



A Multicontextual Model of Counseling: Bridging Brevity and Diversity

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Practice trends in counseling have emphasized the values of brevity and diversity in the delivery of services. In this article the author reviews central elements of brief therapy and multicultural counseling, highlighting the tension created by their differing developmental assumptions. Drawing on recent science and practice literature, the article outlines and illustrates an integrative, multicontextual model of counseling that bridges these important trends by intervening at the interface between individuals and their physical, social, and cultural contexts.

Increasing demands for counseling services, diminishing institutional budgets and staffs, and trends toward managed care are leading counselors and other mental health professionals toward brief models of service delivery (Cummings, 1987; Steenbarger, 1992b). Amid research reports that such models can provide effective services to a range of clientele (Koss & Butcher, 1986; Steenbarger, 1992a), it is reasonable to conclude that brevity in counseling is more than a passing fad.

At the same time, counselors are aware that coming decades will bring a "diversification of America," in which racial and ethnic minorities will approach a statistical majority (Sue, Arredondo, & McDavis, 1992, p. 67). This has sparked considerable interest in approaches to counselor education (LaFromboise & Foster, 1992; Pedersen, 1988; Ponterotto & Casas, 1987; Sue, 1991) and practice (Ibrahim, 1985; Lee & Richardson, 1991; Ramirez, 1991; Sue & Sue, 1990) that address the diverse traditions and worldviews of clients. This movement has assumed particular urgency given findings that minorities underutilize mental health services; that once they have accessed services, they drop out of treatment at significantly higher rates than do nonminorities; and that minorities are underrepresented in the mental health professions (Casas, 1984; Sue & Sue, 1990).

Although it is rarely acknowledged, the values of brevity and diversity are, at best, uneasy bedmates. The administrator who insists that counselors respectfully explore the unique cultural worldviews that inform client meanings—briefly—is not unlike the sinner who implores the Lord to be delivered to a state of purity and grace, but not too soon. Studies suggest that counselors, as a whole, do not view brief treatments as appropriate for a diverse array of clients and conditions (Burlingame & Behrman, 1987) and, indeed, frequently resist the imposition of therapeutic time limitations (Steenbarger, 1992b). As the National Institute of Mental Health (NIMH) Collaborative Study of Depression has illustrated (Elkin, Parloff, Hadley, & Autry, 1985), brevity naturally lends itself to standardized treatments that, in their very uniformity, treat client diversity as "error variance."

In this article I suggest that the gulf separating brief and multicultural counseling is wide and substantive, originating in the very different developmental assumptions embedded within these traditions. Following a review of the traditions and their underpinnings, I outline a multicontextual framework for synthesizing the aims of brevity and diversity and illustrate their application to counseling practice.

BRIEF AND MULTICULTURAL COUNSELING: A COMPARATIVE OVERVIEW

The past decade has witnessed an explosion of interest in brief therapy (Budman & Gurman, 1988; Garfield, 1989; Wells & Giannetti, 1990) and multicultural counseling (Atkinson, Morten, & Sue, 1989; Lee & Richardson, 1991; Pedersen, 1991; Ramirez, 1991; Sue & Sue, 1990). Practitioner interest has been matched by a surge in research activity, investigating processes and outcomes of brief (see Koss & Butcher, 1986; Steenbarger, 1992a, for reviews) and multicultural interventions (see Atkinson & Thompson, 1992; Ponterotto & Casas, 1991), as well as cultural determinants of human development (see Kagitcibasi & Berry, 1989; Segall, 1986). Although it is clearly beyond the scope of a single article to cover such literature exhaustively, it is possible to identify defining themes and their developmental assumptions.

Brief Therapy

Brief therapy itself embraces a diversity of interventions, from single-session therapies (Talmon, 1990) to multisession cognitive-behavioral, psychodynamic, and strategic approaches (see Wells & Giannetti, 1990, for an overview of brief modalities). Practitioners customarily distinguish *brief therapy*, defined as counseling in which time is an intentional aspect of treatment planning, from *time-limited therapy*, in which specific time limits are established at treatment's outset. Summarizing process and outcome findings in the research literature, Steenbarger (1992a) emphasized that brief work is more than time-unlimited counseling stuffed into fewer sessions; rather, it represents an intentional acceleration of the change-producing ingredients found in all therapies.

Although there are many schools of thought within brief therapy, research suggests that, in their mechanisms of operation, these approaches may be more similar than different (Budman & Gurman, 1988; Garfield, 1989; Koss & Butcher, 1986; Steenbarger, 1992a). Common to the major schools of thought are the following:

Time-consciousness. As Burlingame and Fuhrman (1987) noted, short-term work is brief as a result of conceptual planning, not administrative fiat. Brief therapists work with time as a treatment-planning parameter, catalyzing change processes that can persist beyond the point of termination (Gelso & Johnson, 1983; Steenbarger, 1992a).

Criteria of client inclusion. Practitioners of brief therapy universally recognize that such work is not appropriate for all clients or concerns. Typically, clients are most likely to be identified as brief therapy candidates when they (a) have problems that are relatively circumscribed, of recent onset, and expectable at the current developmental phase; (b) have a history of successful interpersonal functioning; and (c) are capable of forming a relatively rapid therapeutic alliance (Budman & Gurman, 1988; Koss & Butcher, 1986; Steenbarger, 1992a). Clients with longer standing concerns may still benefit from short-term work, but they may require modifications of a standard treatment regimen to minimize the increased risks of relapse (Steenbarger, 1992a).

Therapeutic focus. Brief therapy typically attempts a rapid collection of information, development of rapport, and establishment of a treatment focus (Fuhrihan, Paul, & Burlingame, 1986; Steenbarger, 1992a). Whereas longer term therapies are more likely to attempt a general personality reconstruction, brief therapies typically address circumscribed events, symptoms, or patterns (Burlingame & Fuhrihan, 1987).

Therapist activity and client involvement. In attempting to catalyze change processes, brief therapies tend to place counselors in an active role, rapidly assessing client problems and strengths and initiating interpretations, confrontations, reframings, and homework exercises that mobilize client affects and efforts at adaptation (Koss & Butcher, 1986; Steenbarger, 1992a). Clients are often required to participate in change efforts that extend beyond the normal verbal interchanges of therapeutic conversation, by participating in structured exercises both within and outside of sessions.

Structural invariance. An impressive body of research suggests that underlying the various approaches to brief therapy is a dialectical change structure (Steenbarger, 1992a; Tracey & Ray, 1984). This can be described as a series of three stages:

1. Formation of rapport and alliance
2. Challenges to client understandings and patterns
3. Consolidation and generalization of initial shifts in perspective and action

Multicultural Counseling

Although *multicultural counseling* is most often defined as a specialized practice that involves individuals from differing racial or ethnic groups, recent work emphasizes a generic definition that views multiculturalism as a "fourth force" within counseling (Pedersen, 1991). Because all counselors and clients possess meanings, worldviews, and action patterns that reflect their sexuality, socioeconomic status, race, and culture, there is an important sense in which all counseling is multicultural. Shared by all multicultural counselors is a concern with the biases (Pedersen, 1987) and "cultural encapsulation" (Wrenn, 1985) that can result when professionals uncritically accept the assumptions of the dominant culture in which they practice. Although the specific practices of multicultural counseling vary from practitioner to practitioner—and, indeed, as a function of client culture (Lee & Richardson, 1991; Sue & Sue, 1990) and level of identity development (Helms, 1990; Parham, 1989)—a set of common understandings and practices seem to unite the field.

Validation of client identity and worldviews. Many practitioners have noted that cultures are distinguished by distinctive sets of values and worldviews (Carter, 1991; Ibrahim, 1985, 1991; Sue & Sue, 1990). These perspectives help to shape clients' experience, forming a crucial part of racial and cultural identity (Helms, 1985, 1990; Parham, 1990). Recognizing that the dominant culture often devalues client worldviews and impairs the process of identity development, multicultural counsel-

ors are especially concerned with client validation and empowerment (Sue & Sue, 1990). This means that therapists must possess an awareness and knowledge of cultural differences, as well as skills that enable them to work within client frameworks (Pedersen, 1988; Sue et al., 1992).

Attention to the social context of presenting complaints. Many multicultural perspectives emphasize the role of "difference" in the genesis of client problems (Ramirez, 1991; Sue & Sue, 1990). Clients from ethnic and racial minorities have typically experienced expressions of prejudice, ranging from separatism and antilocution to discrimination and physical attack (Ponterotto, 1991). Indeed, multicultural counselors emphasize that it is the lack of fit between the minority client and the dominant culture—and not deficits internal to the client—that often generate presenting complaints (Ramirez, 1991). For this reason, multicultural therapists often function as social ecologists (Aubrey & Lewis, 1988; Conyne, 1987), addressing the needs of social systems as well as individuals (Herr, 1991).

Attentiveness to client distrust. Vontress (1988) noted:

[Minority clients] . . . have encountered so many historical and contemporary wrongs and hardships at the hands of white Americans that they tend to view whites in general with varying degrees of suspicion and hostility. Therefore, in counseling they are apt to be on guard against being duped or hoodwinked by people they have come to consider untrustworthy. (p. 349)

Such distrust may, in fact, account for why mental health utilization rates are lower and dropout rates are higher among minority clients (Posten, Craine, & Atkinson, 1991). An important skill of multicultural counseling is the ability to work nondefensively with this distrust and to build an effective therapeutic alliance (Pedersen, 1988). Ramirez (1991) described the multicultural counselor's stance as one of empathy projection "trying to understand the point of view and the feelings of someone whose values and cognitive styles may be very different from those of the therapist" (p. 54).

BRIEF AND MULTICULTURAL COUNSELING: DIVERGING ASSUMPTIONS

Despite the aforementioned trends toward brevity and diversity in the delivery of counseling services, there seem to be important differences in the means and ends of these approaches. Some of the most important differences are outlined in Table 1.

Locus of client problem. An overview of the major approaches to brief therapy reveals that they tend to be derived from mechanistic and

TABLE 1
Contrasting Developmental Assumptions: Brief and Multicultural Counseling

Assumption	Brief Therapy	Multicultural Counseling
Locus of problems	Individual, intrapsychic	Person-environment interaction
Inclusion criteria	Restricted	Inclusive
Client worldviews	Faulty, in need of change	Crucial to identity, in need of validation
Attitude toward time	Limited resource	Open ended
Counseling goals	Symptom relief, pattern change	Empowerment, identity development

organismic developmental models that stress the acquisition of skills and insights (see Lyddon, 1989, for a review of developmental counseling models). These approaches view problems as internal to clients, resulting from the learning of maladaptive behaviors and cognitions and the disowning of important facets of the self. Multicultural approaches, conversely, are derived from contextualist models of development (Steenbarger, 1991) that posit problems as a function of poor person-environment fit. Thus, client problems are not intrapsychic in this view, but instead are derived from a fundamental tension between the demands and resources of the environment and the needs of the individual (Herr, 1991). As Ivey (1985) noted, multicultural approaches inevitably address person and environment, including strategies for social as well as individual change. Brief therapies, in their relatively individualistic, intrapsychic conceptualizations, run the risk of disempowering clients by denying social causation and by blaming victims (Ivey, 1985; Pedersen, 1987).

Criteria of client inclusion. Brief therapies tend to target "high-functioning" individuals who display circumscribed complaints of recent onset and who are capable of forming a rapid therapeutic alliance (Steenbarger, 1992a). Multicultural approaches, however, draw no such inclusive boundaries and, indeed, assume that clients will not be able to form a ready alliance because of past experiences with prejudice and oppression (Sue & Sue, 1990). Whereas brief therapies tend to view difficulties in alliance formation in terms of client "pathology," multicultural approaches link these to such contextual factors as economic status and social class (Vontress, 1988). This difference may help to account for the observed tendencies of helping agencies to exclude minority clients from desirable forms of psychological treatment (Atkinson, 1985).

Therapeutic methods. Brief therapies, by their very nature, tend to be time bound, stressing the rapid creation of a change focus and an active, catalyzing, hands-on approach to change (Koss & Butcher, 1986; Steenbarger, 1992a). Multicultural counseling, on the other hand, does not necessarily adhere to Western conceptualizations of time (Carter, 1991; Sue & Sue, 1990), emphasizing being as well as doing (Vontress, 1985). Indeed, whereas brief approaches often seek an alliance within the first few sessions, multicultural models devote significant time to exploring client worldviews (Ibrahim, 1985). Similarly, although many brief therapies tend to be challenging and confrontational (Steenbarger, 1992a), multicultural modalities stress a matching of counselor-client communications as a primary intervention strategy (Pedersen, 1988; Sue & Sue, 1990).

Therapeutic aims. A distinctive theme linking the brief therapies is that deficient aspects of client worldviews—cognitions, self-schemata, and interactional patterns—are responsible for presenting complaints. The role of the helping relationship is to challenge these views and generate more adaptive patterns of action and understanding (Steenbarger, 1992a). Alternatively, multicultural therapies seek to validate client worldviews as part of the cultivation of a multicultural identity (Helms, 1986; Parham, 1989; Pedersen, 1988). Thus, symptom relief and pattern change are less central to multicultural counseling than are empowerment and identity development.

TOWARD AN INTEGRATION OF BRIEF AND MULTICULTURAL COUNSELING

The discrepancies highlighted earlier suggest that counselors attempting to adapt to recent trends toward brevity and diversity may find themselves caught between irreconcilable developmental models. In their definition of client concerns, views of the helping process, and underlying therapeutic goals, brief and multicultural counseling models make radically different assumptions. By defining the crucial ingredients of

human change within individuals, independent of history and culture, most brief models embody the very biases eschewed by multicultural therapists (Pedersen, 1987). Given that limits on counseling and community mental health center budgets will continue to fuel demands for brevity and that minority clients continue to be underserved, some reconciliation and integration of these practice trends is imperative.

A Multicontextual Model of Brief Intervention

Recent life span developmental research and theory have emphasized that internal psychological dispositions account for a relatively small proportion of variance in developmental outcomes (Steenbarger, 1991) and that cultural (Kagitcibasi & Berry, 1989; Segall, 1986) and situational (Magnusson & Allen, 1983) factors are important to human development. These perspectives describe human development as occurring within nested and interacting biological, ecological, social, cultural, and historical contexts (Ford & Lerner, 1992; Riegel, 1975). Developmental outcomes, from this vantage point, are a function, not of internal essences (traits, intrapsychic structures), but of the relative goodness of fit between persons and their multiple contexts (Lerner, Baker, & Lerner, 1985; Steenbarger, 1991). Change occurs when shifts in the person-context gestalt dialectically challenge existing modes of adaptation, creating temporary distress ("crisis") and efforts at adaptation (Ford & Lerner, 1992; Ivey, 1986, 1991; Mahoney, 1990; Riegel, 1975).

Historically, counseling has been distinguished by its mission of facilitating human development (Steenbarger, 1990). Recognizing the role of context in the genesis of client concerns, counselors have conceptualized their work as embracing both person-change and system-change strategies, incorporating primary preventive as well as remedial ends (Aubrey & Lewis, 1988; Conyne, 1987; Morrill, Oetting, & Hurst, 1974). Indeed, Ivey (1985) has convincingly argued that a preventive, person-environment perspective is intrinsic to multicultural counseling.

Close examination of the literature on primary preventive (Conyne, 1987) and developmental (Drum & Lawler, 1988) interventions suggests that these, like their remedial counterparts, fall along a continuum of short term to time unlimited. For example, "stand alone" interventions (Drum & Lawler, 1988), such as brochures, campus displays, and media messages, are highly time limited, whereas organizing clients for social change (Conyne, 1987) can be ongoing. All of these strategies, however, differ from remedial, one-to-one counseling in their efforts to affect systems and empower clients (Conyne, 1987)—the very goals of multicultural work (Ivey, 1985).

By conceptualizing the dimension of time (brief to long term) as interacting with those of change target (individuals to groups and systems) and scope (educational and supportive through reconstructive), it is possible to derive a multicontextual model of intervention (see Figure 1). The intersection of these dimensions captures several intervention frameworks, each of which addresses the potential fit or discordance among individuals and their physical, social, and cultural contexts

Brief, system-change strategies. These include helping strategies commonly associated with primary prevention, including the use of media, such as posters, community service broadcasts, taped materials, brochures, and displays; workshops, designed to raise consciousness on such matters as racism and violence; and consultations, addressing the needs of others interacting with clients (Conyne, 1987). Such work attempts changes in focal aspects of the social and cultural milieu that impede development, including group attitudes and institutional policies and procedures. Because most of the offending beliefs and practices are embedded within the broader community, such work must be conducted on an outreach basis, beyond the helper's office (Steenbarger

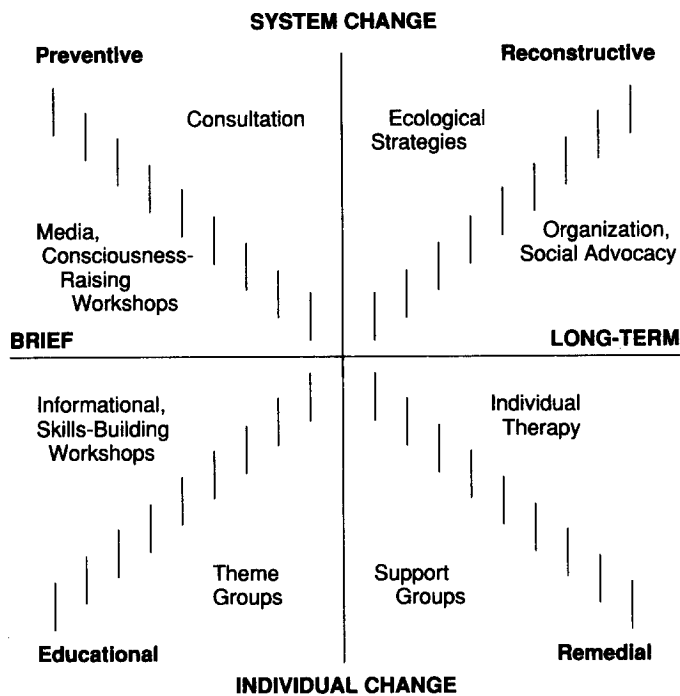


FIGURE 1

A Multicontextual Model of Counseling Interventions

& Zimmer, 1992). This posits the counselor as an active community change agent, challenging existing norms and practices (Aubrey & Lewis, 1988).

Short-term, person-change strategies. These include informational and competency-building interventions designed to impart specific skills to clients in workshop, theme group, and psychoeducational course formats (Conyne, 1987; Drum & Lawler, 1988). In a brief counseling framework, such educational strategies enable students to function more effectively within their current school, work, social, and cultural contexts. The multicontextual counselor is especially concerned with providing individuals with skills that enable them to understand and relate to a diverse array of peers. Ponterotto (1991), for example, identified many persons—as well as system-change strategies for prejudice reduction.

Long-term, system-change strategies. Figure 1 indicates that as counselors move from short-term to long-term intervention modalities, they target person-environment mismatches that are more general than focal. When a social system has institutionalized beliefs and practices that systematically disempower large numbers of individuals, change cannot be expected overnight and, indeed, is generally beyond the efforts of any individual counselor. For this reason, long-term system-change strategies tend to emphasize ongoing, collaborative efforts that can have a reconstructive impact on the client's milieu. Conyne (1987), for example, outlined a variety of strategies for broad system change, including ecological interventions that modify the physical environment and the organization of individuals into groups pressing for change.

Long-term, person-change strategies. Significant experiences of oppression can adversely affect individual development, leaving individuals with a fragmented sense of identity (Sue & Sue, 1990). Ongoing group and individual therapy typically seek to overcome such traumatic

consequences by rebuilding the sense of trust that has been lost and by providing experiences of validation and empowerment (McCann & Pearlman, 1992). Such remedial work is rarely brief, as the trusting foundation of an alliance itself takes a significant period of time to attain. Unlike brief approaches to person change, which target specific competencies, longer term work facilitates identity development by allowing clients to explore the individual, social, and cultural facets of self-hood in an accepting context (Helms, 1990; Parham, 1989; Sue & Sue, 1990).

The Process of Multicontextual Counseling

A multicontextual approach to counseling is grounded in the recognition that client distress frequently owes its genesis to hostile physical, social, and cultural contexts (neighborhoods, workplaces, relationships, families, communities) in which power is maldistributed and misused. This distress is often decontextualized, constructed by self and others as an intrinsic aspect of individuals rather than as a consequence of person-environment mismatch. Thus, distressed individuals come to experience themselves as different, devalued, disempowered, and distrusting. Multicontextual counseling seeks to deconstruct client distress by (a) creating an affirming relationship, (b) recontextualizing complaints (i.e., placing them within broader contexts), and (c) creating experiences by which clients can effectively engage and alter these contexts.

A robust finding in the counseling process literature is that change occurs over a series of distinct stages, from initial engagement and alliance building to the generation of discrepant behaviors and understandings and efforts at generalization (Steenbarger, 1992a). In a multicontextual framework, helping occurs at the client-context interface, so that at each phase of the change process the needs and resources of persons and environments are addressed.

Stage 1: Engagement. The multicultural counselor anticipates that many clients enter counseling feeling alienated and devalued. Whereas engagement in traditional brief therapy begins with the initial contact and the establishment of rapport (Fuhrihan et al., 1986; Steenbarger, 1992a), multicontextual counseling demands that the counselor actively engage the client's life contexts. In college counseling, for example, the counselor must be a visible part of the campus community, participating in organizations, committees, and extracurricular functions—especially those that address the needs of disempowered students. This accomplishes three ends:

1. It demonstrates a willingness to extend counseling to underserved groups, allowing individuals who have been victimized by prejudice to feel welcomed and accepted.
2. It keeps counselors in touch with the community and its needs and concerns.
3. It opens the door for counselors to address needs at individual, group, and institutional levels.

The early phase of counseling is typified by an assessment of the strengths and weaknesses of client and contexts, leading to the formulation of an initial counseling plan. Unlike traditional brief therapy, which focuses on the evaluation of internal client attributes (e.g., behavior patterns, cognitions, interpersonal conflicts), multicontextual counseling emphasizes the assessment of person-environment fit. Initially, no presumptions are made as to whether presenting complaints devolve from personal deficiencies; hostile physical, social, and cultural contexts; or some interaction of these. Rather, an open-ended inquiry attempts to capture the multiple interfaces between clients and their various contexts. During the inquiry, counselors seek information concerning the specific situations associated with client distress and well-

being, identifying the distinctive assets and liabilities of persons and environments.

Such a review provides the counselor with an idea of (a) the nature of the person-environment mismatches that are generating client complaints, (b) the need for specific person- and system-change strategies, and (c) the likelihood of whether complaints can be addressed briefly. From these considerations emerges a counseling plan that spells out the change efforts to be undertaken, at individual and system levels. This plan is drawn collaboratively and is presented as a blueprint for partnership, maximizing the client's sense of empowerment and ownership of the change process (Conyne, 1987). It is not presented as a "treatment plan" to be performed by an active counselor on a passive patient.

Stage 2: Discrepancy. As Steenbarger (1992a) noted in his recent review of the brief counseling literature, the middle phase of such work involves efforts by the counselor to facilitate new modes of experiencing, understanding, and acting. This typically involves a variety of therapeutic strategies, including the provision of new experiences through the conduct of the counseling relationship, the teaching of focal skills, and the use of such interventions as confrontation, interpretation, and reframing in generating new perspectives.

Such work becomes multicontextual when counselor and client collaboratively generate strategies for enhancing personal and environmental resources. Both client and context are often immersed in the patterns of exclusion: The client feels alienated and victimized; the context, threatened by difference, responds defensively, denying the legitimacy of the individual's needs. The ultimate goal of counseling must be to provide client and environment with experiences discrepant from the status quo: experiences of inclusion, cooperation, and empowerment. Thus, the counselor defines helping as change agency: the realignment of the person-context interface.

As Figure 1 suggests, a variety of specific strategies put this overarching goal into practice:

Educational. An important goal of educational interventions is the provision of skills that can enable persons to interact effectively and sensitively with those who are different. Group formats that include members of minority and majority communities, such as workshops, theme groups, and psychosocial courses, are particularly potent modalities, because these permit skills to be developed and used in multicultural settings. Not infrequently, these strategies confront participants with a series of problems drawn from personal experience, allowing for brainstorming and role playing. Educational interventions can also provide information and skills to individuals who wish to engage their environments more effectively, as in the case of orientation sessions that assist students in finding niches within the campus community.

Consciousness-raising. Interventions delivered through mass media and group programming can raise awareness of problems existing at the person-environment interface. Workshops, for example, can present guided exercises and role-played scenarios that enable individuals to identify self-defeating beliefs and destructive prejudices. Such interventions can also help to highlight distinctive values and worldviews that might contribute to more cohesive personal identities and communities.

Ecological. Counselors can work jointly with clients to directly affect communities by encouraging and facilitating input into groups that define policies, procedures, and institutional priorities. On campuses, for instance, such impacts may range from alterations of residence hall policies or structure to reform of the curriculum and institutional hiring procedures.

Consultative. By helping those charged with the responsibility of helping others, counselors and clients can have a major impact on the environment. In-service training sessions, brochures and educational

materials, and direct mediation of conflicts can raise both the awareness and skill level of those routinely interacting with the disempowered.

The brief therapy literature suggests that the impact of an intervention is determined less by its content than by the process of its delivery (Steenbarger, 1992a). In multicontextual counseling, a distinctive process element underlies the various educational, consciousness-raising, ecological, and consultative interventions: The client (i.e., the individual who initiates counseling with a set of presenting complaints) is transformed from a patient into a co-counselor, empowered to have a broad impact on social contexts. The benefits of such counseling are derived not so much from specific intervention modalities as from the expanded sense of self and community that is created when different, devalued, disempowered, and distrustful clients are afforded experiences of inclusion, value, empowerment, and trust.

Stage 3: Consolidation. Research suggests that brief counseling outcomes are more likely to be maintained over time if new insights and experiences can be generalized to a variety of situations (Steenbarger, 1992a). Although very brief interventions can provide a significant measure of initial symptom relief (Talley, 1992), a certain measure of time is needed for new capacities to become internalized into part of an ongoing repertoire. Indeed, research evidence suggests that this process of consolidation extends even beyond counseling's formal termination, as the interventions of brief work instigate a "change in motion" (Gelso & Johnson, 1983; Steenbarger, 1992a). Several strategies can assist in the process of consolidating and expanding initial counseling gains:

Practice. Many counseling formats allow clients to rehearse new behaviors and extend initial insights through a series of active exercises. Role plays and directed tasks allow clients to build competencies, contributing to an expanded sense of efficacy. For example, workshops that are devoted to an exploration of sexual violence may include exercises that require men and women to practice listening and communicating skills.

Feedback. Research suggests that persuasive messages have the most impact when they are delivered by sources that are similar to the recipient (Petty & Cacioppo, 1986). A potent element of group modalities is that they permit rapid peer feedback to clients, maximizing the social influences that are essential to brief work (Steenbarger, 1992a). Whether delivered by counselors or peers, feedback that affirms client change efforts can be instrumental in allowing disempowered individuals to experience themselves as worthy and efficacious.

Establishment of social structures. Many of the interventions of multicontextual counseling result in the creation of new social structures (support groups, organizations, study groups, mentorships) that outlive therapy proper and help to sustain the change process. Indeed, such counseling might be defined as a means by which individuals are empowered to create social structures that can meet their needs. In this sense, counseling never actually reaches a point of termination. Instead, the locus-of-change effort is simply shifted over time from the counselor-client pair to autonomous helping networks.

The Marriage of Brevity and Diversity in Counseling

Traditional brief therapy is deemed ideal for relatively high-functioning clients experiencing focal problems of recent onset; those found to have "entrenched pathology" are frequently excluded (Steenbarger, 1992a). In a multicontextual framework, clearly, the choice of brevity is not dictated by internal client factors alone. Instead, counseling is likely to be of short duration when (a) disruption at the client-context interface is circumscribed, (b) clients and contexts possess significant resources and the capacity to use these constructively, and (c) clients and contexts can rapidly engage counselors in change efforts. In a word, the "health"

of the environment, as much as that of individual clients, will determine the extent that brief work will be viable for disempowered clients.

Consider two recent brief counseling cases at the author's campus (client names and identifying details have been altered to protect confidentiality):

Terence

Terence, a first-year African American medical student, presented concerns over "stress" to the counselor, voicing particular fears of failure. Only after extended questioning did Terence reveal that he had been excluded from elevator conversations and study groups by White medical students and had heard prejudicial remarks from several peers and faculty. Most of these remarks alluded to his alleged lack of "credentials" as a medical student presumed to have been accepted under minority recruitment guidelines. Seemingly placated by the counselor's expressed outrage over these incidents, Terence indicated that he had recently failed an exam, triggering panicky thoughts that, perhaps, he wouldn't be able to "make it" in medical school and, indeed, might harm future patients through his lack of mastery of the course material.

Showing Terence research studies that found no correlation between the clinical competence of physicians and their academic scores (e.g., standardized tests, grade point average), the counselor indicated that he was much more concerned about the unfair treatment Terence was receiving by his peers—and its impact on his learning—than with any putative lack of "credentials." He suggested a "partnership" with Terence that would consist of a two-part plan of action:

1. Reaching out to the medical school class to develop a study and support group that could work—and build effective study strategies—together
2. Petitioning the dean's office and student government for programming on race relations for medical students

Within 2 weeks, Terence had assembled a study group of interested students that met with the counselor weekly for mutual support and skills building. Members of this same group, including Terence, organized a medical student forum during donated course time in which the counselor moderated a successful sharing of experiences between minority and majority communities. Attendance of the forum was near perfect; afterward, many students commented that they hadn't realized that many of their peers felt excluded.

Sarah

Sarah, a graduate student, in her first session, complained of depression that was interfering with her learning and social life. During the session, she sat as far away from her (male) counselor as possible and indicated that she did not feel comfortable talking about her problems. The counselor responded that this was okay and, pointing to a journal dealing with women and violence, indicated that many female clients have every right to distrust a man. Sarah immediately broke into tears and described, in detail, a sexual assault following a student party.

After gently challenging Sarah's statement that she was responsible for the assault by accompanying the man to his room, the counselor suggested a several-part plan:

1. Meetings with a women's support group to hear first-hand accounts of women who were dealing with assault
2. A joint meeting with Sarah and selected significant others (family, friends) to confront her sense of shame and isolation
3. Judicial action against the offender
4. Community action to educate students and officials to the prevalence and impact of sexual assault

Sarah received significant support from the women's group and joint session and decided to undertake judicial action with the assistance of the counselor; this eventually resulted in the perpetrator's dismissal.

Afterward, Sarah contributed to a faculty development workshop conducted by the counselor, alerting mentors to the risks of harassment and assault.

In both of these cases, multicontextual counseling was grounded in several shared elements:

Empathy. The counselor recognized that the client was most likely distrustful and alienated and sought to empathize with the client's plight. This was accomplished in part by verbalizing some of the anger and frustration that the client felt but did not feel empowered to convey.

Recontextualization. The counselor challenged the client's present notion that "there is something wrong with me" and encouraged the client to consider the wider role of the environment in the creation and maintenance of distress.

Partnership. The counseling plan was presented as a joint undertaking, featuring both client and counselor in active roles. Rather than the counselor working on the client's problem, the client and counselor formed a team to address issues in the student's context.

Empowerment. The client was encouraged to act efficaciously as a co-counselor, addressing the needs of the campus community.

Multiple change targets. Counseling never sought to have an impact on the client alone; rather, different facets of the client's context—family, school, peers, institutional policy, and procedure—were targeted for change.

Counseling could be brief in these situations because (a) the client was able to form a rapid alliance with the therapist, (b) the campus environment was open to feedback from counselors and students, and (c) the problems undertaken were relatively circumscribed, not affecting large regions of individual or campus life. In its accelerated and intentional provision of empowering experiences for disempowered clients, counseling was able to effect a marriage of brevity and diversity.

CONCLUSION

Trends toward brevity and diversity in the delivery of counseling services have led to a collision of two developmental models of helping: one locating problems within clients and advocating the treatment of individuals, the other identifying problems at the person-context interface and emphasizing intervention with social and physical environments. In this article I have depicted person- and system-change interventions across a continuum ranging from brief to long term, emphasizing multicontextual strategies that address the fit between persons and their life contexts. Unlike traditional forms of psychotherapy, which tend to firmly separate the roles of counselor and client, multicontextual work seeks to empower clients by treating them as co-counselors—collaborators in the process of system change. Such work can be brief when targeted to focal issues, values, and behaviors, or may be ongoing when addressing structural aspects of the person-context interface. By actively creating experiences of inclusion, value, empowerment, and trust, brief multicultural work does not need to be an oxymoron and, indeed, may represent a desirable and needed addition to counseling repertoires.

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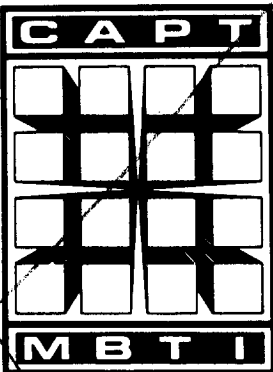
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