get everything you need from a computer program (albeit a highly
complex and expensive one!).

Without wanting to appear simplistic or naive, we offer the observation that human
resource development involves and requires human interaction of a caring, supportive, useful
nature-- that is, counseling. At the core of developmental training, mentoring or coaching
activities, assessment and feedback efforts, employee assistance, and career planning programs,
each of us needs some interaction that can be characterized as counseling. In addition,
performance appraisal, career pathing/succession planning, incentive compensation, and
organization improvement/development processes and methods require some form of counseling
as a catalyst for implementation and often as an essential programmatic component. Although
not necessary, even salary and benefits administration, selection and promotion systems, and
corporate communications could often be helped through counseling interactions. In the efforts
to evolve, or return to a condition in which each manager and leader views HRD as part of their
role, counseling becomes an essential aspect of their interactions. In this pursuit, we attempt to
train managers and leaders to make eye contact with others, listen to them, develop attitudes and
skills to help the other person feel empowered, provide and solicit accurate and timely feedback,
stimulate and provoke conversation about new ideas, innovations, improvements, and development.

From the formal training programs or performance appraisal systems to the informal chats while walking down the hall, HRD depends on counseling. Anecdotal evidence suggests that informal (versus formal), episodic or opportunistic (versus planned), and personal (versus bureaucratic and systematized) counseling interactions are more effective.

Regardless of whether the setting and timing is ideal, there is a need for people who can be effective in counseling interactions. We can define effective counseling as “an activity addressing a problem, opportunity, or perspective in a relationship through a process of interaction.” You do not engage in effective counseling through fortune-cookies nor computer pop-up “Tips.” There are many types of helping situations in which effective counseling is important from those working on deeply personal matters to those teaching someone to use a computer program.

Rogers (1951, 1961) articulated a troika of characteristics that seemed critical for effective “helping” behavior emerging from his work on psychotherapy: empathy, unconditional positive regard, and genuineness. Truax and Carkhuff (1967) and Carkhuff (1969) continued to expand, clarify, and develop these concepts and methods. Although developers or proponents of various approaches to psychotherapy would advocate modifications to this list (e.g., Perls emphasized giving voice to the unspoken and Ellis emphasized pragmatism), the quest for effective helping behavior always returned to characteristics of the helper. Later research on psychotherapy and counseling would suggest that the characteristics of the helper was more important in determining differences in effectiveness than differences in
approach to psychotherapy or schools of thought in which the person was trained (Emrick, 1974).

While HRD keeps developing its specialization, professionalism, and commercialization, a focus on effective counseling may seem simple, or self-evident. Its elusive nature and our frustration in affecting people’s skills and organizational capability to engage in effective counseling in all aspects of human resource development may conspire to allow avoidance of the topic.

In human resource circles, counseling is often associated with employee assistance programs, including referrals for psychotherapy. A computer search for references to counseling or counselors in the business databases will confirm this observation. We need to broaden the understanding (or remind us) of the role of counseling in HRD and help with development of effective counseling as part of all HRD activities.

Several previously unpublished studies of alcoholism counselors provided a unique opportunity to determine and study the characteristics, or competencies, of counselors which resulted in their clients, or patients, doing better at work following the treatment programs.

**Examining Competencies of Effective Alcoholism Counselors**

An increasing concern with the level of competency of alcoholism counselors emerged from three sources. First, critical reviews of research on the effectiveness of treatment for alcoholics suggested that particular treatment techniques utilized did not account for differences in outcome measures, such as the behavior of patients following treatment (Emrick, 1974). Second, evaluation literature in the field of psychotherapy suggested that characteristics of therapists account for substantial differences in outcome measures (Whitehorn and Betz, 1954; Truax and Carkhoff, 1967; Glass, 1976; Burruss, 1977). Third, there was a movement,
supported by the government, to establish a national body to certify alcoholism counselors and establish credentials which indicate the attainment of a professional level of competence in conducting therapy and counseling alcoholics.

Previous research on the competencies of alcoholism counselors had been sparse. Methodological, theoretical, and value conflicts had inhibited attempts to answer the question, "What is a competent alcoholism counselor?" Gideon (1975) and the Littlejohn Report (1974) described models built by asking counselors what they thought were the important characteristics of effective counselors. Crawford et al (1975) also described the tasks needed to be performed by alcoholism counselors. None of these studies had empirically linked the counselor’s characteristics to their performance in the job. The U.S. Navy Alcohol Rehabilitation Program presented a unique opportunity because it was possible to follow personnel treated in the program by specific counselors to see the effects of treatment.

Three studies were conducted between 1977 and 1981. The objective of Study One was to generate a competency model through interviews. The interviews were used to identify competencies as they appeared while working with patients. The objective of Study Two was to validate the competencies and the model on a sample of counselors and their patients with tests. Tests were identified to assess those competencies differentiating the behavior of the small sample of “superior” counselors from a sample of “average” counselors. The test battery consisted of eight tests and took approximately four hours to complete. The tests were administered in the following order: Picture Story Exercise; Helping Resources Inventory; Test of Thematic Analysis; Nowicki-Strickland Measure; Programmed Case; Ward Atmosphere Survey; Scenarios Test, Part I and Part II; and the Focusing Exercise. The objective of Study Three was the same as Study Two but with larger samples of counselors and patients.
**The Criterion Measure: Work Performance**

For an alcoholism counselor in the Navy, the most objective measure of his/her performance is the work disposition of his patients following treatment. The goal of the Navy’s alcohol abuse programs is to help Naval personnel who have been identified, or have identified themselves, as alcoholics return to active duty and satisfactorily complete their duty assignment. This means that a person is able to work without the interference associated with his/her former pattern of alcohol consumption and related behaviors. A work performance measure can be considered a conservative and more difficult treatment goal than abstinence because it requires changes in the patient's behavior, ways of dealing with others, motivations, and self-image as well as changes in his/her drinking behavior.

The criterion data was collected independently of the counselor competency data. First, a list of all patients admitted to Naval alcohol rehabilitation facilities in the continental United States in 1976 was produced. The patients were listed by facility. Second, the list was sent to each facility. Every counselor currently working at each facility was asked to complete a form. If he/she was not working at the facility as a counselor in 1976, he/she would indicate this in response to a question at the top of the form and submit the form. If he/she did work as a counselor at the facility in 1976, he/she would circle the name of each patient with whom his/her records indicated he/she had worked. Since each patient does spend a substantial amount of time with a particular counselor in individual and group therapy, meetings, and other activities, it was assumed that counselors could identify specific patients.

Lists were sent to 34 facilities, and 33 returned completed forms. The completed forms were reviewed. If a counselor at a facility circled the names of all the patients and there were several counselors working at that facility in 1976, his/her data was excluded from the study. It
was assumed that he/she did not confirm having worked with each patient but merely circled the
entire list to fulfill the obligation of completing the form. Any counselor who identified less than
ten patients was also excluded from the study. Sixty-five counselors remained in the study.

The social security numbers of patients were used by the U.S. Navy Bureau of Personnel
(BUPERS) to identify the individual patient's work performance measure for the six months fol-
lowing his/her treatment. This measure was a rating on a three point scale: (a) "1" means that the
person received a general discharge, an undesirable discharge, an honorable discharge but
considered unsuitable or unfit, was still on active duty but had a recommendation against
reenlistment, or had a medical discharge with a recommendation against reenlistment; (b) "2"
means that the person received a medical discharge but no recommendation against reenlistment;
(c) "3" means that the person was still on active duty six months after treatment and had not
received a recommendation against reenlistment, had received an honorable discharge with no
recommendation against reenlistment, or was released to reserve status or to nondisability
retirement.

The following data was recorded on each counselor's data set: (a) average work
performance rating of all patients with whom he/she had worked; (b) percentage of patients with
whom he/she had worked who received a work performance rating of "3" compared to the total
number with whom he/she had worked; (c) percentage of patients who were over twenty-five
years old compared to the total number of patients with whom he/she had worked; and (d)
number of patients on which BUPERS ratings had been collected. Difficulties in filing and
mounting personnel records on the BUPERS tapes and transferring these records to personnel at
the Evaluation and Analysis unit at the Naval Alcohol Rehabilitation Center in San Diego
resulted in patient records not being available on all of the patients in the lists.
Study One Sample

Twenty-six counselors from three of the largest Naval alcohol rehabilitation facilities were asked to list the names of zero, one, two, or three people currently working as alcoholism counselors in the Navy whom they thought were superior alcoholism counselors. A total of ten counselors was listed as "superior" by at least two counselors from the three sites. Of the remaining counselors who were physically available at these sites, 16 were randomly selected to be interviewed. For the purpose of this analysis, these 16 were considered "average" performers. Most of these counselors had not appeared on anyone's list of superior counselors. Some of them were named once as a superior counselor, but a single mention was disregarded due to the observation that a number of counselors listed themselves as superior.

Study Two Sample

Of the 65 counselors in the system in 1976, only 47 were available in 1978 to be tested. Others had left the service, been transferred to other duty, were sick or unavailable for some other reason during the two months in which the testing took place. Of the 47, 42 of those who had been tested had patient record data. For stability in the work performance measure, it was decided to eliminate any counselor from the study for whom there were less than seven patient's records. Twenty-nine counselors remained in the study. Of the 29 counselors remaining in the study, each had patient records on seven to 39 of his/her patients. The average number of patients per counselor was 18. The 29 counselors were located in 15 facilities in the continental United States.

Study Three Sample

In 1979 and 1980, the amount of patient outcome data available relevant to this study tripled, thus making it possible to expand the study to include almost all of the original
counselors. To improve the stability of the outcome measure, the minimum number of patient records required for inclusion was increased from 7 in Study Two to 10 in Study Three. The average number of patients per counselor increased from 18 to 49, with the maximum increasing from 39 to 167. The resultant sample was 45 counselors and 2,212 patients.

The primary caution here, however, lies in the nature of the patient-outcome variable used. Type of discharge from the Navy is only an indirect measure of actual work performance after treatment. While it does reflect the Navy's overall satisfaction with an individual's performance, it also influences and is influenced by the total number of days of service after treatment. Generally, a premature or "early" discharge from the Navy reflects a negative performance, while a multiyear tour of duty is considered positive. If treatment occurred close to a patient's discharge from the service, then the type of discharge may be completely unrelated to treatment effects. We have attempted to control for this somewhat by treating the number of days of active service after treatment as a separate independent variable, along with the counselor competency measures.

**Study One Methods: The Interview**

The interview technique used, called Behavioral Event Interview, is an adaptation of the critical incident method developed by Flanagan (1954) (Boyatzis, 1982; Spencer and Spencer, 1993). In the interview, the person is asked to discuss three events in which he/she felt effective in performing his/her job and three events in which he/she felt ineffective in performing his/her job. As the person describes each incident, he/she is asked to recall specific actions and where possible, recall direct quotes of what he/she said. Interview protocols were typed and analyzed with the exception of the protocols of two of the "superiors." In one case the tape of the interview was lost due to tape recorder malfunction; in the other case the tape was inadvertently recorded
with a later interview. The protocols were analyzed to identify any characteristic of the
counselors' behavior which appeared in many of the interviews with "superior" counselors and
did not appear in any or few of the interviews with "average" counselors.

**Study Two and Three Methods: The Tests**

Tests and specific variables from these tests were identified as the “most appropriate and
psychometrically valid” to assess each of the competencies identified in Study One. For some of
the competencies, no test could be identified, so a new one was developed. The association
between the competencies, tests, and variables is summarized in Figure 1 at the end of the paper.

The Picture Story Exercise is a modified version of the Thematic Apperception Test
(TAT) originally developed by Murray (1943). A person is asked to spend about five minutes
writing a story in response to each of six pictures. The stories were scored by trained scorers,
who have scoring reliability with expert scorers above the 90 percent level, according to the
system described in Atkinson (1958) for Need for Affiliation, and that developed by Winter
(1973) for Need for Power and Activity Inhibition (McClelland, et. al., 1977). These three scores
were adjusted for number of words written with a corrective factor developed by Winter (1979).
The standardized power score was subtracted from the standardized affiliation score and the
difference was multiplied by the square root of the AI score plus one to construct a single
variable. The variable, called the Caring Motive Profile, reflects a greater concern for close
relationships to people than for having impact on them, while having a high degree of impulse
control.

Cognitive Self-Definition was scored from the Picture Story Exercise according to the
system developed by Stewart and Winter (1977) to reflect whether a person habitually thinks in
terms of causes and outcomes or whether a person sees the self as an ineffective victim of events
which have an unknown cause. Persons coding this measure have a reliability with expert scorers above the 90 percent level.

The Picture Story Exercise was also scored for Stages of Ego Development, developed by Abigail Stewart and appeared in McClelland (1975). Persons coding the stages have reliability with expert scorers above the 90 percent level. The stories were scored for imagery in four stages. These stage scores were then combined into a single measure with the following formula (as described in McClelland, 1975): 

\[
\frac{\text{Stage I}+2(\text{Stage II})+3(\text{Stage III})+4(\text{Stage IV})}{\text{Stage I}+\text{Stage II}+\text{Stage III}+\text{Stage IV}}
\]

The Scenarios Test was designed specifically for this study. It consisted of eight scenarios of counseling situations adapted from actual events in the interviews. The person is asked to imagine himself in each situation and to select, in order of preference, two of ten possible responses that he/she would be likely to make. A subset of responses for each category was theoretically designed to reflect Positive Bias, Efficacy, and Use of Resources. These were weighted by multipliers of 2 and 1 according to whether they were first or second choices respectively. This test required approximately 40 minutes to administer.

The Nowicki-Strickland Locus of Control Scale is a forced-choice, respondent measure consisting of 40 questions. The higher the score the more external the orientation (Nowicki and Strickland, 1973).

The Test of Thematic Analysis is a measure of critical thinking, diagnostic ability. Presented with two different groups of information, the test-taker is asked to describe the differences and similarities in any manner that he/she likes. The two groups of information used in this study were six counseling situations derived from the interviews. A person can receive a
score from -3 to +6; the more a person demonstrates critical diagnostic thinking, the more positive the score will be (Winter and McClelland, 1978).

The Programmed Case is a series of 21 episodes of a true life history. Each episode is accompanied by a set of four alternative future episodes of which only one actually happened. The person being tested is asked to guess which of the four alternatives actually happened. A specially designed answer sheet indicates whether he is right or wrong after each guess and he/she is instructed to keep guessing until he/she finds the correct alternative. An important aspect of this instrument is that the person has more information as a result of each guess and, therefore, should have a better understanding or "feeling for" the biographical character.

Counselors' responses on the programmed case were scored according to their overall Performance (i.e., the standardized score of 21 minus the number of guesses made before finding the correct one) and their Improvement (i.e. the increase or decrease in the accuracy of their guesses on the later half of the episodes versus the first half). The Improvement score was adjusted for level of accuracy of early responses.

The Helping Resources Inventory was adapted from the Activities Questionnaire used by McClelland (1975). The respondent was asked to rate, on a scale of ten, "how likely" he would be to consult each of 11 different sources of help (e.g., minister, psychologist, AA sponsor, friend, supervisor, etc.). The mean response per source was then taken to be an index of the person's Willingness to Seek Help. The person was then asked to indicate whether he has actually sought help from each of those same 11 sources within the past month, six months, or year. The mean response to this question, weighted in the direction of recency, was used as an indicator of the person's actual Use of Help. This questionnaire required approximately ten minutes to administer.
Focusing Ability is a modified version of the instrument designed by Gendlin, Beebe, Cassens, Klein, and Oberlander (1968). Prerecorded instructions asked the person to first relax for a moment and then focus on some meaningful personal problem. The instructions continued at brief intervals to guide the person through an exploration of his/her feelings concerning that problem over a ten minute period. At the end of the ten minutes, the person was asked to answer, into an individually held tape recorder, specific questions about the experience.

Two judges independently rated 43 of the 47 recordings on a four-point scale from "Definitely Did Not Focus" on feelings to "Definitely Did Focus" with an interrater reliability of \( r = .79 \). (The first four recordings were used to establish initial agreement on the scale definitions.) Disagreements were discussed and the final score was agreed. This score is referred to in this report simply as Focusing Ability. It was intended to be a measure of Genuineness under the assumption that a person cannot be "honest" or "real" in his behavior unless he is able to readily experience his feelings and describe them. This instrument required approximately 20 minutes to administer.

In addition to the above measures of counselor characteristics, the Ward Atmosphere Scale (WAS) was administered to assess the climate of the treatment facility. This instrument, developed by Moos (1974), is a 100-item questionnaire concerning important characteristics of the social environment. The ten subscales were combined by summing eight of them and subtracting "Anger and Aggression" and "Staff Control", which were scored in the opposite direction. The resultant variable, Climate, was intended to account for impact of treatment facility on patient outcome.
Study One: Results from the Interviews

Eight competencies were identified which were thought to differentiate superior from average counselors. Then all interviews were re-examined by four readers to determine the explicit presence or absence of each competency in the 26 interview protocols.

1. **Belief in People's Ability to Change** was demonstrated by 7 of the 8 superiors and only 1 of the 16 average counselors. There was a positive expectation that a patient would succeed in his rehabilitation efforts. It was usually accompanied by a statement of deep caring for the patient as an individual.

2. **Efficacy** was demonstrated by 7 of the 8 superiors and only 2 of the 16 average counselors. This reflects the degree to which a person feels that he/she is an origin (i.e., the master of his/her fate), that he/she directs the future events in his/her life, and that he/she accepts responsibility for the consequences of his/her actions. A person who feels like an origin tends to treat others as origins, such as allowing the patient to set his/her own rehabilitation goals and direct his/her own rehabilitation process.

   In contrast, some counselors treated their patients like pawns. When a person feels that he/she is a pawn (i.e., at the mercy of fate), that he/she is not in control of the events in his/her future, and that others and/or luck are responsible for the consequences of his/her actions. This appeared in none of the superior and 10 of the 16 average counselors.

3. **Psychological Diagnostic Skill** (i.e., the ability to perceive causal patterns in a patient's behavior) was demonstrated 5 of the 8 superior and only 1 of the 16 average counselors. This was evident in interviews in the counselor's ability to diagnose various causal factors which led to the patient's current behavior and the ability to identify appropriate treatment techniques or modalities.
4. **Desire for Personal Growth**, which includes professional growth, was demonstrated by 6 of the 8 superior and only 1 of the 16 average counselors. This appeared in interviews as a willingness to seek help for personal development and a knowledge of one's own limitations with a description of changes made as a result. Some counselors demonstrated this competency by seeking supervision to improve their skills as counselors.

5. **Ego Maturity** was demonstrated by 6 of the 8 superior and none of the 16 average counselors. This is reflected in a person’s ability to confront someone without attacking him/her (i.e., being assertive without being aggressive). A component of ego maturity is the inhibition of impulses, such as a calm response to a personal attack by a patient.

6. **Empathy**, which is a counselor's sensitivity to verbal and nonverbal cues from a patient, was demonstrated by all of the 8 superior and only 2 of the 16 average counselors. This was demonstrated in interviews as a counselor's ability to use "body language" as a clue to a patient's feelings and/or the ability to respond to the patient's feelings.

7. **Use of Resources** (i.e., the ability to use various treatment resources in helping a patient for a specific purpose) was demonstrated by 6 of the 8 superior and 4 of the 16 average counselors. For example, some counselors used psychological testing or staff discussions to help confirm a diagnosis of a problem perceived in a patient. Other counselors used group members to provide confirmation or support to a client when the counselor thought the client needed it.

8. **Genuineness** is the counselor's ability to be aware of his/her feelings and express them in his/her behavior congruently (i.e., honestly). It was assumed that self-disclosure for the purpose of helping a patient experience his/her own feelings would also be a part of this competency. Coding statements in interviews for this competency was difficult due to the high frequency which all counselors made self-disclosures when talking with patients. Since all
persons interviewed expressed some self-awareness and used some self-disclosure with patients, this competency did not distinguish superior from average counselors. Due to the frequency of observation of this competency and its possible difficulty in coding through typed transcripts, it was decided to include it in the model for further testing.

The eight competencies thought to be related to superior performance as an alcoholism counselor were: (a) Belief in People's Ability to Change; (b) Efficacy; (c) Psychological Diagnostic Skill; (d) Desire for Personal Growth; (e) Ego Maturity; (f) Empathy; (g) Use of Resources; and (h) Genuineness.

**Study Two Results**

Correlations of the competency scores with the average work performance of a counselor’s patients following the treatment program showed significant results for Focusing \( r = .531, n = 29, p < .001, \) one-tailed) and Programmed Case: Improvement \( r = .412, n = 29, p < .01, \) one-tailed). None of the other correlations were significant.

Counselors were classified as "superior" or "average" on the basis of a median split on the mean work performance rating of the patients with whom they worked. The "average" counselors had mean patient work performance ratings ranging from 2.20 to 2.56; the percentage of patients with a rating of "3" ranged from 64 percent to 78 percent with an average of 70.5 percent. The "superior" counselors had mean patient work performance ratings ranging from 2.60 to 3.00; the percentage of patients with a rating of "3" ranged from 75 percent to 100 percent (one of the “superior” counselors had a percentage of 75 percent; the rest had 80 percent or better) with an average of 87.2 percent.

T-tests were computed on each of the measures comparing average and superior counselors. The results, shown in Table 1, were that superior counselors had significantly higher
scores on the Thematic Analysis score, the Programmed Case: Improvement score, and the Focusing score. They also had near significantly higher scores on the Caring Motive Profile, Cognitive Self-Definition score, and the Programmed Case: Performance score. The Use of Resources was statistically significant, but opposite to the predicted direction; average counselors showed higher scores than superior counselors. All other differences were non-significant.

Table 1. Comparison of 15 Superior and 14 Average Counselors

<table>
<thead>
<tr>
<th>Variable</th>
<th>Average Counselor</th>
<th>Superior Counselor</th>
<th>t</th>
<th>Significance Level*</th>
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<tr>
<td>Belief in People’s Ability to Change:</td>
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<td></td>
<td></td>
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<tr>
<td>Scenarios/Positive Bias</td>
<td>2.29</td>
<td>2.53</td>
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<td>Caring Motive Profile</td>
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<td>Efficacy:</td>
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<td>Cognitive Self-Definition</td>
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<td>.066</td>
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<td>Nowicki-Strickland</td>
<td>16.86</td>
<td>15.67</td>
<td>-1.08</td>
<td>ns</td>
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<tr>
<td>Scenarios/Efficacy</td>
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<td>.80</td>
<td>.37</td>
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<tr>
<td>Programmed Case/Perf</td>
<td>55.36</td>
<td>58.85</td>
<td>1.45</td>
<td>.079</td>
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<td>Thematic Analysis</td>
<td>.43</td>
<td>.93</td>
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<td>HRI/Seeking Help</td>
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<td>6.53</td>
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<td>Ego Development</td>
<td>2.43</td>
<td>2.44</td>
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<td>Empathy:</td>
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<tr>
<td>Programmed Case/Improv.</td>
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<td>.054</td>
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<td>Use of Resources</td>
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<td>5.00</td>
<td>-2.16</td>
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<td>Genuineness:</td>
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<td></td>
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<tr>
<td>Focusing</td>
<td>1.71</td>
<td>2.64</td>
<td>2.55</td>
<td>.005</td>
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</table>

*One-tailed significance levels are reported.
On the basis of the t-test and correlational results, six measures indicated that five of the competencies could be considered valid differentiators of superior versus average counseling performance: (1) Belief in People’s Ability to Change as measured by the Caring Motive Profile; (2) Efficacy, as measured by Cognitive Self-Definition; (3) Psychological Diagnostic Skill, as measured by both the Thematic Analysis score and the Programmed Case: Performance score; (4) Empathy, as measured by the Programmed Case: Improvement score; and (5) Genuineness, as measured by the Focusing Ability.

A discriminant function analysis (DFA) was run on the six measures and the derived function used to assign counselors by groups. It was chosen as the multivariate statistical routine to perform this function due to the categorical nature of the patient outcome data. The results are shown in Table 2. The combination of the six measures yielded a high canonical correlation ($r=.677$) and correctly classified 83 percent of the counselors (correctly classified 87 percent of the superior counselors). A DFA was also run on the sum of the standardized scores on each of the measures, yielding an even higher canonical correlation ($r=.898$) and correctly classified 83 percent of the counselors (correctly classified 80 percent of the superior counselors). A third DFA was run on the number of competencies possessed by a counselor. This was computed by giving a counselor a +1 for each measure on which his standardized score was positive, and 0 for each measure on which his standardized score was negative. The sum was computed as the number of competencies possessed by the counselor. This DFA yielded a high canonical correlation ($r=.633$) and correctly classified 83 percent of the counselors (correctly classified 87 percent of the superior counselors).
Table 2. Discriminant Function Analysis of the Model in Study Two

<table>
<thead>
<tr>
<th>Variables</th>
<th>Canonical Correlate</th>
<th>% Counselors Correctly Classified (n=29)</th>
<th>% Superior Counselors Correctly Classified (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring Motive Profile, Programmed Case: Improv. &amp; Perf., Focusing, Thematic Analysis, Cognitive Self-Definition.</td>
<td>.677</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Sum of Standard Scores on all 6 Variables</td>
<td>.898</td>
<td>83%</td>
<td>80%</td>
</tr>
<tr>
<td>Number of Competencies Possessed</td>
<td>.633</td>
<td>83%</td>
<td>87%</td>
</tr>
</tbody>
</table>

The Impact of Situational Variables

Since the counselors worked in different treatment facilities, it was possible that organizational climate of the facilities may affect their performance. The correlation between the Moos Climate score and patient outcome (mean performance rating) was not significant ($r=-.106$, n=29). A t-test of the climate in which superior counselors worked versus the average counselors worked was also not significant, means of 50.00 and 49.93 respectively ($t=.03$, n=29). Another situational characteristic which could possibly have an impact on counselor effectiveness was the age of his/her patients. The correlation of mean work performance rating with the percent of patients over 25 years old was not significant ($r=-.038$, n=29). Average counselors had a mean of 51.06 percent of their patients over 25, while superior counselors had a mean of 49.66 percent of their patients over 25. This difference is not significant ($t=-.39$, n=29). As a further check, correlations were computed of the Moos Climate score and percent patients over 25 against each of the competency measures. None of the correlations with percent patients over 25 was significant. None of the correlations with the Moos Climate score was significant.
Study Three Results

Product-moment correlations computed between each of the competency measures, days of service after treatment, and patient outcome are shown in Table 3. The Days of Service was significantly correlated with Patient Outcome (r = .378; df=43; p<.01) but generally unrelated to the competency measures except for Cognitive Self-Definition. In order to correct for the effect of the significant correlation of Patient Outcome with Days of Service, a new variable called Residuals was created using standardized residuals produced from a simple regression of Days of Service on Patient Outcome. This procedure produced, for all counselors, Patient Outcome scores that were unrelated to length of service after treatment. As in Study Two, it showed significant positive correlations with Programmed Case: Improvement and Focusing (r=.361 and .242;p<.01 and .05, respectively), and was not significantly related to the other competency measures.

Table 3. Correlations of Competency Measures, Days of Service, and Patient Outcome (n=45)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Residuals</td>
<td>.926***</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days of Service</td>
<td>3.78**</td>
<td>.000</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prog. Case: Perf.</td>
<td>.027</td>
<td>-.004</td>
<td>.081</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prog. Case: Improv.</td>
<td>.307*</td>
<td>.362**</td>
<td>-.073</td>
<td>-.101</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Self-Def.</td>
<td>.192</td>
<td>.101</td>
<td>.260*</td>
<td>-.237</td>
<td>.302*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing</td>
<td>.174</td>
<td>.243*</td>
<td>-.131</td>
<td>.100</td>
<td>.025</td>
<td>.057</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thematic Analysis</td>
<td>-.053</td>
<td>-.095</td>
<td>.092</td>
<td>.125</td>
<td>-.166</td>
<td>-.035</td>
<td>.235</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Caring Motive Profile</td>
<td>-.025</td>
<td>-.038</td>
<td>.026</td>
<td>-.018</td>
<td>-.078</td>
<td>-.215</td>
<td>-.006</td>
<td>.57</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*=p<.05, one-tailed; **=p<.01, one-tailed; ***=p<.001, one-tailed
A multiple-regression analysis was conducted with the average patient-discharge rating per counselor as the criterion available (Patient Outcome) and the six counselor test scores as the predictor variables. To control for the confounding effects of unequal time periods between treatment-discharge and service-discharge dates, a seventh independent variable was included, representing the average number of days between treatment and discharge from the service for each counselor's sample of patients. The overall test for the degree of association between Patient Outcome and the seven predictor variables is summarized in Table 4. The observed correlation of these variables was statistically significant (F = 2.4378; df=7.37; P<.05) and generally supports the main hypothesis that the group of variables is predictive of Patient Outcome.

This multiple regression showed a significant multiple correlation (R=.562). A test of curvilinearity (F=.474;p=ns) demonstrated no significant deviation from linearity. A detailed analysis of the individual contribution of each variable revealed, however, that the primary contributors to that relationship are Days of Service, Programmed Case:Improvement, and Focusing.
Table 4. Regression of Competency Measures and Days of Service with Patient Outcome: Summary Table (n=45)

<table>
<thead>
<tr>
<th>Analysis</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>7</td>
<td>.426</td>
<td>.061</td>
<td>2.427</td>
</tr>
<tr>
<td>Residual</td>
<td>37</td>
<td>.924</td>
<td>.025</td>
<td></td>
</tr>
</tbody>
</table>

Multiple R=.562, R²=.316, Standard error=.158

<table>
<thead>
<tr>
<th>Variable</th>
<th>Multiple R</th>
<th>R²</th>
<th>R² Change</th>
<th>Simple R</th>
<th>Beta</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Service</td>
<td>3.78</td>
<td>.142</td>
<td>.143</td>
<td>.378</td>
<td>.459</td>
<td>9.567</td>
</tr>
<tr>
<td>Caring Motive Profile</td>
<td>.380</td>
<td>.144</td>
<td>.001</td>
<td>-.025</td>
<td>-.015</td>
<td>.011</td>
</tr>
<tr>
<td>Programmed Case: Perf.</td>
<td>.380</td>
<td>.144</td>
<td>.000</td>
<td>.027</td>
<td>-.002</td>
<td>.000</td>
</tr>
<tr>
<td>Programmed Case: Impr.</td>
<td>.506</td>
<td>.256</td>
<td>.112</td>
<td>.307</td>
<td>.331</td>
<td>5.117</td>
</tr>
<tr>
<td>Cognitive Self-Def.</td>
<td>.507</td>
<td>.257</td>
<td>.000</td>
<td>.192</td>
<td>-.049</td>
<td>.094</td>
</tr>
<tr>
<td>Focusing</td>
<td>.554</td>
<td>.306</td>
<td>.050</td>
<td>.174</td>
<td>.254</td>
<td>3.113</td>
</tr>
<tr>
<td>Thematic Analysis</td>
<td>.562</td>
<td>.316</td>
<td>.009</td>
<td>-.053</td>
<td>-.101</td>
<td>.495</td>
</tr>
</tbody>
</table>

Discussion of Results

The superior counselors appeared different from the average counselors. This does not imply any difference in the dedication or compassion of the individual counselors, but reflects a difference in their effectiveness. Given the relatively high effectiveness of the Navy alcoholism treatment programs as a whole (Bucky, 1977), the differences discussed do represent the difference between superior and average counselors and not between adequate and inadequate counselors.

The two primary competencies were Empathy and Genuineness, with Efficacy showing some significance when considered in the context of the other competencies (i.e., not looking at its unique impact). The focusing measure was indicative of the Genuineness competency. A
counselor who scores high on this measure is one who is aware of his/her feelings and internal states, allows himself/herself to experience the feelings and their changes, and can describe them.

The Programmed Case:Improvement measure was indicative of the Empathy competency. A counselor who scores high on this measure has the ability to understand what others are feeling and saying (e.g., can understand verbal and nonverbal messages from someone). The Cognitive Self-definite on measure was indicative of the Efficacy competency. A counselor who scores high on this measure is one who has a proactive orientation to his life and environment. He/she sees himself/herself as someone who can cause things to happen and not merely as a victim or subject of the powers that exist in life.

The other two competencies appeared to contribute to the overall effectiveness of a counselor, but did not add unique or distinctive capability. The Thematic Analysis and Programmed Case:Performance measures were indicative of the Psychological Diagnostic Skill competency. A counselor who scores high on these measures is one who has an analytic, conceptual orientation to situations and events. He/she sees situations as problems to be solved and is able to determine causal relationships. The Caring Motive Profile measure was indicative of the Belief in People’s Ability to Change. A counselor who scores high on this measure “cares” about others and believes in them.
The analyses strongly suggest that counselor characteristics account for the majority of variance in effectiveness with patients. Situational factors do not seem to account for variation in patient outcome. Although this study did not include a control for type of treatment technique, it is important to indicate that all of the Navy programs were heavily based on practices and procedures of Alcoholics Anonymous. A variety of other techniques are used, such as psychodrama, education, group and individual therapy, and so forth. Three of the fourteen average counselors were civilian (21 percent) and five of the fifteen superior counselors were
civilian (33 percent), suggesting no differential impact of civilian status. Five of the fourteen average counselors (35 percent) and six of the fifteen superior counselors (40 percent) were not trained in the Alcohol Treatment Specialist program, suggesting no differential impact.

It is important to note that the "success rate" of the average Navy alcoholism counselors (70.5 percent) is almost identical to the 67 percent found in most psychotherapy outcome studies conducted (see Burruss, 1977). This suggests that these counselors are doing at least as well as any other treatment group. The considerably higher "success rate" of the superior counselors (87.2 percent), on the other hand, highlights the efficacy of increasing the number of counselors who possess and utilize specific competencies as a way of improving the overall effectiveness of counseling.

**Empathy, Genuineness, and Efficacy in HRD**

*Counseling is the heart of HRD.* In our HRD efforts, are we currently risking a heart attack? Medical science provides us with metaphoric, alternative solutions of heart transplantation, artificial hearts and components, and sustaining life through resuscitators. But do we first need some EMT to “jolt” our hearts back into functioning?

As we design, improve, reengineer, and innovate in human resource management and development systems, we should remember to check each program, system, or activity for the conditions conducive to effective counseling interactions. We can design the structural opportunities, such as insuring sufficient time for people to discuss and review matters with each other before requiring them to complete forms. We can minimize the imposition of helping relationships, and give people choice in establishing “counseling” relationships. This may result in systems lacking tidy or elegant characteristics. For example, in the implementation of a coaching system for development, we may have to surrender the security of knowing each
person will have an assigned mentor within four months in favor of giving each person the choice to identify, select, and develop the relationship with someone who he/she feels will be an effective coach for him/her.

Time, patience, and flexibility should become required design characteristics in all HRM/D systems. Is there sufficient time for a person to think through what he/she wants? Is their time to build the developmental, counseling relationships that will be important in the system? Is there time and flexibility of procedures to allow each counseling relationship to develop and work the rhythm of discovery, exploration, and change essential to individual development?

Beyond the structural characteristics, these studies have provided further confirmation that Empathy, Genuineness, and to some extent Efficacy, are competencies of effective counselors. As specialization, professionalism, and commercialization have contagiously spread through human resource departments and fields, have we forgotten to build and demonstrate our effective counseling competencies? Screening for Empathy, Genuineness, and Efficacy would insure that our human resources have the competencies, but will they use them? We can provide training to help develop and enhance these skills, but more importantly, the training may serve as a reminder of the importance of these competencies.

If we start working on increasing the likelihood of frequent demonstration of Empathy, Genuineness, and Efficacy with all human resource professionals, we can then expand our scope and seek their development and use by human resource managers and executives. If they model the effective counseling skills at appropriate times, other managers and executives may begin to realize that far more can be grown with the organization’s human resources with a generous but appropriate sprinkling of these competencies.
We are told weekly in business magazines to “watch out for ourselves,” “manage your own careers,” and “do not expect anyone in the organization to take care of you.” At the same time, we still spend a great deal of our waking hours at work. The organization and the economy depend on our energy, creativity, and productivity. Frequent images of downsizing (aka rationalizing or rightsizing) remind us of the dangers of commitment to organizations. But we still want to believe and belong to organizations. This paradox can be eased somewhat if our organizations rekindled a caring atmosphere, where we treated each other and can be expected to be treated with dignity and compassion. If more of us used the competencies of effective counselors everyday, we would be creating a credible basis for culture change and an antidote to stress.

The demand for “change management” has often taken the form of helping people adjust to the pace and nature of change occurring in organizations today. In the past, organizational development practitioners have told us about the processes that effective managers and charismatic leaders have used for years to stimulate change. The processes, attitudes, and competencies discussed here as related to counseling are facilitative of healthy and caring human interactions. They may not change the need to eliminate 100 jobs, close a plant, or keep an organization’s identity in-tact after an acquisition, but they might help us address these issues and events in a sane manner.

The fields of HRD can learn from another development field. International economic development has adopted the concept of sustainable development as an improvement over the past efforts. In the past, economic development was sought as single-minded projects, without regard for the environment (natural or social, and in some countries political). We have become aware of the costs of these approaches. Their objectives were often sound and desirable, but their
methods were blind to the unintentional consequences--they had negative side-effects. For a long time, people took a convenient position, saying, “These side-effects can be, and must be tolerated, for the good of the projects and the development they will bring.” The professionals in these fields are now agreeing that other methods can be developed, with some careful thought, that pursue the objectives and development but minimize the previously observed unintended consequences.

The frequent and consistent and appropriate use of counseling competencies could help us to create a movement of sustainable human resource development. This is not some reactionary plea for “back to basics.” It is a request for “centering” ourselves in the essential, or core elements of our field. The message is not new, and lacks the pizzazz of a new CD-ROM based system. We cannot slow our progress but must continue to innovate and develop HRD, but not at the cost of forgetting the fundamentals of human interaction and helping another person to develop!
REFERENCES


