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THEORY AND PRACTICE

Helping and change without traditional therapy: Commonalities and opportunities

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Abstract
The therapeutic elements of four types of helping interactions (friends/family, religion, cinematherapy/bibliotherapy, and self-help groups), and their commonalities with traditional psychotherapy are explored. Empirical findings in these areas are discussed, along with suggestions for process and outcome research. Recommendations for the integration of self-help and paraprofessional counseling with professional therapy are presented.

Keywords: *self-help, paraprofessionals, common factors, process and outcome research*

Change and healing may occur not only in traditional therapy, but also in extratherapeutic situations (Prochaska & DiClemente, 1992). Therapeutic changes happen whether people pay attention to them or not. Everyday situations, such as a conversation with a trusted friend, reading a book, watching a motion picture, or experiencing an unusual event can produce a variety of changes. These may include sudden realizations, increases in critical information, emotional reactions, event interpretations, solution revelations, and other change events that are also intermediate goals of traditional therapy.

According to Prochaska (1995), a proponent of self-change, focusing on the 1% of the week that clients spend in therapy is not a sufficient strategy to study change. After studying natural occurring change for many years, Prochaska concluded that, just as physicians capitalize on and enhance patient's self-healing (immune) systems, so therapy works in the same way by accelerating and facilitating the client's self-change processes (Prochaska, 1995). Similar assumptions are shared by humanistic models of change (Bohart & Tallman, 1999), as well as solution-focused therapy, which target use of functional solutions applied occasionally by clients themselves (De Shazer, 1985).

People do not seek professional help for every difficulty in their lives but also look for help, support and advice from their immediate environment. When facing everyday

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problems, people often turn first to their social resources. Although these efforts may not be adequate for all individuals with psychosocial difficulties, many people will choose and be able to utilize such services to meet their needs. A wise piece of advice from a trusted friend that provides an insightful solution to a problem may be exactly what some people in some cases of psychological difficulty need. For example, research in media psychology suggests that there are therapeutic benefits for callers to radio call-in psychological programs, such as emotional support and relief, information, advice, and an increase in awareness (Bouhoutsos, Goodchilds, & Huddy, 1986). Other research has shown the importance of social networks and personal resources (such as religious faith) in helping people cope with crises (see Butler, Hobfoll, & Keane, 2004).

Counseling and helping appears to be a common, naturally occurring human interaction. It can range from simple friendly discussion and advice to long-term and highly complex psychotherapy (Feltham, 1995), and includes a variety of helping relationships and self-help. Some well-known types of such helping interactions are (a) friends and family, (b) religious activities and religious counseling, (c) cinematherapy and bibliotherapy, and (d) self-help groups. The proliferation of paraprofessional and self-help approaches has been fueled by contemporary trends in psychotherapy practice and research, including:

1. Research that shows that certain types of self-help interventions are equally effective compared with traditional therapy, for a number of psychological problems (Gould & Clum, 1993; Mains & Scogin, 2003; Marrs, 1995).
2. Research that shows that self-directed therapy produce results superior to traditional therapy when matched to specific client variables, such as high resistance (Beutler et al., 1991).
3. Research that shows that several forms of self-help interventions are widely and increasingly used in therapy (Norcross et al., 2003; O'Connor & Kratochwill, 1999).
4. Research that shows that paraprofessionals may produce therapeutic effects similar to professionals (Friedli, King, Lloyd, & Horder, 1997; Hattie, Sharpley, & Rogers, 1984).
5. Research that shows insignificant differences between active treatments and well-designed placebo therapies (Baskin, Tierney, Minami, & Wampold, 2003).
6. Research that shows that clients largely change by themselves within and outside therapy (Bohart & Tallman, 1999; Lambert, 1992; Prochaska & DiClemente, 1992).
7. The identification of important therapeutic similarities among models of psychotherapy, paraprofessional counseling, and self-change (Frank & Frank, 1991; Hubble, Duncan, & Miller, 1999).
8. Socioeconomic pressures for cost-effective therapy (Austad & Berman, 1991; Christensen & Jacobson, 1994). Paraprofessionals and self-help as an adjunct intervention (or sometimes the only intervention) may substantially reduce the cost of treatment.
9. A need to de-mythologize and de-pathologize mental health, and advance prevention and self-care (Jacobs & Goodman, 1989; Miller, 1969; Rosen, 1993; Szasz, 1978). The trend to give psychology away has been reflected in behavioral therapies' use of self-management programs and self-directed models of change (e.g., Watson & Tharp, 1997), and solution-focused and humanistic approaches to self-change (Hubble et al., 1999).

The promise of research on self-help and change outside traditional therapy lies in four areas: (a) exploration of the natural change process and identification of those qualities

necessary for effective communication, growth, and healing; (b) validation of interventions occasionally used by clients and non professional helpers, which can minimize the financial and psychosocial cost of treatment; (c) enrichment of traditional therapy via the incorporation of findings from the area of paraprofessional counseling and natural change; and (d) enhancement of prevention via the dissemination of findings on natural healing to the public. A selective description of therapeutic factors in four types of helping relationships and self-help follows, along with research findings and recommendations.

Four types of non-traditional counseling and self-help

Friendship and family

People naturally seek support and relief from their social resources. Research data from field studies about help-seeking behavior are enlightening (Wills, 1992): the rate of help-seeking behaviors in hypothetical problematic situations is high (80–90%) among respondents, and the ratio of lay versus formal help-seeking is 5:1 or greater. The difference narrows for serious problems, but lay help-seeking (e.g., from family, friends, or relatives) remains favored even for major psychological problems.

Friendship has been studied throughout antiquity from a number of disciplines and perspectives (for a review see Gurdin, 1986). For instance, from an existential perspective, friendship has been considered as therapy for human loneliness and alienation (Lepp, 1966). Most people at some point in their life have experienced the helping aspects of friendship. A steady supporting system (friends, family, partner) may lessen the need for professional help (for more on the therapeutic value of friendship see Berzoff, 1989; Gurdin, 1988; and Mitchel, 1966). The characterization of the therapeutic relationship as purchased friendship (Schofield, 1964) may sound exaggerated, but it is also indicative of the value of the latter. Comparative research on the therapeutic effectiveness of professional and paraprofessional counselors (e.g., Strupp & Hadley, 1979) has enhanced the idea of existence of common processes and benefits between psychotherapy and friendship. Important commonalities (empathy, genuineness, interest, warmth, concerned listening, advice, etc.) and differences (asymmetry, role training, goals, rights and obligations, etc.) between the two are reviewed in Gurdin (1986). The comparative examination of therapy and friendship (Derlega, Hendrick, Winstead, & Berg, 1991; Reisman & Yamokoski, 1974) may potentially enhance both relationships and cross-fertilize the knowledge from social and counseling psychology fields.

Religion

Religious psychologists have suggested that religion acts in a synergistic way with psychotherapy (Nielsen, Ridley, & Johnson, 2000; Richards & Bergin, 1997). In fact, each religion can be seen as a distinct, comprehensive worldview and counseling theory that deals with both psychosocial and existential issues; it can also be as divergent or similar to the other religions as to any school of therapy. Thus, religion can be viewed as a form of counseling. Indeed, clerics regularly serve as counselors for a variety of psychosocial problems presented to them (Lount & Hargie, 1997; Worthington, Kurusu, McCullough, & Sandage, 1996). Although research findings are mixed and the picture is complex, it seems that there is a positive relationship between mental health and religiosity, especially when the latter is internalized, committed, mature, and unselfish (Richards & Bergin, 1997). Specific traditional religious healing practices include prayer, contemplation,

meditation, reading sacred writings, confession, forgiveness, repentance, worship and ritual, fellowship and service, spiritual direction and moral instruction (Richards & Bergin, 1997). Religion has two important advantages as a counseling intervention: (a) The perception of divine presence can greatly enhance the helpee's expectations for change, and (b) it is based on theistic systems well organized to provide their services through the ages, with adherents comprising more than 80% of the population in Europe and North America (Richards & Bergin, 1997). Examples of recent efforts to integrate religious concepts into psychotherapy are available in Richards & Bergin (1997, 2000, 2004).

However, a distinction should be made between religious counseling provided by lay counselors such as members of the clergy (priests, ministers, rabbis, etc.), and religious counseling provided by trained professionals with degrees in pastoral counseling or other mental health fields. Although only the former type of religious counseling can be considered as lay counseling, professional religious counselors may also use explicitly religious interventions (e.g., prayer, confession, and teaching with Scripture; Worthington et al., 1996). The flourishing empirical research on religion and all types of religious counseling is reviewed in Worthington et al. (1996).

In a similar way, ancient philosophies and civilizations may have a lot to offer in the field of wellness and mental health. The roots of contemporary psychology and psychotherapy can easily be traced to antiquity (Chessick, 1987; Howells, 1975). By studying these systems, psychotherapists may find useful concepts to integrate in contemporary treatments (e.g., mindfulness meditation and cognitive-behavior therapy; Baer, 2003; Segal, Williams, & Teasdale, 2002). Detailed accounts of ancient philosophies, worldviews, and healing practices are available in Chessick (1987), Howells (1975), Frank & Frank (1991), and Sharkey (1982), among others.

Cinematherapy and bibliotherapy

Cinematherapy. National surveys reveal that many practitioners use selected motion pictures with healing effects as components of their treatments and consider them to be effective (Lampropoulos, Kazantzis, & Deane, 2004; Norcross et al., 2003). A person may also self-prescribe specific movies as part of a conscious or unconscious self-healing effort (Solomon, 1995). Many people will recall an intense emotional experience and a feeling of empowerment after watching a high quality motion picture. Clients can identify with the movie characters who face similar difficulties, find support and acceptance for their condition, deepen their emotional states, achieve catharsis, increase their awareness of the problem, get information, find solutions through vicarious learning, and prepare for action (see also Hesley & Hesley, 2001). The depiction of common problems and the solution-oriented ending of many movies can remoralize and motivate people, and may also provide a corrective emotional experience. A variety of high quality healing movies for psychosocial issues such as abandonment, abuse, adoption, addictions, death and dying, divorce, adolescence, family, vocation, friendship, eating problems, mental illness, physical illness, and sexuality, are available (Hesley & Hesley, 2001; Norcross et al., 2003; Solomon, 1995).

Bibliotherapy. In a similar way to movies, bibliotherapy is a well known method of healing throughout history (Hynes & Hynes-Berry, 1986; Rubin, 1978). Perhaps the most often read book used for such purposes is the Bible (and other basic writings in various religions). According to Rubin (1978), more than 400 journal articles had been published in the area

of bibliotherapy by 1950. These publications focused on many aspects of bibliotherapy (i.e., processes, training, goals, participants, theory, counter-indications, therapy structure and delivery), and have covered different client ages and problems, including psychiatric inpatients (Hynes & Hynes-Berry, 1986; Rubin, 1978).

Many books with a great variety of themes, which are more or less psychological in content, are available on the market. Mental health professionals often utilize bibliotherapy as an adjunct intervention. Research shows that most of the clinicians surveyed have used psychological self-help books in their practice and are satisfied with the results (Marx, Royalty, Gyorky, & Stern, 1992; Norcross et al., 2003; O'Connor & Kratochwill, 1999; Starker, 1988). Bibliotherapy shares and operates through the same healing processes as movies. In addition, the book that stands in for a counselor may provide the client with a more enduring, even life long therapeutic relationship, unlike the therapist as a live individual (Frank & Frank, 1991).

However, of the many hundreds of self-help books that are being published each year, only a small number have been tested and supported empirically (Rosen, 1993). This cautions for a critical approach to bibliotherapy. Further, the term bibliotherapy has been used to describe a wide range of books in terms of their psychological and scientific content. Therefore, a distinction should be made between (a) pure "literatherapy" (a synthetic name for literature as therapy; Shiryon, 1978) that includes literary writings of high quality written by non mental health professionals; (b) bibliotherapy that is more psychological in content and includes descriptions of specific psychological problems and treatments, such as clients' autobiographies (Clifford, Norcross, & Sommer, 1999) and practitioners' recountings of clinical cases; and (c) manualized treatment programs for specific disorders, based on psychotherapy principles and delivered through books, with minimal or no therapist interventions (Cuijpers, 1997).

The latter category is a well-researched and supported form of bibliotherapy that may require the minimal presence of a therapist. According to Rosen (1993), more than 100 studies have been conducted in which the benefits of some self-help programs are shown for a variety of psychological problems. For example, cognitive and behavioral bibliotherapies for depression have been tested in randomized clinical trials with adolescents, adults, and the elderly, and have been found to be comparable to individual and group therapies (Cuijpers, 1997; Gregory, Schwer-Canning, Lee, & Wise, 2004). Such forms of bibliotherapy have been reasonably established as efficacious treatments for mild to moderate depression, mild alcohol abuse, and anxiety disorders (Mains & Scogin, 2003), and have shown good results for certain sexual dysfunctions (van Lankveld, 1998), and certain eating disorders (bulimia and binge eating; Wilson, Vitousek, & Loeb, 2000).

Self-help groups

There are a variety of non-religious or non-familial self-help and support groups worldwide. Such groups include Alcoholic Anonymous (AA; as well as Narcotics, Smokers, Cocaine, and Pills Anonymous), Overeaters Anonymous, Gamblers Anonymous, Sex Addicts Anonymous, Adult Children of Alcoholics, Incest Survivors, and Parents with Autistic Children, among others. Empirical research has supported the effectiveness of self-help groups such as AA (Moos, 1999; Tonigan, Toscoova, & Miller, 1995), medical self-help groups (Barlow, Burlingame, Nebeker, & Anderson, 2000), and mutual support groups for depression (Bright, Baker, & Neimeyer, 1999).

There are estimates that as many people are participating in self-help groups as are in professional therapy in the United States (Jacobs & Goodman, 1989). Predictions of mental

health experts rate self-help groups and paraprofessionals as the treatment providers of the future (Norcross, Alford, & DeMichele, 1992; Norcross, Hedges, & Prochaska, 2002). After summarizing research and describing the social-psychological processes in help-seeking in everyday life, DePaulo (1982) explained how semiformal helping arrangements such as self-help groups may allow people to overcome their aversion to help seeking: while sharing many therapeutic processes, the advantages of self-help groups over professional counseling may include a sense of community among people with similar problems, the opportunity not only to receive but to offer help, a sense of self-achievement, less perceived inadequacy and threat to self-esteem, internal attributions of success, opportunity to establish and maintain interpersonal relationships, and no financial cost (DePaulo, 1982; see also Reissman & Caroll, 1995). Moreover, research shows that peers with similar background are preferred to professional helpers (Medvene, 1992). This similarity is the basis for organizing self-help groups and is communicated through reciprocal self-disclosures that are also crucial in friendship development and intimacy. Such research findings from the study of self-help groups can also be used to enhance traditional clinical practice.

It should be noted here that non-professional helping relationships and self-help may not always be effective or may even have a negative impact. For instance, friends may not always be objective or sincere, religion-based helping can sometimes be judgmental, and a self-helper may miss the point of a therapeutic movie or book. Also, because of the lack of appropriate research, the present discussion does not intend to support the view that all these non-professional helping interactions are necessarily beneficial or equally effective alternatives to professional therapy. Most of these interactions are more likely to be used as adjunct interventions (e.g., therapeutic movies) or at least need some minimal guidance by professional or paraprofessional counselors (e.g., bibliotherapy, self-help groups and religious counseling). The focus of this paper is to identify important therapeutic elements in lay counseling and self-help approaches, with the purpose of developing research and practice recommendations. Last, some other types of self-help and nontraditional counseling may exist but are not reviewed here. These include therapeutic writing (e.g., focused expressive writing, correspondence, personal diaries; Mahoney, 1991; Smyth & Helm, 2003), art therapy (e.g., music, poetry; Harrower, 1978), and counseling/support via the Internet (Newman, 2004; Wolf, 2003).

Research opportunities in self-help and paraprofessional helping

Outcome research methodology offers a plurality of methods that could be applied to the evaluation of religious interventions, self-help groups, bibliotherapies, or other types of lay counseling and self-help. Empirical research to date offers preliminary support for the effectiveness of bibliotherapies and self-help groups (Christensen & Jacobson, 1994; Mains & Scogin, 2003). For example, meta-analytic reviews of the effectiveness of self-administered treatments (e.g., books and tapes) for a variety of problems conclude that these methods are more effective than no treatment and that effect sizes are comparable to those of professional therapy (Cuijpers, 1997; Gregory et al., 2004; Gould & Clum, 1993; Marrs, 1995). Outcome studies of secular treatments adapted for religious clients show equivalent results for these treatments with secular ones and definite superiority to no treatment (McCullough, 1999; Worthington et al., 1996).

Ecological validity is an important issue in the study of non-professional counseling and self-help processes which need to be measured in their natural environments. Outcome research recommendations for practitioners (Lampropoulos et al., 2002;

Sexton, Whiston, Bleuer, & Walz, 1997; Whiston, 1996) may be helpful here. Counselors who are routinely involved in the provision of paraprofessional counseling and facilitation of self-help (i.e., recommend self-help materials, religious counselors, self-help group facilitators) can become active researchers of their own practices, using field methodologies (Whiston, 1996).

A fruitful strategy maybe the study of selected promising interventions and processes that occur in paraprofessional counseling and self-help. For example, Worthington et al. (1996) recommended research on (a) the effectiveness of explicitly religious techniques and interventions (e.g., use of sacred writings in counseling, prayer, confession); and (b) techniques that can cut across religious and non-religious populations (e.g., forgiveness), among others. Traditional counseling process research measures and methods (Greenberg & Pinsoff, 1986) can also be valuable in the study of paraprofessional counseling.

Aptitude-treatment interaction research

Although some effectiveness issues have been clarified in self-help and lay counseling research, other equally important questions remain. For instance, certain bibliotherapies for depression have already been shown to be efficacious in comparisons against control groups and other therapies. However, the potential differential efficacy of bibliotherapy and traditional therapy for specific types of depressed clients remains unknown, and research to guide treatment selection is needed.

The appropriate research methodology to study treatment selection in eclectic practice is aptitude-treatment interaction research (ATI; Shoham—Salomon, 1991). ATI methodology is based on Paul's (1967) question: ''*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?'' Possible variables described as ''aptitude'' in ATI might be specific clients' problems, individual preferences, and diagnostic or non-diagnostic personality characteristics. ATI design includes the comparison of at least two interventions that could potentially produce differential effects according to a meaningful hypothesis. ATI research has revealed important differential findings (Beutler, Clarkin, & Bongar, 2000; Dance & Neufeld, 1988). For example, the therapeutic superiority of matching clients with high resistance potential to self-directed counseling (i.e., self-help readings assisted by non-professional counselors) has been supported against two types of professional therapy (Beutler et al., 1991).

ATI methodology can also be used to compare (a) professional and paraprofessional counseling (e.g., cognitive or humanistic therapy versus explicitly religious activities or religious counseling), and (b) different types of paraprofessional counseling and self-help (e.g., religious activities/counseling versus bibliotherapy). Specifically, based on empirical findings and theoretical hypotheses, some possible research areas that can produce differential outcomes might be:

1. Self-help bibliotherapy for the client who is an educated, resourceful, mildly disturbed, motivated reader, psychologically-minded, positive towards self-help, resistant to authority, concerned about social stigma, and has a high generalized self-efficacy and internal locus of control; more intense professional treatment for the severely disturbed, defensive client, with reading and concentration problems, multiple diagnoses, and lack of social support, etc. (Beutler et al., 1991; Cuijpers, 1998; Mahalik & Kivlighan, 1988; Mains & Scogin, 2003).
2. Religious counseling or explicitly religious activities for the religion-oriented client versus secular counseling for the science-oriented client (locus of control

may also be relevant here). Moreover, comparative process research could focus on interventions employed by religion and different counseling models in the same phase of treatment (or client's stage of change), such as (a) repentance vs. awareness raising/insight into problems, (b) worship vs. therapeutic engagement/commitment, (c) confession vs. client's information provision plus catharsis, (d) forgiveness vs. empty-chair dialogue for unfinished business.

3. Self-help group participation for individuals with mild psychological problems, a strong need for affiliation with others, and a high level of perceived threat to self-esteem versus individual counseling for clients with juxtaposed characteristics and many complex problems (DePaulo, 1982; Medvene, 1992; Project MATCH Research Group, 1997).
4. Client's attributions of their problems and their solutions might also be a promising strategy for matching clients to helping models (Brickman et al., 1982; Karuza, Zevon, Rabinowitz, & Brickman, 1982): (a) *The medical model* (passive; client is not held responsible for either the cause of the problem or its solution) indicates pharmacotherapy or a directive intervention as the treatment of choice; (b) *The compensatory model* (client is not responsible for the cause but still responsible for the solution) indicates an intervention where clients sustain an active role, e.g., community action programs, or cognitive-behavior modification; (c) *The moral model* (client is held responsible for both the cause of the problem and its solution) calls for active, self-help, and existential therapy models; (d) *The enlightenment model* (client is held responsible for the cause of the problem but not its solution, at least not alone) calls for directive therapeutic communities, such as AA (Brickman et al., 1982; Karuza et al., 1982).
5. Similarly, a related model proposed by Fisher & Nadler (1982) according to the dimensions of a medical versus a social learning cause and cure, can also have matching implications to treatments (drugs versus self-help interventions, respectively). Generally, matching clients to different treatments according to their perceptions of the causes of their problems has already received some support in psychotherapy (Addis & Jacobson, 1996; Elkin et al., 1999).

In conclusion, the goals of the foregoing research proposals are twofold: by studying naturally occurring helping relationships and change, counselors can first identify and then test their healing elements with different populations. Subsequently, these can be taught and used by clients and counselors, when appropriate. This eclectic use of ATI research findings can have important implications both for prevention and treatment. Effective natural therapeutic processes will reduce the cost of mental health care and improve clients' quality of life. At the same time, professionals can incorporate findings from natural healing in their practice. In a similar way, research in professional therapy can enrich and improve paraprofessional counseling and self-help.

Unfortunately, practice and research on non professional counseling and self-help may have been devalued by mental health professionals (Norcross, 2000). However, any resistance to research and practice of effective adjuncts or alternatives to traditional therapy is unscientific and unprofessional. The role of psychological counseling should be on de-mythologizing and de-pathologizing mental health, as well as advancing prevention and self care (Jacobs & Goodman, 1989; Miller, 1969; Rosen, 1993; Szasz, 1978). The next section discusses issues related to the integration of self-help and paraprofessional counseling into traditional clinical practice.

Integrating paraprofessional counseling, self-help, and traditional therapy

There is a growing amount of theoretical, clinical, and research literature devoted to trends such as self-change and paraprofessional counseling. This is consistent with research on dose-effect relationships (Howard et al., 1986), and very brief therapies (Rosenbaum, 1994), which have yielded interesting findings: Much of the therapeutic change comes quickly for many clients, and many clients prefer and benefit from 1–3 counseling sessions. Taking the socioeconomic pressures from managed health care into account (Austad & Berman, 1991), and clients' rights for brief, affordable, and cost-effective therapy, treatment guidelines consistent with a stepped-care model (Mains & Scogin, 2003) need to include findings from the fields of self-help and paraprofessional counseling. Accordingly, recommendations for clinical practice include:

1. The organization of findings on the efficacy of certain treatments for specific populations and problems from all areas of mental health (pharmacotherapies, psychotherapy, self-help and paraprofessional counseling) into systematic treatment selection models (e.g., Beutler et al., 2000). Mental health professionals should evaluate the needs of a prospective client and make cost-effective treatment plans and appropriate referrals. Using available empirical data from the areas of medication, psychotherapy, self-help and paraprofessional counseling, mental health practitioners should make decisions regarding who needs long vs. brief therapy, inpatient vs. outpatient therapy vs. papraprofessional counseling, and pharmacotherapy vs. psychotherapy vs. self-help, and so on (see also Beutler, 1999).
2. Mental health professionals could be trained in therapist-assisted self-help, such as cognitive and behavioral bibliotherapy for depressed adolescents, adults, and the elderly. The practice of empirically supported bibliotherapies could increase accessibility to treatment for a number of clients resistant to traditional counseling or unable to cover its cost. At a minimum, counselors could incorporate in their treatment effective forms of self-help such as therapeutic movies or books (Norcross, 2000).
3. Counselors should emphasize in their work educating clients on how to use their natural social support systems and personal resources (Antonucci & Depner, 1982; Moos & Mitchel, 1982). Clients, due to their situation or lack of skills, often cannot take advantage of their support systems, which may also be inadequate or nonexistent. Counselors can help their clients to overcome interpersonal barriers, rather than merely providing situational relief and symptom-reduction. If clients learn how to create, utilize, and maintain strong social support systems and personal resources, they will have been offered a great preventative and therapeutic service.
4. Collaboration of professional and paraprofessional helpers. Clients would often utilize some form of self-help or lay counseling as an adjunct form of treatment, and receive benefit from it. Although mental health professionals will continue to provide treatment in the future, possibly focusing on more severe cases and long-term therapy, it is expected that some mental health treatment will be increasingly administered by trained paraprofessionals (Christensen & Jacobson, 1994; Norcross et al., 2002). On the other hand, professional therapists could educate paraprofessionals (e.g., the clergy, self-help group facilitators), where chances arise, to identify and refer clients who need professional help. Examples of collaboration between mental health professionals and clergy can be found in Edwards, Lim, McMinn, & Dominguez (1999).

To conclude, it seems that the contemporary trends towards self-help, short-term, and paraprofessional counseling will continue (Christensen & Jacobson, 1994; Norcross, 2000; Norcross et al., 2002; Scogin, 2003), and clinicians should accommodate these developments in their practice. However, caution is advised until additional research becomes available. To this end, counselors could use their practice, whenever possible, to study such phenomena.

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