SECOND EDITION

A Brief Orientation to COUNSELING

Professional Identity, History, and Standards

Edward S. Neukrug

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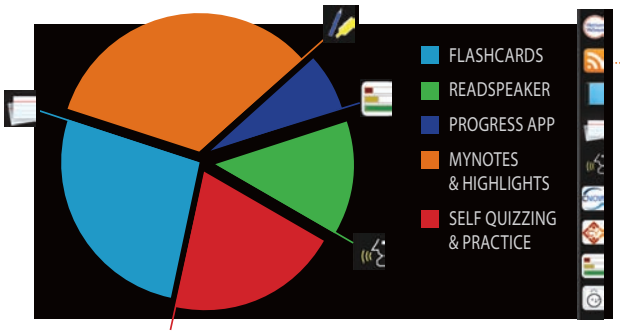

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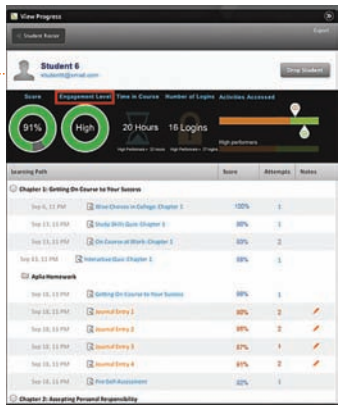

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A Brief Orientation to COUNSELING

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Edward S. Neukrug

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***A Brief Orientation to Counseling: Professional Identity, History, and Standards*, Second Edition**
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Dedicated to All Counseling Professionals

Contents

Preface

Welcome to the second edition of *A Brief Orientation to Counseling: Professional Identity, History, and Standards.* The purpose of this book is to highlight those aspects of counseling that are most important in developing a counseling perspective and in building an affiliation with the field. The book has three sections, the first of which focuses on professional identity, the second of which looks at history and trends, and the last of which examines standards in the profession. An afterword provides information on applying to graduate school and on applying for a job. Let's take a quick look at these sections and the afterword and describe some of the special features of the book.

Section I: Professional Identity of the Counselor

Chapter 1: What Is Counseling and Who Is the Counselor? begins by offering a historical perspective on the words *guidance*, *counseling*, and *psychotherapy* and describes the difference between these three words. After acknowledging that some counselors do all three, the chapter moves on to offer a recent definition of *counseling* that was recently developed through a collaboration of 30 counseling associations. Next in the chapter, we discuss different types of counselors while noting their respective types of accreditation, credentialing, and professional associations. We briefly do the same for a number of related non-counseling mental health professionals so that you are familiar with those individuals with whom you will likely work.

Chapter 2: Professional Associations in Counseling and Related Fields examines the importance of professional associations and then describes, in a fair amount of detail, the American Counseling Association (ACA) as well as its 20 divisions, 56 branches, and 5 professional partnerships. In addition, specific membership benefits are relayed. As in Chapter 1, we offer information about our non-counseling professional colleagues by providing a brief overview of a number of professorial associations for non-counseling mental health professionals. These include the American Art Therapy Association (AATA), the American Association of Marriage and Family Therapy (AAMFT), the American Association of Pastoral Counselors (AAPC), the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the American Psychological Association (APA), the National Association of School Psychologists (NASP), the National Association of Social Workers (NASW), the National Organization of Human Services (NOHS), and the National Rehabilitation Counseling Association (NRCA).

The last chapter in this section, *Chapter 3: Characteristics of the Effective Counselor*, examines a number of qualities that are embraced by effective counselors. We begin this chapter by offering a quick review of some of the research that has examined the effectiveness of counseling. Then we suggest there are nine factors that collectively work toward increasing counselor effectiveness, including six that jointly describe the working alliance—empathy, acceptance, genuineness, embracing a wellness perspective, cultural

competence, and the "it factor"—and three that together are related to the counselor's ability to deliver his or her theoretical approach: belief in one's theory, competence, and cognitive complexity.

Section II: History and Current Trends in the Counseling Profession

The first chapter of this section, *Chapter 4: Predecessors to the Counseling Profession: From Antiquity to Early Social Work, Psychology, and Psychiatry,* begins by identifying and discussing antecedents to the development of the mental health professions. The rest of the chapter gives a relatively brief history of social work, of psychology, and of psychiatry. In particular, how the early beginnings of these fields impacted the counseling profession is discussed. A summary table is provided at the end of the chapter to highlight points and help you remember salient events.

Chapter 5: The History of the Counseling Profession focuses solely on the 100-year history of counseling. The chapter takes us through the early history of vocational guidance and the impact testing and early methods of psychotherapy had on counseling. It then moves on to cover the emergence, diversification, and proliferation of the field during the second half of the twentieth century. In addition, new issues that have arisen within the past 20 years that will likely impact the counseling profession in the future are discussed. As in *Chapter 4*, a summary table is provided at the end of the chapter to highlight points and help you remember salient events.

Because the past is intimately connected with the future, the last chapter in this section is *Chapter 6: Current Issues and Future Trends in the Counseling Profession.* Here, we highlight a number of new approaches to counseling that are being emphasized today; the impact that technology is having and will have on counseling; new trends in health management, such as counselor inclusion within health care management, the use of medications, and the recent publication of the new diagnostic and statistical manual; changes in standards, such as the development of a new ethics code, new accreditation standards, international standards, changes in credentialing, and the adoption of multicultural counseling competencies and advocacy competencies; and recent professional issues such as division expansion and division autonomy, the 20/20 vision statement, and globalization.

Section III: Standards in the Counseling Profession

We begin this section with *Chapter 7: Accreditation in Counseling and Related Fields.* We start by describing the history of the Council for Accreditation of Counseling and Related Educational Professions (CACREP), and then discuss the many benefits of accreditation. We then offer an overview of the CACREP standards that includes a quick look at the master's- and doctoral-level standards. Next, we very briefly mention a new accreditation in counseling, the master's in psychology and counseling accreditation (MPCAC), and conclude with a brief description of accrediting bodies in related mental health fields.

Chapter 8: Credentialing in Counseling and Related Fields begins with a history of credentialing in counseling and related fields. We then discuss the benefits of credentialing

and distinguish three types of credentialing: registration, certification, and licensing. We next describe, in some depth, different kinds of counselor licensure and certification and how credentialing can serve as a unifying force for the counseling profession. The chapter concludes with a brief overview of credentialing in related mental health professions and a short discussion of the importance of lobbying for credentialing and other counseling-related concerns.

Chapter 9: Ethics in Counseling begins by defining values and morality and discussing their relationship to the law. We then go on to discuss the development of and need for ethical codes. After describing the ACA code in some detail, we next identify ethical "hot spots" and describe four models of ethical decision-making: problem solving, moral, social constructionist, and developmental. How to report ethical violations is discussed next, followed by legal issues related to ethical violations, understanding the difference between civil and criminal liability, the role of ethical codes in lawsuits, the importance of malpractice insurance, and using best practices to avoid malpractice suits.

The last chapter of this section is *Chapter 10: Culturally Competent Helping: Multicultural Counseling and Social Justice Work.* This chapter first defines multi-cultural counseling and social justice work and then goes on to offer some reasons why counseling is not working for many individuals from nondominant groups. After offering definitions for a number of common terms related to multicultural counseling and social justice work, we go on to describe three conceptual models to help us understand ourselves and our clients: the RESPECTFUL acronym, the tripartite model, and developmental models of cultural/racial identity. The chapter concludes with a description of the Multicultural Counseling Competencies and the Advocacy Competencies and how multicultural counseling and social justice work are considered the fourth and fifth forces in the history of the counseling profession.

Afterword: Applying to Graduate School and Finding a Job

At some point, most students who read this book will be applying to graduate school and/or applying for a job in the counseling profession. The afterword was developed to make this process easier. In the afterword you will find items to consider when choosing a graduate program and/or finding a job, some pointers to remember in the application process, how to develop your résumé and portfolio, specific resources to help you find a graduate program or a job, and how to deal with being chosen by or being denied entrance to your favorite school or your dream job.

Activities to Enhance Learning

You will find a number of items throughout the book that will add to the learning process. For instance, on a number of occasions I refer students to websites to gain additional information or to do a quick exercise to enhance your learning (e.g., to obtain your positivity ratio). I also offer a list of websites of professional associations in Appendix A. In addition, a number of tables can be found throughout the text that highlight points and enhance learning, such as the definitions Meyers and Sweeney use in their 5-factor Indivisible Self wellness inventory, which students can use to assess their

wellness levels, or a table that shows the diverse nature of the United States. In addition, I have reflection exercises peppered throughout the book. These exercises allow you to consider a salient point more fully, such as when I ask you to think about what you might do if faced with a client who was suicidal or homicidal. In a similar vein, I have included activities throughout the book to highlight points. Finally, at the end of each chapter of this edition you will find a case study relative to each chapter's content.

Changes to This Edition

Although the order of the chapters and the main thrust of the chapters remain the same, there have been considerable changes in this edition. In addition to updating chapter content and references, I've added new material throughout the text. For instance, this book includes information about the Julea Ward case, which impacted how counselors work with clients who have different values; offers information about the stand ACA has taken against referring to counselors who practice sexual orientation change efforts (conversion or reparative therapy); and presents the Tarasoff case that speaks about how to handle counseling relationships where there is "foreseeable harm." I also updated the information about the ACA ethics code, as the 2014 version has now been developed. Similarly, information about CACREP was updated to reflect the new, 2016 standards. New statistics and information about credentialing was added, such as information about the board-certified coach (BCC) and the approved clinical supervisor (ACS). Each chapter had added to it a case study for students to reflect upon, and new activities and reflection exercises were peppered throughout. Also, this book now has a glossary of all of the major terms that are highlighted in the text. Although there were many additions to this text, the book maintains its core identity: to offer a brief review of the professional identity, history, and standards of the counseling profession in a manner that is interesting and sometimes even fun. Enjoy!

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Designed to help bridge the gap between coursework and practice, the Helping Professions Learning Center (HPLC) offers a centralized online resource that allows students to build their skills and gain even more confidence and familiarity with the principles that govern the life of the helping professional. The interactive site consists of the following learning components: video activities organized by curriculum area and accompanied by critical thinking questions; ethics-, diversity-, and theory-based case studies; flashcards and practice quizzes; a professional development center; and a research and writing center.

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Although there is just one author of this book, the team that goes into developing it is many. First, there are a number of individuals from Cengage Learning that help. Julie Martinez, Product Manager, is particularly supportive of me and also has given me ideas

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A good text has thorough reviewers who can point out problems and suggest revisions. In this case, we had a number of faculty who helped with this lastest revision, including Aimee Adams—Lehigh University, Alan Basham—Eastern Washington University, Nancy Forth—University of Central Missouri, Johanna Garrison—WITC-Superior, Jonathan Lent—Marshall University, Cheryl Neale-McFall—West Chester University, Rebecca Rudd—Eastern Washington University, and Tiffany Stewart—Midwestern State University.

Final Thoughts

This book is streamlined and covers the most essential elements needed to help you build your professional identity and to assist you on your journey to becoming a professional counselor. It is filled with critical information that is known by only a chosen few—those who become counselors! The knowledge in this book makes us special and gives us a sense of purpose. Throughout the book you will find short exercises and some vignettes to highlight points. These are meant to be interesting, fun, and placed in the text to expand your knowledge base. My hope is that by the time you finish this book, you will be a changed person in the sense that you will have crossed over into the world of the counselor and have a new and important professional identity and affiliation.



PROFESSIONAL IDENTITY OF THE COUNSELOR

SECTION 1

This first section of the text describes the professional identity of the counselor. Although professional identity can be described in multiple ways, in these chapters we zero in on the kinds of degrees obtained and specialty areas focused upon by counselors, define the word *counseling,* highlight the purposes of professional associations, identify the professional associations of counselors, list credentials of counselors, and note the kinds of accreditation processes in the counseling field. In addition, to contrast the counselor with other professionals in the mental health field, we briefly identify related mental health professions and list their types of credentials and accreditation processes. Finally, to gain a perspective on the qualities that most counselors view as critical to a successful counseling relationship, we delineate nine personal and professional characteristics that lead toward counselor effectiveness.

What Is Counseling and Who Is the Counselor?

CHAPTER 1

LEARNING OBJECTIVES

LO 1 Define counseling and distinguish it from guidance and from psychotherapy.

LO 2 Examine similarities and differences between counselors and related mental health professionals on a variety of attributes, including education, accreditation, credentialing, and more.

LO 2a Identify and describe the different types of counselors, including school counselors; clinical mental health counselors; marriage, couple, and family counselors; addiction counselors; career counselors; college counselors and student affairs professionals; clinical rehabilitation counselors; and pastoral counselors.

LO 2b Identify and describe related mental health professionals, including social workers, psychologists, psychiatrists, psychoanalysts, psychiatric-mental health nurses, creative and expressive therapists, human service professionals, and psychotherapists.

LO 3 Provide an overview of the various types of counselors and related mental health professionals discussed in the chapter.

> *… counseling has proven to be a difficult concept to explain. The public's lack of clarity is due, in part, to the proliferation of modern-day services that have adopted the counselor label. They range from credit counselors to investment counselors, and from camp counselors to retirement counselors. Although their services share the common ingredient of verbal communication and possibly the intention to be helpful, those services have little in common with … [psychological counseling].*
>
> *(Hackney & Cormier, 2013, p. 2)*

How come when I tell people I am a counselor, they often seem to look at me sideways—as if they are asking me to repeat what I said? Maybe it's because they are ill-informed about counselors, or maybe it's because there are so many different types of counselors (e.g., school, mental health, rehabilitation, college, and

so forth). Perhaps it's because some people view the word *counselor* generically—a word that encompasses a number of mental health professionals such as psychologists, social workers, or human service professionals. Whatever the reason, I know that as a counselor my identity is unique and different from those of other related professionals. This chapter will help us define counseling, describe who the counselor is, and distinguish counselors from related mental health professionals.

LO 1

Defining Counseling

When I hear the word **counseling***, I think of the following: "facilitative, here-and-now, short-term, change, problem-solving, being heard, and awareness." Distinguish this from the word **psychotherapy**, which I associate with "deep, dark, secretive, sexual, unconscious, pain, hidden, long-term, and reconstructive." And lastly, the word **guidance** makes me think of "advice-giving, direction, on-the-surface, advocacy, and support." However, not all people make similar distinctions. In fact, over the years some have suggested counseling could be anything from a problem-solving, directive, and rational approach to helping "normal" people—an approach that is distinguishable from psychotherapy (Williamson, 1950, 1958); to a process that is similar to but less intensive than psychotherapy (Nugent & Jones, 2009); to an approach that suggests there is no essential difference between the two (Corey, 2013; Neukrug, 2015).

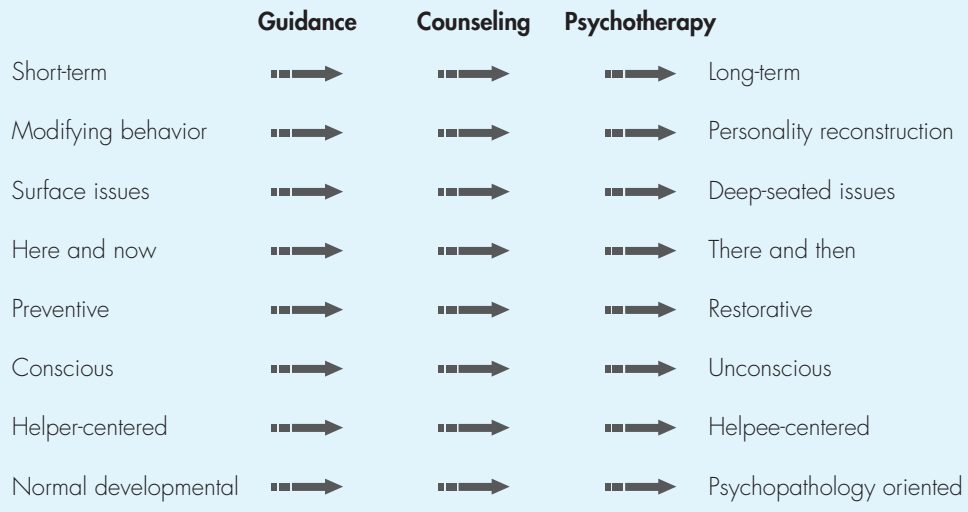
Some confusion in distinguishing counseling from guidance and psychotherapy rests in the related history of the three words. The word guidance first appeared around the 1600s and was defined as "the process of guiding an individual." Early guidance work involved individuals acting as moral compasses and giving advice. This definition continued into the twentieth century when vocational guidance counselors used the word to describe the act of "guiding" an individual into a profession and offering suggestions for life skills. Meanwhile, with the development of psychoanalysis near the end of the nineteenth century came the word *psychotherapy*. Derived from the Greek words *psyche*, which means spirit or soul, and *therapeutikos*, which means caring for another, psychotherapy literally translates to "caring for the soul" (Kleinke, 1994).

During the early part of the twentieth century, vocational guidance counselors became increasingly dissatisfied with the word guidance and its heavy emphasis on advice giving and morality. Consequently, the word counseling was adopted to indicate that vocational counselors, like their distant cousins the psychoanalysts who practiced psychotherapy, also dealt with social and emotional issues and were not strictly advice givers. As mental health workers became more prevalent during the mid-1900s, they too adopted the word *counseling*, rather than use the word *guidance* with its moralistic implications, or *psychotherapy*, which was increasingly associated with psychoanalysis. Tyler (1969) noted that "those who participated in the mental health movement and had no connection with vocational guidance used the word counseling to refer to what others were calling [psycho]therapy …" (p. 12).

Today, most lay people, many counseling students, and a fair number of counselor educators view some counselors and related mental health professionals as practicing what traditionally have been called guidance activities, others as conducting counseling, and still others as doing psychotherapy (see Figure 1.1). And perhaps they are right. For example, many school counselors probably use techniques that place them on the

*Words in bold are listed at the end of every chapter and are defined in the glossary.

FIGURE 1.1 Guidance, Counseling, and Psychotherapy Continuum



left of the continuum in Figure 1.1, while a fair number of clinical mental health counselors likely use skills that place them on the right side of the figure. Where do you think rehabilitation counselors, college counselors, pastoral counselors, and addiction counselors might fall? And what about social workers and counseling and clinical psychologists? Where do you think they fall?

Despite the fact that different kinds of counselors sometimes practice in different ways, their training is remarkably similar. In fact, it has always been argued that a person with a master's degree in counseling is primarily a **counselor** and secondarily a school counselor, clinical mental health counselor, college counselor, or other type of counseling specialist (Shallcross, 2013). Thus, in an effort to unify the many counseling specialty areas, 29 counseling organizations endorsed a broad-based definition of counseling that most counselors could embrace:

> *Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. (Kaplan, Tarvydas, & Gladding, 2014, p. 366)*

This definition places us under one umbrella—where we all are counselors, practicing counseling, and empowering our clients to accomplish their "mental health, wellness, education, and career goals." Now that we have defined the word *counseling*, this chapter will start us on our journey of examining the counseling profession, distinguishing counseling specialty areas from one another, and differentiating the counseling profession from related mental health professions (see Activity 1.1).

Activity 1.1 Defining Counseling

Are you satisfied with the definition above? Come up with your own definition of *counseling*. Consider doing the same for the words *guidance* and *psychotherapy*.

LO 2

Counselors and Related Mental Health Professionals†

Although we tend to find a fair amount of overlap in the ways that various mental health professionals learn their skills, there also exist huge differences (Kottler & Shepard, 2015; Neukrug, 2016; Urofosky, 2013). This section of the chapter will first describe the kinds of degrees, credentials, and professional associations associated with counselors, including school counselors; clinical mental health counselors; marriage, couple, and family counselors; addiction counselors; college counselors and student affairs professionals; rehabilitation counselors; and pastoral counselors. Then we will offer brief descriptions of related mental health professionals including social workers, psychologists (clinical, counseling, and school), psychiatrists, psychoanalysts, psychiatric-mental health nurses, creative and expressive therapists, human service professionals, and psychotherapists. Table 1.1, which compares counselors and related mental health professions, will conclude the chapter.

Chapter 2 will go on to further describe the professional identities of counselors and related professionals by describing their professional associations. In Chapter 2, we will pay particular attention to the **American Counseling Association (ACA)** and its divisions, all of which represent the major counseling associations to which counselors belong. Prior to moving on in this chapter, you might want to complete Activity 1.2.

Activity 1.2 Comparing Mental Health Professionals

Prior to reading this section, compare school counselors; clinical mental health counselors; college counselors and student affairs professionals; addiction counselors; career counselors; rehabilitation counselors; and marriage, couple, and family counselors on each of the criteria below. When you have finished, do the same with related mental health professions (e.g., psychologists, social workers, psychotherapists, psychiatrists, and so forth). Based on your responses, discuss your current level of knowledge of these professions.

	Education	Accreditation	Credentials	Professional Associations	Amount Earned
Type of Counselor					

LO 2a

Counselors

In the past, the word **counselor** referred to any mental health professional who practiced counseling (Chaplin, 1975). However, today, counselors are generally seen as those who hold a master's degree in counseling. Today, we find a wide variety of counselors, such as school counselors, college counselors, mental health counselors, counselors in private practice, pastoral counselors, rehabilitation counselors, counselors in business and industry, and more. The counselor's training is broad and includes expertise in individual, group, and family counseling; administering and interpreting educational and psychological assessments; offering career counseling; administering grants and conducting research; consulting on a broad range of educational and psychological matters; supervising others; and presenting developmentally appropriate psychoeducational activities

†See Appendix A for a list of professional associations and their web addresses.

for individuals of all ages. Although not all counselors have in-depth expertise in psychopathology, they all have knowledge of mental disorders and know when to refer individuals who might need more in-depth treatment.

Today, counselors tend to have had coursework in common areas defined by the **Council for Accreditation of Counseling and Related Educational Programs (CACREP**, 2014a), the program accreditation body for most counseling programs. Although not all programs are CACREP accredited, most follow their guidelines. These include knowledge in the following eight content areas (for more details, see Chapter 7):

1. Professional counseling orientation and ethical practice
2. Social and cultural diversity
3. Human growth and development
4. Career development
5. Counseling and helping relationship
6. Group counseling and group work
7. Assessment and testing
8. Research and program evaluation

In addition to the eight content areas, a counselor has taken coursework in a counseling specialty area, such as clinical mental health counseling, school counseling, college counseling and student affairs, and others. Such classes usually include content in the history, roles and functions, and knowledge and skills of that specialty area. Finally, all counselors have had the opportunity to practice their acquired skills and knowledge at field placements, such as a practicum or internship.

Master's level counseling programs accredited by CACREP include programs in **school counseling**; **clinical mental health counseling**; **marriage, couple, and family counseling**; **addiction counseling**; **career counseling**; and **college counseling and student affairs**. Currently, CACREP requires 60 credit semester hours for clinical mental health counseling; marriage, couple, and family counseling, and addiction counseling. The other programs currently require a minimum of 48 semester credit hours. However, beginning July of 2020, all master's level programs will require a minimum of 60 semester credit hours

In addition, to the above programs, there is a 48-credit **rehabilitation counseling** program accreditation that is administered through the **Council on Rehabilitation Education (CORE)**, as well as a new, 60-credit **clinical rehabilitation counseling** accreditation process that is jointly administered by CORE and CACREP. CORE and CACREP recently signed a planned merger agreement, and in July of 2017, CACREP will administer all of the rehabilitation counseling programs (CACREP, 2014b, n.d.a).

A master's level counselor can become a **National Certified Counselor (NCC)** by passing the **National Counselor Exam (NCE)** offered by the **National Board for Certified Counselors (NBCC)** (NBCC, 2015a). Students who are matriculated in CACREP-accredited programs can take the exam prior to graduating, and become certified upon passing the exam and graduating from their program, while others have to obtain post-master's clinical experience (NBCC, 2015a, 2015b). NBCC also offers subspecialty certifications as a **Certified Clinical Mental Health Counselor (CCMHC)**, **National Certified School Counselor (NCSC)**, and **Master Addictions Counselor (MAC)**. In addition, today all 50 states, Guam, Puerto Rico, and the District of Columbia have established licensing laws that allow a counselor who has a master's degree, additional training, and supervision to practice as a **Licensed Professional Counselor (LPC)** (some states use a

different, but similar term) (ACA, 2011; 2015a). Whereas certification is generally seen as mastery of a content area, licensure allows counselors to practice independently and obtain **third-party reimbursement** for their practice. (An in-depth discussion of credentialing can be found in Chapter 8.) The American Counseling Association (ACA), and its 20 divisions, focus on a variety of counseling concerns and are the major professional associations for counselors (see Chapter 2).

The following describes the most common types of master's level counselors, including school counselors; clinical mental health counselors; marriage, couple, and family counselors; addiction counselors; career counselors; college counselors and student affairs professionals; rehabilitation counselors; and pastoral counselors.

School Counselors.

School counselors have received their master's degrees in counseling with a specialty in school counseling. Some states credential school counselors on the elementary, middle, and secondary levels, while other states offer credentialing that covers kindergarten through 12th grade (K–12). The professional association for school counselors is the **American School Counselor Association (ASCA)**, which is a division of ACA, although one can become a member of ASCA without joining ACA. In recent years, the **ASCA National Model** has been used as a model for the training of school counselors (ASCA, 2012). In addition, over the past few decades, there has been a push by professional training programs, professional associations, and many in the field to replace the term **guidance counselor** with **school counselor**, as the latter term is seen as de-emphasizing the guidance activities of the school counselor (Baker & Gerler, 2008).

School counselors are certified or licensed by their state boards of education, usually directly after having graduated from a state-approved school counseling program. If they so choose, school counselors can also become National Certified Counselors (NCCs), National Certified School Counselors (NCSCs), certification as a school counselor by the National Board for Professional Teaching Standards (NBPTS), and, in most states, with additional coursework and supervision, Licensed Professional Counselors (LPCs) (ASCA, 2015; NBCC, 2015b). Other certifications are also available if the school counselor chooses to specialize (e.g., addiction counseling, etc.).

Clinical Mental Health Counselors (Agency Counselors).

Clinical mental health counselors are individuals who have obtained their degrees in clinical mental health counseling, or a closely related degree in counseling (e.g., agency counseling). Those who obtain a degree in clinical mental health counseling, or related degrees, are generally trained to conduct counseling for those who are struggling with life problems, emotional issues, or mental health disorders. They are usually found working in a wide variety of agencies or, in private practice, conducting counseling and psychotherapy.

The clinical mental health counselors' professional association is the **American Mental Health Counselors Association (AMHCA)**, which is a division of ACA, although one can now be a member of AMHCA without joining ACA. If they so choose, clinical mental health counselors can become NCCs and LPCs. Other certifications are also available if the clinical mental health counselor chooses to specialize (e.g., Certified Clinical Mental Health Counselor [CCMHC], Master Addictions Counselor [MAC], and more) (NBCC, 2015b).

Marriage, Couple, and Family Counselors.

Marriage, couple, and family counselors are specifically trained to work with couples and with families and can be found in a vast array of agency settings and in private practice. These counselors tend to have specialty coursework in systems dynamics, couples counseling, family therapy,

family life stages, and human sexuality, along with the more traditional coursework in the helping professions. The **International Association of Marriage and Family Counselors (IAMFC)**, a division of ACA, is one professional association these counselors can join; another is the **American Association of Marriage and Family Therapy (AAMFT)**. These days, one can join IAMFC without joining ACA.

Although all 50 states and the District of Columbia have some requirement for marriage and family licensure, the requirements can vary dramatically (Association of Marital and Family Therapy Regulatory Boards [AMFTRB], 2015). Generally, these individuals have the title **Licensed Marriage and Family Therapist (LMFT)**, or something similar. While some states license marriage and family counselors who have studied from programs that follow the 60 semester credit CACREP guidelines, other states prefer licensing counselors who have studied from programs that follow the guidelines set forth by AAMFT's **Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)**, and still others have set their own curriculum guidelines for credentialing. Most states that offer marriage and family counselor credentialing allow related licensed helping professionals (e.g., licensed professional counselors, licensed clinical social workers, licensed psychologists) to also practice marriage and family counseling as long as they have some expertise in this area. Often, couple, marriage, and family counselors can become NCCs, LPCs, and obtain other specialty certifications, if they so choose.

Addiction Counselors.

Addiction counselors study a wide range of addiction disorders, such as substance abuse (drugs and alcohol), eating disorders, and sexual addiction. They are familiar with diagnosis and treatment planning and understand the importance of psychopharmacology in working with these populations. Many addiction counselors can become certified through their state. In addition, NBCC offers a certification as a Master Addictions Counselor (MAC) (NBCC, 2015b). Often addiction counselors can become NCCs, LPCs, and obtain other specialty certifications, if they so choose. In addition to AMHCA, addiction counselors often belong to the **International Association of Addictions and Offender Counselors (IAAOC)**, which is also a division of ACA.

Career Counselors.

Career counselors focus on vocational and **career counseling** and may work in a variety of settings, including private practice, vocational rehabilitation settings, college career centers or counseling centers, schools, and in some agencies. Career counselors often join the **National Career Development Association (NCDA)** and/or the **National Employment Counseling Association (NECA)**, both divisions of ACA. Like most other counselors, career counselors can become NCCs, LPCs, or obtain other specialty certifications.

College Counselors and Student Affairs Professionals.

Sometimes referred to as postsecondary counselors, these **college counselors and student affairs professionals** work in a variety of settings in higher education including college counseling centers, offices of educational accessibility, career centers, residence life, advising, multicultural student services, and other campus settings where counseling-related activities occur. Usually, college counselors and student affairs professionals will have taken specialty coursework in college student development and student affairs practices.

Often counselors who work in college settings can become NCCs, LPCs, and obtain other specialty certifications (e.g., MAC), if they so choose. There are two main

professional associations of counselors in higher education settings: **College Student Educators International** (this organization was formerly the American College Personnel Association and has kept the acronym ACPA), which tends to focus on administration of student services, and the **American College Counseling Association (ACCA)**, which is a division of ACA and tends to focus on counseling issues in college settings. Today, one can join ACCA without joining ACA.

Rehabilitation and Clinical Rehabilitation Counselors.

Rehabilitation counselors and **clinical rehabilitation counselors** offer a wide range of services to people with physical, emotional, and/or developmental disabilities. As noted earlier, currently CORE and CACREP both accredit rehabilitation counseling programs and CACREP will be accrediting all such programs starting in 2017 (CACREP, 2014b, n.d.a).

Both CORE and CACREP accredited rehabilitation counseling programs include coursework on vocational evaluation, occupational analysis, medical and psychosocial aspects of disability, legal and ethical issues in rehabilitation, and the history of rehabilitation counseling. The **Commission on Rehabilitation Counselor Certification (CRCC)** credentials rehabilitation counselors as **Certified Rehabilitation Counselors (CRCs)**, and rehabilitation counselors can usually obtain other related credentials, if they so choose (e.g., NCC, LPC, MAC). Many rehabilitation counselors join the **National Rehabilitation Counseling Association (NRCA)** and/or the **American Rehabilitation Counseling Association (ARCA)**, a division of ACA. Today, one can join ARCA without joining ACA.

Pastoral Counselors.

Pastoral counselors sometimes have a degree in counseling but can also have a degree in a related social service field or even just a master's degree in religion or divinity. Pastoral counselors sometimes work in private practice or within a religious organization. Pastoral counselors, religious counselors, or counselors with spiritual orientations might join the **Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)**, a division of ACA, and/or the **American Association of Pastoral Counselors (AAPC)**. AAPC offers a certification process for those who are interested in becoming Certified Pastoral Counselors (CPCs) (AAPC, 2005–2012a), and pastoral counselors who have a master's degree in counseling can often go on to obtain certification as pastoral counselors and may be eligible to become LPCs or NCCs.

LO 2b Related Mental Health Professionals

Counselors work closely with many other mental health professionals, and although a counselor's training is somewhat different, all mental health professionals have the same basic goal: to help individuals with their psychosocial concerns and problems. The following describes the most common kinds of other mental health professionals you may someday find yourself working next to.

Social Workers.

Although the term **social worker** can apply to those who have an undergraduate or a graduate degree in social work or a related field (e.g., human services), more recently the term has become associated with those who have acquired a **master's degree in social work (MSW)**. Historically found working with the underprivileged, with families, and within social systems, today's social workers provide counseling

and psychotherapy for all types of clients in a wide variety of settings, including "public agencies, private businesses, hospitals, clinics, schools, nursing homes, private practices, police departments, courts," and more (NASW, "About the Profession," 2015a, para. 1). Social workers usually have extensive training in counseling techniques but less preparation in career counseling, assessment techniques, and quantitative research methods.

With additional training and supervision, social workers can become nationally certified by the **Academy of Certified Social Workers (ACSW)**. In addition, all states have specific requirements for becoming a **Licensed Clinical Social Worker (LCSW)**. Two other, more advanced credentials include the **Qualified Clinical Social Worker (QCSW)** and the **Diplomate in Clinical Social Work (DCSW)** (NASW, 2015b). Social work programs are accredited by the **Council on Social Work Education (CSWE)**, and the professional association for social workers is the **National Association of Social Workers (NASW)**.

Psychologists.

The American Psychological Association (APA, 2015a) has identified as many as 19 different types of **psychologists** that practice in a wide range of settings, including public and private agencies, hospitals, private practice, health maintenance organizations, universities, business and industry, law enforcement, schools, private practice, and more. Psychologists are often found in administrative and/or clinical roles in agencies, leading research teams, consulting with business and industry, or serving in supervisory roles for all types of mental health professionals.

Of the 19 types of psychologists, generally three are identified as those who practice counseling and psychotherapy: **counseling psychologists**, **clinical psychologists**, and **school psychologists**. Today, all states offer licensure in counseling psychology, clinical psychology, or both, and many states allow individuals with a Psy.D., a practitioner doctorate in psychology, to become licensed as clinical or counseling psychologists. School psychologists are credentialed by state boards of education and can also become certified as **Nationally Certified School Psychologists (NCSP)**. The **APA Commission on Accreditation (APA-CoA)** accredits psychology programs, and APA is the professional association for psychologists. Counselors are likely to have more contact with clinical and counseling psychologists and with school psychologists than with other types of psychologists. These specialty areas are described next.

Clinical Psychologists, Counseling Psychologists, and Doctorates in Psychology (Psy.D.)

Clinical and counseling psychologists tend to have a particularly strong background in research and practice and work with a wide range of clients. Historically, clinical psychologists have focused somewhat more on psychopathology and individuals with chronic mental health problems (APA, 2015a), although these differences have lessened over the years. The **Psy.D.**, a degree established in 1973, tends to have a stronger clinical focus, although less of a research focus, than either of Ph.Ds. In addition to obtaining the doctorate from an APA-accredited program in one of the three above areas, to become a **licensed counseling psychologist** or **licensed clinical psychologist** requires extensive post-doctoral supervised experience and the passing of a national licensing exam, although passing scores vary by state. Today, many states offer hospital privileges for licensed psychologists, which afford psychologists the right to treat those who have been hospitalized with serious mental illness. Not surprisingly, psychologists have recently sought, with very limited success, the right to prescribe medication for emotional disorders (Rinaldi, 2013). Graduates with these degrees will often join

Division 12 of the APA (the Society of Clinical Psychology) or **Division 17 of the APA (the Society of Counseling Psychology)**.

School Psychologists. School psychologists have a master's degree or more in school psychology and are licensed by state boards of education. Their work focuses on improving the lives of children and families, usually within the schooling process. Their training tends to focus on consultation, evaluation and assessment, intervention, prevention, crisis preparedness, instructional support, and research and planning (National Association of School Psychologists [NASP], 2014). Many school psychologists today are found working with students with learning problems, their parents, and their teachers. Although most school psychologists work in schools, you can sometimes also find them in private practice, in agencies, and in hospital settings. The professional associations for school psychologists are the **National Association of School Psychologists (NASP)** and **Division 16 of the APA (School Psychology)**.

Psychiatrists. Generally, a **psychiatrist** is a licensed physician who has completed a residency in psychiatry, meaning that in addition to medical school, he or she has completed extensive field placement training in a mental health setting. In addition, most psychiatrists have passed an exam to become board certified in psychiatry. Being a physician, the psychiatrist has expertise in diagnosing organic disorders, identifying and treating psychopathology, and prescribing medication for psychiatric conditions. Although a limited number of states and some federal agencies have granted psychologists prescription privileges for psychotropic medication (Rinaldi, 2013), currently it is psychiatrists, and in some cases psychiatric nurses, who take the lead in this important treatment approach.

Because psychiatrists often have minimal training in techniques of individual and group counseling, assessment techniques, human development, and career counseling, they are sometimes not seen as experts in the delivery of counseling and psychotherapeutic services. Psychiatrists are employed in mental health agencies, hospitals, private practice settings, and health maintenance organizations. The professional association for psychiatrists is the **American Psychiatric Association (APA)**.

Psychoanalysts. **Psychoanalysts** are professionals who have received training in psychoanalysis from any of a number of recognized psychoanalytical institutes. Although, in past years, the **American Psychoanalytic Association (APsaA)**, the professional association of psychoanalysts, would only endorse psychiatrists for training at psychoanalytical institutes (Turkington, 1985), they now allow other mental health professionals to undergo such training (APsaA, 2014). Because states do not tend to license psychoanalysts, clients who are seeing a psychoanalyst should make sure that the analyst was trained at an institute sanctioned by the American Psychoanalytic Association and that he or she has a license in a mental health field (e.g., psychiatrist, psychologist, licensed professional counselor, or licensed clinical social worker). The **American Board for Accreditation in Psychoanalysis (ABAP)** accredits psychoanalytic institutes.

Psychiatric-Mental Health Nurses. Primarily trained as medical professionals, **psychiatric-mental health nurses (PMHNs)** are also skilled in the delivery of mental health services (American Psychiatric Nurses Association [APNA], 2015). Most PMHNs work in hospital settings, with fewer numbers working in community agencies, private practice, and educational settings. Psychiatric-mental health nursing is practiced

at two levels. The **Registered Nurse-PMHN** does basic mental health work related to nursing diagnosis and nursing care. The **Advanced Practice Registered Nurse (APRN)** has a master's degree in psychiatric-mental health nursing and assesses, diagnoses, and treats individuals with mental health problems. Currently holding prescriptive privileges in all 50 states (Von Gizycki, 2013), APRNs provide an important service in many mental health settings. Because of their training in both medicine and basic counseling skills, the RN-PMHN and the APRN hold a unique position in the mental health profession. Psychiatric-mental health nurses can acquire certification in a number of mental health areas based on their education and experience (see American Nurses Credentialing Center, 2014). The professional association of psychiatric-mental health nurses is the **American Psychiatric Nurses Association (APNA)**. The **American Association of Colleges of Nursing (AACN)** and the **National League for Nursing** accredit psychiatric-mental health nursing programs.

Creative and Expressive Therapists.

Creative and expressive therapists include art therapists, play therapists, dance/movement therapists, poetry therapists, music therapists, and others who use creative tools to work with individuals who experience trauma or emotional problems in their lives (Deaver, 2015). Through the use of expressive therapies, it is hoped that individuals can gain a deeper understanding of themselves and work through some of their symptoms. Creative and expressive therapists work with individuals of all ages and do individual, group, and family counseling. They work in many settings and are often hired specifically for their ability to reach individuals through a medium other than language. Many creative and expressive therapists obtain degrees in counseling or social work and later pick up additional coursework in creative and expressive therapy. However, there are programs that offer curricula in creative and expressive therapies, such as those approved by the **American Art Therapy Association (AATA)**. Other related associations include the **Association for Creativity in Counseling (ACC)**, a division of ACA; the **American Dance Therapy Association (ADTA)**; the **American Music Therapy Association (AMTA)**; and the **Association for Play Therapy (APT)**. Although certifications exist for some kinds of creative and expressive therapies (e.g., see Art Therapy Credentials Board, 2015), states generally do not license creative and expressive therapists. However, some creative and expressive therapists can become licensed if their degree is in a field credentialed by the state (e.g., counseling or social work) or if the state licensing board of the therapist allows the individual to take additional courses so that their coursework matches the curriculum requirements of the existing state licenses (see American Association of State Counseling Boards, 2015a).

Human Service Professionals.

Human service professionals have generally obtained an associate's or bachelor's degree in human services. These programs are accredited by the **Council for Standards in Human Service Education (CSHSE)**, which sets specific curriculum guidelines for the development of human service programs. Individuals who hold these degrees are often found in entry-level support and counseling jobs and serve an important role in assisting counselors and other mental health professionals. The professional organization for human services is the **National Organization of Human Services** (NOHS, 2015a). Recently, the **Center for Credentialing and Education (CCE)**, in consultation with CSHSE and NOHS, created a certification in human services called the **Human Services Board Certified Practitioner (HS-BCP)** (Hinkle & O'Brien, 2010; Sparkman & Neukrug, 2014).

Psychotherapists. Because the word **psychotherapist** is not associated with any particular field of mental health practice, most states do not offer legislation that would create a license for "psychotherapists." One result of this lack of legislation is that in most states, individuals who have no mental health training can call themselves psychotherapists. However, legislatures generally limit the scope of psychotherapeutic practice to those individuals who are licensed mental health professionals within the state (e.g., psychologists, LPCs, LCSWs). The bottom line is that in most states anyone can claim to be a psychotherapist, but only licensed practitioners can practice psychotherapy.

LO 3

Overview of Counselors and Related Mental Health Professionals

There are many different kinds of counselors and a variety of mental health professionals. Although we sometimes find ourselves pitted against each other as we vie for similar jobs or try to obtain our share of third-party reimbursements, we all serve a similar purpose—to help individuals with their mental health concerns. And, although our training is different in many ways, we probably share more similarities than differences. Table 1.1 provides an overview of the chapter and lists some of the different degrees, accrediting bodies, and credentials that one can obtain in the varying mental health professions.

TABLE 1.1 Comparing the Varying Mental Health Professionals

Professional	Degree	Accrediting Body*	Most Common Credential**
Counselor School counselor	Master's in counseling	CACREP	State board of education credential\NCC\National Certified School Counselor
Clinical mental health counselor	Master's in counseling	CACREP	LPC\NCC\Certified Clinical Mental Health Counselor (CCMHC)
Marriage, couple, and family counselor	Master's in counseling or couples and family therapy	CACREP COAMFTE	LMFT\LPC\NCC
Addiction counselor	Master's in counseling	CACREP	MAC\LPC\NCC
Career counselors	Master's in counseling	CACREP	LPC\NCC
College counselors and student affairs professionals	Master's in counseling	CACREP	LPC\NCC
Rehabilitation counselor/Clinical Rehabilitation Counselor	Master's in counseling	CORE and CACREP	CRC\LPC\NCC
Pastoral counselor	Master's in counseling, related field, or religion/spirituality	None	LPC\NCC (if degree is in counseling)
Social Worker	Master's in social work	Council on Social Work Education	ACSW\LSCW\QCSW\DCSW

Professional	Degree	Accrediting Body*	Most Common Credential**
Psychologist Clinical	Doctorate in psychology	Commission on Accreditation of the American Psychological Association	Licensed psychologist
Counseling	Doctorate in psychology	Commission on Accreditation of the American Psychological Association	Licensed psychologist
School	Master's or more in psychology	Commission on Accreditation of the American Psychological Association	State board of education credential\ National Certified School Psychologist (NCSP)
Psychiatrist	Medical degree	Association of American Medical Colleges	Licensed physician\Board certification in psychiatry
Psychoanalyst	Graduate degree in helping profession	American Board for Accreditation in Psychoanalysis (ABAP)	Credential in specific mental health profession (e.g., LPC\ LMFT\ Licensed psychologist)
Psychiatric-Mental Health Nurse	Bachelor's or master's degree in psychiatric-mental health nursing	American Association of Colleges of Nursing (AACN) and the National League for Nursing	Advanced Practice Registered Nurse (APRN)
Creative and Expressive Therapist	Usually, master's degree in helping profession	No broad-based accreditation; some accreditation in specific expressive therapy areas	Registered Art Therapis (ATR). Can become credentialed in many states (e.g., LPC)
Human Service Professional	Associate's or bachelor's in human services	Council on Human Service Education (CHSE)	Human Services Board Certified Practitioner (HS-BCP)
Psychotherapist	No degree needed	None	None

* For additional information on accreditation, see Chapter 7. For additional information on credentialing, see Chapter 8.
** Many professionals can obtain additional credentials. For instance, with experience, most counselors can become Certified Clinical Mental Health Counselors (CMHCs), Master Addictions Counselors (MACs), and Licensed Professional Counselors (LPCs) and obtain state-specific certifications. For additional information on credentialing, see Chapter 8.

Case Study 1.1 Carla

Carla is a new student in the counseling program. She always hoped to be a counselor but wasn't sure whether she wanted to be a school counselor or clinical mental health counselor. After taking her first course, she realizes that her definition of counseling was very different than the definition given to her in her class. In fact, she thought that counseling was almost always advice giving, directive, helper-centered, and mostly "here and now" issues. She now realizes that some counselors practice more in-depth counseling and that all counselors will work with clients who have severe mental health problems at some point at their job. Although she felt confident before that she could learn the skills needed to be a counselor, she now wonders if she has the ability to work with clients who have severe emotional issues. She is now pondering whether she has picked the right profession and is considering switching to a social work program. She is distressed because she thinks her lifelong dream may have been shattered.

1. Do you think that Carla can find a place for herself in the counseling field? Why or why not?
2. Do you believe that the social work field would be a better fit for her? Why or why not?
3. Based on what you currently know of Carla, what counseling specialty is likely to fit her best? Why?

4. Do you think Carla has the ability to master the skills that will allow her to work with clients who have severe emotional disorders? If yes, how would that come about? If no, would it be good enough for Carla to refer the more difficulty clients to other professionals?
5. Can you relate to Carla's dilemma in any way? How?

Summary

This chapter began by explaining the historical differences in the words *guidance, counseling,* and *psychotherapy* and then discussed their current common usage. We then noted that delegates from a number of counseling organizations came together in an effort to unify the counseling profession and to capture a common definition for the word counseling to which all would agree.

The chapter then went on to describe a number of mental health professionals. Starting with counselors, we explained the kinds of training counselors receive in CACREP-accredited programs and noted that CACREP accredits programs in school counseling; clinical mental health counseling; marriage, couple, and family counseling; addiction counseling; career counseling; college counseling and student affairs; and clinical rehabilitation counseling (with CORE). We then went on to offer descriptions of a number of different kinds of counselors, including school counselors; clinical mental health counselors; marriage, couple, and family counselors; addiction counselors; career counselors; college counselors and student affairs professionals; rehabilitation counselors; and pastoral counselors.

The rest of the chapter gave brief descriptions of related mental health professionals including social workers, psychologists (clinical, counseling, Psy.D., and school), psychiatrists, psychoanalysts, psychiatric-mental health nurses, creative and expressive therapists, human service professionals, and psychotherapists. The chapter concluded with a table that elucidated the different types of professionals, along with their degrees, accreditation bodies, and possible credentials to obtain.

Key Terms

Academy of Certified Social Workers (ACSW)
Addiction counseling
Addiction counselors
Advanced practice registered nurse (APRN)
American Art Therapy Association (AATA)
American Association of Colleges of Nursing (AACN)
American Association of Marriage and Family Therapy (AAMFT)
American Association of Pastoral Counselors (AAPC)
American Board for Accreditation in Psychoanalysis (ABAP)
American College Counseling Association (ACCA)
American Counseling Association (ACA)
American Dance Therapy Association (ADTA)
American Mental Health Counselors Association (AMHCA)

American Music Therapy Association (AMTA)
American Psychiatric Association (APA)
American Psychiatric Nurses Association (APNA)
American Psychoanalytic Association (APsaA)
American Rehabilitation Counseling Association (ARCA)
American School Counselor Association (ASCA)
APA Commission on Accreditation (APA-CoA)
ASCA National Model
Association for Creativity in Counseling (ACC)
Association for Play Therapy (APT)
Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)
Career counseling
Center for Credentialing and Education (CCE)
Certified Clinical Mental Health Counselor (CCMHC)
Certified Rehabilitation Counselors (CRCs)
Clinical mental health counseling
Clinical mental health counselors
Clinical psychologists
Clinical rehabilitation counseling
Clinical rehabilitation counselors
College counseling and student affairs
College counselors and student affairs professionals
College Student Educators International
Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
Commission on Rehabilitation Counselor Certification (CRCC)
Council for Accreditation of Counseling and Related Educational Programs (CACREP)
Council for Standards in Human Service Education (CSHSE)
Council on Rehabilitation Education (CORE)
Council on Social Work Education (CSWE)
Counseling
Counseling psychologists
Diplomate in Clinical Social Work (DCSW)
Division 12 of the APA (the Society of Clinical Psychology)
Division 16 of the APA (School Psychology)
Division 17 of the APA (the Society of Counseling Psychology)
Creative and expressive therapists
Guidance
Guidance counselor
Human service professional
Human Services Board Certified Practitioner (HS-BCP)
International Association of Addictions and Offender Counselors (IAAOC)
International Association of Marriage and Family Counselors (IAMFC)
Licensed clinical psychologist
Licensed Clinical Social Worker (LCSW)
Licensed counseling psychologist
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselor (LPC)
Licensed psychologist
Marriage, couple, and family counseling
Marriage, couple, and family counselors
Master Addictions Counselor (MAC)
Master's degree in social work (MSW)
National Association of School Psychologists (NASP)
National Association of Social Workers (NASW)
National Board for Certified Counselors (NBCC)
National Career Development Association (NCDA)
National Certified Counselor (NCC)
National Certified School Counselor (NCSC)
Nationally Certified School Psychologists (NCSP)
National Counselor Exam (NCE)
National Employment Counseling Association (NECA)

National League for Nursing
National Organization for Human Services (NOHS)
National Rehabilitation Counseling Association (NRCA)
Pastoral counselors
Psychiatric-mental health nurses (PMHNs)
Psychologist
Psychotherapist
Psychotherapy
Psy.D.
Qualified Clinical Social Worker (QCSW)
Rehabilitation counseling
Rehabilitation counselors
Registered Nurse-PMHN
School counseling
School counselors
School psychologists
Social worker
Third-party reimbursement

Professional Associations in Counseling and Related Fields

CHAPTER 2

LEARNING OBJECTIVES

LO 1 Delineate benefits that joining a professional association provide such as a sense of belonging, workshops and conferences, mentoring and networking, job fairs, lobbying, publications, standards, building your portfolio, scholarships and grants, offering wide range of services, and a place to become known.

LO 2 Review the many benefits of the American Counseling Association; highlight the 20 specialty branches; and become familiar with the many branches, partners, and associates to ACA such as NBCC, CACREP, ACAF, CSI, and CORE.

LO 3 Familiarize ourselves with some of the more prominent related mental health professional organizations which other professionals may be members of and which we may have contact with throughout our careers.

So, I've added it all up, and this year I've spent about $500 on professional memberships. I sometimes think that maybe I should give them up—save a little money. But reason always prevails. Despite the fact that students can obtain pretty low student membership rates, when I teach my classes, I often hear students complain about how much they cost. I try, usually successfully, to explain why it's important to belong. There are some fundamental reasons to join professional associations, despite their cost, and this chapter will highlight these and provide you with information about some of the different associations out there.

The chapter will begin by describing a number of purposes for professional associations. Then, we will describe, in some detail, the American Counseling Association (ACA), the benefits it offers, and its divisions, branches, regions, and professional partners. We will conclude the chapter with a brief overview of other professional associations in mental health fields.

LO 1

Importance of Professional Associations†

Therefore, by virtue of the authority vested in me by the Universitatus Committeeatum e plurbis unum, I hereby confer upon you the honorary degree of Th.D.… Yeah—that… that's Dr. of Thinkology! (The Wizard of Oz)

Our **professional associations** are our homes. They are where we go to learn, grow, and find friendship, collegiality, and mentoring. They are a place where we help others grow and learn, and they are a place where awards are conferred. Like the Wizard who bestows the diploma upon the Scarecrow who has shown his ability to think wisely, we have bestowed upon us awards by our professional associations when we have shown our colleagues our greatness. And each of us has greatness. We sometimes just need to find a place where it can shine. Our professional associations can allow us to shine brightly.

I find that new students entering the counseling profession generally have some vague sense of the purposes that professional associations serve. For instance, they often correctly assume that such organizations run a yearly conference, maybe publish a journal, and might be good for networking. Although these are three important reasons for the existence of professional associations, there are many more. For instance, professional organizations provide members with the following (Bourgeois, 2011; Johnson, 2012; Morrison, 2014):

- *A Sense of Belonging:* Professional associations provide us with a mechanism for being around others who share a similar values and understanding of the world and provide us with a sense of collegiality, support, and friendship.
- *Workshops and Conferences:* One major role of organizations is to provide local, regional, and national conferences so that we can learn new techniques and continue to offer innovative counseling services.
- *Mentoring and Networking Opportunities:* Mentoring and networking allows us to develop new friendships, find better ways of working with our clients, develop our research and scholarship, find individuals to teach and supervise us, and find new consulting and job opportunities.
- *Job Fairs:* Some conferences, especially the larger ones (e.g., ACA's national conference), have job fairs that enable individuals to apply and even interview for jobs at a conference.
- *Lobbying Efforts:* Professional organizations organize lobbying efforts that influence important policy issues. For instance, the expansion of school counseling to the middle and elementary levels, the licensing of counselors in all 50 states, and the increased parity that private practitioners have in third-party billing are the result of lobbying efforts. Where do organizations obtain the money to help in these efforts that serve each of our interests? From us, of course, when we pay our dues!
- *Scholarly Publications:* Whether it's a local professional organization's newsletter, a state-wide journal, a national magazine, or a national journal, our professional organizations provide publications to ensure we are keeping up with current trends. These publications are generally reviewed, edited, and put together by teams of volunteers who ensure they are worthwhile and innovative.

- *Standards in the Profession:* Professional organizations are critical in the development of professional standards. For instance, ACA developed the first ethical code for counselors during the early 1960s, embraced the **Multicultural Counseling Competencies** in the 1990s, and recently endorsed the **Advocacy Competencies.** ACA and other professional associations were also key to the development of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which accredits counseling programs, as well as the National Board for Certified Counselors (NBCC), which offers a number of credentials for counselors.
- *Ways to Build Your Professional Portfolio:* Professional organizations allow individuals to build their professional portfolios and develop areas of expertise. This occurs when members offer workshops, submit articles to professional publications, develop programs through the organization for national consumption (e.g., crisis counseling), volunteer for important professional development committees (e.g., revision of the ethical code), and, of course, list the organizational memberships on their résumés.
- *Scholarships and Grants:* Most professional organizations provide scholarships and grants: For example, some state organizations provide support for graduate students to come to their conferences, and some national organizations provide money for researchers to work on projects.
- *Awards:* If you work hard you are rewarded by being given an award. Who bestows the award? The professional organizations, through a careful selection process. Awards are symbols that what we have done, we have done well.
- *Needed Services for Members:* Many associations provide a wide-range of needed services for their individual members, including malpractice insurance, credit cards at reduced interest rates, legal services, consultation on ethical issues, and more.
- *A Place Where We Can Become Famous:* I went to teach one evening, and in my classroom was an environmental engineer instructor finishing up his class. I greeted him and quickly added that my brother, Howard Neukrug, was an environmental engineer. He said, "Oh, he's famous!" Later that evening I called my brother and told him the news! My brother said, "Yea, we're all famous in our own little worlds." What a gem of wisdom—which leads me to the last purpose of professional associations: They allow us to become famous. Professional associations provide places where people get to know who we are and how we work, and where we can be encouraged for our abilities. And, if we're lucky, perhaps we'll even get nominated for an award, become acknowledge, and yes, become famous within our own little world.

Now that you have reviewed a list of a few of the many benefits that most professional organizations offer, you might be wondering which organization you should belong to. Some of you may have already joined, or are thinking of joining, the American Counseling Association (ACA) and/or one of its divisions, such as the American School Counseling Association (ASCA) or the American Mental Health Counseling Association (AMHCA). To help you in your decision, the following offers a description of the American Counseling Association, its benefits, and its divisions, branches, regions, and professional partners. This is followed by short descriptions of other professional associations in the mental health field. As you read about the many organizations in our field, consider which ones would be important to you.

LO 2

The American Counseling Association

Although officially established in 1952, the beginnings of the **American Counseling Association (ACA)** can be traced back to the founding, in 1913, of the **National Vocational Guidance Association (NVGA)** (ACA, 2015b). After undergoing many changes of name and structure over the years, today's ACA is the world's largest counseling association. This 55,000-member not-for-profit association serves the needs of all types of counselors in an effort to "enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity" (ACA, 2015c, para. l).

Membership Benefits of ACA

Membership in ACA provides a number of unique opportunities and benefits,

- Subscriptions to the ***Journal of Counseling and Development,*** the monthly magazine ***Counseling Today,*** and to other professional journals based on division membership
- Professional development programs, such as conferences, online courses, free webinars and podcasts, and continuing education workshops
- Links to ACA's electronic mailing lists for graduate students (**COUNSGRADS**) and those interested in diversity issues (**Diverse grad-L**)
- A variety of discount and specialty programs (e.g., rental cars, auto insurance, hotels, discounts on book)
- Counseling resources, including books, ethical codes, DVDs, audio files, electronic news, and journals
- Links to ACA divisions and other relevant professional associations
- Supporting lobbying efforts at the local, state, and national levels
- Legislative updates and policy setting for counselors
- Consultation on ethical issues and ethical dilemmas
- Discounts on insurance, hotels, merchandise, etc.
- Links to ACA listservs and interest networks
- Networking and mentoring opportunities
- Computer-assisted job search services
- Professional liability insurance
- Graduate student scholarships
- A counselor directory

Divisions of ACA

ACA currently sponsors 20 divisions, all of which maintain newsletters, provide a wide variety of professional development activities, and publish at least one journal. Table 2.1 offers the name of each association, the year it was chartered, a brief purpose of the association, and the journal(s) the association publishes. Each division provides a number of specialized member benefits.

TABLE 2.1 ACA's Divisions

Acronym/ Chartered	Name	Purpose*	Name of Journal
AADA/1986	Association for Adult Development and Aging	"… serves as a focal point for information sharing, professional development, and advocacy related to adult development and aging issues; addresses counseling concerns across the lifespan."	*Adultspan*
AACE/1965	Association Assessment and Research in Counseling	"… to promote the effective use of assessment in the counseling profession."	*Measurement and Evaluation in Counseling and Development (MECD)* *Counseling Outcome Research and Evaluation (CORE)*
ACAC/2013	Association for Child and Adolescent Counseling	"… to promote greater awareness, advocacy, and understanding of diverse and creative approaches to counseling."	*Journal of Child and Adolescent Counseling*
ACC/2004	The Association for Creativity in Counseling	"… to promote greater awareness, advocacy, and understanding of diverse and creative approaches to counseling."	*Journal of Creativity Mental Health*
ACCA/1991	American College Counseling Association	"… to foster student development in colleges, universities, and community colleges."	*Journal of College Counseling*
ACES/1952	Association for Counselor Education and Supervision	"… emphasizes the need for quality education and supervision of counselors for all work settings."	*Counselor Education and Supervision*
ACH/1952	Association for Humanistic Counseling	"… provides a forum for the exchange of information about humanistically-oriented counseling practices and promotes changes that reflect the growing body of knowledge about humanistic principles applied to human development and potential."	*Journal of Humanistic Counseling*
ALGBTIC/1997	Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling	"Educates counselors to the unique needs of client identity development; and a non-threatening counseling environment by aiding in the reduction of stereotypical thinking and homoprejudice."	*Journal of LGBT Issues in Counseling*
AMCD/1972	Association for Multicultural Counseling and Development	"… strives to improve cultural, ethnic and racial empathy and understanding by programs to advance and sustain personal growth."	*Journal of Multicultural Counseling and Development*
AMHCA/1978	American Mental Health Counselors Association	"… represents mental health counselors, advocating for client access to quality services within the health care industry."	*Journal of Mental Health Counseling*
ARCA/1958	American Rehabilitation Counseling Association	"… enhancing the development of people with disabilities throughout their life span and in promoting excellence in the rehabilitation counseling profession's practice, research, consultation, and professional development."	*Rehabilitation Counseling Bulletin*

(*Continued*)

TABLE 2.1 (*Continued*)

Acronym/ Chartered	Name	Purpose*	Name of Journal
ASCA/1953	American School Counselor Association	"… promotes school counseling professionals and interest in activities that affect the personal, educational, and career development of students. ASCA members also work with parents, educators, and community members to provide a positive learning environment."	*Professional School Counseling*
ASERVIC/1974	Association for Spiritual, Ethical, and Religious Values in Counseling	"… devoted to professionals who believe that spiritual, ethical, religious, and other human values are essential to the full development of the person and to the discipline of counseling."	*Counseling and Values*
ASGW/1973	Association for Specialists in Group Work	"… provides professional leadership in the field of group work, establishes standards for professional training, and supports research and the dissemination of knowledge."	*Journal for Specialists in Group Work*
CSJ/2002	Counselors for Social Justice	"… seek equity and an end to oppression and injustice affecting clients, students, counselors, families, communities, schools, workplaces, governments, and other social and institutional systems."	*Journal for Social Action in Counseling and Psychology*
IAAOC/1974	International Association of Addictions and Offender Counselors	"… advocate the development of effective counseling and rehabilitation programs for people with substance abuse problems, other addictions, and adult and/or juvenile public offenders."	*The Journal of Addictions and Offender Counseling*
IAMFC/1989	International Association of Marriage and Family Counselors	"… help develop healthy family systems through prevention, education, and therapy."	*The Family Journal: Counseling & Therapy for Couples & Families*
MCGA/1984	Military and Government Counseling Association (MCGA)	"… dedicated to counseling clients and their families in local, state, and federal government or in military-related agencies."	*Journal of Military and Government Counseling*
NCDA/1952	National Career Development Association	"… inspires and empowers the achievement of career and life goals by providing professional development, resources, standards, scientific research, and advocacy."	*Career Development Quarterly*
NECA/1964	National Employment Counseling Association	"… to offer professional leadership to people who counsel in employment and/or career development settings."	*The Journal of Employment Counseling*

*American Counseling Association. (2015d). *ACA divisions: Enhance your professional identity.* Retrieved from www.counseling.org/about-us/divisions-regions-and-branches/divisions

Many of ACA's divisions can now be joined separately from ACA, as they have moved to semi-independent status from their parent association. However, we believe that you, and the profession, can gain the most if you join the parent association *and* one or more divisions (see Activity 2.1).

Activity 2.1 Creating Your Own Division

Create your own division of ACA. Include the following:

1. Requirements to be a member (e.g., student member, degree in counseling, membership in ACA, other?)
2. Purpose statement
3. Benefits
4. Cost of membership

Branches and Regions of ACA

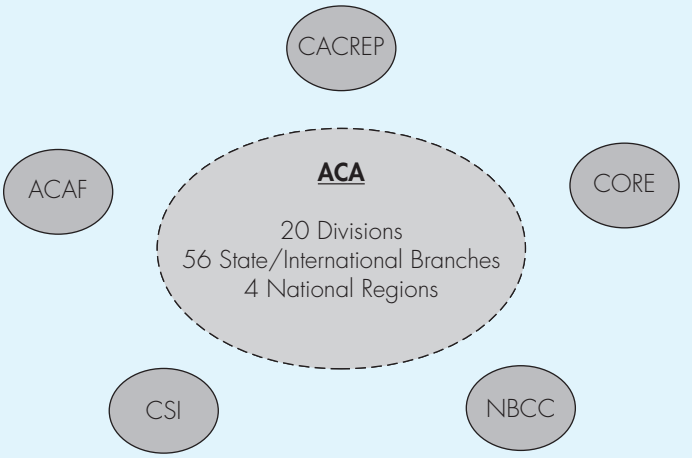
In addition to ACAs 20 divisions, the association has 56 chartered branches that include the 50 states, the District of Columbia, Puerto Rico, Latin America, the Virgin Islands, the Philippines, and Europe (ACA, 2015e). Branches often house other associations that mimic the national divisions. For instance, most state branches have a state school counseling and a state clinical mental health counseling association. Additionally, four regional associations support counselors throughout the United States: the North Atlantic Region, Western Region, Midwest Region, and Southern Region. These regions generally support the branches with which they are affiliated and sometimes offer a yearly regional conference.

Partners with and Associations that Support ACA

In addition to the branches and regions, ACA works closely with number of affiliates and organizations that contribute to the betterment of the counseling profession in unique ways (see Figure 2.1). Brief descriptions follow.

- The **American Counseling Association Foundation (ACAF).** A partner to ACA, the ACAF offers support and recognition for a wide range of projects, including scholarships for graduate students, recognition of outstanding professionals, publishing materials for counselors and to advance the profession, partnering with others, and supporting counselors and others in need (ACAF, n.d.).
- The **Council for Accreditation of Counseling and Related Educational Programs (CACREP).** CACREP is an independent organization that develops standards and provides accreditation processes for counseling programs (CACREP, 2014a).
- The **Council on Rehabilitation Education (CORE).** CORE is an independent organization that develops standards and provides accreditation processes for rehabilitation counseling programs (CORE, 2015).
- The **National Board for Certified Counselors (NBCC).** NBCC provides national certification for counselors, including the **National Certified Counselor (NCC)**, for all counselors; the **Certified Clinical Mental Health Counselor (CCMHC)**, for mental health counselors; the **National Certified School Counselor (NCSC)**), for school counselors; and the **Master Addiction Counselor (MAC)**, for substance abuse counselors (NBCC, 2015c).

FIGURE 2.1 ACA and Its Professional Partners



- **Chi Sigma Iota (CSI).** CSI is an honor society that promotes and recognizes scholarly activities, leadership, professionalism, and excellence in the profession of counseling (CSI, 2015).

LO 3

Professional Associations in Related Mental Health Professions

The following represent some of the more popular professional associations in related mental health professions. Although most counselors join ACA or its divisions, counselors sometimes join these associations. For instance, although some rehabilitation counselors will join the American Rehabilitation Counseling Association (ARCA), which is a division of ACA, others will join the National Rehabilitation Counseling Association (NRCA), which is a standalone association. Others will join both. Similarly, counselors who have an interest in art therapy might join the American Art Therapy Association (AATA), while counselors who have an interest in pastoral counseling might join the American Association of Pastoral Counselors (AAPC). On the other hand, it is extremely unlikely that counselors will join the National Association of Social Workers (NASW), as a degree in social work is required for membership to this organization and the organization clearly focuses on issues somewhat askew to counseling. However, knowledge of this association and others is also included in this section so that you can become familiar with the backgrounds and associations of colleagues with whom we often share clients and work next to.

The American Art Therapy Association (AATA)

Established in 1969, the **American Art Therapy Association (AATA)** is open to any individual interested in art therapy. AATA is "dedicated to the belief that making art is

healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy" (AATA, 2015, para. 1). The association establishes criteria for the training of art therapists, supports licensing for art therapists, maintains job banks, sponsors conferences, and publishes a newsletter and one journal: *Art Therapy.*

The American Association of Marriage and Family Therapy (AAMFT)

If you have a counseling degree, you may be interested in joining the International Association of Marriage and Family Counselors (IAMFC), which is a division of ACA. However, in recent years the **American Association of Marriage and Family Therapy (AAMFT)**, with its 25,000 members, has become a major association in the field of marriage and family counseling. Founded in 1942 as the American Association of Marriage and Family Counselors, AAMFT was established by family therapy and communication theorists. Today, AAMFT "facilitates research, theory development and education … [and develops] standards for graduate education and training, clinical supervision, professional ethics and the clinical practice of marriage and family therapy" (AAMFT, 2002–2014a, para. 4). AAMFT publishes the *Journal of Marital and Family Therapy.*

The American Association of Pastoral Counselors (AAPC)

The purpose of the **American Association of Pastoral Counselors (AAPC)** is "to bring healing, hope, and wholeness to individuals, families, and communities by expanding and equipping spiritually grounded and psychologically informed care, counseling, and psychotherapy" (AAPC, 2005–2012b, para. 1). The association provides an annual conference, a code of ethics, employment opportunities, information about publications in pastoral counseling, ways of finding pastoral counselors, a list of accredited centers in pastoral counseling, and much more. It also supports certification of pastoral counseling that includes a 3-year degree from a seminary, a graduate degree in a mental health discipline, supervision, and an assessment process (AAPC, 2005–2012c). AAPC publishes *Reflective Practice: Supervision and Formation in Ministry* and a new e-journal: *Sacred Spaces.*

The American Psychiatric Association (APA)

Founded in 1844 as the Association of Medical Superintendents of American Institutions for the Insane, today the **American Psychiatric Association (APA)** (which has the same acronym as the American Psychological Association, "APA") has over 36,000 members. The association's main purpose is to "ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders" (American Psychiatric Association, 2015, para. 1). The association offers workshops on psychiatric disorders, evaluates and publishes statistical data related to psychiatric disorders, supports educational and research activities in the field of psychiatry, and advocates for mental health issues. The APA publishes journals in the field of psychiatry and is responsible for the development and publication of the ***Diagnostic and Statistical Manual-5.***

The American Psychiatric Nurses Association (APNA)

Founded in 1986 with 600 members, today the **American Psychiatric Nurses Association (APNA)** has close to 10,000 members. APNA today is "committed to the specialty practice of psychiatric mental health nursing, health and wellness promotion through identification of mental health issues, prevention of mental health problems and the care and treatment of persons with psychiatric disorders" (APNA, 2015, bottom of page). APNA offers a number of continuing education and professional development activities and publishes the *Journal of the American Psychiatric Nurses Association*. The association provides advocacy for psychiatric nurses to improve the quality of mental health care delivery.

The American Psychological Association (APA)

Founded in 1892 by **G. Stanley Hall**, the **American Psychological Association (APA)** started with 31 members and now maintains a membership of about 130,000. The main purpose of this association is to "advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives" (APA, 2015b, para. 1). The association has 56 divisions in various specialty areas and publishes numerous psychological journals. The **Counseling Psychology Division (Division 17) of the APA** shares many of the same goals and purposes of some divisions of the American Counseling Association. APA offers a particularly wide range of services to its members, including all that were noted earlier in this chapter.

The National Association of School Psychologists (NASP)

In 1969, the **National Association of School Psychologists (NASP)** was formed with its mission being to empower "school psychologists by advancing effective practices to improve students' learning, behavior, and mental health" (NASP, 2012, Mission section). Today, this association has 25,000 members and offers workshops and conferences, supports public policies for school psychologists, provides a career center, develops training standards, and sponsors a national certification for school psychologists (**Nationally Certified School Psychologists [NCSP]**). NASP publishes the journal *School Psychology Review* and numerous other types of publications for parents, educators, and school psychologists.

The National Association of Social Workers (NASW)

The **National Association of Social Workers (NASW)** was founded in 1955 as a merger of seven membership associations in the field of social work. Serving both undergraduate- and graduate-level social workers, NASW has about 136,000 members. NASW seeks "to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies" (NASW, 2015c, para. 1). The association publishes five journals and other professional publications. It has 56 chapters which include every state as well as additional chapters in New York City, District of Columbia, Puerto Rico, Virgin Islands, Guam, and an international

chapter. As does APA, NASW offers a particularly wide range of services to its members, including all that were noted earlier in this chapter.

The National Organization for Human Services (NOHS)

Founded in 1975, the mission of the **National Organization for Human Services (NOHS)** is to "strengthen the community of human services by: expanding professional development opportunities, enhancing internal and external communications, nurturing financial sustainability and growth of the organization, promoting professional and organizational identity through certification, [and] advocating and implementing a social policy and agenda" (NOHS, 2015a, para. 1). NOHS is mostly geared toward undergraduate students in human services or related fields, faculty in human services or related programs, and human service practitioners. NOHS publishes one journal, the *Journal of Human Services.*

The National Rehabilitation Counseling Association (NRCA)

The largest association representing rehabilitation counselors, the **National Rehabilitation Counseling Association (NRCA)** was founded in 1958. Developed to "represent the unique concerns of practicing rehabilitation counselors" (NRCA, 2015, para. 1), NRCA offers a process for maintenance of one's credential as a **Certified Rehabilitation Counselor (CRC)**, provides employment opportunities, offers awards to practitioners, publishes the *Journal of Applied Rehabilitation Counseling*, and more. (See Reflection Activity 2.1.)

Reflection Activity 2.1

This chapter examined the benefits of a wide variety of professional associations. If money was not an issue, consider which associations of the many that were discussed you would want to join. What do they have to offer you? What do you have to offer them?

Case Study 2.1 Sean

Sean has recently completed his master's degree in counseling with a specialization in college counseling. He does not feel any affinity to school counselors, clinical mental health counselors, rehabilitation counselors, and other counselors. In fact, he has often been overheard saying, "Those people don't know what they're getting into. I've got the best job. I'll have summers pretty much off, and will have really long holiday breaks. And, I won't have to join ACA or any of those stupid divisions." He believes the professional associations are useless, and because he's going into college counseling, he believes that he won't need to become a National Certified Counselor (NCC) or a Licensed Professional Counselor (LPC). He also thinks that he will not have to purchase any liability insurance, because he will be covered by the college at which he finds a job. "That will save me a bundle," he has said. Finally, he notes that he hopes that wherever he works, they won't send him to those silly, costly, conferences. "I've learned all I've needed to learn," he has said.

1. Do you think Sean's degree has little in common with other counseling degrees? Why or why not?

2. What do you think about Sean's attitude toward the amount of time he perceives he'll have off at his job?
3. Is Sean missing out on anything by not joining the professional associations? What might he gain if he were to join one? What professional association(s) do you think might benefit him?
4. What do you think about Sean's idea that he does not need to become certified or licensed?
5. Do you think Sean should purchase liability insurance at his college job?
6. What do you think about Sean's desire to not attend conferences?

Summary

This chapter began by highlighting a number of common benefits professional organizations offer to their members, including providing a sense of belonging, offering workshops and conferences, providing mentoring and networking opportunities, offering job fairs, supporting lobbying efforts, publishing scholarly materials, developing standards for the profession, providing a vehicle for building professional portfolios, making available scholarships and grants, giving awards, and offering a number of other needed services.

The chapter next discussed specific professional associations. Beginning with ACA, we noted that this large association for counselors offers a wide range of benefits for its members and has 20 divisions representing different counseling specialty areas as well as 56 state/international branches and 4 national regions. The divisions were highlighted in Table 2.1. In addition, the association collaborates and supports a number of professional partners, including the American Counseling Association Foundation (ACAF), the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Council on Rehabilitation Education (CORE), the National Board of Certified Counselors (NBCC), and Chi Sigma Iota (CSI).

The chapter concluded with a brief description of popular professional associations in fields related to counseling. Here, we briefly discussed the American Art Therapy Association (AATA), the American Association of Marriage and Family Therapists (AAMFT), the American Association of Pastoral Counselors (AAPC), the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the American Psychological Association (APA), the National Association of Social Workers (NASW), the National Organization of Human Services, and the National Rehabilitation Counseling Association (NRCA).

Key Terms

Advocacy Competencies
American Art Therapy Association (AATA)
American Association of Marriage and Family Therapy (AAMFT)
American Association of Pastoral Counselors (AAPC)
American Counseling Association (ACA)
American Counseling Association Foundation (ACAF)
American Psychiatric Association (APA)
American Psychiatric Nurses Association (APNA)
American Psychological Association (APA)
Branches and Regions of ACA

Certified Clinical Mental Health Counselor (CCMHC)
Certified Rehabilitation Counselor (CRC)
Chi Sigma Iota (CSI)
Council for Accreditation of Counseling and Related Educational Programs (CACREP)
Council on Rehabilitation Education (CORE)
Counseling Psychology Division (Division 17) of the APA
Counseling Today
COUNSGRADS
Diagnostic and Statistical Manual
Diverse grad-L
Divisions of ACA
Hall, G. Stanley
Journals of ACA Divisions
Journal of Counseling and Development
Master Addiction Counselor (MAC)
Membership Benefits of ACA
Multicultural Counseling Competencies
National Association of School Psychologists (NASP)
National Association of Social Workers (NASW)
National Board for Certified Counselors (NBCC)
National Certified Counselor (NCC)
National Certified School Counselor (NCSC)
Nationally Certified School Psychologists (NCSP)
National Organization for Human Services (NOHS)
National Rehabilitation Counseling Association (NRCA)
National Vocational Guidance Association (NVGA)
Nationally Certified School Psychologists (NCSP)
Partners with and Associations that Support ACA
Professional associations



Characteristics of the Effective Counselor

CHAPTER 3

LEARNING OBJECTIVES

LO 1 Examine the research concerning counseling effectiveness with a particular emphasis on evidence based learning (EBP) and common factors.

LO 2 Understand the nine factors of being an effective counselor—six that comprise the working alliance, which include empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence, and the "it factor," and three that comprise the counselor's ability to deliver his or her theoretical approach, which include compatibility with and belief in your theory, competence, and cognitive complexity.

I've been doing counseling and teaching counseling for over 30 years, and sometimes I think I'm great at what I'm doing, and other times I wonder if I really have the skills necessary to be effective. Because I've taught counseling for so long, I certainly know what I'm *supposed* to do, but my hunch is that knowing what one is supposed to do and being effective are not always the same. So, what makes a counselor effective? Is it having a handle on specific skills, is it knowing a variety of skills, or are some other factors needed also? This chapter is going to take a broad look at counselor effectiveness and identify some characteristics of the helper that seem, empirically, to lead to being an effective counselor.

LO 1 Does Counseling Work?

In 1952, **Eysenck** examined 24 uncontrolled studies that looked at the effectiveness of counseling and psychotherapy and found that "roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, *whether they are treated by means of psychotherapy or not*" (p. 322). Although

found to have serious methodological flaws, Eysenck's research led to debate concerning the effectiveness of counseling and resulted in hundreds of studies that came to some very different conclusions:

> *It is a safe conclusion that as a general class of healing practices, psychotherapy is remarkably effective. In clinical trials, psychotherapy results in benefits for patients that far exceed those for patients who do not get psychotherapy. Indeed, psychotherapy is more effective than many commonly used evidenced-based medical practices. … (Wampold, 2010a, p. 66)*

But what makes counseling effective? First, some client factors such as readiness for change, psychological resources, and social supports may affect how well a client does in counseling (Beutler, 2014). However, these factors are intimately related to the counselor's ability to work with the client.

When looking specifically at the counselor, the importance of the helper accurately matching empirically supported treatment methodologies to the client's presenting problems has been shown to be critical to positive client outcomes. Called **evidence-based practice** (EBP) (Laska, Gurman, & Wampold, 2014), EBP is generally touched on in training programs, but usually needs to be continued and strengthened with continuing education, supervision, and postgraduate training clinics.

In addition to EBP, it has also become clear that specific counselor qualities, sometimes called **common factors,** may be more important to positive counseling outcomes than matching a treatment approach to a presenting problem (Hilsenroth, 2014; Wampold, 2010a, 2010b, 2010c; Wampold & Budge, 2012). For instance, the counselor's ability at creating a strong **working alliance** with the client may be the most significant factor in creating client change. This alliance has been alluded to by almost every counselor and therapist from Freud to the modern-day "new age" counselor. Based on the research, and perhaps some of my own biases, I would contend that this working alliance is composed of the following six components: *empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence*, and something that I call the "*it factor*."

In addition to the working alliance, another common factor that seems to be related to positive counseling outcomes is the counselor's ability to deliver his or her theoretical approach (Wampold, 2010a). This factor contains three components: *compatibility with and belief in your theory, competence,* and *cognitive complexity.* Let's take a look at all nine essential characteristics for effective counseling that, together, make up these two common factors (see Figure 3.1).

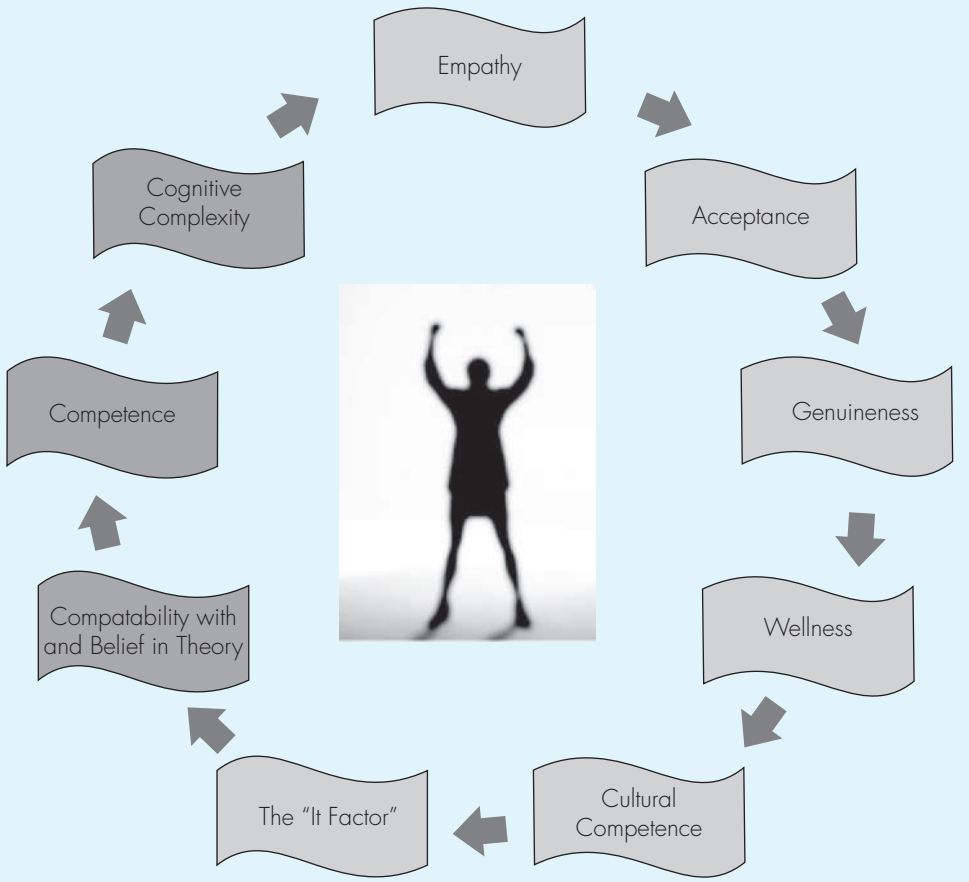
LO 2

The Nine Characteristics of the Effective Counselor

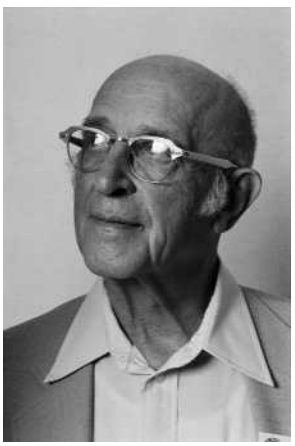
Empathy

More than any other component, **empathy** has been empirically shown to be related to positive client outcomes and is probably the most important ingredient to building a successful working alliance (Elliot, Bohart, Watson, & Greenberg, 2011; Laska et al., 2014; Norcross, 2010). Understanding our clients, or being empathic,

FIGURE 3.1 The Nine Characteristics of the Effective Counselor



> *… means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this acceptant understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. Listening, of this very special, active kind, is one of the most potent forces of change that I know. (Rogers, 1989, p. 136)*



Carl Rogers Memorial Library

Whether or not one can truly understand the inner world of another has been discussed for centuries and was spoken of by such philosophers as Plato and Aristotle (Gompertz, 1960). However, **Carl Rogers** (1957) is given credit for bringing this concept to life in the twentieth century. With respect to the counseling relationship, understanding through empathy is seen as a skill that can build rapport, elicit information, and help the client feel accepted (Egan, 2014).

Although empathy is an important skill that one learns how to apply, it is also a quality that grows over the years as one increasingly tries to be more understanding to others, be they clients, friends, or significant others (Neukrug, Bayne, Dean-Nganga, Pusateri, 2012). As you move through your counseling program, you will have the opportunity to learn this important skill in what is usually called a "skills" or "methods" class. However, I hope that over the years you will also continue to try to increase your ability at being empathic with all people so that we all can lead a gentler, more understanding life.

Acceptance

Acceptance, sometimes called **positive regard,** is another component likely related to building a strong working alliance (Laska et al., 2014; Norcross, 2010). Acceptance is an attitude that suggests that regardless of what the client says, within the context of the counseling relationship, the client will not feel judged. Just about every counseling approach stresses the importance of acceptance (see Neukrug, 2011, 2015). For instance, person-centered counseling suggests that one of the core conditions in the helping relationship is **unconditional positive regard,** or the ability to accept clients "without strings attached." Behavior therapists suggest that issues cannot be discussed and goals cannot be developed if clients do not feel accepted by the therapist or by themselves. Solution-focused behavior therapy stresses the importance of acceptance in helping to quickly develop preferred goals. Reality therapy suggests that the suspension of judgment (acceptance) is one of the critical "tonics" or relationship-building skills. Psychoanalysts talk about the importance of **analytic neutrality** and empathy in building a relationship in which all feelings, thoughts, and behaviors can be discussed. And even **Albert Ellis,** not a person typically known for his relationship-building skills, suggested in his rational emotive behavioral approach that clients be shown unconditional acceptance and not be berated for thinking, feeling, and acting in any particular manner.

A reciprocal relationship exists between empathy and acceptance. If the counselor can be accepting, the client is more likely to reveal deeper parts of him- or herself. Then, if the counselor can be empathic as the client shares these parts, the client will reveal more. Sometimes, these deepest parts are well-held secrets and not liked by the client or condoned by society. It is here that the counselor must show even greater acceptance. This acceptance provides the client with the space to fully understand his or her feelings and actions. Acceptance and empathy are also closely related to genuineness, our next characteristic.

Genuineness

Another quality related to positive outcomes in counseling (Norcross, 2010; Laska et al., 2014; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010), **genuineness,** refers to the counselor's ability to be authentic, open, and in touch with his or her feelings and thoughts within the context and parameters of the helping relationship. Thus, one may not have all aspects of one's life "together," but within the counseling relationship, the counselor is real and seen by the client as being in a state of **congruence** (feelings, thoughts, and behaviors are in sync). Carl Rogers (1957) is known for popularizing the word *genuineness*

(or congruence) and for noting that, along with empathy and unconditional positive regard, genuineness was a core condition of the helping relationship.

Emotional intelligence, or the ability to monitor one's emotions, seems to be related to knowing the appropriate time to share one's feelings and thoughts (be genuine) with the client (Martin, Easton, Wilson, Takemoto, & Sullivan, 2004). For instance, monitoring one's emotions may be important when a client shares something that results in the counselor feeling turned off or even angry. "Should I share my feelings about the client at this point?" says the authentic or genuine counselor to himself or herself. Rogers (1957) suggested that it was important to monitor or be aware of those feelings and not always wise to share one's immediate feelings. Sometimes, he suggested that it was best to discuss and understand one's negative feelings with a colleague or supervisor. Other times, he noted that as the client increasingly shares deeper parts of him- or herself, the counselor gains a greater understanding of those aspects of the client that earlier left the counselor with negative feelings toward the client. This deeper understanding of the client almost always, said Rogers, leads to loving and caring feelings toward the client.

Research by Gelso (2009; Marmarosh et al., 2009) suggests that, regardless of one's theoretical orientation, there exists an ongoing *real relationship* in which the client, to some degree, will see the therapist realistically. This means that at some point in the relationship, the client will sense the real you and that the real you will affect the relationship. Thus, even when one is good at monitoring one's emotions and holds off on sharing one's true or real self, the client will sense the real self of the counselor. This is why being genuine, or sharing one's real self, may be critical at some point in the helping relationship. Effective counselors know when to share in the moment and when to hold off sharing.

Embracing a Wellness Perspective

> *The difference in professional quality of life between counselors with high and low Wellness levels in this study was quite strong, suggesting that, overall, greater Wellness translates to dramatically improved professional quality of life. (Lawson & Myers, 2011, p. 170)*

It is pretty clear that stress, burnout, compassion fatigue, and vicarious traumatization from the work of the counselor, along with unfinished psychological issues on the part of the counselor, have the potential for preventing the building of a working alliance with clients (Cole, Craigen, Cowan, 2014; Puig et al., 2012). This is due to the fact that work-related stress and unfinished business are likely to result in empathic blunders, an inability to be accepting, difficulty at building a real relationship, and **countertransference**, "or the unconscious transferring of thoughts, feelings, and attitudes onto the client by the therapist" (Neukrug, 2011, p. 50).

Students of counseling, and counselors in general, need to attend to their own wellness by *embracing a wellness perspective* if they are to be effective counselors (Neswald-Potter, Blackburn, & Noel, 2013; Reese, Lewis, Myers, Wahesh, Iverson, 2014). One method of assessing your level of wellness is by examining what Myers and Sweeney (2008) identify as the **Indivisible Self.** This model views wellness as a primary factor composed of five subfactors and also takes into account an individual's context. The factors, which include the **creative self, coping self, social self, essential self,** and **physical self,** and contexts are summarized in Activity 3.1.

Activity 3.1 Assessing Your Self Through the Indivisible Self Model

Using this summary of the Indivisible Self model below (Myer & Sweeney, 2008), conduct an informal assessment on each of the five subfactors and determine what areas you might want to address in your life. For instance, score yourself from 1 to 5 on each of the subfactors, with 5 indicating the area you most need to work on. Then, find the average for each of the primary five factors (creative self, coping self, etc.). Next, write down the ways you can better yourself in any of the primary or subfactors for which your scores seem problematic (probably scores of 3, 4, or 5). You might also want to consider how your scores may change as a function of the context in which you find yourself. You can view the whole model at: Myers, J., & Sweeney, T. J. (2008). Wellness counseling: The evidence base and practice. *Journal of Counseling and Development*, *86,* 482–493.

Summary of Indivisible Self Model

Creative Self: This aspect of self has to do with our uniqueness in our interpersonal relationships and how we come to understand our place in the world. It has to do with our ability to be mentally sharp and open minded (thinking); being in touch with our feelings (emotions); being intentional and planful and knowing how to express our needs (control); being effective at work and using our skills successfully (work); and being able to deal with life as it comes at us (positive humor).

Coping Self: This aspect of self is related to our ability to deal with life's events and to effectively cope with negative situations. It is composed of our ability to develop leisure activities (leisure), successfully cope with stress (stress management), valuing ourselves and having good self-esteem despite problems (self-worth), and having the capacity to be imperfect and to realize that it is unrealistic to think we can be loved by all (realistic beliefs).

Social Self: The social self is the part of self that is connected to others through our friendship and intimate relationships and through family. It is composed of the ability to connect with others in supportive, emotional, and sometimes sexual ways (friendship), and is also the part of us that can share deeply with others and be mutually respectful and appreciative (love).

Essential Self: This has to do with how we make meaning in life in relationship to ourselves and to others. It has to do with recognizing the part of us that is beyond our mind and body (spirituality), feeling comfortable in the way we identify with our gender (gender identity) and with our culture (cultural identity), and being able to care for ourselves through self-care and by minimizing harm in our environment (self-care).

Physical Self: This is the part of ourselves that is reflected through our biological and physical aspects of self and is related to ensuring that we have adequate physical activity in our lives (exercise) and that we eat well, have a good diet, and avoid being overweight or underweight (nutrition).

Contexts: Context has to do with the systems in which we live, such as our family, community, social and political system, work system, and global system. When assessing your self on the five subfactors, consider how your self might change based on the context in which you find yourself.

Finally, although many avenues to wellness exist, one that must be considered for all counselors is attending their own counseling. Counseling for ourselves helps us:

- attend to our own personal issues;
- decrease the likelihood of countertransference;
- examine all aspects of ourselves to increase our overall wellness; and
- understand what it's like to sit in the client's seat.

It appears that counselors and other mental health professionals understand the importance of being in counseling, as 85% of helpers have attended counseling (Bike, Norcross, & Schatz, 2009). However, some counselors resist attending counseling and therapy, perhaps for good reasons (e.g., concerns about confidentiality, feeling as if family and friends offer enough support, or believing they have effective coping strategies) (Norcross, Bike, Evans, & Schatz, 2008). So, have you attended counseling? If not, have you found other ways to work on being healthy and well?

> *Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional*

> *services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.… (ACA, 2014a, Standard C.2.g.)*

Cultural Competence

If you were distrustful of counselors, confused about the counseling process, or felt worlds apart from your helper, would you want to go to or continue in counseling? Assuredly not. Unfortunately, this is the state of affairs for many clients from diverse cultural groups. In fact, it is now assumed that clients from nondominant groups will frequently be misunderstood, often misdiagnosed, and, as compared to Whites, find counseling less helpful, attend counseling at lower rates, and terminate counseling more quickly (Davis, 2011; Sewell, 2009; U.S. Department of Health and Human Services, 2001). Unfortunately, it has become clear that many counselors have not learned how to effectively build a bridge—a working alliance with clients who are different from them.

Clearly, the effective counselor needs to be culturally competent if he or she is going to connect with his or her client (Anderson, Lunnen, & Ogles, 2010). Although some argue that all counseling is cross-cultural, when working with clients who are from a different culture than one's own, the schism is often great. Therefore, all counselors must be cross-culturally competent. One model that can help bridge that gap is D'Andrea and Daniels's **RESPECTFUL Counseling Model,** which highlights 10 factors counselors should consider addressing with clients:

R – religious/spiritual identity

E – economic class background

S – sexual identity

P – level of psychological development

E – ethnic/racial identity

C – chronological/developmental challenges

T – various forms of trauma and other threats to one's sense of well-being

F – family background and history

U – unique physical characteristics

L – location of residence and language differences (Lewis, Lewis, Daniels, & D'Andrea, 2011, p. 54)

The RESPECTFUL model can assist you in developing a deeper understanding of all your clients as you develop your skills as a counselor. Chapter 10 will examine cross-cultural issues in more detail and offer some additional models to help you become a culturally competent counselor. In addition, you will have multicultural counseling coursework infused throughout your program and are likely to have a separate course in social and cultural issues to assure your cross-cultural competence.

The "It Factor"

I worked at a suicide crisis center, and one of the counselors had an uncanny ability to make jokes on the phone that would result in suicidal clients laughing. If I had made those same jokes, it would have driven the caller to commit suicide! "So, is there a bridge nearby?" I would hear him say in a jovial way. This counselor had "it"—a way with words, a special voice intonation, and a way of being that would get the client laughing, the suicidal client. And he knew he had *it* and he would use *it*. I knew I didn't have *it*—well, I didn't have his *it*, so I knew not to try to make my clients laugh. For me, just listening and being empathic was my way.

I believe all great counselors and therapists have their own "it factors," or special ways of working with and ultimately building alliances with their clients. And more often than not, these great helpers want us to use their "it factors." So, *Carl Rogers*, who was great at showing empathy, unconditional positive regard, and genuineness, suggested we all use these core conditions with our clients; and *Albert Ellis*, who was a master at challenging his clients' **irrational thinking,** said we all should approach our clients in this manner; and **Michael White,** a **postmodernist** who believed that social injustices fueled mental illness, wanted all counselors to help clients see how oppressed by language they are; and of course **Sigmund Freud,** who believed in the **unconscious,** told us to show analytic neutrality to our clients so that we would allow the unconscious to be projected onto the therapist. **Salvador Minuchin** (1974), the well-known family therapists, talked about the "it factor" when he used the word **joining** in highlighting the importance of each counselor finding his or her unique way of working with clients:

> *The therapist's methods of creating a therapeutic system and positioning himself as its leader are known as joining operations. These are the underpinnings of therapy. Unless the therapist can join the family and establish a therapeutic system, restructuring cannot occur, and any attempt to achieve the therapeutic goals will fail. (p. 123)*

So, what is your "it factor"? What do you have that's special and will enable you to bond? Is it the way you show empathy, the way you make people laugh, a tone, a look, or a way of being? Do you have *it*? (See Activity 3.2.)

Activity 3.2 What Is Your "It"?

Write down the unique personality characteristics that allow you to build a bond with others. Talk to others in your class, and see what their "it factor" is. Your instructor might want to make a master list on the board. After reviewing the list, discuss which characteristics may be inherent and which may be learned. Can a person acquire new ways of bonding with clients as he or she develops as a counselor?

Compatibility With and Belief in a Theory

There are literally hundreds of counseling theories to choose from when working with clients (Neukrug, 2015). However, I find that most of them, for one reason or another, just don't fit me. They don't seem compatible with my way of understanding the world. Maybe it's because they place too much emphasis on genetics, or spirituality, or early child-rearing, or maybe they're just a little too directive, or too nondirective. Perhaps they

are too long-term or too brief for my taste. Whatever the reason, they just don't sit well with me. I am not compatible with them, and I choose not to use them. But thankfully, there are enough theories out there with which I am compatible. I drift toward them and those are the ones I use.

Wampold (2010a) suggests that helpers "are attracted to therapies that they find comfortable, interesting, and attractive. Comfort most likely derives from the similarity between the worldview of the theory and the attitudes and values of the therapist" (p. 48). He goes on to say that if you are drawn to a theory, and if you believe that the theory you are drawn to works, then, and only then, you will likely see positive counseling outcomes (Wampold, 2010a, 2010b; Wampold & Budge, 2012). So, what theories are you drawn to? If you aren't sure yet, you'll have an opportunity to explore your theoretical orientation in courses in which you will examine your view of human nature and the potential theories it best matches. Want to start the process now? Then go to the survey highlighted in Activity 3.3. As you continue to examine your view of human nature and theoretical orientation, over time, you will hopefully feel an increased sense of **compatibility with and belief in a theory** (see Activity 3.3).

Activity 3.3 What Is Your Theoretical Orientation?

Want to take a survey to find the counseling approach to which you are most aligned? Go to the following website, www.odu.edu/sgt, and click "book/survey/DVD" to take a 20-minute survey to assess your theoretical orientation.

Competence

Counselor expertise and mastery (**competence**) has been shown to be a crucial element for client success in counseling (Wampold, 2010a, 2010c; Wampold & Budge, 2012). Competent counselors have a thirst for knowledge. They continually want to improve and expand their expertise at delivering their theories. Such counselors exhibit this thirst through their study habits, their desire to join professional associations, through mentoring and supervision, by reading professional journals, through their belief that education is a lifelong process, and through their ability to view their own approaches to working with clients as always broadening and deepening.

Counselors have both an ethical and legal responsibility to be competent (Corey, Corey, Corey, & Callanan, 2015). For instance, Section C.2 of ACA's (2014a) ethics code elaborates on eight areas of competence, including (1) practicing within one's boundary of competence, (2) practicing only in one's specialty areas, (3) accepting employment only for positions for which one is qualified, (4) monitoring one's effectiveness to ensure optimal practice, (5) knowing when to consult with others, (6) keeping current by attending continuing education activities, (7) refraining from offering services when physically or emotionally impaired, and (8) assuring proper transfer of cases when one is incapacitated or leaves a practice (see Appendix A). As Kaslow et al. (2007) highlight, the legal system reinforces these ethical guidelines because "competence is thus the touchstone by which the law will judge" (p. 488).

Finally, clients pick up on incompetence. They can see it, smell it, and feel it. And, of course, clients are less likely to improve when a counselor is incompetent. And not surprisingly, incompetent counselors are sued more frequently.

Cognitive Complexity

The best helpers not only believe in their theory but also are willing to question it. This apparent contradiction makes sense. You have a way of working, but you are also willing to constantly examine if your way *is* working in any given instance. In other words, you are able to reflect on what you are thinking and what you are doing—you are able to consider if your approach is working well for your client (Ridley, Mollen, & Kelly, 2011). Counselors who have this capacity are often said to be cognitively complex. Not surprisingly, **cognitive complexity** has been shown to be related to being empathic, more open-minded, more self-aware, more effective with individuals from diverse cultures, better able to examine a client's predicament from multiple perspectives, seeing strengths in all clients, and better able to resolve "ruptures" in the counseling relationship (McAuliffe & Eriksen, 2010; Norcross, 2010; Ridley et al., 2011; Welfare, Farmer, & Lile, 2013). Such a counselor is willing to integrate new approaches into his or her usual way of practicing counseling and is a helper who doesn't believe that his or her theory holds the lone "truth" (Wampold, 2010a). So, ask yourself: Do you have this quality? Are you able to self-reflect, question truth, take on multiple perspectives, and evaluate situations in complex ways? Counselor training programs are environments that seek to expand this type of thinking (McAuliffe & Eriksen, 2010). Hopefully, in your program, you'll be exposed to such opportunities.

Final Thoughts

Now that we've looked at all nine characteristics, ask yourself, are you empathic, accepting, genuine, wellness oriented, culturally competent, aware of your own "it factor," compatible with and confident in your theory, competent, and cognitively complex? As we start on our journey to help others, let's always think about how we can improve ourselves in all of these areas, as helping ourselves will significantly improve the manner in which we work with others.

Case Study 3.1 Chelsea, Brianna, William, Tiffany, and Liam

Chelsea, Brianna, William, Tiffany, and Liam are in a growth group experience in their master's degree program. This group experience is taken at the beginning of their master's degree and is focused upon helping them learn more about themselves psychologically. Here's the transcript of part of their first group experience where they were asked to talk about the characteristics of the effective counselor:

Chelsea: "Well, I think all of those characteristics are great, but I'm not sure that I can live up to them. I feel like I should already be skilled at empathy, acceptance, genuineness, and be perfectly healthy. And, I can't even remember the rest of those characteristics."

Brianna: "Chill out Chelsea. You're much too much of a perfectionist. You need to learn how to just go with the flow. You'll learn those characteristics over time, and if you don't, who cares. It's not like anyone is REALLY looking over your shoulder."

William: "Well, I don't think you should have to rely on someone looking over your shoulder. You should want to embrace those characteristics on your own."

Tiffany: "I don't know about you guys, but I am excited about the one called cultural competence. We all need to learn how to be more competent when working with diverse clients. That one characteristic is the most important. The others are all secondary."

Liam: "I love the characteristics called competence and cognitive complexity. I look forward to slowly gaining in competence as I go through this program, and I hope to view the world in more complex ways. I think I see that some of you are pretty dualistic in your thinking, and maybe if you all would learn how to understand different perspectives, you would be better off."

1. Do you think Liam's observations of the other students are on target? Can you describe how some or all of the other students may be dualistic?
2. Do you think that Liam is dualistic in any way?
3. Who are you most drawn to (if anyone) in this short dialog? Why do you think that is the case?
4. What characteristics do you think are most important? Why?
5. Do you think the other characteristics, not identified in Item 4, will be not as well attended to because of your preference towards the ones you picked in Item 4? Can you make an argument for giving special attention to the one's you did not pick? Why or why not?
6. What expectations do you have for your master's degree helping you grow in the development of the characteristics of the effective helper?

Summary

This chapter began by discussing whether or not counseling works. Beginning with Eysenck's controversial and flawed study suggesting counseling was not effective, we moved on to show the overwhelming evidence that counseling is helpful. We then went on to note that there are some client factors that lead to positive counseling outcomes, including the client's readiness for change, psychological resources, and social supports. Then we pointed out that in recent years there has been a move toward counseling methods that are evidence-based, which speaks to the importance of using techniques that fit the client's presenting problem.

Although client factors and evidence-based practice are important, the bulk of the chapter was spent discussing common factors that seem to be particularly important in positive client outcomes. I suggested that that there are nine factors that collectively work toward increasing counseling effectiveness, including six that contribute to the working alliance—empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence, and the "it factor"—and three that contribute to the counselor's ability to deliver his or her theoretical approach—belief in one's theory, competence, and cognitive complexity (see Figure 3.1). Each of these nine factors was discussed, and the chapter concluded by suggesting that embracing all nine of these qualities is a lifelong process.

Key Terms

Acceptance
Analytic neutrality
Cognitive complexity
Common factors
Compatibility with and belief in a theory
Competence
Congruence
Coping self
Countertransference
Creative self
Cultural competence
Ellis, Albert
Emotional intelligence
Empathy
Essential self
Evidence-based practice

Eysenck
Freud, Sigmund
Genuineness
Indivisible Self
Irrational thinking
It factor
Joining
Minuchin, Salvador
Physical self
Positive regard
Postmodernist
RESPECTFUL Counseling Model
Rogers, Carl
Social self
Unconditional positive regard
Unconscious
Wellness (embracing a wellness perspective)
White, Michael
Working alliance



HISTORY AND CURRENT TRENDS IN THE COUNSELING PROFESSION

SECTION 2

Our roots—our history—tell a story about where we have been and who we are today, and suggest in what direction we might be moving. Thus, in this section of the text we discuss antecedents to the counseling profession, the 100-year-old history of the counseling profession, and current trends in the field. We begin by reviewing the early history of mental health treatment. We then explore the roots of social work, psychology, and psychiatry, and describe how these related fields influenced the counseling profession. We then move on to describe, in some detail, the history of the counseling profession, which began around the turn of the twentieth century. As we take you through the twentieth century and into the new millennium, you will begin to see that what we are today is intimately related to the kinds of decisions that were made over the past 100 years. This section concludes with a review of some recent trends in the field and some thoughts about likely trends in the future.



Predecessors to the Counseling Profession: From Antiquity to Early Social Work, Psychology, and Psychiatry

CHAPTER 4

LEARNING OBJECTIVES

LO 1 Learn how helping has a tradition that is traced back to early antiquity.

LO 2 Learn about the history of the social work profession and how it impacted the counseling profession.

LO 3 Learn about the history of the psychology profession and how it impacted the counseling profession.

LO 4 Learn about the history of the psychiatry profession and how it impacted the counseling profession.

LO 5 Highlight and learn names and dates.

Imagine your extended family, siblings, cousins, uncles, and aunts. You all share similar roots, yet you recognize that each family member is distinct and unique—some a bit more unique than others! Our professional family is similar. Our professional cousins—social work, psychology, and psychiatry—are all related to us, yet different in many ways. And if we look back in time, we can see that social work, psychology, psychiatry, and counseling had somewhat different beginnings, with the social work field developing out of the desire to assist the destitute, psychology starting as both a laboratory science and an attempt to understand the nature of the person, psychiatry growing out of modern medicine's effort to alleviate mental illness through medical interventions, and counseling growing out of the early vocational guidance movement of the twentieth century.

This chapter will explore the historical antecedents of the counseling profession. Starting with early antiquity and then briefly reviewing the historical

roots of the social work, psychology, and psychiatric professions, we will see how philosophy, religion, and the roots of the early mental health professions impacted counseling in unique and important ways. Chapter 5 will focus solely on the 100-year-old history of the counseling profession.

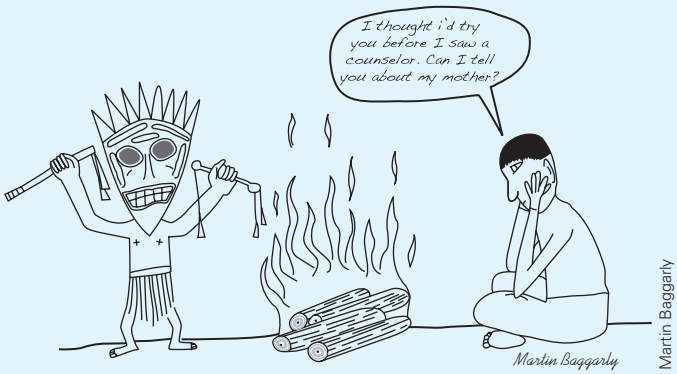
LO 1

Understanding the Human Condition: From Early Antiquity to the Modern Era

> *The first counselors were leaders of the community who attempted to provide inspiration for others through their teachings. They were religious leaders such as Moses (1200 B.C.), Mohammed (A.D. 600), and Buddha (500 B.C.). They were also philosophers like Lao-Tzu (600 B.C.), Confucius (500 B.C.), Socrates (450 B.C.), Plato (400 B.C.), and Aristotle (350 B.C.). (Kottler & Shepard, 2015, p. 30)*

Since the dawn of our existence, people have attempted to understand the human condition. Myths, magic, belief in spirits, ritualism, and sacred art have been used by people as means of gaining introspection and understanding the world around us (Ellwood & McGraw, 2014) (see Figure 4.1). Shamans, or individuals who had special status due to their mystical powers, have been considered caretakers of the soul and thought to have knowledge of the future. Later in history, the concept of **soul** often gave way to the concept of **psyche** (see Activity 4.1).

FIGURE 4.1



Activity 4.1 Myths and Rituals in Your Family of Origin

Oftentimes in our own families of origin certain myths and rituals were used to protect us or create a positive sense of mental health. For instance, in my family getting angry was seen as unhealthy, so our myth was to "keep a lid" on our anger. Also, when a person was upset in our family, the individual was invariably asked whether they were hungry—as food seemed a cure for all ills. Other families might pray together or share "magic artifacts" (stones, stuffed animals). Write down any myths and rituals used in your family, and if there is the opportunity, share them in class.

One of the first written treatises of a psychological nature can be traced back to an Egyptian papyrus of 3000 BCE that shows a primitive attempt to understand some basic functions of the brain (Breasted, 1930). Almost 1,000 years later, also in ancient Egypt, a wise man who was obviously psychologically minded expounded on the importance of being nonjudgmental, listening, and accurately reflecting a person's inner thoughts within a close, one-on-one relationship:

> *If thou searchest the character of a friend, ask no questions, (but) approach him and deal with him when he is alone.… Disclose his heart in conversation. If that which he has seen come forth from him, (or) he do aught that makes thee ashamed for him,… do not answer. (Breasted, 1934, p. 132)*

Such writings show that the counseling way clearly preceded modern times. However, it was the Greek philosopher **Hippocrates** (460–377 BCE), whose treatises reflected on the human condition, who was to greatly change the Western world's view of emotional and physical illnesses. Whereas contemporaries of Hippocrates believed that evil spirits were responsible for such problems, Hippocrates suggested there were environmental, diet related, and other natural causes. In fact, by today's standards, some of his treatment recommendations might be considered right on target; on the other hand, some might seem a bit odd. For instance, for melancholia he recommended sobriety, a regular and tranquil life, exercise short of fatigue, and bleeding, if necessary. For hysteria, he recommended getting married!

With the advent of monotheistic religion, we see abundant examples of humankind's attempt to understand the self further. The Old and New Testaments, the Quran, and other religious writings abound with such examples (Belgium, 1992). For instance, in Buddhism, the Sanskrit term *duhkha* speaks about the pain and suffering that people carry due to what are called **delusive perceptions** (Epstein, 2013), and the Old and New Testaments offer us many reflections on the concepts of atonement and guilt—reflections that are closely related to the many painful issues people discuss in counseling:

> *The concept of atonement is closely associated to forgiveness, reconciliation, sorrow, remorse, repentance, reparation and guilt. It is a spiritual concept which has been studied since time immemorial in Biblical and Kabbalistic texts. (Williams, 2010, p. 83)*

With guidance from religious texts, over the years, a number of philosophers and theologians have reflected on the nature of the person, the soul, and the human condition. For example, such philosophers as Plotinus (205–270), who believed the soul was separate from the body, had a lasting impact on the dualistic fashion in which the Western world views the mind and body.

The Renaissance, in Europe (roughly fourteenth to seventeenth centuries), might be considered the start of the modern era, and with it came the printing press and the writings of modern philosophers. Individuals like **Descartes** (1596–1650), who believed that knowledge and truth were derived through deductive reasoning, and **John Locke** (1632–1704), who believed that the mind is a blank slate, changed our understanding of the human experience. Soon after, **James Mill** (1773–1836) suggested that mental states were a function of associations of ideas that were imprinted or "stamped" onto a passive mind. These individuals and others set the stage for modern psychology, the beginnings of modern-day social work and psychiatry, and the origins of the counseling field.

LO 2

A Brief History of Social Work

Historical Background

Social work practice can be traced to work with the poor and destitute. For instance, during the 1500s, the **Elizabethan Poor Laws** in England made the Church responsible for overseeing the raising and administering of funds for the destitute (Burger, 2014). Until then, such relief had been provided on a voluntary basis. Modeling that system, during the colonial period in the United States, local governments enacted laws to assist the poor and destitute. Around this same time, organized charities that were usually affiliated with religious groups began to arise. In the 1800s, the growth of urban populations produced an increasingly large underclass whose needs could not be met by the traditional charitable organizations. Mounting political pressure thus led to the creation of specialized institutions such as reform schools, lunatic asylums, and orphanages. To assist the underprivileged who were not institutionalized, two approaches evolved: the **Charity Organization Society (COS)** and the **settlement movement** (Popple & Leighninger, 2011). Charity Organization Societies had volunteers, called **friendly visitors,** who would visit the poor, aid in educating children, give economic advice, and assist in alleviating the conditions of poverty. In contrast, the settlement movement had individuals living in the poorer communities.

> *In essence it was simply a residence for university men in a city slum …. These critics looked forward to a society that encouraged people's social responsibility, not self-interest, to create a life that was kindly, dignified, and beautiful, as well as progressive and prosperous. Some of these thinkers rejected capitalism in favor of an idealized medieval community. (Leiby, 1978, p. 129)*

Idealistic young people in the settlement houses, such as **Jane Addams** (1860–1935) at **Hull House** in Chicago, believed in community action and tried to persuade politicians to provide better services for the poor (Addams, 1910/2012).

Out of involvement with the underprivileged arose articles, books, and eventually social work training programs that focused on **social casework**, **group work, advocacy,** and **community organizing.** During the 1940s and 1950s, an increased emphasis on understanding the dynamics of **social systems** and **family systems** emerged. As social workers had already been working with families and social systems, this emphasis became a natural focus for many social work programs. One social worker, **Virginia Satir** (1967), was particularly instrumental in reshaping the practices of the mental health profession to include a greater systems focus.

In 1955, a number of social work organizations combined to form the **National Association of Social Work (NASW).** In 1960, NASW established the **Academy of Certified Social Workers (ACSW),** which sets standards of practice for master's level social workers. Today, social workers can be found in a variety of social service settings, from hospitals to mental health centers to agencies that work with the homeless and the poor. Although many social workers today do individual counseling and family therapy, others work in community settings doing advocacy work, and still others administer social service organizations.

Social Work's Influence on the Counseling Profession

Social work's emphasis on understanding systems has provided the counseling profession with an understanding of the individual from a family and social system perspective. And, because many of the early family therapists were social workers, counselors have adapted many of these individuals' concepts with clients. Also, social work's emphasis on field experience has rubbed off on counseling, as counselor education programs have increasingly offered more field experience in their training programs. Finally, social work's focus on advocacy is a constant reminder to counselors that their clients are greatly affected by the culture from which they come and the larger dynamics of society. Today, a focus upon **advocacy** and **social justice** has become a major thrust of the counseling profession.

LO 3

A Brief History of Psychology

Historical Background

The psychology profession often traces its early beginnings to the great Greek philosophers as far back as the seventh century BCE. These philosophers reflected on the nature of life and the universe. And, as noted earlier, one of the more "modern" Greek philosophers, Hippocrates, offered notions on how to treat mental and physical illness, and **Plato** (427–347 BCE) discussed the idea that introspection and reflection were roads to knowledge, that dreams and fantasies were substitute satisfactions, and that the human condition had physical, moral, and spiritual origins. However, many consider Plato's student **Aristotle** (384–322 BCE) to be the first psychologist in that he used objectivity and reason to study knowledge, and his writings were psychological in nature (Iannone, 2001; Wertheimer, 2012).

Although **Augustine** (354–430) and **Thomas Aquinas** (1225–1274) highlighted the importance of consciousness, self-examination, and inquiry, there was a paucity of writing about psychological thinking during the 800-year span between their lives. This was partly due to the rise of Christianity, which at that point downplayed the role of reason and objectivity and highlighted the presence of the supernatural. However, the Renaissance, during the fourteenth to seventeenth centuries, saw a rediscovery of the Greek philosophies and a renewed interest in questions regarding the nature of the human condition. This interest sparked philosophical discussions regarding the nature of the person as well as the development of the scientific method.

Although psychology's beginnings can be traced back to the early philosophers, modern-day psychology began during the nineteenth century and was influenced by the new scientific theories of physics and evolution. For instance, **Wilhelm Wundt** (1832–1920) and **Sir Francis Galton** (1822–1911), two of the first **experimental psychologists,** developed laboratories to examine how individuals' responses to external stimuli were related to the workings of the mind (Green, 2009). In the United States, **G. Stanley Hall** (1846–1924) and **James Cattell** (1860–1940) opened experimental psychology laboratories in the late 1800s (Capshew, 1992). Also during the nineteenth century, **William James** (1842–1910) published his theory of **philosophical pragmatism,** which suggested that reality is continually constructed as a function of the practical purpose it holds for the individual (Leary, 1992). Thus we saw the beginning of two important schools of psychology: the philosophical and the scientific.

One natural outgrowth of **laboratory science** was the development of **psychological and educational tests.** For instance, during the early 1900s **Alfred Binet** (1857–1911) developed one of the first intelligence tests, which was used for classroom placement of children with intellectual disabilities in the Paris public schools (Neukrug & Fawcett, 2015). The beginning of the twentieth century saw the first use of school achievement tests, vocational assessment, and some of the first "modern day" personality tests.

The testing movement paralleled the rise of **psychoanalysis,** the first comprehensive psychotherapeutic system. Developed by **Sigmund Freud** (1856–1939), psychoanalysis was influenced by the new emphasis on the scientific method (Bishop, 2015). In fact, **Anton Mesmer** (the term **mesmerize** was derived from his name) (1734–1815) and **Jean Martin Charcot** (1825–1893) were practicing a new scientific technique called **hypnosis.** Freud originally used hypnosis to uncover **repressed memories,** but later stopped in favor of other techniques and subsequently developed his complex theory to understand the origins of human behavior. Freud's views on mental health were revolutionary and continue to profoundly affect the conceptualization of client problems (Bishop, 2015; Neukrug, 2011). Although he was trained as a physician, Freud's concepts were quickly adopted by the psychology profession.

In addition to traditional psychoanalysis, the end of the nineteenth century saw the beginnings of other schools of psychology (Neukrug, 2015). For instance, **Ivan Pavlov** (1849–1936) and others developed behaviorism as they experimented with **classical conditioning.** During this same period, **phenomenological psychology** and **existential psychology** had their beginnings and stressed the nature of existence and the study of reality. Also around this time, **Gestalt psychology** tried to answer questions about how individuals organize experience into reality. The early days of behaviorism, existential psychology, phenomenological psychology, and Gestalt psychology represent the roots of many of today's **cognitive-behavioral therapies** and **humanistically oriented therapies.**

In 1892, the **American Psychological Association (APA)** was founded as an association mostly of experimental psychologists (Sokal, 1992). During the mid-1940s, APA expanded and embraced many new clinical associations such as **Counseling Psychology (Division 17)** (Pepinsky, 2001; Routh, 2000; Schmidt, 2000). This division shares a common history with, and has goals similar to, those of the counseling profession.

Today, we still find experimental psychologists, who work in the laboratory trying to understand the psychophysiological causes of behavior, and clinical and counseling psychologists, who practice counseling and psychotherapy. In addition, we also find other highly trained psychologists doing testing in schools, working within business and industrial organizations, and applying their knowledge in many other areas.

Psychology's Influence on the Counseling Profession

Although psychology was the first profession to use a comprehensive approach to therapy, the counseling field was soon to follow and borrowed many of the theories used by early psychologists. Tests developed by psychologists at the turn of the twentieth century were used by the early **vocational guidance counselors** and later adapted by counselors in many different settings. Research techniques developed by the early experimental psychologists became the precursors to modern-day research tools used by counselors to assess the efficacy of counseling approaches and to evaluate programs they have developed. Finally, many modern-day **counseling skills** are adaptations from

counseling skills developed by psychologists during the early part of the twentieth century. Psychology is truly the first cousin of counseling.

LO 4

A Brief History of Psychiatry

Historical Background

Until the late 1700s, mental illness was viewed as something mystical, demonic, and not treatable, but this perspective gradually gave way to new ways of understanding and treating mental illness. In the late 1700s in France, **Philippe Pinel** (1745–1826), known as the *founder of psychiatry,* was one of the first to view insanity from a scientific perspective. Administering two mental hospitals, Pinel removed the chains that bound inmates and made one of the first attempts to treat inmates humanely (Weissmann, 2008).

In the United States, such individuals as **Benjamin Rush** (1743–1813) and **Dorothea Dix** (1802–1887) advocated for more humane treatment of the mentally ill (Baxter, 1994). However, despite their desire to treat the mentally ill more humanely, early treatment was anything but humane (see Reflection 4.1).

Reflection 4.1 Early Mental Hospital in the United States

In 1773 the Publick Hospital for Persons of Insane and Disordered Minds admitted its first patient in Williamsburg, Virginia. The hospital, which had 24 cells, took a rather bleak approach to working with the mentally ill. Although many of the employees of these first hospitals had their hearts in the right place, their diagnostic and treatment procedures left a lot to be desired. For instance, some of the leading reasons that patients were admitted included masturbation, womb disease, religious excitement, intemperance, and domestic trouble—hardly reasons for admission to a mental institution. Normal treatment procedures were to administer heavy dosages of drugs, to bleed or blister individuals, to immerse individuals in freezing water for long periods of time, and to confine people to straitjackets or manacles. Bleeding and blistering were thought to remove harmful fluids from the individual's system (Zwelling, 1990).

As you read through the description of the "mental hospital" of the eighteenth century and reflect on how archaic the treatments seem, what treatments in today's psychiatric hospital do you think people will find archaic in 100 years?

One result of the work of individuals like Rush and Dix, the spread of mental hospitals, and the impetus towards more humane treatment of the mentally ill was the founding, in 1844, of the Association of Medical Superintendents of American Institutions for the Insane, the forerunner of the **American Psychiatric Association (APA)**.

In the 1800s, great strides were made in the understanding, diagnosis, and treatment of mental illness. Individuals such as **Emil Kraepelin** (1855–1926) developed one of the first **classifications of mental diseases**, and others like **Jean Martin Charcot** (1825–1893) and **Pierre Janet** (1859–1947) saw a relationship between certain psychological states and disorders that were formerly considered only organic in nature (Solomon, 1918).

In the first half of the twentieth century many psychiatrists became entrenched in the **psychoanalytic movement**, others drifted toward **psychobiology**, and still others became involved in **social psychiatry** (Sabshin, 1990). With the spread of psychiatry, perhaps it's not surprising that during the 1950s the American Psychiatric Association developed the first ***Diagnostic and Statistical Manual of Mental Disorders*** (*DSM-I*). Now in its fifth edition (*DSM-5*), the purpose of the diagnostic manual is to provide uniform criteria for making clinical diagnoses and enhancing agreement among clinicians (American Psychiatric Association, 2013a).

The second half of the twentieth century saw a greater need for psychiatric treatment as the result of the increased use of psychopharmacology, the development of **community-based mental health centers** in the 1960s, and the 1975 Supreme Court ruling of ***Donaldson vs. O'Connor*** (see Highlight 4.1), which led to the **deinstitutionalization** of hundreds of thousands of hospitalized patients who now needed to be seen in community-based clinics.

Highlight 4.1 *Donaldson vs. O'Connor*

Kenneth Donaldson, who had been committed to a state mental hospital in Florida and confined against his will for 15 years, sued the hospital superintendent, Dr. J. B. O'Connor, and his staff for intentionally and maliciously depriving him of his constitutional right to liberty. Donaldson, who had been hospitalized against his will for paranoid schizophrenia, said he was not mentally ill, and he stated that even if he were, the hospital had not provided him adequate treatment.

Over the 15 years of confinement, Donaldson, who was not in danger of harming himself or others, had frequently asked for his release and had relatives who stated they would attend to him if he were released. Despite this, the hospital refused to release him, stating that he was still mentally ill. The Supreme Court unanimously upheld lower court decisions stating that the hospital could not hold him against his will if he was not in danger of harming himself or others (Swenson, 1997). This decision, along with the increased use and discovery of new psychotropic medications, led to the release of hundreds of thousands of individuals across the country who had been confined to mental hospitals against their will and who were not a danger to themselves or others.

Today, with research indicating that some mental illness is predominantly or partially biologically based (Chase, 2012), psychiatrists have been playing an increasingly important role in the mental health field. In addition, with the advent of new and much improved **psychopharmacological drugs,** psychiatrists have become very important consultants to counselors and other mental health professionals.

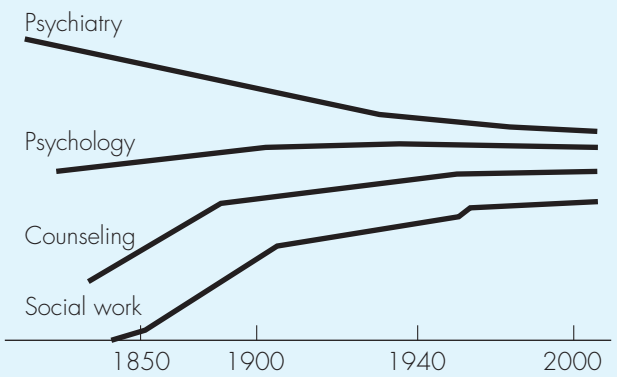
Psychiatry's Influence on the Counseling Profession

Psychiatry's focus on diagnosing mental illness and exploring psychopathology has assisted counselors and other professionals in diagnosis and development of treatment plans for clients, which sometimes includes psychopharmacology. In addition, the awareness that some mental health problems may be organic has helped counselors understand that at times it is critical to make a referral to an expert in psychopharmacology and psychobiology.

Conclusion

Despite, or maybe because of their different origins, the fields of social work, psychology, and psychiatry have all impacted the field of counseling. Whether it's the systems or advocacy emphasis of social work; the assessment, research and theoretical underpinnings of psychology; or the diagnosis or psychopharmacology focus of psychiatry; each has provided the counseling field with important ways to understand mental health and mental illness. As we move into Chapter 5, we will see how the counseling profession both borrowed from these professions and also created its own unique identity as it developed over the past 100 years. And although all four professions have disparate beginnings, today the fields of social work, psychology, psychiatry, and counseling have all slowly moved toward many of the same theoretical conclusions and can be viewed as having slightly different yet parallel paths (see Figure 4.2).

FIGURE 4.2 The Coming Together of the Major Fields of Mental Health



Source: Army Beta Test, found at http://official-asvab.com/armysamples_coun.htm

LO 5

A Lot of Names and Dates to Learn

Well, there certainly were a fair amount of names to learn about in this chapter, and there will be more in the next. But they are important names and dates because they have influenced our professional identity. To help you remember some of them, Table 4.1 summarizes most of the important facts in this chapter.

TABLE 4.1 Summary of Important Historical Events

3000 BCE Ancient Egypt	Psychological writings found on papyrus
400 BCE Hippocrates	Wrote the first modern-day reflections on the human condition
350 BCE Plato	Believed introspection and reflection to be the road to knowledge
350 BCE Aristotle	Considered by many to be first psychologist—studied objectivity and reason
250 Plotinus	Believed in dualism—the concept that the soul is separate from the body
400 Augustine	Examined the meaning of consciousness, self-examination, and inquiry
1250 Thomas Aquinas	Examined the meaning of consciousness, self-examination, and inquiry
1500s Elizabethan Poor Laws	Established legislation for the Church to help the destitute in England
1650 Descartes	Believed that knowledge and truth come through deductive reasoning
1700 John Locke	Believed the mind is a blank slate upon which ideas are generated
1800 James Mill	Believed the mind is a blank slate upon which ideas are generated
1800 Philippe Pinel	Founder of the field of psychiatry; viewed insanity from scientific perspective; advocated for humane treatment of the mentally ill
1800 Benjamin Rush	Founder of American psychiatry, advocated for humane treatment of the mentally ill

(*Continued*)

TABLE 4.1 (*Continued*)

1800 Anton Mesmer	Discovered the first uses of hypnosis
1800s Charity Organization Societies	Volunteers (friendly visitors) offered assistance to the poor and destitute
1800s Settlement Houses	Individuals lived in communities to help the poor and destitute
1844 Origins of APA	Founding of the Association of Medical Superintendents of American Institutions for the Insane (precursor to the American Psychiatric Association)
1850 Jean Martin Charcot	Used hypnosis to understand disorders, saw the relationship between psychological and organic states
1850 Dorothea Dix	Advocated for humane treatment for the mentally ill, helped establish 41 modern mental hospitals
1875 Wilhelm Wundt	First experimental psychologist
1875 Sir Francis Galton	Early experimental psychologist
1890s Sigmund Freud	Developed the theory of psychoanalysis
1890s G. Stanley Hall	Founded the APA; early American experimental psychologist
1890s James Cattell	Early American experimental psychologist
1890s William James	Philosophical Pragmatism: reality is continually constructed as a function of its utility or practical purpose
1889 Jane Addams	Established Hull House in Chicago
Around 1900 Emil Kraepelin	Developed one of the first classifications of mental diseases
Around 1900 Alfred Binet	Developed the first individual intelligence test for the French Ministry of Public Education
Around 1900 Pierre Janet	Saw a relationship between certain psychological states and organic disorders
Around 1900 Ivan Pavlov	Developed one of the first behavioral models of learning
1940s Division 17 of APA	Division 17 formally became part of APA
1950s Virginia Satir	One of first social workers to stress contextual or systems thinking
1950s *DSM*	First diagnostic manual developed
1955 NASW	National Association of Social Workers founded from a merger of seven associations
1960	NASW establishes Association for Certified Social Workers
1975 *Donaldson vs. O'Connor*	Deinstitutionalization of hundreds of thousands of hospitalized patients

Case Study 4.1 Mary

Mary is 42 years old, poor, periodically homeless, and often can be found delusional and talking to herself. When she has had a place to live, she has been placed on antipsychotic medication from the local mental health center. She reports that the medication helped her considerably. She talks about "needing to talk to someone" because of her "depression and crazy thoughts" and would like to try to eventually get a job. She says she has two children who live with her former boyfriend, but does not want to see them in her current state. However, she yearns to see her children again but believes that if she were to do so, she would need to better her current situation. She is hoping that someone can help her with her depression and her "crazy thoughts" and believes that if she could get some help, she could eventually get a job and a new home. This, she states, would allow her to feel good enough to see her children.

Increasingly, mental health professionals are asked to work in teams to address client problems. The history of psychiatry, psychology, and social work have led these related professional groups to work in somewhat

different ways from one another, and these differences can complement one another. Based on your knowledge of these groups, and what you read in this and previous chapters, how do you think psychiatrists, psychologists, social workers, and counselors could work together to help Mary? What different foci would each professional group have in helping Mary become stabilized and feeling better about herself?

Summary

This chapter examined the history of counseling from its early beginnings to current-day practices. We learned that the human condition has been pondered for thousands of years, and noted that myths, magic, sprits, ritualism, and sacred art have all been used to understand ourselves and the world around us. We pointed out that shamans, or individuals with special mystical powers, were seen as early caretakers of the soul. We also noted that early treatises that were psychological in nature were found in Egypt and that philosophy, as well as early religious texts, offered us much to ponder from a psychological perspective. Although the Renaissance was void of psychological writings to a large extent, we did note that some individuals like Descartes, John Locke, and James Mill offered us the ingredients for modern psychology.

More specifically, in this chapter we examined the historical roots of the field of social work and saw how social work's emphasis on systems and advocacy has influenced the counseling profession. We also saw how social work's emphasis on "in-the-field" experiences has impacted counselor education training and its recent trends toward increasing practicum and internship hours. In addition to social work, we offered a brief overview of the field of psychology and noted that many of the philosophical roots of modern-day counseling theories arose from psychology's early beginnings. We examined how laboratory science and research techniques have become important tools for counselors as they research the efficacy of programs they develop and of specific counseling techniques they use. We also examined how tests used by many counselors today had their origins in the early days of testing as originated by psychologists. Finally, we saw how the field of psychiatry has offered us ways of understanding and classifying mental health problems and how crucial it is for counselors to have an understanding of the possible organic nature of some mental health problems.

Key Terms*

Academy of Certified Social Workers (ACSW)
Addams, Jane
Advocacy
American Psychiatric Association (APA)
American Psychological Association (APA)
Aquinas, Thomas
Aristotle
Augustine
Binet, Alfred
Cattell, James
Charcot, Jean Martin
Charity Organization Society (COS)
Classical conditioning
Classifications of mental diseases
Cognitive-behavioral therapies
Community organizing
Community-based mental health centers
Counseling Psychology (Division 17)
Counseling skills

*Please see Table 4.1 for descriptions of individuals and key events.

Deinstitutionalization
Delusive perceptions
Descartes
Diagnostic and Statistical Manual of Mental Disorders
Dix, Dorothea
Donaldson vs. O'Connor
Elizabethan Poor Laws
Existential psychology
Experimental psychologists
Family systems
Freud, Sigmund
Friendly visitors
Galton, Sir Francis
Gestalt psychology
Group work
Hall, G. Stanley
Hippocrates
Hull House
Humanistically oriented therapies
Hypnosis
James, William
Janet, Pierre
Kraepelin, Emil
Laboratory science
Locke, John
Mesmer, Anton
Mesmerize
Mill, James
National Association of Social Work (NASW)
Pavlov, Ivan
Phenomenological psychology
Philosophical pragmatism
Pinel, Philippe
Plato
Psyche
Psychoanalysis
Psychoanalytic movement
Psychobiology
Psychological and educational tests
Psychopharmacological drugs
Repressed memories
Rush, Benjamin
Satir, Virginia
Settlement movement
Social casework
Social justice
Social psychiatry
Social systems
Soul
Vocational guidance counselors
Wundt, Wilhelm

The History of the Counseling Profession

CHAPTER 5

LEARNING OBJECTIVES

LO 1 Learn the 100-year-old history of the counseling profession, including:

- **LO 1a** The antecedents of the counseling profession with vocational guidance during the 1800s
- **LO 1b** The first vocational and guidance counselors during the early 1900s
- **LO 1c** How testing impacted the counseling profession during the first half of the twentieth century
- **LO 1d** How the spread of psychotherapy impacted the counseling profession during the first half of the twentieth century
- **LO 1e** The emergence, expanse, and diversification of the counseling profession during the 1950s
- **LO 1f** The increased diversification of the counseling profession during the 1960s
- **LO 1g** The proliferation of the counseling field during the 1970s
- **LO 1h** Changes to the counseling profession during the late twentieth century
- **LO 1i** Recent changes to the field

LO 2 Highlight and learn important names and dates.

Counseling represents the fusing of many influences. It brings together the movement toward a more compassionate treatment of mental health problems begun in the mid-nineteenth century France, the psychodynamic insights of Freud and psychoanalysis, the scientific scrutiny and methodology of the behavioral approach, the quantitative science of psychometrics, the humanistic perspective of client-centered therapy, the philosophical base of existentialism, and the practical insights and applications that evolved from the vocational guidance movement. (Belkin, 1988, p. 19)

As you learned from Chapter 4, the counseling profession shares common roots with psychology, social work, and psychiatry. In that chapter we noted how social workers, early on, worked in humane ways with the poor and the destitute, established a systemic perspective to viewing families and communities, and saw the importance of advocacy for their clients. We noted that psychologists focused on testing and research and were the first to embrace a systematic psychotherapeutic approach to working with clients. And we saw that psychiatry's focus on the humane treatment of the mentally ill, the classification of mental illness, and the importance of psychopharmacology changed the way that individuals were treated. All of these events were to profoundly affect the emergence of the counseling profession and impact how counselors were to eventually work. However, our profession has its own unique history, which dates back to the early days of vocational guidance. Let's take a look at the 100-year-old history of counseling.

LO 1a

Vocational Guidance in the 1800s

Although modern-day vocational guidance activities and theory began in the latter part of the 1800s, interest in vocational adjustment far preceded the 1800s. For instance, as far back as the tenth century, writings in an Iraqi text addressed occupational information, while the first job classification system was developed in Spain as early as 1468 by **Sanchez de Arevalo,** who wrote ***Mirror of Men's Lives*** (Carson & Altai, 1994). At the end of the nineteenth century, dramatic shifts took place in the United States that were partially responsible for the development of the **vocational guidance movement** and ultimately set the stage for the establishment of the counseling profession. At that time in history we saw the rise of social reform movements, the impact of the Industrial Revolution, and an increase in immigration, mostly to large northeastern cities. Jointly, these events led to the large-scale need for vocational guidance. During the early to mid-1800s, prior to the development of **vocational theory,** a number of poorly written, moralistic books on occupational choice were written (Zytowski, 1972). However, by the end of the century, the stage was set for the development of the first comprehensive approaches to **vocational guidance**—approaches that would at least be partially based on the new science of testing (Herr, Cramer, & Niles, 2004).

LO 1b

The First Vocational and Guidance Counselors: Early 1900s

> *It is difficult even to imagine the difference of conditions now and in the early years of the century.… Think of what life would be without the railroad, only the stage-coach to carry our letters and ourselves across the country. Think of pulling oranges from Florida or California to Boston stores by team. Think of a city without a street-car or a bicycle, a cooking stove or a furnace, a gas jet*

> *or electric light, or even a kerosene lamp! Think of a land without photographs or photogravures, Christmas cards or color prints.… (Parsons, cited in Watts, 1994, p. 267)*

It was a different world at the beginning of the twentieth century, but the rumblings of a new age were everywhere to be found. Social reformers were caring for the poor and demanding changes in education; Psychiatry was changing its methods of treatment for the mentally ill; psychoanalysis and related therapies were in vogue; the modern-day use of tests was beginning; and the impact of the Industrial Revolution could be seen everywhere. In subtle, but important ways, each of these events would affect early vocational guidance and the emergence of the field of counseling.

The first part of the twentieth century saw the beginnings of systematic vocational guidance in America. Although the concepts had been floating around in the latter part of the 1800s, the 1900s brought the first comprehensive approach to vocational guidance. Then in 1907, troubled by the attitudes of youth, **Jesse Davis** (1871–1955) developed one of the first guidance curricula that focused on moral and vocational guidance, which was presented during English composition classes in the Grand Rapids, Michigan, schools. At around the same time **Eli Weaver** (1862–1922), a New York City principal who had written a booklet called *Choosing a Career*, started vocational guidance in New York. Similarly, **Anna Reed** (1871–1946) soon established guidance services in the Seattle school system, and by 1910, 35 cities had plans for the establishment of vocational guidance in their schools (Aubrey, 1977). Although revolutionary in their thinking, many of these early vocational guidance reformers were motivated by moralistic thinking and theories of the time, such as social Darwinism, that suggested individuals should fervently follow their supervisors and "fight their co-workers for advanced status" (survival of the fittest) (Rockwell & Rothney, 1961, p. 352).

The person who undoubtedly had the greatest impact on the development of vocational guidance in America was **Frank Parsons** (1854–1908) (Briddick, 2009a; McDaniels & Watts, 1994). Seen today as the **founder of guidance** in America, Parsons was greatly influenced by the social reform movements of the time, such as the work of **Jane Addams** at **Hull House** who advocated for better conditions for the poor. Eventually establishing the **Vocational Bureau**, which assisted individuals in "choosing an occupation, preparing themselves for it, finding an opening in it, and building a career of efficiency and success" (Parsons cited in Jones, 1994, p. 288), Parsons hoped that vocational guidance would eventually be established in the public schools—a hope he would not see come to fruition due to his untimely death in 1908, at the age of 54. In 1909, his book ***Choosing a Vocation*** was published posthumously. Soon after his death, perhaps as a tribute to the energy he gave to the vocational guidance movement, his hometown of Boston became the site for the first vocational guidance conference. This conference resulted in the founding of the **National Vocational Guidance Association (NVGA)** in 1913, which is generally considered the distant predecessor of the **American Counseling Association (ACA)**.

Frank Parsons was a man with a vision (Briddick, 2009b; Pope & Sveinsdottir, 2005). He envisioned systematic vocational guidance in the schools, he anticipated a national vocational guidance movement, he foresaw the importance of individual counseling, and he hoped for a society in which cooperation was more important than competition and where concern replaced avarice (Jones, 1994). Clearly, Parsons's principles of vocational guidance greatly affected the broader field of counseling.

Parsons's main thrust toward vocational guidance is usually presented as a three-part process in which an individual would develop:

1. a clear understanding of yourself, your aptitudes, interests, ambitions, resources, limitations, and their causes;
2. a knowledge of the requirements and conditions of success, advantages and disadvantages, compensation, opportunities, and prospects in different lines of work; and
3. true reasoning on the relations of these two groups of facts (Parsons, 1909/2009, p. 5).

However, a deeper examination of Parsons' work shows us that many of his principles eventually became some of the major tenets of the counseling profession (Jones, 1994). For instance, Parsons noted the importance of having an expert guide when making difficult decisions. In addition, he suggested that even an expert guide cannot make a decision *for* a person, as only the individual can decide what's best for him- or herself. He also suggested that the counselor should be frank (genuine) and kind with the client and that it was crucial for the counselor to assist the client in the development of analytic skills. Frank Parsons clearly deserves the title founder of vocational guidance, and in many ways he can also be seen as the **founder of the counseling field**.

Parsons developed the beginnings of a theoretical orientation to counseling and with the founding of NVGA, the vocational guidance movement was established. Although the spread of the movement did not occur as quickly as some might have liked (Aubrey, 1977), a number of acts were eventually passed to strengthen vocational education (Herr, 1985). One such act, the Depression-era **Wagner O'Day Act** of 1932, established the U.S. Employment Services and provided ongoing vocational guidance and placement to all unemployed Americans. **Vocational counseling** as part of the landscape of the United States was here to stay, and it would soon have an impact on all facets of counseling.

Although vocational guidance in the schools soon became widespread, it was not long before individuals advocated for an approach that attended to a broader spectrum of students' psychological and educational needs. For instance, **John Brewer** (1932) suggested that guidance should be seen in a **total educational context** and that guidance counselors should be involved in a variety of functions in the schools, including adjustment counseling, assistance with curriculum planning, classroom management, and, of course, occupational guidance. One tool used by the counselor was the test (Aubrey, 1982).

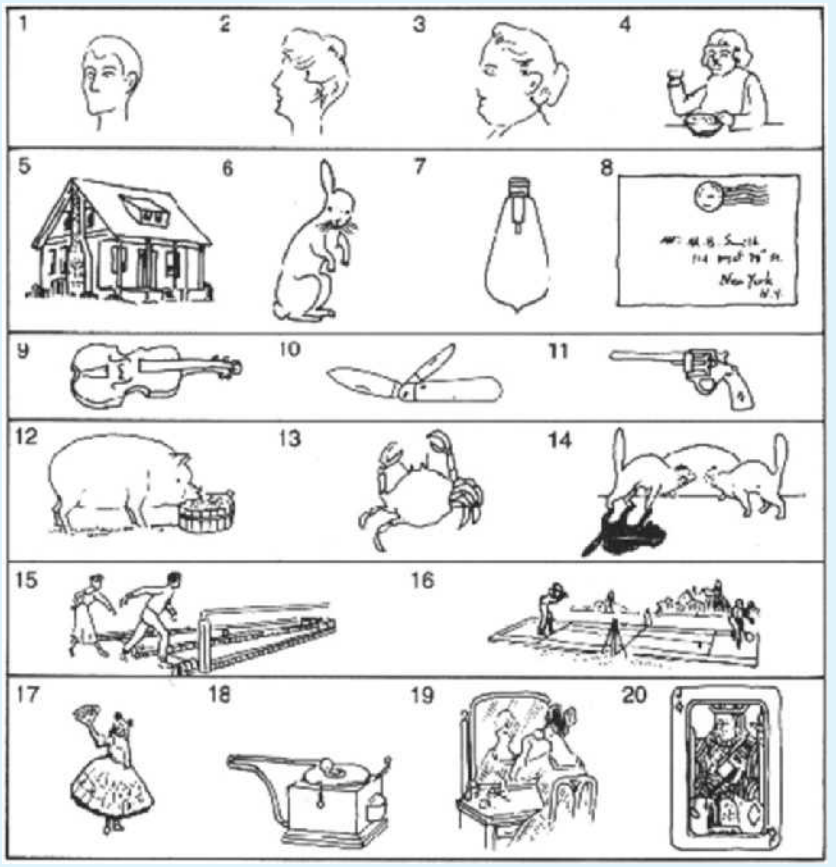
LO 1c

The Expansion of the Testing Movement: 1900–1950

> *It is doubtful that vocational guidance would have survived without a psychological support base in psychometrics. (Aubrey, 1977, p. 290)*

With the advent of the vocational guidance movement, testing was to become commonplace. Parsons, for instance, strongly advocated the use of tests in vocational guidance (Williamson, 1964). During World War I, some of the first crude tests of ability were used on a large-scale basis. For instance, the **Army Alpha** was a test used for "literates"

FIGURE 5.1 Picture Completion Test of the Army Beta



Source: Army Beta Test, found at http://official-asvab.com/armysamples_coun.htm

to determine placement of recruits, while the **Army Beta** was used for "illiterates" (see Figure 5.1).

The use of tests to assist in vocational counseling was promoted by the development of one of the first major interest inventories, the **Strong Vocational Interest Blank,** in 1927 (Campbell, 1968). This test, which in its revised form is still one of the most widely used instruments of its kind, was to revolutionize vocational counseling. But the use of tests extended beyond vocational assessment. For instance, **Woodworth's Personal Data Sheet** was an early personality instrument used by the military to screen out emotionally disturbed individuals.

The successful large-scale use of tests by the military led to the development and adoption of similar instruments in the schools, business, and industry (Neukrug & Fawcett, 2015). By the middle of the twentieth century, tests to measure achievement, cognitive ability, interests, intelligence, and personality were commonplace. Although often used in vocational counseling, many of these tests soon found their way into all kinds of counseling practices.

LO 1d

The Spread of Psychotherapy and Its Impact on Counseling: 1900–1950

> *Most sane people think that no insane person can reason logically. But this is not so. Upon reasonable premises I made most reasonable deductions, and that at the time when my mind was in its most disturbed condition. (Beers, 1908/1948, p. 18)*

In 1908, **Clifford Beers** (1876–1943), a Yale graduate who had been hospitalized for years due to schizophrenia, wrote ***A Mind That Found Itself.*** In 1909, he helped to establish the **National Committee for Mental Hygiene**, which lobbied the U.S. Congress to pass laws that would improve the deplorable conditions of mental institutions. Soon, this committee began to organize the first **child guidance clinics**, staffed by social workers, psychologists, and psychiatrists. At the same time, **psychoanalysis** was beginning to come out of the elite office of the psychiatrist and work its way into the community. The end of World War I saw a number of psychologists offering their services to returning doughboys who had psychological problems associated with the war (today such problems are often diagnosed as **posttraumatic stress disorder,** or **PTSD**). Since the long-term treatment approaches of the psychoanalysts were of little use to these clinicians, they soon began to develop new, shorter-term approaches.

As treatment approaches to the individual changed, and as mental health clinics spread, the need for psychological assistants, often with bachelor's or master's degrees, became evident. The master's level assistants often had degrees in social work, but increasingly there were individuals with a relatively new degree—a master's degree in counseling, which had its origins as a degree in vocational guidance. It was a natural transition for individuals with the vocational guidance degree to move into the mental health field, because they were trained both in counseling techniques and in assessment.

The emergence of the counseling field as something other than pure vocational guidance made its greatest leap forward during the 1930s, when **E. G. Williamson** (1900–1979) developed what is considered the **first comprehensive theory of counseling** (as distinguished from Freud's theory of psychoanalysis). Known as the **Minnesota Point of View** (for the University of Minnesota, where Williamson was a faculty member), or **trait and factor theory,** Williamson's approach initially grew out of the ideas of Frank Parsons. Although originally vocationally oriented, the approach was modified and became a generic approach to **counseling and psychotherapy.** The trait and factor approach involved a series of five steps, which included the following (Williamson & Darley, 1937):

1. *Analysis:* Examining the problem and obtaining available records and testing for the client
2. *Synthesis:* Summarizing and organizing the information to understand the problem
3. *Diagnosis:* Interpreting the problem
4. *Counseling:* Aiding the individual in finding solutions
5. *Follow-up:* Ensuring proper support after counseling had ended

With the rise of Nazism during the 1930s and 1940s, many humanistic philosophers, psychiatrists, and psychologists fled Europe for the United States and dramatically

influenced the field of psychotherapy and education in their new country. One of those influenced by these humanists was **Carl Rogers** (1902–1987). Called one of the most influential psychologists and psychotherapists of the latter part of the twentieth century ("Ten most influential …," 2007), Rogers initially worked from a **psychodynamic** perspective at the **Rochester Guidance Center** but later revolutionized the practice of counseling with his *client-centered approach*. His **nondirective approach** to working with individuals was viewed as shorter-term, more humane, more honest, and more viable for most clients than the psychodynamic approaches to counseling. The early 1940s saw the publication of Carl Rogers's book *Counseling and Psychotherapy*, which was to have a major impact on the counseling profession (Rogers, 1942). Rogers and others in the newly established field of **humanistic counseling and education** were responsible for moving the counseling field from a vocational guidance orientation to one with a much broader base. Rogers's approach was ripe for the times, as it reflected the increased focus on personal freedom and autonomy of the post-WWII years (Aubrey, 1977). Although Rogers and other humanists during the 1940s had a great impact on the field of counseling, the second half of the century would witness even more dramatic changes than had already occurred.

LO 1e

Emergence, Expansion, and Diversification: The 1950s

> *If one decade in history had to be singled out for the most profound impact on counselors, it would be the 1950s. (Aubrey, 1977, p. 292)*

During the 1950s, the counseling profession shifted increasingly toward a humanistic, nondirective orientation. This decade saw Carl Rogers become an even greater influence on the field as he published his second book, entitled *Client-Centered Therapy: Its Current Practice, Implications and Theory* (Rogers, 1951). In addition, impacted by the push to depathologize individuals, this decade saw the promulgation of **developmental theories** in the areas of **career counseling** (e.g., Ginzberg, Ginsburg, Axelrad, & Herma, 1951; Super, 1953), **child development** (e.g., Piaget, 1954), and **lifespan development** (e.g., Erikson, 1950). These theories stressed the notion that individuals would face predictable tasks as they passed through the inevitable developmental stages of life and that knowledge of such tasks could greatly aid counselors in their work with clients.

Perhaps the most important event that would affect counseling during this time was the 1957 launching of the first satellite in space, Sputnik. The launching of this Russian satellite sent a chill through many Americans and provided the impetus for Congress passing the **National Defense Education Act** (NDEA), in 1958, which allocated funds for training institutes that would quickly graduate secondary school counselors. These counselors, it was hoped, would identify students gifted in math and science who could be future scientists. The obvious result of this legislation was the significant increase in secondary school counselors in the late 1950s and 1960s. The bill was extended to include the training of elementary school counselors in 1964.

Besides the dramatic increase in school counselors, the 1950s also saw the first full-time college counselors and the beginning of **college counseling centers.** With the GI Bill funding college expenses for World War II veterans, there was increased enrollment in

colleges and an increased need for college counselors to address the needs of these soldiers and other students (Kraft, 2011). As with other aspects of the counseling profession, college counseling centers quickly took on the humanistic and developmental approach to working with students and were generally staffed by counselors and psychologists. Other college student services offices (e.g., career centers) that employed counselors also expanded rapidly during this time.

Community agencies also saw an influx of counselors and psychologists during the 1950s. The discovery of antipsychotic, antidepressant, and antianxiety medications and the controversial yet widespread use of **electroconvulsive therapy** enabled the release of large numbers of people from state hospitals who then found needed services at local community agencies (Kornetsky, 1976; Mehr & Kanwischer, 2011). In addition, this decade saw counselors increasingly staffing **vocational rehabilitation centers,** working to address both the physical and psychological needs of individuals, especially those who had been seriously injured during World War II.

This decade saw the formation of the **American Personnel and Guidance Association (APGA,** the forerunner of ACA) from a merger of four counseling-related associations, and it was not long before a number of divisions representing the growing diversity of counselors in the field emerged. These included: the **American School Counselor Association (ASCA)**, the **Association for Counselor Education and Supervision (ACES),** the **National Career Development Association (NCDA),** the **American Rehabilitation Counseling Association (ARCA)**, and the **Counseling Association for Humanistic Education and Development** (now the **Association for Humanistic Counseling [AHC]**).

Changes were not only taking place in the counseling profession around this time. In 1945, the **American Association of Marriage and Family Counseling (AAMFC, now AAMFT)** was formed, and the 1950s saw the formation of the **National Association of Social Workers (NASW)** and the changing of the name of **Division 17 of the APA** from the Counseling and Guidance Division to the Division of Counseling Psychology. Whereas Division 17 required a doctorate for full membership, APGA, AAMFT, and NASW were focusing on master's level training. Differentiation and solidification of the various mental health fields was clearly occurring.

LO 1f

Increased Diversification: The 1960s

During the first half of the twentieth century three approaches to counseling and therapy were particularly popular: **psychodynamic approaches** (e.g., Freud), **directive theories** (e.g., Williamson), and **client-centered theories** (e.g., Rogers) (Neukrug, 2015). However, the late 1950s and the 1960s saw a number of new, at the time revolutionary, approaches to counseling to take shape, including the **rational emotive (cognitive) approach** of **Albert Ellis** (Ellis & Harper, 1961); **behavioral approaches** of **Albert Bandura** (1969), **Joseph Wolpe** (1958), and **John Krumboltz** (1966a, 1966b); **William Glasser**'*s* **reality therapy approach** (1961, 1965); the **Gestalt therapy** approach of **Fritz Perls** (1969); the communication approach of **transactional analysis** (Berne, 1964); and the **existential approaches** of **Viktor Frankl** (1963), **Rollo May** (1950), and others. These counseling approaches were at least partially developed due to the increased demand for therapists. Can you imagine being a young mental health professional during this time? The sheer

number of new theories and new thought-provoking approaches to working with clients would have been incredibly stimulating!

The need for counselors and other mental health professionals expanded as a direct result of the passage of many legislative actions related to President Johnson's **Great Society** initiatives (Kaplan & Cuciti, 1986). One such legislative act, the **Community Mental Health Centers Act** of 1963, funded the nationwide establishment of mental health centers to provide short-term inpatient care, outpatient care, partial hospitalization, emergency services, and consultation and education services. These centers made it possible for individuals with adjustment problems, as well as those with severe emotional disorders, to obtain free or low-cost mental health services. Approximately 600 community-based mental health centers were established as a result of this act (Burger, 2014).

Many other acts were also passed during this decade. For instance, amendments to the 1964 NDEA expanded the training of counselors to include counselors from elementary school through junior college (Lambie & Williamson, 2004). In fact, by 1967 nearly 20,000 school counselors had been trained as a result of this act. In addition, a number of other acts provided job opportunities for counselors, such as the **Manpower Development and Training Act, Job Corps, Elementary and Secondary Education Act, Head Start,** and the **Work Incentive Program.** Other key legislative initiatives such as the **Civil Rights Act, Economic Opportunity Act,** and **Voting Rights Act** helped to reshape attitudes toward social problems and community service, with one result being a more accepting attitude toward the counseling profession. Clearly, the 1960s was a decade of expansion, acceptance of counselors, and diversification of the counseling profession largely as the result of legislative actions.

With expansion and diversification came an increased need for professionalism in the field. Thus, it was at this time that we saw the emergence of **ethical standards of practice**, such as APGA's first ethical code in 1961. The 1960s also saw a flurry of activity around the need for accreditation standards of counseling programs. Meetings were held throughout the country that would be the precursors to the development, in 1981, of the **Council for Accreditation of Counseling and Related Educational Programs (CACREP)**. Finally, the 1960s saw the continued expansion of APGA with increased membership, the formation of what would become the **Association for Assessment in Counseling and Education (AACE)** (now the **Association of Assessment and Research in Counseling [AARC]**) and the **National Employment Counseling Association (NECA)**, and the recommendation in 1964 by APGA to have state branches (ACA, 1995a).

LO 1g

Continued Proliferation of the Counseling Field: The 1970s

During the 1970s a number of events increased the need for counselors. For instance, the 1975 Supreme Court decision in ***Donaldson vs. O'Connor*** led to the deinstitutionalization of tens of thousands of state mental hospital patients who had been hospitalized against their will (see Highlight 4.1). This case concluded that individuals who were not in danger of harming themselves, or others, could not be held against their will. With the release of individuals from the hospitals came an increased need for

community mental health counselors. Thus, in 1975 Congress passed an expansion of the original Community Mental Health Centers Act and extended from 5 to 12 the categories of services that mental health centers were required to provide. They included:

1. Short-term inpatient services
2. Outpatient services
3. Partial hospitalization (day treatment)
4. Emergency services
5. Consultation and education
6. Special services for children
7. Special services for the elderly
8. Pre-institutional court screening
9. Alcoholism services
10. Follow-up care for mental hospitals
11. Transitional care from mental hospitals
12. Drug abuse services

The 1970s also saw the passage of legislation for individuals with disabilities. These laws increased the demand for highly trained rehabilitation counselors and expanded the role of school counselors. For instance, the **Rehabilitation Act** of 1973 ensured vocational rehabilitation services and counseling for employable adults who had severe physical or mental disabilities that interfered with their ability to obtain and/or maintain a job. The **Education for All Handicapped Children Act (PL94-142)** of 1975 ensured the right to an education within the least restrictive environment for all children identified as having disabilities that interfered with learning. PL94-142 resulted in school counselors increasingly becoming an integral part of the team that would determine the disposition of students with disabilities.

This decade also saw a major shift in the training of counseling students. The influence of the humanistic movement had fully taken hold by the 1970s, and a number of individuals began to develop what became known as **microcounseling skills training** (Carkhuff, 1969; Egan, 1975; Ivey & Gluckstein, 1974). The teaching of microcounseling skills was based on many of the skills deemed critical by Carl Rogers and other humanistic counselors and psychologists. These packaged ways of training counselors showed that basic counseling skills, such as attending behaviors, listening, and empathic understanding, could be learned in a relatively short amount of time and that the practice of such skills would have a positive impact on counseling outcomes (Neukrug, 1980). It was also during this decade that we began to see the blossoming of publications in the area of **cross-cultural counseling.** Seminal works by **Derald Sue, Paul Pedersen, William Cross, Donald Atkinson,** and others began to make their way into the counselor education curriculum.

The 1970s was also the decade of increased professionalization in the field. For instance, the early 1970s saw the **Association for Counselor Education and Supervision (ACES)** provide drafts of standards for master's level counseling programs. National **credentialing** became a reality when **certification** was offered for the first time by the **Council on Rehabilitation Education (CORE)** in 1973 and by the **National Academy for Certified Mental Health Counselors (NACMHC)** in 1979 (Sweeney, 1991). Finally, state **licensure** had its beginnings when, in 1976, Virginia became the first state to offer licensing for counselors.

The legislative actions of the 1970s led to increased diversification of the counseling field, resulting in large numbers of counselors settling into the mental health, rehabilitation, higher education, and school counseling specialty areas. One result of this diversification was the burgeoning membership of APGA, which reached 40,000, and the founding of a number of divisions of ACA (then called APGA), including the **Association for Multicultural Counseling and Development (AMCD,** in 1972), the **Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC,** in 1974), the **Association for Specialists in Group Work (ASGW,** in 1973), the **International Association of Addictions and Offender Counselors (IAAOC,** in 1972), and the **American Mental Health Counselors Association (AMHCA,** in 1978) (ACA, 1995a; Goodyear, 1984).

LO 1h

Changes During the Late Twentieth Century: 1980–2000

The 1980s and 1990s saw continued expansion and diversification as well as a settling-in phase marked by an increased focus on professionalism. Counselors could now be found in almost any mental health setting, while expanded services were offered in colleges and schools. Counselors also began to practice in areas where minimal mental health services had been provided, including substance abuse agencies, agencies that worked with older persons, and business and industry. With the profession clearly having come of age, it became evident that there was an urgent need for the standardization of training and the credentialing of counselors. Therefore, in 1981, CACREP was formed to further delineate standards for the profession. Today, CACREP accredits master's programs in school counseling; clinical mental health counseling; marriage, couple, and family counseling; addictions counseling; career counseling; college counseling and student affairs; and clinical rehabilitation counseling and doctoral programs in counselor education and supervision (see Chapter 7 for a detailed discussion of CACREP).

The 1980s and 1990s saw a phenomenal increase in the types of credentials being offered and the numbers of individuals becoming certified or licensed. In 1982, APGA (now ACA) established the **National Board for Certified Counselors (NBCC)** and began to administer the first national generic certification exam for counselors (NBCC, 2015d). In addition, in 1994 the **International Association of Marriage and Family Counselors (IAMFC,** 2015a), a division of ACA, began to offer a credential as a **Certified Family Therapist (CFT).** It was also during this decade that an increasing number of states began offering licensure for counselors (Neukrug, Milliken, & Walden, 2001). Probably one of the greatest changes in the field of counseling during the 1980s and 1990s was the increased focus on **multicultural counseling** (Claiborn, 1991). This new emphasis was partly due to CACREP's requirement that multicultural counseling be infused into the curricula of all accredited graduate programs, the ever-increasing volumes of work being published in the field of multicultural counseling, and the 1991 adoption by AMCD of **Multicultural Counseling Competencies,** which counseling training programs were encouraged to follow (Arredondo et al., 1996; Evans & Larrabee, 2002).

The 1990s also saw an increased emphasis on the importance of ethical issues in counseling. Whereas prior to 1980 few counseling texts discussed ethical issues to any great extent, this decade saw research and publications on **ethics** greatly expanded with particular focus on ethical decision-making, ethics in supervision, ethics in teaching, and even the ethics of online counseling (ACA, 1995b; Attridge, 2000, 2004). Not surprisingly, the 1990s brought a revision of the **ACA Code of Ethics** as well as the development of separate ethical guidelines for online counseling by ACA and by NBCC.

In 1992 the **American College Personnel Association (ACPA),** one of ACA's founding divisions, disaffiliated from the association. Also, in the latter part of the 1990s the boards of the two largest ACA divisions, AMHCA and ASCA, both threatened disaffiliation from ACA. This movement toward independent functioning of the divisions was a precursor to the divisional autonomy that was to occur in the twenty-first century.

There is little doubt that the changes that took place during the 1980s and 1990s were reflected in changes in the professional associations. In 1983 APGA changed its name to the **American Association for Counseling and Development (AACD),** and in 1992 the association underwent another name change to the more streamlined **American Counseling Association (ACA).** This name change seemed here to stay.

NVGA → APGA → AACD → ACA

The 1980s and 1990s saw the founding of a number of new divisions, including the **Military and Government Counseling Association (MCGA,** in 1984), the **Association for Adult Development and Aging (AADA,** in 1986), the **International Association of Marriage and Family Counselors (IAMFC,** in 1989), the **American College Counseling Association (ACCA,** in 1991), the **Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC,** in 1997; now **ALGBTIC**). Around the same time, an affiliate organization was founded: **Counselors for Social Justice (CSJ,** 1999). Membership in ACA soared and by 2000 had surpassed 55,000, with AMHCA and ASCA representing the two largest divisions. At that point, ACA had 17 divisions and 1 affiliate, representing the differing specialty areas in counseling, with close to 500 counselor training programs in the United States (Hollis & Dodson, 2000).

LO 1i

The New Millennium: 2000 and On

The first decade of the new millennium brought cutting edge issues to the forefront. Some of these, which will be expanded on in Chapter 6: Current Issues and Future Trends in the Counseling Profession, stand out:

1. *Credentialing:* All 50 states now offer licensing of professional counselors (California was the last state in 2010), and there has been a great expansion of the number and types of credentialed counselors.
2. *Licensure Portability:* With all 50 states now having licensure laws, in 2012 ACA began to push for **license portability,** sometimes called reciprocity, of one's license from state to state.
3. *Division Expansion and Autonomy:* Some of ACA's 20 divisions, such as ASCA and AMHCA, have become increasingly autonomous and have expanded their membership.

4. *Evidence-based Practice and Common Factors in Counseling:* The new millennium has seen a push toward using methods in counseling that match the client's presenting problem (**evidence-based practice: EBP**) as well as the **common factors** of all counseling approaches that lead to positive client outcomes.
5. *Multicultural Counseling:* Although this movement started over 25 years ago, it continues to pick up speed and expand: ACA endorsed the Multicultural Counseling Competencies in 2002 and more research and training continues to be conducted.
6. *Social Justice Focus:* With the adoption of the **Advocacy Competencies** in 2003, ACA fully embraced a new **social justice focus**.
7. *ASCA's National Model:* With the adoption of **ASCA's National Model** in 2003, ASCA began its push toward a new model of school counseling.
8. *New Ethics Code:* In 2014, ACA (ACA, 2014a) adopted a new ethics code, which addresses changing times and a changing counseling profession.
9. *New CACREP Standards:* In 2016, CACPREP revised its standards and increased the number of credits needed in some specialty areas. By 2020, all CACREP accredited programs will be 60 semester credits.
10. *Crisis, Disaster, and Trauma Counseling:* With CACREP's 2009 standards requiring a focus on **crisis, disaster, and trauma counseling**, it became clear that this area would be important in the years to come.
11. *Technology and Online Counseling:* **Technology and online counseling** has changed the ways that counseling and counselor education are delivered. Clearly, this will continue to be the case in upcoming years.
12. *20/20: A Vision for the Future of Counseling:* Thirty-one counseling associations have come together to develop a common **vision for counseling** as well as a new definition of counseling (see Activity 5.1).

Activity 5.1 Your Vision for the Future

On your own, develop a list of important skills, knowledge, and tools that might be needed for the future of counseling that were not discussed in this chapter. Then create and discuss a combined list in class.

13. *Globalization of Counseling:* Counseling has gone international and counseling programs and credentialing has emerged around the world. As a response to the **globalization of counseling,** the **International Registry of Counselor Education Programs (IRCEP)** was created by CACREP in 2009 to assist in the approving of program and the creation of standards (CACREP, 2015a).
14. *DSM-5:* The release, in 2013, of the fifth edition of the ***Diagnostic and Statistical Manual (DSM-5)*** with its 250 diagnoses will impact the manner in which counselors and other mental health professionals work with clients.
15. *Changes in the Health Care System:* The Affordable Care Act (Obamacare) and the acceptance of counselors as providers for government-sponsored health insurance policies, such as Tricare and through the Veterans Administration (VA), has impacted the counseling field, will likely change the manner in which counselors interact with their clients, and may be a vehicle for the growth of the counseling profession (NBCC, 2015e).

LO 2

A Lot of Names and Dates to Learn

The names and events highlighted in this chapter are important because they are the backbone of our professional identity. We have become what we are because of our history, and the present will shape what we will be in the future. So, let's embrace our history. And, to help you do so, Table 5.1 summarizes most of the important facts in this chapter.

TABLE 5.1 Summary of Important Historical Events (Cont'd from Chapter 4)

1906 Eli Weaver	Developed vocational guidance in New York City schools
1907 Jesse Davis	Developed one of the first guidance curriculums in Grand Rapids, Michigan, schools
1908 Anna Reed	Established vocational guidance in the Seattle school system
1908 Frank Parsons	Founder of vocational guidance; developed the first comprehensive approach to vocational guidance
1908 Clifford Beers	Institutionalized for schizophrenia; wrote *A Mind That Found Itself*; advocated for humane treatment of the mentally ill
1913 NVGA	National Vocational Guidance Association formed: distant forerunner of ACA
1917 Army Alpha Test	First large-scale use of tests of ability
1917 Woodworth Personal Data Sheet	One of the first structured personality tests
1927 Strong Interest Inventory	One of the first interest inventories to assist in career counseling process
1930 E. G. Williamson	Developed the first comprehensive theory of counseling, called the Minnesota Point of View, or trait and factor approach
1932 John Brewer	Suggested that guidance be seen in a total educational context
1932 Wagner O'Day Act	Established the U.S. Employment Service
1940s Carl Rogers	Developed a nondirective approach to counseling, advocate of humanistic counseling and education
1940s Division 17 of APA	Division 17 formally became part of APA
1945 AAMFT	AAMFT officially formed
1952 APGA	American Personnel and Guidance Association formed out of four associations: forerunner of ACA
1955 NASW	National Association of Social Workers founded from a merger of seven associations
1958 NDEA	National Defense Education Act: training for and expansion of school counselors
1960s Great Society Initiatives	Numerous laws passed under President Johnson: development of social service agencies nationally
1961 Ethical Codes	Development of first APGA guidelines for ethical behavior
1963 Community Mental Health Centers Act	Federal law provided for the establishment of community mental health centers nationally
1970s	Development of microcounseling skills training (e.g., Carkhuff, Ivey, Egan)
1970s Cross-cultural Issues	Seminal works published in the area of cross-cultural counseling by such individuals as Donald Atkinson, William Cross, Paul Pedersen, Derald Sue
1973 Rehabilitation Act	Ensured access to vocational rehabilitation services for adults; increased need for trained rehabilitation counselors
1973 CORE	Council for Rehabilitation Education offered the first credentialing for counselors
1975 PL94-142	Education of All Handicapped Children Act provided access to education within least restrictive environments: passage of this act extended the need for school counselors

TABLE 5.1 Summary of Important Historical Events (Cont'd from Chapter 4)

1975 *Donaldson vs. O'Connor*	Supreme Court decision leading to deinstitutionalization of mental hospital patients
1979 NACMHC	National Academy for Certified Mental Health Counselors offered national certification
1981 CACREP	Council for Accreditation of Counseling and Related Educational Programs was founded: established accreditation standards for counseling programs
1982 NBCC	National Board for Certified Counselors offered generic certification for counselors
1983 AACD	APGA became the American Association for Counseling and Development (AACD)
1990s Increased Emphasis	Increased focus on ethical issues, accreditation, professionalism, and multicultural issues
1990s	Many new divisions of ACA founded
1991 Multicultural Competencies	Proposed and adopted by AMCD: competencies suggest how to address multicultural training
1992 ACA	AACD becomes the American Counseling Association
1994 CFT	IAMFC offers national certification as a Certified Family Therapist (CFT)
2000–present	Division expansion and autonomy
2000–present	Evidence-based practice and common factors
2000–present	Credentialing: all 50 states have licensure; expansion of certification processes
2002–present	Multicultural Counseling Competencies are adopted by ACA
2003–present	Social Justice Focus/Advocacy Competencies are adopted by ACA
2003–present	ASCA's National Model is approved
2009	2009 CACREP standards
2009	Crisis, Disaster, and Trauma Training is infused into curriculum
2009	International Registry of Counselor Education Programs (IRCEP) created by CACREP
2010–present	20/20 Standards: A new vision for counseling
2012–present	Push for licensure portability
2013	*DSM-5* published
2014–present	New ethical code adopted
Ongoing	Technology impacts counseling; changes in health care
2016	New CACREP Standards

Case Study 5.1 Bill

Bill has been in the counseling profession for close to 40 years. When he began his career, there were just two specialty areas: school counseling and mental health counseling. There was no CACREP accreditation, no certification, and no licensing. Multicultural counseling was barely ever mentioned and advocacy work was not part of the field. Bill is a really nice guy, but a bit of a dinosaur in the profession. His friend, Esther, has also been in the profession for the same amount of time. However, she has kept up with the changes. She believes that becoming certified, learning the multicultural counseling competencies, knowing how to be an advocate, and generally keeping up with trends is critical to today's counselors. One day, she decides to go up to Bill and says, "You know Bill, we've been friends for many years; however, I've got to tell you that I think that you are acting unprofessionally, and maybe even unethically, by not keeping up with the current trends in the field. Particularly, you should be learning about multicultural counseling and advocacy, and I think it would be good if you went and became a nationally certified counselor."

Bill looks at Esther and says, "Esther, you know that I've been doing this for a long time know. My clients seem to like me, I am successful in my work, and I see no reason to change now. Where's the problem? I think that perhaps you have bought into some new ways of working that may not be as beneficial as you believe. How about just letting me do what has always worked? After all, it took me many years to get as skilled as I am."

1. What about Esther's point of view do you think is correct?
2. Do you believe Bill is acting ethically and professionally?
3. What about Bill's point of view do you think might be credible?
4. Would you feel comfortable working with Bill?

Summary

This chapter examined the unique history of the counseling profession. With its early focus on vocational counseling, we saw how, over the years, the counseling profession has moved from the somewhat moralistic, directive approach of vocational guidance to the humanistic approach it adopted starting in the 1940s. We examined how the profession expanded and diversified in the latter part of the twentieth century and how a number of legislative actions during that part of the century greatly influenced the direction and expansion of the profession. We explored how the development of ACA paralleled the expansion and diversification of the profession during the twentieth century. We also saw how the professionalism of the counseling field increased over the years, as evidenced by the expansion of ACA, the creation of ethical standards, the increase in the types and numbers of individuals becoming credentialed, and the establishment of accreditation standards for counseling programs.

As we shifted our focus to the current century, we highlighted a number of issues that will continue to be important to the counseling profession. These included a continued increase in the numbers and types of credentialed counselors; new ACA divisions and the assertion by other divisions of their autonomy from ACA; a focus on evidence-based practice and on common factors; ACA's endorsement of the Multicultural Counseling Competencies and an expanded focus on multicultural counseling research and training; endorsement by ACA of the Advocacy Competencies and a new social justice focus; adoption of ASCA's National Model and a push for a new training paradigm in school counseling; adoption of a new ethics code; adoption of new CACPREP standards; a new focus on crisis, disaster, and trauma training; technology and online counseling; the recent adoption of 20/20: A Vision for the Future of Counseling; the globalization of counseling, *DSM-5*; and changes in the health care system.

Key Terms*

ACA Code of Ethics
Addams, Jane
Advocacy Competencies
American Association for Counseling and Development (AACD)
American Association of Marriage and Family Counseling (AAMFC, now AAMFT)
American College Counseling Association (ACCA)

*Please see Table 5.1 for descriptions of individuals and key events.

American College Personnel Association (ACPA)
American Counseling Association (ACA)
American Mental Health Counselors Association (AMHCA)
American Personnel and Guidance Association (APGA)
American Rehabilitation Counseling Association
American School Counselor Association (ASCA)
A Mind That Found Itself
Army Alpha
Army Beta
ASCA's National Model
Association for Adult Development and Aging (AADA)
Association for Assessment in Counseling and Education (AACE)
Association for Counselor Education and Supervision (ACES)
Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC)
Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)
Association for Humanistic Counseling (AHC)
Association for Multicultural Counseling and Development (AMCD)
Association for Specialists in Group Work (ASGW)
Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)
Association of Assessment and Research in Counseling (AARC)
Atkinson, Donald
Bandura, Albert
Beers, Clifford
Behavioral approaches
Brewer, John
Career counseling
Certification
Certified Family Therapist (CFT)
Child development
Child guidance clinics
Choosing a Career
Choosing a Vocation
Civil Rights Act
Client-centered theories
Client-Centered Therapy: Its Current Practice, Implications and Theory
College counseling centers
Common factors
Community Mental Health Centers Act
Council for Accreditation of Counseling and Related Educational Programs (CACREP)
Council on Rehabilitation Education (CORE)
Counseling and psychotherapy
Counseling Association for Humanistic Education and Development
Counselors for Social Justice (CSJ)
Credentialing
Crisis, Disaster, and Trauma Counseling
Cross-cultural counseling
Cross, William
Davis, Jesse
Developmental theories
Diagnostic and Statistical Manual (DSM-5)
Directive theories
Division Expansion and Autonomy
Division 17 of the APA (Counseling Psychology)
Donaldson vs. O'Connor
Economic Opportunity Act
Education for All Handicapped Children Act (PL94-142)
Electroconvulsive therapy
Elementary and Secondary Education Act
Ellis, Albert
Ethical standards of practice
Ethics
Evidence-based practice (EBP)
Existential approaches
First comprehensive theory of counseling
Founder of guidance
Founder of the counseling field
Frankl, Viktor
Gestalt therapy
Glasser, William
Globalization of counseling
Great Society
Head Start

Hull House
Humanistic counseling and education
International Association of Addictions and Offender Counselors (IAAOC)
International Association of Marriage and Family Counselors (IAMFC)
International Registry of Counselor Education Programs (IRCEP)
Job Corps
Krumboltz, John
Licensure
Licensure portability
Lifespan development
Manpower Development and Training Act
May, Rollo
Microcounseling skills training
Military and Government Counseling Association (MCGA)
Minnesota Point of View
Mirror of Men's Lives
Multicultural counseling
Multicultural Counseling Competencies
National Academy for Certified Mental Health Counselors (NACMHC)
National Association of Social Workers (NASW)
National Board for Certified Counselors (NBCC)
National Career Development Association (NCDA)
National Committee for Mental Hygiene
National Defense Education Act (NDEA)
National Employment Counseling Association (NECA)
National Vocational Guidance Association (NVGA)
Nondirective approach
Parsons, Frank
Pedersen, Paul
Perls, Fritz
Posttraumatic stress disorder, or PTSD
Psychoanalysis
Psychodynamic
Psychodynamic approaches
Rational emotive (cognitive) approach
Reality therapy approach
Reed, Anna
Rehabilitation Act
Rochester Guidance Center
Rogers, Carl
Sanchez de Arevalo
Social Justice Focus
Strong Vocational Interest Blank
Sue, Derald
Technology and online counseling
Total educational context
Trait and factor theory
Transactional analysis
Vision for the Future of Counseling (20/20: Vision)
Vocational Bureau
Vocational counseling
Vocational guidance
Vocational guidance movement
Vocational rehabilitation centers
Vocational theory
Voting Rights Act
Wagner O'Day Act
Weaver, Eli
Williamson, E. G.
Wolpe, Joseph
Woodworth's Personal Data Sheet
Work Incentive Program



Current Issues and Future Trends in the Counseling Profession

CHAPTER 6

LEARNING OBJECTIVES

LO 1 Highlight and learn about recent innovations in counseling, including crisis, disaster, and trauma counseling; life-coaching; genetic counseling; adaptations to the classic counseling approaches; radical new approaches to counseling; and evidence-based practice and common factors.

LO 2 Highlight and learn how technology has impacted the counseling profession relative to computers and related technologies, online counseling, and the recent addition of section H of the ACA ethics code, which covers distance counseling, technology, and social media.

LO 3 Highlight and learn about trends in health management in the counseling profession, including counselor inclusion within health care management, the use of the *Diagnostic and Statistical Manual-5 (DSM-5)*, and the use of psychopharmacology.

LO 4 Highlight and learn about changing standards in the counseling profession, including the recent update of the ACA ethics code, changes in CACREP's accreditation standards, the development of international standards (IRCEP), the status of credentialing bodies, and the recent adoption of multicultural competencies and advocacy competencies.

LO 5 Highlight and learn about recent professional issues that have impacted the counseling profession, including division expansion and division autonomy; the 20/20 vision statement, which offers the counseling profession a push toward unity; and globalization of the counseling profession.

From the astrologer came the astronomer, from the alchemist came the chemist, from the mesmerist came the mental specialist. The quack of yesterday is the professor of tomorrow.
(Sir Arthur Conan Doyle, 1922, p. 15)

What seems archaic from our past was cutting edge then. And, what seems cutting edge today will seem antiquated in years to come. Yet, as humans, we seem driven to create and progress. Sometimes, what initially is developed for the good of humanity becomes dreaded and feared.

For instance, those who discovered the lobotomy and those who created new counseling approaches later shown to be harmful believed that what they were discovering was humane. As we create and invent new things, we are constantly called to monitor their worth. We mustn't be swept up by the newness of what we are inventing, and must always take into account the moral and ethical implications of what we are creating. Otherwise, we may create something we will later regret:

> *When you see something that is technically sweet, you go ahead and do it and you argue about what to do about it only after you have had your technical success. That is the way it was with the atomic bomb. (Oppenheimer, 1954, p. 81)*

This chapter is about change and progress as our profession develops and integrates new ideas, new technologies, new standards, and new ways of being a counselor. First, the chapter will examine six trends in the practice of counseling: increased training in crisis, disaster, and trauma counseling; life-coaching; genetic counseling; adaptations to classic counseling approaches; the use of radical new counseling approaches; and the use of evidence-based practices and common factors when conducting counseling. The chapter will then explore the impact of technology on counselors, with a particular focus on enhanced ways of practice due to computers and related technologies, counseling online, and Section H of the ACA Ethics Code: Distance Counseling, Technology, and Social Media. Next, we will look at trends in health management, including counselor inclusion in health care management, the relatively new *Diagnostic and Statistical Manual-5* (*DSM-5*), and the use of psychopharmacology in counseling. As the chapter continues, we will examine changes in our professional standards, such as the recent revision of the ACA ethical code, changes in the CACREP standards, development of an International Registry of Counsellor Education Programs (IRCEP), trends in credentialing, and the development of multicultural counseling competencies and advocacy competencies. We will conclude by focusing on three important professional issues that will influence our professional identity as counselors: division expansion and division autonomy, the 20/20 vision statement, and the globalization of counseling. But before we start, let's see what *you* think might be some important issues in the near future (see Activity 6.1).

Activity 6.1 Your View of the Future

As a new counselor, make a list of the issues you think are cutting edge and important to the counseling profession. Your instructor will give you an opportunity to share your list with others in the class.

LO 1 New Trends in Counseling

In this section of the chapter we will examine the potential impact of a number of new approaches to counseling, including crisis, disaster, and trauma counseling; life-coaching; genetic counseling; adaptations to the classic counseling approaches; radical new approaches to counseling; and evidence-based practice and common factors.

Crisis, Disaster, and Trauma Counseling

The horror of the tragic shootings at Sandy Hook Elementary School, Columbine High School, and Virginia Tech; Hurricane Katrina; and the attack on the Twin Towers graphically illustrated that as a country our readiness to react to a disaster was not particularly good, and that many counselors were inadequately prepared to address crises, disasters, and trauma. With this in mind, the 2009 standards of the Council for the Accreditation of Counseling and Related Programs (CACREP, 2009) included **crisis, disaster, and trauma counseling** as an area that should be addressed within the curriculum (Graham, 2010).

With this push by CACREP, counselors have increasingly been trained to work with individuals in crisis, people who have lived through disasters, and those who have experienced traumatic incidents (Bowman & Roysircar, 2011). One model sometimes used in this training is offered by the **National Child Traumatic Stress Network and National Center for PTSD** that delineates eight steps that counselors can focus upon, including: (1) contact and engagement, (2) safety and comfort, (3) stabilization (if needed), (4) information gathering: current needs and concerns, (5) practical assistance, (6) connection with social supports, (7) information on coping, and (8) linkage with collaborative services (Brymer et al., 2009).

Life-Coaching

Although it has been seen as a service that was provided by non-counselors, **life-coaching** has slowly and steadily moved into the counseling realm (Labardee, Williams, & Hodges, 2012). In contrast to counseling, coaching spends little time examining the past, focuses on solutions and goals, is viewed as a partnership rather than as a therapeutic relationship, is strength-based, does not require diagnosis or third-part payments, and is often conducted in a less-structured environment than is counseling (Shallcross, 2011). Life coaches will likely not replace counselors, but rather, coaching may be a new hat that some counselors may wear as part of a treatment modality or helping strategy.

Counselors may find coaching an attractive alternative to counseling because of the increased freedom and reduced paperwork. Additionally, the coaching relationship is less clinical, and clients may experience less stigma seeing a coach as compared to a counselor. Drawbacks to coaching include the fact that it may not be conducive to digging up underlying, core issues, and the fact that few, if any, health insurance companies cover coaching services (Shallcross, 2011). In addition, because coaching sacrifices depth in favor of efficiency, it probably has limited efficacy in treating more serious mental health issues (Ley, 2014).

Today, coaching has become its own specialty area and individuals with a master's degree or higher in counseling can now become certified as a **Board Certified Coach** through the **Center for Credentialing and Education (CCE,** n.d.a). In the coming years, we will have a better sense of the popularity of life-coaching and whether coaching will move into the mainstream of counseling services (see Reflection 6.1).

Reflection Activity 6.1 Coaching: Should We Be Doing It?

With the emergence of coaching, some have said that it does not require the training nor does it have the depth of practice that counseling does. With this in mind, do you think that counselors should be practicing coaching at all? Why or why not?

Genetic Counseling

With advances in our understanding of the genome, it has become increasingly more likely that the identification of a gene that causes a disorder, or carries a predisposition to a disorder, will precede the actual treatment of the disease (Pence, 2014). For instance, as a result of genetic research, individuals now have the ability to know whether or not they have the gene for Huntington's Disease (HD), a debilitating, progressive, neurological disease, which has no cure and leads to a horrible death within 5 years. HD is one of many genetic diseases. For instance, some forms of diabetes, cancer, dementia, heart disorders, bipolar disorders, and schizophrenia, as well as tendencies toward depression, anxiety disorders, and a host of other physical and mental health problems, have been found, or are suspected, to have genetic links.

The ability to identify whether or not one carries a gene for a disorder raises a number of issues, including whether or not one should be tested for a disease, how a person should live his or her life knowing that a gene for a disease is present, whether one should have children if not tested or if one discovers the gene is present, and whether to share the knowledge that one carries a gene for a particular disease with family and friends (Pence, 2014; Thomas, Gonzales-Garay, Pereira, & McGuire, 2014). These are difficult personal decisions with which a well-trained counselor, as well as other professionals, might assist (see Reflection 6.2).

Reflection Activity 6.2 What Decision Would You Make If Faced with a Potential Disease?

In recent years, the actor Angeline Jolie made the decision to have a mastectomy and to have her ovaries removed due to genetic markings that suggested she had a predisposition to breast cancer and ovarian cancer. Such choices, clearly, are difficult ones to make and as individuals increasingly gain knowledge about their genetic makeup, they will be faced with such decisions.

If you knew that you had more than a 50-50 chance of obtaining breast cancer or prostate cancer, what would you do? And, what if you knew that you were likely to become bipolar, what kind of decisions would you make for your life? How might counseling help you with such a decision?

Genetic counselors hold graduate degrees in any number of areas including law, medicine, and counseling. With predictions that **genetic counseling** will grow "much faster than average" (Bureau of Labor Statistics, 2014–2015), this field may soon become an important aspect of what the counselor and other professionals do. The **American Board of Genetic Counseling (ABGC,** 2013) offers a credential as a **certified genetic counselor (CGC)** to any individual who has gone through a program **accredited** by the Accreditation Council for Genetic Counseling.

Adaptations to the Classic Counseling Approaches

The twentieth century saw the development of a number of classic approaches to counseling. As we moved toward the end of the century and into the new millennium, **adaptations to the classical counseling approaches** began to arise. For instance, many of the **postpsychoanalytic models** have moved significantly away from stressing the role instincts play in the formation of the **ego** and toward the importance of relationships in ego formation. Some of the more popular approaches include **Erikson's psychosocial**

theory, relational psychoanalysis, self-psychology, and **relational-intersubjectivity approaches** (Wilson, 2015).

In a similar vein, many adaptations of **cognitive-behavioral therapy** have been developed in recent years—approaches that have drastically moved away from the more traditional approaches practiced by the early theorists. Some of these include **multimodal therapy,** which assesses a wide range of client domains; **dialectical behavior therapy (DBT),** which uses a mixture of mindfulness, behavioral analysis, and cognitive techniques; **acceptance and commitment therapy (ACT),** which views behaviors and cognitions as a complex web of relational associations and uses a mixture of cognitive therapy, behavioral techniques, and Eastern philosophy; **motivational interviewing,** which uses empathy, "change talk," collaboration, and gentle nudging to induce change in clients; **constructivist therapy,** which views therapy as a mechanism to help clients understand their meaning-making systems through cognitive schemas; and others (Sperry, 2015). As these approaches gain in popularity, we will increasingly find counselors using them.

Radical New Approaches to Counseling

In addition to adaptations of the classic approaches, **radical new approaches to counseling** have been developed that have found a niche in the practice of counseling. For instance, a wide range of **neurological and psychophysiological therapies** have arisen in recent years. Called by some the **final frontier of counseling,** these approaches are based on the **neuroplasticity** of the brain, and assume that there is an intimate relationship between psychological and neurological change (Lukow & Mills, 2015). One popular approach, **eye movement desensitization response (EMDR)** therapy, focuses on how rhythmic stimulation (e.g., rapid eye movements, tapping) can lessen symptoms associated with traumatic events. Allen Ivey's (Zalaquett & Ivey, 2015) **Developmental counseling and therapy** approach assumes that matching developmental level and intervention strategies will make new neurological connections. Some other approaches include **neuroprocessing, neurofeedback, hypnotherapy, eye movement integration therapy (EMIT), cerebral electric stimulation,** and more (Neukrug, 2015).

Other novel approaches that we have also seen gain popularity in recent years include **gender aware therapy** (**feminist therapy** and **counseling men**), which focuses on the way that men and women are impacted by cultural stereotypes and how each gender can develop new, more adaptive roles (Matthews, 2015); **positive psychology,** which helps clients (and non-clients) focus on their strengths and assists them in developing a positive framework so they can live more fulfilling lives (Frisch, 2015) (see Activity 6.2); and a whole range of **complementary, alternative, and integrative therapies,** which use a holistic approach that focuses on all aspects of a person's wellness, such as wellness instruments (see Chapter 3), body awareness therapies, energy therapies, scented oils to help people heal and become whole, and more (Berger, 2015).

Activity 6.2 What Is Your Positivity Ratio?

Want to determine your positivity ratio? Go to www.positivityratio.com/ and take the quiz.

These new, and sometimes radical approaches just described represent some of the few recently developed radical approaches now being used to counsel clients (Neukrug, 2015).

Evidence-Based Practice and Common Factors

This century has challenged counselors to ensure that what they do is based on scientific evidence. For instance, discussed in Chapter 3, **evidence-based practice (EBP)** highlights the importance of the helper accurately matching empirically supported treatment methodologies to the client's presenting problems to help ensure positive client outcomes (Laska, Gurman, & Wampold, 2014). Other research, also noted in Chapter 3, suggests that **common factors** may be even more important to positive counseling outcomes than matching a treatment approach to a presenting problem (Hilsenroth, 2014; Wampold, 2010a, 2010b, 2010c; Wampold & Budge, 2012). Two of these factors include having a strong working alliance and being effective at delivering your theoretical approach, regardless what the approach is. Whether practicing evidence-based counseling or ensuring the use of common factors, having a research base to support what one is doing is reinforced in ACA's ethical code and is likely to continue to be important factors to consider when working with clients.

> *When providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. (ACA, 2014a, Section C.7.a)*

LO 2

Trends in Technology

Recent changes in technology have affected all of our lives, and the world of the counselor has not been immune to these changes. Thus, this section will examine how computers and related technologies, online counseling, and section H of the ACA ethics code, which covers distance counseling, technology, and social media, have impacted and will impact the counselor.

Computers and Related Technologies

Today, approximately 89% of homes in the United States have computers and 74% of these are connected to the Internet. These are amazing statistics, especially in light of the fact that as of 1998, only 37% of households had a computer and 19% had Internet access (U.S. Department of Commerce, 2014a, 2014b).

Counselors, and other mental health professionals, have quickly adapted to the use of computers and other technologies and will be faced with a rapidly changing technological landscape in the future (Cottone, 2015). For instance, counselors now use **computers and related technologies** (e.g., interactive videos, CDs, DVDs) in case management, record keeping, diagnosis, case conceptualization, testing and assessment, career counseling, billing, marketing, and assisting clients in the learning of new skills (e.g., parenting skills, assertiveness training, vocational skills training) (Goss & Anthony, 2009).

Computers, and the use of the Internet, have also been shown to be successful in training counselors and other helping professionals (Kate, 2015). For instance, the Internet has brought web-based courses, web-based portfolios, search engines for research, webinars, continuing education, online supervision, and more (see Activity 6.3) (Buono, Uellendahl, Guth, & Dandeneau, 2011; Goss & Anthony, 2009). Undoubtedly, the

continued expansion of technological counseling related activities will continue as we move along in this century.

Activity 6.3 Merging the Past with the Future Using Technology

As I write this book, I am in the process of developing two websites entitled "Stories of the Great Therapists" and "Great Therapists of the Twentieth Century (GTTC)." These sites enable individuals to hear oral stories about famous therapists and interact with animations of famous therapists to learn more about them. If you get a chance, go to: www.odu.edu/sgt and take a look at these websites.

Counseling Online

When I first learned about counseling on the Internet I thought it was a joke. "How could one develop the depth of the relationship online?," "How could one read another person's nonverbal behaviors?," and "How could one soothe a person in his or her deepest moments of pain?," I pondered. But recently something has changed. I think it was the counselor avatar I saw one of my students show in class. Suddenly, I realized the potential of counseling over the Internet. I am slowly becoming a convert. So given that it's here to stay, let's look at some of the positives and negatives of **counseling online** (Carlisle, Carlisle, Hill, Kirk-Jenkins, & Polychronopoulos, 2013; Cottone, 2015; Craigen, Cole, & Cowan, 2013; Hodges, 2014) (see Table 6.1).

TABLE 6.1 Drawbacks and Benefits of Internet Counseling

Drawbacks	Benefits
➤ It can allow clients to hide behind the anonymity of the Internet (especially if a video camera is not used).	➤ Because Internet counseling can sometimes seem more anonymous, clients might be able to reveal issues they would be embarrassed or afraid to reveal in person.
➤ It raises concerns about how to respond if a client is suicidal or homicidal.	➤ It provides counseling services for those individuals who live in areas where there are few mental health professionals.
➤ It can raise concerns about security and confidentiality if other individuals can hack into a counseling session.	➤ It provides additional options for the supervision of the counselor through the use of professional discussion boards and online supervision.
➤ It may lower the ability of the counselor to appropriately read the client.	➤ It has the potential to offer lower cost services because rented office space is not needed.
➤ It prevents the kind of here-and-now relationship that is present when people are face-to-face.	➤ It can allow clients to seek out counseling services at times at which traditional counseling services may not be available (e.g., 6 a.m., 10 p.m.).
➤ It raises credentialing issues for individuals conducting counseling, as interstate commerce laws may not apply on the Internet.	➤ It allows clients concerned about leaving their homes (e.g., those with agoraphobia or disabilities or those who live in high crime areas) to feel safe.
➤ It may not be covered by insurance companies.	➤ It allows counselors to potentially counsel multiple clients at one time, as counseling online typically moves more slowly than face-to-face counseling, thus allowing the counselor to be interacting with more than one client at a time.
➤ Technological difficulties could be problematic.	
➤ Counseling online typically moves more slowly than face-to-face counseling.	
➤ For clients counseled through a typing method (e.g., e-mail), the amount communicated is typically less than when speaking and counselor response time can be slower.	

Today, we see counselors working with clients online, through e-mail or live through Skype and related technologies. Increasingly, counselors may no longer sit directly across from the client; instead, they will be connected with the client electronically. In the not too distant future we may see electric stimulation of the brain conducted from a distance, the offering of preset treatment plans that can be accessed on one's phone, and traditional counseling through holograms, avatars, and much more (Cottone, 2015; Hodges, 2014). There is little question that technology will change the manner in which we do counseling; however, the exact direction it will take is unknown. I guess we'll have to wait and see.

Today, there is even a professional association that has arisen that supports online counseling. Requirements for joining the **American Distance Counseling Association (ADCA)** include a state license in a mental health profession and one year of online counseling experience. Given that counseling online is certainly different than face-to-face counseling, a number of guidelines have been developed to ensure that clients are afforded the best and most ethical services possible. The next section examines some of these.

Section H of the ACA Ethics Code: Distance Counseling, Technology, and Social Media

With the impact that technology has had on the counseling profession, it is not surprising that the 2014 ACA ethics code has included a whole section entitled *Distance Counseling, Technology, and Social Media* (Section H). Summarizing some of the highlights of this aspect of the code, we find it is important to do the following.

1. Maintain competence in the use of counseling-related technologies.
2. Ensure clients are fully informed about the risks and benefits of distance counseling and that distance clients have access to emergency services.
3. Abide by the laws of the state in which the counselor works and the state(s) in which the counselor is assisting others.
4. Have clients give informed consent for such practices and inform them fully of the limitations of technology.
5. Explain any limitations of confidentiality due to technology.
6. Verify that the counselor is indeed working with his or her client when using such technologies (e.g., a code word if using e-mail).
7. Consider the limits of not viewing the nonverbal and/or verbal cues of the client.
8. Not view clients' social media unless given permission to do so.
9. Maintain electronic records using encryption devices and other security measures and have a backup of records.
10. Consider whether electronic counseling services are effective for the client and if deemed not productive, consider a referral to a face-to-face counselor.
11. Ensure that clients with disabilities, or clients whose primary language is not English, can access and understand the counselor's website.
12. Have counselors manage their social media presence so it does not blur boundaries, and not viewing clients social media unless they are given permission to by the client.

LO 3

Trends in Health Management

Changes in health management have dramatically affected how counselors work. Some of these will likely continue as we move further into this century. This section of the chapter will explore counselor inclusion within health care management, the use of the *Diagnostic and Statistical Manual-5 (DSM-5)*, and understanding the importance of psychopharmacology in treatment today.

Counselor Inclusion Within Health Care Management

With the Affordable Care Act comes many changes to our health care system, including the mandate that mental health services are given parity with medical services by all insurance companies; that is, that mental health services are part of services that insured individuals have access to (Mershon, 2015). As ObamaCare becomes a reality, counselors will increasingly need to make sure that they are included as providers for all insurance companies.

Similarly, in this century, counselors will be continually vying to be providers for health maintenance organizations (HMOs) and government-sponsored health insurance policies, such as TRICARE, and be granted employment status for all government agencies that provide counseling, such as the Veterans Administration (VA) hospitals (National Board for Certified Counselors [NBCC], 2015e; ACA, 2014b).

DSM-5

Developed by the American Psychiatric Association, the first ***Diagnostic and Statistical Manual (DSM-I)*** was published in 1952 and over the years has been revised, with its newest manual, *DSM-5*, being recently published (American Psychiatric Association, 2013a). In addition to the print version of ***DSM-5***, an online component (www.psychiatry.org/dsm5) is available for supplemental materials, and subsequent revisions, like computer software, will follow with editions 5.1, 5.2, 5.3, and so on. Whereas counseling programs had traditionally played down the importance of a **diagnosis** (Jones, 2010; Patureau-Hatchett, 2009), this attitude has changed as counselors have realized a classification system can increase accuracy of a diagnosis, can be helpful in treatment planning, is typically needed by insurance companies, and is necessary if we are to talk intelligently with our related mental health professionals (Neukrug & Fawcett, 2015; Schwitzer & Rubin, 2015).

With up to 20% of children and 25% of adults struggling with a mental disorder each year (Centers for Disease Control and Prevention [CDC], 2013a, 2013b), *DSM-5* has become a critical diagnostic tool by providing hundreds of diagnoses within 21 diagnostic categories (see Appendix B). In addition, *DSM-5* assists helpers in identifying psychosocial and environmental stressors (e.g., homelessness, divorce, job loss) through the use of V Codes or Z Codes, also found in the *DSM-5*. Mental disorders and V or Z codes utilize the same diagnostic coding as the International Classification of Disease (ICD) manual used by doctors, nurses, and other health care providers. In addition to listing a **mental disorder** and V or Z codes, clinicians are also encouraged to list medical

diagnoses when it has an impact one's psychological functioning. Thus, a diagnosis of an individual could look this:

296.22 (F32.1)	Major depression, single episode, moderate
V62.29 (Z56.9)	Problems related to employment
V61.10 (Z63.0)	Relationship distress with spouse
722.0	Displacement cervical intervertebral disc (chronic back pain)

DSM does have its critics, including those who question some diagnoses, believe a diagnosis is dehumanizing, suggest diagnoses can lead to labeling, and state that the *DSM* does not account for societal factors that impact the formulation of diagnosis (Jackson, 2012; Miller, 2012; Pickersgill, 2013). Despite these naysayers, *DSM-5* has become the most widespread and accepted diagnostic classification system of mental disorders, and whole courses are taught that just focus on diagnosis and the *DSM*.

Psychopharmacology

One benefit of having a diagnosis for a client is that it helps us determine the kinds of medication that might be useful in the remediation of a person's mental disorder or problems they are working on. In fact, recent advances in brain research and the subsequent development of new medications have had a dramatic effect on treatment strategies (Preston, O'Neal, & Talaga, 2013). The development of new **psychotropic medications** has occurred rather quickly in the brief history of mental health treatment. In fact, I remember when advertising a drug was unheard of! Now, you can hardly turn on the TV or the computer and not see an ad for some type of psychotropic medication.

Today, there are promising new medications that can be beneficial in the treatment of psychoses, mood disorders, depression, anxiety, attention deficit disorder, dementia, and other mental disorders and emotional disturbances (Ingersoll & Rak, 2016). With the most recent research indicating that one in five adults are on a prescription drug for a mental health issue, literally millions of Americans now take medication as a partial or full treatment for psychological problems (Medco, 2011). In today's world, to treat an individual without knowledge of the effectiveness of these medications would be incompetent practice, as noted in the ACA (2014a) ethical code:

> *Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations. (Section C.2.f)*

LO 4

Changing Standards

To keep up with changing times, standards that help professionals respond appropriately to their clients must change. Thus, this section will examine recent changes in our ethical code and our accreditation standards, the development of international standards, the status of our credentialing bodies, and the relatively recent adoption of multicultural competencies and advocacy competencies.

Changes to ACA's Ethical Code

Representing its fifth revision since it was originally developed in 1961, the new, 2014 ACA ethical code includes a number of revisions that challenge counselors to work in new ways (Daniel-Burke, 2014) (see Chapter 9 for a review of ethics and the new ethical code).

One addition to the current code is that in its preamble, the values of the counseling profession are now clearly delineated. Also in the new code is a much expanded focus on distance counseling, technology, and social media, with a whole section that focuses on this important area as well as infusion of these issues throughout the code. Some examples were highlighted earlier in this chapter (see Section H of the ACA Ethics Code: Distance Counseling, Technology, and Social Media).

In addition to adding ethical guidelines related to distance counseling, technology, and social media, the current code took out the **"end-of-life" exemption** from the 2005 code, which allowed counselors to remove themselves (e.g., refer to another counselor) from a situation in which a client may be considering suicide as an end-of-life decision. Instead, it is stated that when counselors have values conflicts with their clients (e.g., differences on end-of-life suicide decisions, abortion, sexual orientation), they should seek out supervision, consultation, and/or further education as opposed to exiting the situation. However, counselors can refer someone due to incompetence or lack of training (see Reflection 6.3).

Reflection Activity 6.3 Julea Ward vs. Board of Regents of Eastern Michigan University (EMU)

Julea Ward, a graduate student in counseling at EMU, discovered that she would be counseling a client who had been in a same-sex relationship (Kaplan, 2014; Rudow, 2013). Believing she could not counsel him due to her religious beliefs regarding same-sex relationships, she asked her supervisor to refer him to another counselor. At that point, the supervisor scheduled an informal review of Ward, which resulted in the faculty informing her that she would have to set aside her religious beliefs, as the 2005 ACA ethics codes stated that "counselors do not condone or engage in discriminate based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status or any basis proscribed by law" (ACA, 2005, Section C.5.). She was asked to complete a remediation program or have a formal hearing with the faculty. She requested a formal hearing, which eventually led to her dismissal from the program. Ward sued EMU, and after years of litigation, the courts upheld the school's decision and the ACA code. The case, which was appealed and eventually settled out of court, influenced the development of ACA's (2014a) ethics code that now states that "Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors" (Section A.11.b).

The Julea Ward case was one of the driving forces behind the statement in ACA's current ethics code that stresses that one should not refer a client due to differences in values, and in instances where there are values clashes, the counselor should seek consultation and/or supervision. Do you think you could counsel someone who has dramatically different values than your own?

The new code also altered its statement about what to do if a client has a contagious and life-threatening illness, stating that the counselor has a responsibility to assess if the client has placed others at risk and to act in a responsible manner to ensure that others are safe and to warn others, if necessary. The code now has a statement encouraging pro bono services, or having counselors refer clients to other inexpensive services, if clients cannot afford their services. The code also suggests that counselors consider providing other services to the public (e.g., lectures or psychoeducational groups) as a means of reaching individuals who may not be able to afford services. Finally, the current code states that when providing services, counselors should use techniques grounded in theory and research. Although counselors can use a developing theory, the code states

that counselors need to clearly describe the risks and benefits of the theory and work to minimize any potential risks. In a similar vein, the code states that counselors do not use techniques that have been shown to be harmful, even if a client requests it.

Changes in CACREP Accreditation Standards

Today, 279 CACREP-accredited institutions offer 634 accredited programs in a number of specialty areas, including clinical mental health counseling; school counseling; college counseling and student affairs; addictions counseling; career counseling; marriage, couples, and family counseling; clinical rehabilitation counseling, and doctoral programs in counselor education (CACREP, 2009, 2015b). The 2009 CACREP standards and the 2016 standards have made a number of important changes, a few of which are highlighted below:

1. The requirement of training in crisis, disaster, and trauma counseling.
2. An increased focus on leadership training, advocacy, and social justice.
3. A requirement that by 2020, all master's programs will be 60-semester credits.
4. The addition of a clinical rehabilitation counseling accreditation.
5. All new full-time faculty hired into a CACREP-accredited program must have graduated from a doctoral program in counselor education and supervision (or have been grandfathered in due to prior experience).

Such changes will undoubtedly impact how counselor education is taught and the ways in which new students implement counseling practice.

Development of the International Registry of Counsellor Education Programs (IRCEP)

The **International Registry of Counsellor Education Programs (IRCEP)** is an organization that was created by the **Council for Accreditation of Counseling and Related Educational Programs (CACREP)** in 2009 (CACREP, 2015a). A subsidiary of CACREP, IRCEP's vision is to "promote the ongoing development and recognition of the counselling profession worldwide through the creation of a registry of approved counsellor education programs that use common professional requirements essential to the education and training of counsellors regardless of culture, country, region, work setting, or educational system" (CACREP, 2015c, para. 1) (note that the British spelling of "counselling" is used). IRCEP's mission focuses on creating standards, approving programs, maintaining a registry of approved programs, and networking counselors, students, and professionals in the field in an effort to foster excellence.

CACREP-accredited programs can apply for IRCEP approval, and today, about 30 universities are IRCEP approved (CACREP, 2015d). The benefits of IRCEP approval includes a review from an international group of counselors, the prestige of international recognition, and the assurance of high standards.

Status of Credentialing

Today, there are about 55,000 **National Certified Counselors (NCCs)** and 120,000 **Licensed Professional Counselors (LPCs)** (ACA, 2011; NBCC, 2015b). With NBCC now offering subspecialty certifications in clinical mental health counseling, school

counseling, and addictions counseling and with every state in the country as well as Puerto Rico, Guam, and the District of Columbia having licensure laws, **credentialing** has and will continue to become increasingly important for job attainment, third-party reimbursement, and professional recognition.

Finally, now that counselors have obtained licensure in all 50 states, **portability** (sometimes called **reciprocity**) of licenses between states has become a pressing issue. Currently, ACA and the **American Association of State Counseling Boards (AASCB)** are designing separate initiatives that would allow counselors to more easily move their licenses from state to state (AASCB, 2015a, 2015b; Bray, 2015). Hopefully, these initiatives will become a reality and portability between states will be achieved for licensed counselors.

Adoption of Multicultural Counseling Competencies and Advocacy Competencies

Developed in 1991 by the **Association for Multicultural Counseling and Development (AMCD),** the **Multicultural Counseling Competencies** were officially adopted by ACA in 2002. These competencies delineate **attitudes and beliefs, knowledge, and skills** in three areas: the counselor's awareness of the client's worldview, the counselor's awareness of his or her own cultural values and biases, and the counselor's ability to use culturally appropriate intervention strategies (Arredondo, 1999; Arredondo et al., 1996). Then, in 2003, ACA endorsed the **Advocacy Competencies,** which encompass three areas (client/student, school/community, public arena), each of which are divided into two levels: whether the counselor is **acting on behalf of the competency area** or **acting with the competency area** (Toporek, Lewis, & Crethar, 2009). The purpose of the competencies is to ensure that counselors are actively taking steps toward helping clients overcome some of the external and oppressive barriers they face in their lives.

Although both sets of competencies are described in Chapter 10, they are highlighted here because they have greatly impacted, and will continue to affect, counselors' work with clients from nondominant groups. To be an effective counselor today means you must be a culturally competent counselor who fights against social injustices.

LO 5

Professional Issues

As professions develop, changes occur, and this section will examine some of the more important changes in the past 20 years including division expansion and division autonomy; the 20/20 vision statement, which offers us a push toward unity; and globalization of the counseling profession.

Division Expansion and Division Autonomy

Since 2000, we have seen the addition of three new divisions of ACA: the **Association for Creativity in Counseling (ACC), Counselors for Social Justice (CSJ),** and the **Association for Child and Adolescent Counseling (ACAC),** (ACA, 2015d). With 20 divisions covering a vast array of counseling interests, ACA is a diverse group. After nearly a century of pulling together the divisions into one unified force under ACA, some

divisions are asserting that their differences are too great to continue to justify this unification. Some initiatives—such as the development, in 2003, of the **American School Counselor Association's (ASCA)** National Model (**ASCA National Model;** ASCA, 2012), which increases the focus of the school counselor toward student learning, and the **American Mental Health Counselors Association's** (AMHCA) push toward a greater clinical focus—have made these divisions deeper. Today, one can join some divisions without being a member of ACA.

Although we are all counselors, we have many different strengths and areas of expertise, which is reflected in our individual professional identities and the professional associations to which we belong. What will happen to ACA and its divisions? At this point, it's anybody's guess, but wherever we go, we'll end up stronger.

A Push Toward Unity: The 20/20 Vision Statement

There are many contrasts in life. Just as I write a section on the split between ACA and some divisions, I switch gears and focus on unity. In sharp contrast to the problems between some divisions and ACA is the development of the **20/20 vision statement**. From 2005–2013, 31 counseling organizations decided it was time for the counseling profession to develop a shared vision—an understanding that would unite all counselors toward the future (ACA, 2015f). These counseling associations came together to develop 20/20: A Vision of the Future of Counseling, which includes the following shared vision:

- Sharing a common professional identity is critical for counselors.
- Presenting ourselves as a unified profession has multiple benefits.
- Working together to improve the public perception of counseling and to advocate for professional issues will strengthen the profession.
- Creating a portability system for licensure will benefit counselors and strengthen the counseling profession.
- Expanding and promoting our research base is essential to the efficacy of professional counselors and to the public perception of the profession.
- Focusing on students and prospective students is necessary to ensure the ongoing health of the counseling profession.
- Promoting client welfare and advocating for the populations we serve is a primary focus of the counseling profession. (Kaplan & Gladding, 2011, p. 372)

Today, the 20/20 delegates continue to work, and as noted in Chapter 1, they recently came up with a shared definition of counseling (ACA, 2015f). It is hoped that their work will result in increased unity through shared missions and that goals will coalesce.

Globalization

Counseling has gone international, and counseling programs, counseling associations, and credentialing have emerged around the world (International Association for Counseling, 2014). For instance, as mentioned earlier, IRCEP approves international programs and helps counselors and counselor educators from all over the world network (CACREP, 2015a). In addition, counseling associations can now be found in every continent in the world. Although the United States was one of the first countries to develop the field of counseling, there is a lot for us to learn from the mental health practices of others.

Case Study 6.1 Tara the Traditionalist

Tara is a new student in your counseling program. She proudly calls herself a traditionalist. To Tara, this means that she does not believe in diagnosis, because she thinks it is a contrived system that ends up labeling people and "putting them in a box" as if they are "one-dimensional." She also does not believe in the use of psychotropic medications, stating that "all medications do is stop you from feeling. This is the last thing you want a client to do." As to technology, she has a radio, but no TV or computer, and believes that technology in general has isolated people and contributed to the dehumanization and alienation of society. She feels very strongly about the use of some types of non-proven complementary, alternative, and integrative methods such as scented oils and deep body work (deep massage to help release inner tensions and repressed thoughts). Although she is willing to do the work to get credentialed so she will eventually become a licensed professional counselor, she believes that much of what she is doing is just to get her a "ticket" so that she could work in her way with clients. Her ways includes no technology, scented oils, body work, "depth" therapy, no medications, and no diagnosis.

1. What do you think about Tara's beliefs? Be specific.
2. Do you believe Tara could work ethically, in today's world, with her belief system?
3. Are there any ethical or professional concerns that you have for Tara?
4. Would you be willing to discuss any ethical or professional concern you have with Tara?

Summary

This chapter examined current issues and future trends in the counseling profession. Beginning with how we provide counseling, we noted that counselors had not been adequately trained in crisis, disaster, and trauma counseling and that training in these areas is now required in most counseling programs. We pointed out the differences between life-coaching and counseling and noted that for some counselors, life-coaching may be a viable alternative or addition to doing counseling. Noting that research on the genome has made it easier for individuals to discover whether they may have the gene for a disease, we pointed out the importance of genetic counseling and that this might become a new specialty area for counselors to work within. We also noted a number of adaptations to the classic approaches to counseling and then identified some new, radical approaches to counseling—all of which we may see more of in the years to come. We concluded this section with the recent emphasis in the field on evidence-based practice and common factors.

Moving on to the area of technology, we identified how computers and technology have impacted a wide range of counseling activities. However, of all the changes, we noted that counseling online is probably the most interesting and the most controversial. We thus delineated a number of benefits and drawbacks to counseling online. Partly due to the ethical concerns raised with counseling individuals online, we noted that the 2014 ACA ethics code added Section H, which focuses on Distance Counseling, Technology, and Social Media. We highlighted some of the salient aspects of this section of the code.

As the chapter continued on, we spoke of some trends in health management, including the fact that the Affordable Care Act has mandated that mental health services be on par with medical services by all insurance companies and the fact that counselors are increasingly being included as providers by insurance companies, such as TRICARE,

and government agencies, such as the Veterans Administration. We then went onto discuss the recent publishing of the *DSM-5*. This new diagnostic model, we noted, offers hundreds of diagnoses within 21 diagnostic categories, V or Z codes that help to identify psychosocial and environmental stressors, and suggests identifying a medical diagnosis when it has an impact on one's psychological functioning. We noted some of the benefits and drawbacks of diagnosis in general. The last part of this section addressed the use of psychopharmacology when working with clients. We pointed out that diagnoses help counselors identify which medications might be useful for clients and that there are promising new medications that might be useful for a wide range of mental disorders. We noted that not considering the use of medication may be considered incompetent practice.

As the chapter moved along, we noted the importance of standards changing to keep up with current trends. With this in mind, we highlighted a number of changes to the recent, 2014, ACA ethical code with particular emphasis on how the Julea Ward case impacted how counselor's deal with values clashes with clients. We then went on to point out some of the changes in the 2009 and the 2016 CACREP-accreditation standards, and this was followed by an introduction to the International Registry of Counsellor Education Programs (IRCEP), which was established to focus on international counseling. We next pointed out that today, there are about 55,000 NCCs and about 120,000 LPCs, that licensing occurs in all 50 states, DC, Puerto Rico, and Guam, and that portability, sometimes called reciprocity, is an important issue of our times and being addressed by ACA and AASCB. Finally, we noted the important adoption of the multicultural counseling competencies and advocacy competencies in recent years. These two important standards have had, and will continue to have, a great impact on how counselors work and will be discussed further in Chapter 10: Multicultural Counseling and Social Justice: The Fourth and Fifth Forces.

The chapter concluded with a brief discussion of recent division expansion and division autonomy and the fact that this has changed the face of the counseling profession today. However, in somewhat of a paradox to this discussion, we noted that the 20/20 Vision Statement, developed by a number of counseling organizations, has resulted in a shared vision of the counseling profession. We highlighted this vision. Finally, we noted that the counseling profession is going global. With IRCEP, and with counseling programs and credentialing occurring internationally, counseling can now be found all over the globe and as others can learn from what we have done, we can now learn from what others are doing.

Key Terms

Acceptance and commitment therapy (ACT)
Accredited
Acting on behalf of the competency area or acting with the competency area
Advocacy Competencies
Adaptations to the classic counseling approaches
American Association of State Counseling Boards (AASCB)
American Board of Genetic Counseling (ABGC)
American Distance Counseling Association (ADCA)
American Mental Health Counselors Association (AMHCA)
American School Counselor Association (ASCA)
ASCA National Model

Association for Child and Adolescent Counseling (ACAC)
Association for Creativity in Counseling (ACC)
Association for Multicultural Counseling and Development (AMCD)
Attitudes and beliefs, knowledge, and skills
Board Certified Coach
Center for Credentialing and Education (CCE)
Cerebral electric stimulation
Certified Genetic Counselor (CGC)
Cognitive-behavioral therapy
Common factors
Complementary, alternative, and integrative therapies
Computers and related technologies
Constructivist therapy
Council for Accreditation of Counseling and Related Educational Programs (CACREP)
Counseling men
Counseling online
Counselors for Social Justice (CSJ)
Credentialing
Crisis, disasters, and trauma counseling
Developmental counseling and therapy
Diagnosis
Diagnostic and Statistical Manual
Diagnostic and Statistical Manual-5 (DSM-5)
Dialectical behavior therapy (DBT)
Ego
"End-of-life" exemption
Eriksen's psychosocial theory
Evidence-based practice (EBP)
Eye movement desensitization response (EMDR)
Eye movement integration therapy (EMIT)
Feminist therapy
Final frontier of counseling
Gender aware therapy
Genetic counseling
Globalization
Hypnotherapy
International Registry of Counsellor Education Programs (IRCEP)
Licensed Professional Counselors (LPCs)
Life-coaching
Mental disorder
Motivational interviewing
Multicultural Counseling Competencies
Multimodal therapy
National Certified Counselors (NCCs)
National Child Traumatic Stress Network and National Center for PTSD
Neurofeedback
Neurological and psychophysiological therapies
Neuroplasticity
Neuroprocessing
Portability
Positive psychology
Postpsychoanalytic models
Psychopharmacology
Psychotropic medications
Radical new approaches to counseling
Reciprocity
Relational psychoanalysis
Relational-intersubjectivity approaches
Section H of the ACA Ethics Code: Distance Counseling, Technology, and Social Media
Self-psychology
Trends in health management
20/20 vision statement
Ward, Julea



STANDARDS IN THE COUNSELING PROFESSION

SECTION 3

This last section of the book identifies important standards in the counseling profession and helps us further delineate who we are and how we distinguish ourselves from related mental health professionals. We begin, in Chapter 7, by focusing on the CACREP accreditation process, the accrediting body for most counseling programs, although we also list accrediting bodies in related mental health fields. In Chapter 8 we define credentialing and highlight the many credentials in the counseling profession. We contrast these with related credentials in non-counseling mental health professions. The next standard we discuss, in Chapter 9, is ethics, and we distinguish ethics from values and morality and examine the relationship between ethics and the law. We explore the importance of an ethical code and spend a fair amount of time discussing ACA's ethical code, although we list other, related codes. We point out ethical "hot spots," models of ethical decision-making, how to report ethical violations, legal issues related to ethical violations, the importance of malpractice insurance, and of knowing our best practices so we can best serve clients and avoid lawsuits. Finally, in Chapter 10, the last chapter in this section and in the book, we focus on multicultural counseling and suggest that social justice work is a subsection of this important area. We highlight reasons why counseling is not working for many clients from nondominant groups and go on to define a number of important words and terms associated with multicultural counseling. We offer models to help us understand ourselves and clients from diverse cultures and describe two relatively recent standards: the Multicultural Counseling Competencies and the Advocacy Standards.

Accreditation in Counseling and Related Fields

CHAPTER 7

LEARNING OBJECTIVES

LO 1 Learn the history of the Council for Accreditation in Counseling and Related Educational Programs (CACREP).

LO 2 Examine the benefits of accreditation.

LO 3 Gain an understanding of the CACREP accreditation process at the master's and doctoral levels.

LO 4 Examine the reasons for the development of the Master's in Psychology and Counseling Accreditation (MPCAC) standards.

LO 5 Learn the names of accrediting bodies in related mental health fields.

Unfortunately, the United States is cluttered with bogus "institutions of higher learning" that issue master's and doctor's "degrees" that are not worth the paper they are printed on and that can even get you into legal trouble if you attempt to proffer them as legitimate credentials. …Avoid these rip-offs as you would the plague.
(Keith-Spiegel, P., & Wiederman, 2000, p. 53)

When I graduated from my doctoral program there were no accredited programs in counseling. The professional identity of the counselor and counselor educator were still forming, and it was not unusual to find others with related degrees in fields like psychology, teaching alongside those who had degrees in counselor education. It's now 35 years later and we have come far. In fact, today, the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) requires that new full-time faculty who are hired to teach in accredited programs must have doctoral degrees in counselor education from a CACREP-accredited program. Accreditation has pushed us toward a unified professional identity, one in which all faculty in counselor education will

have degrees in counselor education, one in which all students will eventually graduate from accredited programs, and one in which all programs will be following the same curriculum guidelines. This chapter explores accreditation. We will look at the many benefits of accreditation as well as a few of its drawbacks. We will identify the accreditation process in related mental health fields. But mostly, we will look at CACREP—explore its history, how it currently accredits programs—and we will discuss the future of accreditation in the counseling profession. Let's start with the **history of CACREP**.

LO 1

A Brief History of CACREP

> *The acronym CACREP is a mouthful to say… . In fact, without the Council for Accreditation of Counseling and Related Educational Programs, counseling would be far less credible as a profession compared to other human service fields that have such an agency. (Sweeney, 1992, p. 667)*

Professionals in mental health fields often have responsibilities that heavily impact the lives of others, many of whom are exceptionally vulnerable. Shoddy or inept training can result in a helper harming his or her clients, oftentimes inadvertently. Accreditation has been one way of assuring that programs are meeting minimum standards while promoting excellence in training professionals. Some of the first programs to offer training standards were in social work during the early part of the twentieth century—soon to be followed by psychology programs in the mid-1940s (Morales, Sheafor, & Scott, 2007; Sheridan, Matarazzo, & Nelson, 1995). Although starting a little later than these closely related professions, the counseling field has made great strides in its efforts toward accreditation.

The idea of having standards for counselor education programs can actually be traced back to the 1940s (Sweeney, 1992); however, it was not until the 1960s that such standards began to take form with the adoption of training standards for elementary school counselors, secondary school counselors, and student personnel workers in higher education (Altekruse & Wittmer, 1991; Sweeney, 1995). Soon, the **Association for Counselor Education and Supervision (ACES)** began to examine the possibility of merging these various standards into one document entitled the **Standards for the Preparation of Counselors and Other Personnel Service Specialists.** Although the standards were being unofficially used as early as 1973, it was not until 1979 that the **American Personnel and Guidance Association (APGA),** now the **American Counseling Association (ACA),** officially adopted them, and in 1981 APGA created the **Council for the Accreditation of Counseling and Related Educational Programs (CACREP),** a freestanding incorporated legal body that would oversee the accrediting process (Brooks & Gerstein, 1990). Adoption of the CACREP standards started slowly, and they have gone through a number of revisions prior to taking on their most recent form, the 2016 standards. Today, these standards are the benchmark to which most counseling programs try to conform (Urofsky, Bobby, & Ritchie, 2013).

In addition to U.S. based counseling programs, CACREP recently established the **International Registry of Counselor Education Programs (IRCEP)** (CACREP, 2015a)

whose focus is to foster excellence in training programs internationally. A new organization, IRCEP is discussed in Chapter 6: Current Issues and Future Trends in the Counseling Profession.

Finally, CACREP and the **Council on Rehabilitation Education (CORE)** have recently reached an agreement whereby 48-hour CORE-accredited rehabilitation programs can become CACREP accredited as 60-credit clinical rehabilitation counseling programs (CACREP, 2014b). In addition, in July of 2017, CACREP will administer all rehabilitation counseling programs (CACREP, 2014b, n.d.a).

Considering the vast number of changes that most programs have to make and the amount of time it takes to implement such changes, it is a tribute to CACREP that 279 CACREP institutions offer 634 accredited programs in the various specialty areas (Y Peña, personal communication, February 6, 2014). Of these, over 60 programs offer doctoral degrees in counselor education (CACREP, 2015e). With New York and California fairly recently obtaining licensure for counselors, it is likely that there will be a push in those states to accredit additional counseling programs. As you might guess, all evidence seems to indicate that there will be continued expansion of the number of CACREP-accredited programs.

LO 2 Benefits of Accreditation

One of the reasons that CACREP accreditation has spread so rapidly is the many **benefits of accreditation** (O'Brien, 2009; Urofsky, Bobby, & Ritchie, 2013). Some of these include the following:

- Accreditation is the impetus for setting high standards and almost always results in improved programs and a stronger sense of professional identity.
- Accredited programs often attract better students and better faculty.
- Accredited programs produce students who tend to be more knowledgeable about core counseling issues.
- Accreditation is often a factor in determining eligibility for credentialing. For instance, students in CACREP accredited programs can take the National Counselor Exam to become a nationally certified counselor (NCC) prior to graduation, whereas others have to wait to complete postgraduate experience.
- Accredited programs tend to offer longer field placements and practice more hands-on experience.
- Some third-party payers are beginning to reimburse only counselors who have graduated from CACREP-accredited program.
- Those who graduate from accredited programs generally have better job opportunities.
- Those who graduate from accredited programs are sanctioned less frequently for ethical violations.

Although you can see why CACREP-accredited programs may have an edge over nonaccredited programs, a nonaccredited program may still be a strong program. In fact, some have argued that accredited programs stifle creativity, are too costly, and limit what can be offered (see Activity 7.1).

Activity 7.1 Developing Accreditation Standards

Consider what you would require of a counseling program if you were working for an accreditation body charged with developing accreditation standards. Specifically, speak to each of the following:

1. Admissions requirements
2. Curriculum
3. Number of credits
4. Faculty-student ratio
5. Minimum number of full-time faculty
6. Minimum full-time to adjunct faculty ratio
7. Type of gatekeeping process for ensuring that students are personally and professionally able to be a counselor
8. Degrees and experience of faculty
9. Comprehensive exam and/or thesis
10. Acceptability of online or distance learning courses
11. Number of total hours for field placement (e.g., practicum and internship)
12. How you might assess the program
13. Other

LO 3

CACREP Accreditation: An Overview

Today, CACREP (2014a, 2015b) offers standards for master's degrees in the following specialty areas: **clinical mental health counseling** (60 credits), **school counseling** (48 credits), **college counseling and student affairs** (48 credits), **career counseling** (48 credits), **addiction counseling** (60 credits), **marriage, couple, and family counseling** (60 credits), and **clinical rehabilitation counseling** (60 credits). Starting July 1, 2020, all new master's-level programs will be 60 credits. Please note, however, that you will find CACREP-accredited master's degree programs in counseling with different names from the ones just noted (e.g., community counseling). These programs were accredited under previous standards. As their accreditation periods run out, they will either become reaccredited under one of the new names or, less likely, give up their accreditation. In addition to master's-level programs, CACREP also offers standards for the **doctoral degree in counselor education and supervision.**

Master's-Level Standards

For all master's programs seeking CACREP accreditation, the **master's-level standards** delineate a variety of requirements within four primary areas: the **learning environment, professional counseling identity, professional practice,** and **evaluation in the program.** In addition, each specialty area has a wide range of additional curriculum requirements that need to be covered if that specialty area is to be accredited. The following offers abbreviated descriptions of the four primary areas as well as the specialty areas.

The Learning Environment.

This aspect of the accreditation process sets minimal standards for the **institution** (the college or university), for the **academic unit** (the counseling program), and for **faculty and staff.** For instance, institutions are expected to support the counseling program financially, have adequate research and scholarly

resources available, provide personal counseling for students, provide support for faculty to participate in professional organizations, provide an adequate instructional environment, provide technical support, and much more.

The academic unit should require the minimum number of credits as noted earlier; make attempts to attract and retain diverse students and faculty; have an admissions process that considers cultural context, aptitude, potential for success, career goals, and more; provide a student handbook that includes a mission statement, information about professional organizations, expectations of students, information about remediation and dismissal, and more; have a 10:1 faculty-student ratio; ensure that students have an advisor, and more.

In relation to faculty and staff, CACREP requires that core (e.g., full-time) faculty have a degree in counselor education, preferably from a CACREP-accredited program (some exceptions are made); that faculty are involved in appropriate professional and scholarly activities, that core faculty determine the curricula; that faculty have relevant experience in the area they are teaching; that there is a designated program leader and field placement coordinator, and more.

Professional Counseling Identity. The second primary area that CACREP reviews, professional counseling identity, focuses on the **foundation of the program** and the **counseling curriculum.** The foundation of the program includes ensuring that the program has a mission statement that is made public, program objectives, and that students are actively participating in professional counseling related activities (e.g., professional organizations, workshops, and the like).

The counseling curriculum must have appropriate syllabi, ensuring that research is infused throughout the program and demonstrating that eight **common-core curricular** experiences are covered in the program (see Fact Sheet 7.1).

Fact Sheet 7.1 CACREP's Eight Common-Core Curricular Experiences

Common-Core Area	Abbreviated Descriptions Based on 2016 Standards*
1. Professional Counseling Orientation and Ethical Practice	History, roles and responsibilities, advocacy, professional organizations, credentialing, ethics, technology, personal and professional self-evaluation, self-care, counseling supervision.
2. Social and Cultural Diversity	Research related to multiculturalism, theories, strategies, knowledge, attitudes and beliefs about, identity development, social justice and advocacy, spirituality.
3. Human Growth and Development	Theories of development, learning, and addictive behaviors; factors that impact development; knowledge of crisis, disaster, and trauma counseling; wellness and resilience.
4. Career Development	Theories of; approaches to; resources related to; knowledge of abilities, interests, values, and personality related to career; and assessment tools related to career counseling.
5. Counseling and Helping Relationships	Theories of counseling; systems theory; counselor characteristics related to effective helping; interviewing skills, suicide prevention; and crisis counseling and psychological first-aid strategies.
6. Group Counseling and Group Work	Theories of; group dynamics and process; effective group leadership skills; understanding group formation; ensuring that students have a least 10 hours of experience as a group member.

(*Continued*)

Fact Sheet 7.1 (*Continued*)

Common-Core Area	Abbreviated Descriptions Based on 2016 Standards*
7. Assessment and Testing	History; knowledge of danger to self and others; diagnosis; testing; reliability and validity of tests; knowledge of a variety of different types of tests and assessment procedures.
8. Research and Program Evaluation	Importance of; needs assessment, qualitative and quantitative research methods; knowledge of program evaluation; statistical concepts related to research; evaluation of counseling programs.

*Each common-core curriculum has numerous objectives, which are not listed above. For a full description of the common-core curricula, see the 2016 standards at www.cacrep.org.

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Professional Practice. The third primary area that CACREP examines focuses on the students' development of counseling theory and skills while under supervision. Here, CACREP requires that students must complete a minimum of 100 hours of field work for practicum, with at least 40 of them being direct service hours (working with clients). For internship, students must complete a minimum of 600 hours of fieldwork with at least 240 of them being direct service hours. One hour of individual or triadic supervision (two supervisees with one supervisor), per week, and 1.5 hours of group supervision, per week, are also required for practicum and for internship. It also states that students must be covered by liability insurance, identifies qualifications and roles of the supervisor. Finally, it states that there must be a 1:6 faculty-student ratio for individual or triadic (two students and one supervisor) supervision if the program supervisor is providing the only supervision, or a 1:12 ratio in group program supervision if the student is also receiving site supervision.

Evaluation in the Program. This last area describes the evaluation process of students and of the program. Program evaluation includes a wide range of assessment including an assessment of whether the program is meeting its objectives, how well students are learning, how well students are assessed by supervisors and employers, and much more. It also includes evaluation of students for their knowledge, their skills, and on their professional disposition. In addition, faculty and supervisors must also be continually evaluated for their effectiveness by students.

Entry-Level Specialty Areas. It has been said that an individual who obtains a degree in counseling is first a counselor, and secondarily a school counselor, clinical mental health counselor, college counselors and student affairs professionals, and so forth. Thus, all students who graduate from CACREP-accredited programs have coursework in the common-core curriculum areas noted in Fact Sheet 7.1 and must complete the required number of field placement hours as noted. However, there certainly are differences among **specialty areas,** so CACREP also delineates the "foundations, contextual dimensions, and practice" (e.g., knowledge, skills, and practices) students must learn based on their specialty areas. One example of these specialty guidelines for clinical mental health counseling is noted in Fact Sheet 7.2. To see others, visit the CACREP 2016 standards (CACREP, 2015b).

Doctoral-Level Standards

CACREP-accredited doctoral programs in counselor education and supervision must conform to **doctoral-level standards.** For matriculation into a doctoral program, students who have graduated from a non-CACREP accredited master's program must show equivalence of coursework to students who have graduated from a CACREP-accredited program. If they cannot, they will have to take additional courses to meet this requirement. Doctoral programs require a minimum of 48 semester hours of graduate-level credits in addition to the credits already obtained from the student's master's degree, along with any courses taken to meet equivalence. Doctoral programs in counselor education

Fact Sheet 7.2 Example of Specialty Guidelines in Clinical Mental Health Counseling

1. FOUNDATIONS

a. history and development of clinical mental health counseling
b. theories and models related to clinical mental health counseling
c. principles, models, and documentation formats of biopsychosocial case conceptualization and treatment planning
d. neurobiological and medical foundation and etiology of addiction and co-occurring disorders
e. psychological tests and assessments specific to clinical mental health counseling

2. CONTEXTUAL DIMENSIONS

a. roles and settings of clinical mental health counselors
b. etiology, nomenclature, treatment, referral, and prevention of mental and emotional disorders
c. mental health service delivery modalities within the continuum of care, such as inpatient, outpatient, partial treatment and aftercare, and the mental health counseling services networks
d. diagnostic process, including differential diagnosis and the use of current diagnostic classification systems, including the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the International Classification of Diseases (ICD)
e. potential for substance use disorders to mimic and/or co-occur with a variety of neurological, medical, and psychological disorders
f. impact of crisis and trauma on individuals with mental health diagnoses
g. impact of biological and neurological mechanisms on mental
h. classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for appropriate medical referral and consultation
i. legislation and government policy relevant to clinical mental health counseling
j. cultural factors relevant to clinical mental health counseling
k. professional organizations, preparation standards, and credentials relevant to the practice of clinical mental health counseling
l. legal and ethical considerations specific to clinical mental health counseling
m. record keeping, third party reimbursement, and other practice and management issues in clinical mental health counseling

3. PRACTICE

a. intake interview, mental status evaluation, biopsychosocial history, mental health history, and psychological assessment for treatment planning and caseload management
b. techniques and interventions for prevention and treatment of a broad range of mental health issues
c. strategies for interfacing with the legal system regarding court-referred clients
d. strategies for interfacing with integrated behavioral health care professionals
e. strategies to advocate for persons with mental health issues

Source: Council for Accreditation of Counseling and Related Educational Programs. (2016). 2016 CACREP standards. pp. 22–23. Retrieved from www.cacrep.org/wp-content/uploads/2015/05/2016-CACREP-Standards.pdf

and supervision require knowledge attainment in five core areas: counseling, supervision, teaching, research and scholarship, and leadership and advocacy. In addition, doctoral students must participate in a 100-hour practicum, 40 hours of which must be direct service, and a 600-hour internship that includes three of the five doctoral core areas listed above. All practicum and internship experience is conducted under the supervision of a counselor education faculty member or related professional. Finally, all doctoral students must complete a dissertation that focuses on relevant research in the area of counselor education and supervision.

Final Thoughts on CACREP Accreditation

To meet the accreditation standards, most programs find that they need to undertake at least moderate changes. Following the changes, and often while they are being made, a **self-study report** is written that spells out how the program meets each of the sections of the program standards. This report is then sent, with an application, to the CACREP office, which has independent readers review the report. If the report is accepted, then a CACREP team is appointed to visit and review the program and make a final recommendation for or against accreditation (see Activity 7.2). Ultimately, the CACREP board decides on whether or not to accept this recommendation.

Activity 7.2 Assessing Your Program

Your instructor will make available the CACREP accreditation standards or tell you how to access them. The instructor will then assign various aspects of the standards to individuals or small groups (e.g., a group might be assigned the core-curricular standards). After reviewing the standards:

1. Summarize the aspect of the standards you examined.
2. Using those aspects of the standards you reviewed, critically evaluate your counseling program.
3. Make suggestions for change in your counseling program as a result of your critical review in item 2.
4. Critically review the standards. What makes sense? What could be changed?

LO 4

Master's in Psychology and Counseling Accreditation Council (MPCAC)

Recently, a second accreditation body, the **Master's in Psychology and Counseling Accreditation (MPCAC),** has arisen to compete with CACREP (MPCAC, 2013). From their point of view, CACREP has (1) become restrictive by insisting that counselor educators who graduated from CACREP-accredited programs be hired by CACREP programs,

Reflection Activity 7.1 Is CACREP Too Big for Its Britches?

Now that you've read about the CACREP accreditation process, as well as some criticisms of CACREP by those advocating for MPCAC accreditation, what are your thoughts about the accreditation process? Do you think that CACREP has become too large and limits other types of programs? Do you think there is room for more than one accreditation process? Why do you think the counseling field has these competing accrediting bodies but other fields, such as social work and psychology, do not?

(2) restricted access of counselors from non-CACREP accredited programs from obtaining to certain jobs, (3) lobbied states to only license those from CACREP-accredited program, and (4) not required enough diversity training or social justice work in their programs ("Coalition of …," n.d.). Since only 13 counseling programs are currently accredited by MPCAC, it will only be briefly mentioned here. Only time will tell if this new accreditation process will take off. (See Reflection Activity 7.1.)

LO 5 Other Accrediting Bodies

A number of other accreditation bodies set standards in related fields. For instance, the Council on Rehabilitation Education (CORE, 2015) accredits rehabilitation counseling programs, and as just mentioned, CORE and CACREP have reached an agreement where 48-hour CORE-accredited rehabilitation programs can become accredited through CAREP as 60 credit clinical rehabilitation programs, and eventually, CACREP will take over all accreditation of rehabilitation programs (CACREP, 2014b, n.d.a). In another related field, we find training centers being approved by the **American Association of Pastoral Counselors (AAPC,** 2005–2012d). These centers do not offer degrees, but do offer training in pastoral counseling. Usually, a pastoral counselor already has obtained his or her degree in counseling or a related field prior to going to one of these training centers.

In the field of psychology, the **Commission on Accreditation (CoA)** of the **American Psychological Association** currently sets standards for doctoral-level programs in counseling and clinical psychology (APA, 2015c). The **Council on Social Work Education (CSWE,** 2015) is responsible for the accreditation of both undergraduate and graduate social work programs, while the **American Association for Marriage and Family Therapy's (AAMFT) Commission on Accreditation for Marital and Family Therapy Education (COAMFTE)** is an accrediting body for marriage and family therapy programs (AAMFT, 2002–2014b). Although somewhat in conflict with CACREP's accreditation of marriage and family therapy counseling programs, this commission has accredited about 118 marriage and family therapy programs in the United States and Canada (AAMFT, 2002–2014c). Finally, the **Council for Standards in Human Service Education (CSHSE)** sets standards for undergraduate human services programs (CSHSE, 2010).

Case Study 7.1 CACREP versus Non-CACREP Programs

Juanine just finished her master's degree in clinical mental health counseling from a CACREP-accredited institution. Jessica, finished her master's degree in clinical counseling from a non-CACREP accredited institution. This is a conversation they had about their programs.

Juanine: My program met all of the national standards. The faculty I had were all counselor educators and the courses I had followed the CACPREP common-core content areas. I was able to take my certification exam prior to graduating, and when I did graduate, I immediately became an NCC. I know that the training I received was top notch, because it followed the standards, and I'm competent I will have no trouble becoming a licensed professional counselor. And, if I wish, I can go back to school, pick up the extra school counseling courses, take an additional internship, and become a credentialed school counselor. There are just so many benefits to having gone to

my accredited program, including being able to obtain a job more easily and being able to eventually obtain third-party reimbursements. Plus, I know my professors were better than those non-CACREP accredited programs.

Jessica: Well, it's true you have some benefits—if you call them benefits. For instance, in my program we didn't have to follow the CACPREP curriculum standards and because of it, I believe I received a much stronger education. For instance, my program had continual field placement activities throughout and was not bound by stupid restrictions that CACREP places on field placements. Therefore, I was able to work with an art therapist and a counselor who had experience in nontraditional alternative methods. It would have been really hard to find supervisors like these if I had to have licensed counselors. And, I had an array of different types of courses, and wasn't stuck by those CACPREP common-core courses. For instance, I took a course on complementary, alternative, and nontraditional therapeutic approaches. Also, I was able to do some independent studies on methods I thought were important, and new. I found a series of workshops on neuropsychophysiology and was even able to get certified as an Eye Movement Desensitization and Reprocessing (EMDR) therapist. Now I can work with individuals who have experienced trauma. If I had gone through a traditional CACREP program I would have been locked into so many courses, I never would have been able to experiment. Plus, in my program not all my professors were counselor educators. One had his degree in psychology and another was even a psychiatrist. Boy, did they give me different perspectives. Sure, you got the traditional education, but I think I got the better education.

Respond to the following questions:

1. After reading about Juanine and Jessica, which point do you tend to agree with?
2. Can you defend Juanine's point of view?
3. Can you defend Jessica's point of view?
4. Which program would you rather go through?
5. Should CACREP be more flexible?

Summary

This chapter examined accreditation in counseling and related fields and began with a brief history of the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). It was first noted that in the counseling profession, the idea of standards dates back to the 1940s, although the official CACREP standards were not adopted until 1981. Making quick progress, we noted that today, CACREP accredits 279 institutions and offers 634 accredited programs in a variety of counseling specialty programs as well as about 50 programs at the doctoral level.

The next part of the chapter highlighted some of the benefits of accreditation, including better programs, better faculty, better students, a stronger professional identity, more field experiences, an easier time becoming credentialed, the maintenance of high standards, the possibility of having an easier time getting third-party reimbursements, and an easier time getting a job or getting into a doctoral program. On the other hand, we noted that accreditation may limit the kinds of faculty and courses taught and makes it difficult for small programs to thrive.

Offering a quick overview of the CACREP standards and the self-study process, we pointed out that the 2016 master's-level standards provides accreditation guidelines for the specialty areas of clinical mental health counseling, school counseling, college counseling and student affairs, career counseling, addiction counseling, clinical rehabilitation counseling, and marriage, couple, and family counseling. It was noted that the CACREP standards delineate requirements within four primary areas: the learning environment,

professional counseling identity, professional practice, and evaluation of the program, each of which was briefly described. In addition, it was noted that each specialty area must address the domains of foundations, contextual dimensions, and practice (knowledge, skills, and practice), and an example from clinical mental health counseling was given. It was stressed that an individual who obtains a degree in counseling is first a counselor, and secondarily a school counselor, clinical mental health counselor, college counselor and student affairs professional, rehabilitation counselor, and so forth.

Noting that CACREP also accredits doctoral programs in counselor education and supervision, we pointed out that such programs require a minimum of 48 semester hours beyond the master's degree; that five core areas are focused upon: counseling, supervision, teaching, research and scholarship, and leadership and advocacy; and that a 100-hour practicum and 600-hour internship, as well as a dissertation, were required. We noted that those who enter CACREP doctoral programs from non-CACREP master's degrees sometimes have to take additional courses to achieve equivalency in their coursework at the master's level. Finally, we noted that recently a new accrediting body has arisen to challenge CACREP's domination in the field. Those involved in the Master's in Psychology and Counseling Accreditation Council (MPCAC) believe that CACREP's dominance has made it difficult for some counselors and counseling programs to compete in the mental health field. Since only a handful of programs are MPCAC accredited, only time will tell if this accreditation process will be a threat to CACREP.

In addition to CACREP, other accreditation or approval processes exist and those were listed in this chapter. Some of the more common ones in the mental health fields include the Council on Rehabilitation Education (CORE), the approval process of the American Association of Pastoral Counselors (AAPC), the American Psychological Association's Commission on Accreditation (CoA), the Council on Social Work Education (CSWE), the American Association of Marriage and Family Therapy's (AAMFT) Commission on Accreditation for Marital and Family Therapy Education (COAMFTE), and the Council for Standards in Human Service Education (CSHSE).

Key Terms

Academic unit
Addiction counseling
American Association for Marriage and Family Therapy (AAMFT)
American Association of Pastoral Counselors (AAPC)
American Counseling Association (ACA)
American Personnel and Guidance Association (APGA)
American Psychological Association
Association for Counselor Education and Supervision (ACES)
Benefits of accreditation
Career counseling
Clinical mental health counseling
Clinical rehabilitation counseling
College counseling and student affairs
Common-core curriculum
Commission on Accreditation (CoA)
Commission on Accreditation for Marital and Family Therapy Education (COAMFTE)
Counsel for the Accreditation of Counseling and Related Educational Programs (CACREP)
Council for Standards in Human Service Education (CSHSE)
Council on Rehabilitation Education (CORE)
Council on Social Work Education (CSWE)

Credentialing in Counseling and Related Fields

CHAPTER 8

LEARNING OBJECTIVES

LO 1 Learn about the history of credentialing in the mental health professions with a particular emphasis on the counseling profession.

LO 2 Explore the benefits of credentialing.

LO 3 Understand the different types of credentialing, including registration, certification, and licensing.

LO 4 Survey the different types of counselor credentials including Licensed Professional Counselor (LPC), Credentialed School Counselor, National Certified Counselor (NCC), Certified Clinical Mental Health Counselors (CCMHC), National Certified School Counselor (NCSC), Master Addictions Counselor (MAC), Certified Rehabilitation Counselor (CRC), Certified Family Therapist (CFT), Approved Clinical Supervisor (ACS), Board-Certified Coach (BCC), and specific state certifications.

LO 5 Survey credentials in related mental health professions including Licensed Clinical Social Worker (LCSW), member of the Academy of Certified Social Workers (ACSW), Qualified Clinical Social Workers (QCSW), Diplomate in Clinical Social Work (DCSW), specialty certifications in social work, licensed psychologists, licensed and certified school psychologists, Licensed Marriage and Family Therapists (LMFT), Board-Certified Psychiatrist, Basic Psychiatric-Mental Health Nurse (PMHN), Psychiatric-Mental Health—Advanced Practice Registered Nurses (PMH—APRN), Registered Art Therapists (ATR), and Certified Pastoral Counselors (CPC).

LO 6 Understand the importance of lobbying efforts to ensure that counselor intiatives relative to credentialing and related activities are being fulfilled.

It is the year 1224 in the city of Sicily, and a young physician gathers his credentials to file for a medical license. He collects proof that he has studied for over eight years in physick, surgery and logic. He proudly adds a letter from his master physician mentor extolling his extraordinary skill in leech placement and uncanny facility in astrology. The young physician nervously heads off, credentials in hand, to be examined in public

> *by a committee of master physicians. If he passes, the emperor himself will issue a medical license. If he fails, he will be jailed if he attempts to practice medicine again.*
> *(Scoville & Newman, 2009, para.1)*

As you can see from the aforementioned quote, **credentialing** in the allied health professions can be traced back to the thirteenth century when the Holy Roman Empire set requirements for the practice of medicine (Hosie, 1991). Interestingly, today, the process of obtaining a credential is not dissimilar to the process in 1224 Sicily. First, you study for a number of years. Then you demonstrate that a mentor (e.g., supervisor) deems you ready, and finally, you take a credentialing exam. However, unlike the young physician in the quote above, *you* won't get jailed if you fail your credentialing exam. And anyway, I'm sure you'll pass!

This chapter will explore the credentialing process. First, we will offer a brief overview of the history of credentialing in the mental health professions. Then, we will describe benefits of credentialing followed by a discussion of the difference between registration, certification, and licensure. Next, we will provide a description of the different kinds of credentials in the counseling profession followed by a brief survey of credentials in related mental health professions. The chapter will conclude with a discussion about lobbying and its relationship to credentialing.

LO 1

A Brief History of Credentialing in the Mental Health Professions

Despite the fact that the credentialing of professionals started hundreds of years ago, in the mental health professions, credentialing is a modern-day phenomenon. Although Puerto Rico enacted a law regulating the practice of social work in 1934, and California did the same in 1945, credentialing of social workers was slow to pick up speed (Biggerstaff, 1995; Dyeson, 2004). In fact, it wasn't until the 1980s, when 25 states passed regulation of social worker credentials (generally called *licenses*), that this process really took off, and by 1993 all states and the District of Columbia obtained regulation of social workers. Today, the **Association of Social Work Boards (ASWB)** helps states with their licensing process. Paralleling the licensing of social workers, in 1960 the **Academy of Certified Social Workers (ACSW)** was established and represented the first national credential (the "ACSW") for those who had the qualifications to join the academy (National Association of Social Workers [NASW], 2015b).

In the field of psychology, the **American Board of Professional Psychology (ABPP)** was formed in 1947, and soon after, offered **board certifications** of psychologists in the specialty areas of clinical, counseling, and industrial/organizational psychology (Alberts, Ebbe, & Kazar, 2014). Today, offering certifications in 14 specialty areas, the purpose of this board certification is to demonstrate excellence in a specialty area and for protection of the consumer (ABPP, 2015). Meanwhile, during the 1950s California and New York became two of the first states to license psychologists (Cummings, 1990), and by 1977, all 50 states had enacted a process for the licensure of psychologists.

Although the first credentialing of counselors can be traced back to the certification of school counselors in the 1940s (Bradley, 1995), other forms of counselor credentialing did not begin until the 1970s. In 1974, rehabilitation counseling set the stage by establishing the **Certified Rehabilitation Counselor (CRC)** credential through the **Commission on Rehabilitation Counselor Certification (CRCC)** (Livingston, 1979). Then, in 1982 the **National Board for Certified Counselors (NBCC)** was founded to "establish and monitor a national certification system, to identify those counselors who have voluntarily sought and obtained certification, and to maintain a register of those counselors" (NBCC, 2015d, para. 1). Over the years, NBCC has expanded and today prides itself in certifying 55,000 counselors as **National Certified Counselor (NCC), National Certified School Counselors (NCSC), Certified Clinical Mental Health Counselors (CCMHC),** and **Master Addictions Counselors (MAC)** (NBCC, 2015b).

Spurred on by psychologists trying to prevent counselors the right to independent practice, in 1974 the **American Personnel and Guidance Association (APGA)** (now the **American Counseling Association [ACA]**) created the **Licensure Committee** to assist in the development and passage of credentialing bills for counselors (Bloom et al., 1990; Brooks & Gerstein, 1990). In 1976, Virginia passed the **first licensing law for counselors,** and other states soon followed suit. By 2010, all 50 states, Puerto Rico, Guam, and the District of Columbia offered counselor licensing, and the most recent count shows that there are about 120,000 licensed counselors nationally (see ACA, 2011).

During the latter part of the twentieth century, many states passed licensing laws for marriage and family counselors. Today, every state licenses marriage or family counselors, usually called **Licensed Marriage and Family Therapist (LMFT)** (**Association of Marital and Family Therapy Regulatory Boards [AMFTRB],** 2015). Requirements for marriage and family licensing can vary dramatically from state to state as a function of whether the state follows the curriculum guidelines set by the **Council for the Accreditation of Counseling and Related Educational Professions (CACREP),** the guidelines set forth by the American Association of Marriage and Family Therapy's (AAMFT) **Commission on Accreditation of Marriage and Family Therapy (COAMFTE),** or other guidelines. AMFTRB helps states regulate the licensing process and provides a national exam for those states who wish to use it. In addition to licensure, in 1994 the **International Association of Marriage and Family Counselors (IAMFC),** a division of ACA, developed a certification process through the **National Credentialing Academy (NCA)** that enables a marriage and family counselor to become a **Certified Family Therapist (CFT)** (NCA, n.d.).

LO 2 Benefits of Credentialing

Credentialing offers many benefits to the counselor, the counseling profession, and the consumer of counseling services (Corey, Corey, Corey, & Callanan, 2015; IAMFC, 2015b). Some of the **benefits of credentialing** include:

1. *Increased professional identity.* A credential is a method of delimiting a professional group by establishing certain criteria that all credentialed members must meet. This helps identify who belongs to the profession and highlights areas of expertise of the professional group.

2. *Increased sense of professionalism.* Credentialing increases the status of members of a profession because it assures minimum levels of competency have been met by those who practice.
3. *Demonstrating expertise within a profession.* Credentialing shows that some individuals within a profession may have more expertise in a specialized area than others within that same professional group (e.g., a counselor with a certification as a Master Addictions Counselor versus one who does not have this credential), thus making it easier for the consumer to choose which professionals they may wish to see.
4. *Gaining parity.* Credentialing helps counselors achieve parity with closely related mental health professions in the areas of status, salary, and insurance reimbursement.
5. *Protecting the public.* Credentials help the public identify those individuals who have the appropriate training and skills versus those who do not.

LO 3

Types of Credentialing

Although credentialing takes many forms, the three most common include registration, certification, and licensure.

Registration

Registration is the simplest form of credentialing and involves a listing of the members of a particular professional group (Sweeney, 1991). Registration, which is generally regulated by each state, implies that each registered individual has acquired minimal competence, such as a college degree and/or apprenticeship in his or her particular professional area. Registration of professional groups usually implies that there is little or no regulation of that group. Generally registration involves a modest fee. Today, few states provide registration for professionals, instead opting for the more rigid credentialing standards of certification and/or licensure.

Certification

Certification involves the formal recognition that individuals within a professional group have met certain predetermined standards of professionalism (ACA, 2015a). Although more rigorous than registration, certification is less demanding than licensure. Generally, viewed as a **protection of a title** (Remley & Herlihy, 2014), certification attests to a person's attainment of a certain level of competence but does not define the **scope and practice** of a professional (what a person can do and where he or she can do it). A yearly fee must usually be paid to maintain certification.

Certification is often overseen by national boards, such as the National Board for Certified Counselors (NBCC, 2015a, 2015b, 2015c). Although national certification suggests that a certain level of competence in a professional field has been achieved, unless a state legislates that the specific national certification will be used at the state level, such certification carries little or no legal clout. Many individuals will nevertheless obtain certification because it is an indication that they have mastered a body of knowledge, which can sometimes be important for hiring and promotion. Certification often requires ongoing continuing education if a professional is to maintain his or her credential.

Finally, some certifications are offered by states in specialized areas (e.g., substance abuse, child abuse), and professionals should contact their appropriate state regulatory office to inquire what certifications a state offers and the rules and competencies needed to become certified in their states.

Licensure

The most rigorous form of credentialing is **licensure**. Generally regulated by states, licensure denotes that the licensed individual has met rigorous standards and that individuals without licenses cannot practice in that particular professional arena (ACA, 2014b, 2015a). Whereas certification protects the title only, licensure generally defines the scope of what an individual can and cannot do. For instance, in Virginia the counselor licensing law not only defines the requirements one must meet to become licensed but also defines what is meant by counseling, who can do it, the limits of **confidentiality and privileged communication,** legal regulations related to suspected violations of the law (e.g., child abuse), and other various restrictions and regulations (Virginia Board of Counseling, 2014).

In terms of day-to-day professional functioning, the most important aspect of counselor licensure has become the fact that in most states licensure carries with it legislation that mandates **third-party reimbursement** privileges. Such legislation requires insurance companies to reimburse licensed individuals for counseling and psychotherapy. As with certification, licensure generally involves a yearly fee and continuing education requirements are generally mandated (see Reflection 8.1).

Reflection Activity 8.1 The Topsy-Turvy World of Credentialing

Professional school counselors are required by law and/or regulation in every state, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands to obtain a state-issued credential in order to be employed in public schools. In some states, this credential is called "certification"; others term it "licensure" or "endorsement" (Lum, 2011, p. 2).

As is evidenced by this quote, there are many caveats to the definitions of registration, certification, and licensing. For instance, although I was a licensed psychologist in Massachusetts and New Hampshire, when I moved to Virginia, the psychology licensing board would not license me. I was, however, quite content to obtain my license as a professional counselor (LPC). You see, state licenses are often not reciprocal.

Also, whereas some state boards of education use the word *certification* for school personnel (e.g., teachers, school counselors, school psychologists), others use the word *licensure*. In both cases, it usually means the same—that the individual has successfully graduated from a state-approved program in his or her respective area. However, there is little rhyme or reason why one state will use the words *certified school counselor* while another will use *licensed school counselor*. And, in these cases, the words do not carry the same meaning as the national certifications or state licenses described earlier. Finally, you will find other idiosyncratic usages of the words *certification* and *licensure* depending on the state in which you live.

Why do you think different states use different terms to describe credentialed individuals? And, what are the terms that are used in your state? Finally, are there credentialed individuals in your state that are not noted in this chapter?

LO 4

Credentialing for Counselors

Within the past 30 years, great strides have been made in the credentialing of counselors. From the credentialing of rehabilitation counselors, to the expansion of counselor certification and licensure, to the recent certification for coaching, the credentialing process in counseling has now taken firm hold. The following describes some of the more prominent counselor credentials.

Licensed Professional Counselor

With the first counselor licensure starting in 1976 in Virginia (Bradley, 1995), it is quite something that today, there are over 120,000 licensed counselors (ACA, 2015a). Although usually called **Licensed Professional Counselors (LPCs),** some states use alternative names (e.g., **licensed counselor**). As some densely populated states, like New York and California, have fairly recently approved counselor licensure, the current number of LPCs will surely rise quickly. Although the National Counselor Exam (see "National Counselor Certification" section) is used by many states for the licensure exam, licensure is almost always more involved than certification. For instance, in addition to an exam, licensure generally includes a minimum of 2 years of post-master's-degree supervision, sometimes additional coursework, and other requirements depending on the state.

Finally, now that all 50 states have counselor licensure, ACA and the **American Association of State Counseling Boards (AASCB)** have been jointly working on developing a system of **portability,** sometimes called **reciprocity,** of licenses. One initiative involves a joint letter going to all state licensing boards asking them to adopt the same professional title—Licensed Professional Counselor. A second letter, is planned to be sent solely by AASCB and will encourage licensing boards to allow counselors with 5 years of experience and a license from another state to be granted a license when a counselor moves to their new state (AASCB, 2015a, 2015b; Bray, 2015).

Credentialed School Counselors

State boards of education credential school counselors but vary on whether they call the credentials a **license, certification,** or simply an **endorsement.** In any case, in the vast number of cases, graduation from a **state-approved school counseling program** is enough to gain the credential, regardless of what it is called. However, some states may have additional requirements, such as a teaching credential, work experience, or more (see "State Certification Requirements," **American School Counselor Association [ASCA],** 2015). Some states credential K–12 school counselors while others credential school counselors at the elementary, middle, and high school levels. However, not all states currently require school counselors at all grade levels (ASCA, 2015). In either case, with the national average of school counselors being about 500 to 1 students (ASCA recommends 250 to 1) (Strauss, 2013), there are likely well over 200,000 **credentialed school counselors** in the United States (United States Department of Labor, 2014).

National Certified Counselor

Established in 1982 to maintain and monitor a **National Counselor Certification** process, the National Board for Certified Counselors (NBCC) has credentialed over 55,000 counselors as National Certified Counselors (NCCs) (NBCC, 2015b). Students who have graduated from a CACREP-approved program may take the **National Counselor Exam (NCE)** prior to their graduation and, assuming they pass, are certified upon graduation. Those who have not graduated from a CACREP-approved program may take the NCE immediately following graduation; however, they become an NCC only after they have successfully completed a minimum of 2 years of post-master's experience with 100 hours of supervision and 3,000 hours of work experience (NBCC, 2015f). Finally, many states

use the NCE, or the **National Clinical Mental Health Counselor Exam (NCMHCE;** see next section), as part of their licensing process (NBCC, 2015g). By the year 2022, one must graduate from a CACREP-accredited program to obtain the NCC.

To highlight expertise in a particular counseling specialty area, NBCC offers three **specialty certifications** after one has become an NCC. These include Certified Clinical Mental Health Counselor (CCMHC), National Certified School Counselor (NCSC), and Master Addictions Counselor (MAC). To be eligible to sit for the exam to attain any of these certifications, specific education, coursework, supervision, work experience, and, in the case of the CCMHC, a videotape is required (NBCC, 2015b).

Certified Rehabilitation Counselor

As noted earlier, in 1974 the Commission on Rehabilitation Counselor Certification (CRCC, 2015a; Livingston, 1979) was one of the first organizations to offer credentialing in counseling, and since its inception, CRCC currently has credentialed 17,000 Certified Rehabilitation Counselors (CRCs) (CRCC, 2015b). CRCC's purpose is to promote quality services for individuals with disabilities and provide leadership and advocacy in rehabilitation counseling.

Certified Family Therapist

Have expertise in couples and family counseling? Then you might be interested in becoming a Certified Family Therapist (CFT). As noted earlier, this certification was developed by the International Association of Marriage and Family Counselors (IAMFC) through the National Credentialing Academy (NCA). With its purpose being to promote family therapy, identify those who meet high standards in marriage and family work, and ensure a national standard (NCA, n.d.), the certification is open to individuals who hold a wide-range of graduate degrees in the helping professions and can show verification of graduate training in marriage and family work, post-graduate supervision, and letters of recommendations or endorsement.

Approved Clinical Supervisor

Although not technically a certification, this approval process, developed in 1997 by the NBCC and now administered by the Center for Credentialing and Education (CCE, n.d.b), shows that a counselor has expertise as a clinical supervisor and is a required credential in some states for those who supervise counselors wishing to become licensed. Approved Clinical Supervisors (ACSs) must have their master's degree in a mental health field, be NCC's or a licensed or certified mental health provider or clinical supervisor, have a course or workshops in clinical supervision, and have experience in the mental health field (an alternate process is also noted).

Board-Certified Coach

Although there are many avenues to becoming a **Board-Certified Coach (BCC),** for those in the counseling profession, individuals who are NCCs, LPCs, or have a master's or more in counseling, are eligible (CCE, n.d.a). BCC's can also specialize in executive/

corporate/business/leadership; health and wellness; career concerns; or personal life issues. See Chapter 6 for a definition of life-coaching.

Specific State Certifications

In addition to the certifications noted above, each state may have its own unique certifications for master level counselors (e.g., substance abuse, child abuse) and you should check with the regulatory office of your state to see if there may be some other counselor certification for which you might be eligible.

Counselor Credentialing: A Unifying Force

In the past 25 years, the credentialing process has done much for the professionalization of the counseling field. Signifying competence in our field, counselor licensure or certification has become a unifying force that suggests a high level of professionalism. Similar to the medical field, in which one is first a physician and secondarily a cardiologist, pediatrician, psychiatrist, and so forth, a counselor is first a counselor and secondarily a Licensed Professional Counselor, Credentialed School Counselor, National Certified Counselor, Certified Clinical Mental Health Counselor, National Certified School Counselor, Master Addictions Counselor, Certified Rehabilitation Counselor, Certified Family Therapist, Approved Clinical Supervisor, or Board-Certified Coach (see Activity 8.1).

Activity 8.1 Credentials Obtained, Credentials Desired

Write down all the credentials you hold—even if they are not in the helping professions. Then, write down all of the credentials you want to hold. If you have already gained some credentials, reflect on the process and what obtaining the credential has meant to you. Then, consider what the future holds—what will you have to do to obtain your desired credential and what will it mean to you to gain it. If your instructor is able, he or she will collect the lists from the students and share them with the class. Discuss the list in class if possible.

LO 5

Credentialing in Related Helping Professions

> *It is recognized that there is competition for clients among professionals providing mental health services and that there is also concern about the degree of preparation and expertise of a number of professions to deliver those services. (Garcia, 1990, p. 495)*

Although written over 25 years ago, this quote is still relevant today. Competition between credentialed mental health professionals is real, and whether or not a professional is credentialed will make a huge difference in one's ability to obtain clients. Let's take a look at some of the different credentials available to our professional cousins.

Social Work Credentialing

Although the numbers are not clear, there are probably well over 100,000 master's level credentialed social workers (National Center for O*NET Development, 2015) in a variety of areas. For instance, master's-level social workers can be members of the **Academy of Certified Social Workers (ACSW),** become **Licensed Clinical Social Workers (LCSWs),** be **Qualified Clinical Social Workers (QCSWs),** be **Diplomates in Clinical Social Work (DCSW),** or hold a number of specialty credentials (NASW, 2015b).

Academy of Certified Social Workers (ACSW).

To be a member of ACSW, an individual needs to be a member of NASW, have 2 years of postgraduate social work employment and supervision, be professionally validated by a supervisor and two work colleagues, have 20 hours of continuing education, and adhere to appropriate codes of ethics and standards.

Licensed Clinical Social Worker (LCSW).

Like counselor licensure, becoming an LCSW is state-driven, and requirements can vary from state to state with some states using a slightly different name (e.g., Licensed Social Worker [LSW]) (socialworklicensure.org, 2011–2015). However, most states require a 60-credit master's degree in social work, supervision beyond the master's degree, and a licensing exam in order to obtain one's LCSW.

Qualified Clinical Social Worker (QCSW).

A Qualified Clinical Social Worker (QCSW) needs to have a master's in social work, document 3 years (4,500 hours) of postgraduate supervised clinical experience, have 30 hours of post-degree continuing education, hold a state social work license (e.g., LCSW), and adhere to appropriate codes of ethics and standards.

Diplomate in Clinical Social Work (DCSW).

A Diplomate in Clinical Social Work (DCSW) needs to have a master's in social work, be a member of NASW, document 3 years (4,500 hours) of postgraduate clinical social work, have 30 hours of post-degree continuing education, provide professional evaluations of his or her work, hold a state clinical license (e.g., LCSW), and adhere to appropriate codes of ethics.

Specialty Credentials.

There are ten specialty credentials in social work, each with different qualifications. They include credentials in clinical work, gerontology, hospice and palliative work; youth and family; military, leadership, health care; addictions; case management; and education (NASW, 2015b).

Psychology Credentialing

The most frequent kinds of credentials in psychology include licensed psychologist, credentialed school psychologist, and certified school psychologist.

Licensed Psychologist.

With about 93,000 practicing licensed psychologists, this field is one of the larger mental health professions (APA, 2015d). Generally, those who hold doctorates in clinical psychology, counseling psychology, or a Psy.D. can become **licensed psychologists.** The requirements for licensure as a psychologist are fairly

consistent from state to state and require 2 years of post-doctoral clinical supervision and the passing of a national licensing exam, although each state sets its own cut-off scores for passing. Licensure as a psychologist ensures access to third-party reimbursement and allows one to practice independently.

Psychology Board Certifications.

Established in 1947, the American Board of Professional Psychology (ABPP) is the major national credentialing body for psychologists and offers **board certifications in psychology in 14 areas:** clinical child and adolescent psychology, clinical health psychology, clinical neuropsychology, clinical psychology, cognitive and behavioral psychology, counseling psychology, couple and family psychology, forensic psychology, group psychology, organizational and business consulting psychology, police and public safety psychology, psychoanalysis, rehabilitation psychology, and school psychology. The certification process includes a review of credentials, an examination of peer-reviewed case examples, an oral exam, and sometimes a written exam (ABPP, 2015).

Credentialed School Psychologist.

State boards of education certify **credentialed school psychologists,** with most states requiring a master's degree or more (e.g., Ed.S., Ph.D.) in school psychology. States vary on whether they call the credential a license or a certification, but in either case, the requirements are the same: to have graduated from a state-approved school psychology program.

National Certified School Psychologist.

Sponsored by the **National Association of School Psychologists (NASP),** certification as a **National Certified School Psychologist (NCSP)** requires 60 graduate semester hours of coursework, a 1,200-hour internship, and passing of a national exam (NASP, n.d.). Currently, there are approximately 14,000 National Certified School Psychologists (J. Epstein, personal communication, April 16, 2015).

Marriage, Couple, and Family Therapy Credentialing

In addition to becoming a Certified Family Therapist (CFT), as noted earlier, today, each state has enacted credentialing laws for the approximately 50,000 couple, marriage, and family counseling, with credentialed professionals generally called Licensed Marriage and Family Therapists (LMFT) (**American Association for Marital and Family Therapy [AAMFT],** 2002–2014a). In some cases, state licensure boards have followed the guidelines set forth by COAMFTE. In other cases, licensure has been subsumed under the counseling board and tends to follow CACREP guidelines. Still other boards have set their own guidelines for marriage, couple, and family therapy credentialing.

Psychiatry Credentialing

Because licensure as a physician is not specialty-specific, individuals are licensed as medical doctors, not pediatricians, psychiatrists, surgeons, and so forth. Therefore, a physician who obtains a license within a state can theoretically practice in

any area of medicine. However, because hospital accreditation standards generally require the hiring of **board-certified physicians,** almost all physicians today are board-certified in a specialty area. Board certification means that the physician has had additional experience in the specialty area and has taken and passed a rigorous exam in that area. Thus, most of the approximately 25,000 psychiatrists are not only licensed physicians within the state where they practice but are generally **board-certified in psychiatry** (American Board of Medical Specialties, 2015; U.S. Department of Labor, 2015).

Psychiatric-Mental Health Nurses Credentialing

There are two levels of psychiatric-mental health nurses—the basic and the advanced. **Basic Psychiatric-Mental Health Nurses (PMHN)** generally do not have advanced degrees and can work with clients and families doing entry-level psychiatric nursing. In contrast, **Psychiatric-Mental Health—Advanced Practice Registered Nurses (PMH—APRN)** can do a wide-range of mental health services, can prescribe medication, and can receive third-party reimbursement in many states. Basic and advanced psychiatric-mental health nurses take licensing exams to become a registered nurse and many will take a specialty certification examine to become certified in psychiatric-mental health nursing. APRNs can also become certified as a Nurse Practitioner and, if so, can prescribe medication in all 50 states (American Nurses Credentialing Center, 2014; American Psychiatric Nurses Association, 2015).

Art Therapy, Pastoral Counseling, and Other Certifications

Credentialing of mental health professionals is not limited to the credentials listed above. For instance, certification exists for some kinds of expressive therapies (e.g., **Registered Art Therapist [ATR],** see **Art Therapy Credentials Board,** 2015). Similarly, the **American Association for Pastoral Counselors (AAPC,** 2005–2012a) offers a certification process for those who are interested in becoming **Certified Pastoral Counselors (CPCs)**. These individuals can also become licensed if they hold degrees in areas in which the state offers licensure (e.g., counseling, social work, psychology). Those who do not hold such degrees can sometimes become licensed as a counselor, social worker, or psychologist if they take additional coursework that matches the curriculum requirements of the existing state licenses and if they gain other, required experiences (e.g., supervision) (Wadeson, 2004). In addition to the above credentials, no doubt other credentials in related mental health professions also exist.

Overview

Table 8.1 lists the various credentials identified in this chapter, their acronyms, and where you can find additional information about them.

TABLE 8.1 Various Credentials, Acronyms, and Web Addresses

Counselor Credentialing	Acronym	Website for Additional Information
Licensed Professional Counselor	LPC	www.aascb.org
National Certified Counselor	NCC	www.nbcc.org/OurCertifications
Certified Rehabilitation Counselor	CRC	www.crccertification.com
Certified Clinical Mental Health Counselor	CCMHC	www.nbcc.org/OurCertifications
National Certified School Counselor	NCSC	www.nbcc.org/OurCertifications
Master Addictions Counselor	MAC	www.nbcc.org/OurCertifications
Certified Family Therapist	CFT	http://nationalcredentialingacademy.com
Credentialed School Counselor	—	www.schoolcounselor.org/content.asp?contentid=242
Social Work Credentialing		
Licensed Clinical Social Worker	LCSW	www.aswb.org (click"Find a licensing board")
Academy of Certified Social Workers	ACSW	www.naswdc.org/credentials
Diplomate in Clinical Social Work	DCSW	www.naswdc.org/credentials
Eight Specialty Certifications	—	www.naswdc.org/credentials
Psychology Credentialing		
Licensed Psychologist	—	www.asppb.net
Fourteen Specialty Certifications	—	www.abpp.org (click"Member Specialty Boards")
Credentialed School Psychologist	—	www.nasponline.org/certification/state_info_list.aspx
National Certified School Psychologist	NCSP	www.nasponline.org/certification/index.aspx
Couple, Marriage, and Family Therapy Credentialing		
Licensed Marriage and Family Therapist	LMFT	aamft.org (click"MFT Licensing Boards Directory")
Psychiatry Credentialing		
Licensed Physician	—	www.fsmb.org
Board Certification	—	www.abms.org/about-abms
Psychiatric-Mental Health Nurse Credentialing		
Basic Psychiatric-Mental Health Nurse	PMHN	www.nursecredentialing.org/FamilyPsychNP-Eligibility.aspx
Psychiatric-Mental Health—Advanced Practice Registered Nurse	PMH—APRN	www.nursecredentialing.org/FamilyPsychMentalHealthNP
Other Certifications		
Registered Art Therapist	ATR	www.atcb.org
Certified Pastoral Counselor	CPC	www.aapc.org/membership/certifications/?

LO 6

Lobbying for Credentialing and Counseling-Related Issues

Political action committees, lobbyists, and offering free lunches to legislators—certainly these are not within the realm of counselors, or are they? In point of fact, **lobbying** and

grassroots efforts that counseling associations take to introduce and/or defeat legislation have become crucial to the survival of the counseling profession (see ACA, 2015g). For instance, if counselors hadn't lobbied for the establishment of elementary and middle school counselors, they would not be in existence today. Similarly, counselors had to continually push to obtain licensure of professional counselors in all 50 states. And, in a circular manner, once we obtain our credentials, we have more credibility to lobby for our profession.

Today, we must continue to lobby to ensure that we are included as providers for various health insurance plans, to lower counselor to student ratios in the schools, and to ensure that state and federal funding sources are aware of counselors in all specialty areas. Who pays for our lobbying efforts? We do! A portion of our professional association membership fees goes to pay for lobbyists and legislative initiatives that will support our own interests. When *you* do not join your professional association, you reap the benefits for which others are paying!

Case Study 8.1 A Day in the Life of Tiffany

Tiffany wakes up at 5:30 a.m. to go to the elementary school where she works. A certified school counselor, she enjoys her job working with the "young ones," as she calls them. Her day often involves early morning duty (ensuring the students arrive safely at school), running psychoeducational groups, doing individual and group counseling, filling in for the principal when she is out of the building, sitting on child study teams for students with possible learning disabilities, meeting with teachers and parents, and more. Her day at the school ends about 3:30 p.m., at which point she rushes to her private practice. You see, Tiffany has also obtained her LPC and her certification as a Board-Certified Coach (BCC). Generally she sees one or two clients, four days a week—but no more than about five clients in a week. Switching between doing counseling and doing coaching is sometimes challenging, but Tiffany feels she can do it well. In addition to her private practice counseling and coaching, Tiffany is also involved with her professional state counseling association, and has committed herself to advocacy and lobbying work. Two times a year the association conducts "legislative day," when a few dozen counselors take a trip to the capital to advocate for counseling-related issues with their legislators. In addition, there is an ongoing "letter/e-mail campaign" that Tiffany and others have taken on to ensure counselors aren't short thrifted at the state level. Finally, Tiffany arranges to meet with her Approved Clinical Supervisor once every other week to ensure that she is practicing ethically. The supervisor helps her watch for counter transference and also helps her attend to her self-care and wellness, as Tiffany has taken on a lot. She pays her supervisor out of pocket.

Tiffany is pleased with all she does but hopes that her work and professional activities aren't taking a toll on her mental health and physical well-being. And, oh yea, she is also concerned that her work may be taking a toll on her marriage and her ability to parent her two young children. She tries to find a balance with all of her work and life responsibilities.

1. How do you think Tiffany was able to obtain her credential as a school counselor and as a licensed professional counselor?
2. Do you think Tiffany could have practiced without supervision? Would that have been ethical and professional?
3. Is Tiffany obtaining enough supervision?
4. Do you think Tiffany has taken on too much? How might Tiffany's work and professional activities impact her job as a school counselor, her marriage, her relationship with her children, and her parenting skills?
5. Could you be able to do all of what Tiffany does?

Summary

This chapter presented an overview of credentialing in the mental health professions with a particular focus on counselor credentialing. We began by noting that credentialing in the allied health professions is hundreds of years old, but highlighted the fact that credentialing in the mental health professions is relatively new, starting in the twentieth century.

We pointed out that early credentialing started with regulation of social workers in Puerto Rico and California and noted that by 1993 all 50 states had licensure of social workers, which is overseen by the Association of Social Work Boards (ASWB). We noted that psychology offered certifications in the 1940s and today offers 14 certification specialty areas. We also pointed out that by 1977 all 50 states had psychology licensure.

In counseling, we noted that certification of school counselors started in the 1940s, that in 1974 the first rehabilitation counselor was certified, and in 1976 Virginia was the first state to license counselors. In 2010, all 50 states, Puerto Rico, Guam, and the District of Columbia had counselor licensure. We also noted that, today, the National Board for Certified Counselors (NBCC) offers certification as a National Certified Counselor (NCC) and subspecialties as a National Certified School Counselor (NCSC), Certified Clinical Mental Health Counselor (CCMHC), and Master Addictions Counselors (MAC). We also noted that, today, every state licenses marriage and family counselors and that there is a national certification as a family therapist (CFT).

Some of the many benefits of credentialing that we highlighted included increased professional identity, increased sense of professionalism, demonstrating expertise within a profession, gaining parity with other mental health professionals, and protection of the public.

Next in the chapter, we described the difference between registration, certification, and licensure, with licensure being the most rigorous, as it not only defines the specific requirements one needs to have to become credentialed, but also defines the scope of what a person can do. In addition, it generally is the ticket for the ability to obtain third-party reimbursement.

The next part of the chapter identified the various types of credentialed counselors as well as related credentialed mental health professionals. For counselors, we identified Licensed Professional Counselors (LPCs), credentialed school counselors, National Certified Counselors (NCCs), Certified Clinical Mental Health Counselors (CCMHCs), National Certified School Counselors (NCSCs), Master Addictions Counselors (MACs), Certified Rehabilitation Counselors (CRCs), Certified Family Therapists (CFT), Approved Clinical Supervisors (ACS), Board-Certified Coach (BCC), and specific state certifications. We noted a new system for licensure portability developed by ACA and AASCB.

Some of the credentialed professionals we noted in social work included Licensed Clinical Social Workers (LCSWs), members of the Academy of Certified Social Workers (ACSW), Qualified Clinical Social Workers (QCSWs), Diplomates in Clinical Social Work (DCSWs), and those with specialty certifications in one or more of ten specialty areas. In psychology, we distinguished between licensed psychologists (counseling, clinical, and Psy.D.) and school psychologists (state-credentialed and National Certified School Psychologists [NCSPs]). We also noted that the American Board of Professional Psychology (ABPP) offers board certifications in 14 areas.

Other credentialed professionals we noted were Licensed Marriage and Family Therapists (LMFTs), board certified psychiatrists, basic Psychiatric-Mental Health Nurses

(PMHN), Psychiatric-Mental Health—Advanced Practice Registered Nurses (PMH—APRN), Registered Art Therapists (ATR), and Certified Pastoral Counselors (CPCs). Table 8.1 identified most of these credentials and gave websites where you can find more information about them. The chapter concluded with a quick note about the importance of lobbying for credentialing and counseling-related issues.

Key Terms*

Academy of Certified Social Workers (ACSW)
American Association for Pastoral Counselors (AAPC)
American Association of Marriage and Family Therapy (AAMFT)
American Association of State Counseling Boards (AASCB)
American Board of Professional Psychology (ABPP)
American Counseling Association (ACA)
American Personnel and Guidance Association (APGA)
American School Counselor Association (ASCA)
Approved Clinical Supervisors (ACSs)
Art Therapy Credentials Board
Association of Marital and Family Therapy Regulatory Boards (AMFTRB)
Association of Social Work Boards (ASWB)
Basic Psychiatric-Mental Health Nurses (PMHN)
Benefits of credentialing
Board certifications
Board certifications in psychology in 14 areas
Board-certified coach
Board-certified in psychiatry
Board-certified physicians
Certification
Certified Clinical Mental Health Counselor (CCMHC)
Certified Family Therapist (CFT)
Certified Pastoral Counselors (CPCs)
Certified Rehabilitation Counselor (CRC)
Commission on Accreditation of Marriage and Family Therapy (COAMFTE)
Commission on Rehabilitation Counselor Certification (CRCC)
Confidentiality and privileged communication
Council for the Accreditation of Counseling and Related Educational Professions (CACREP)
Couple, marriage, and family therapy credentialing
Credentialing
Credentialed School Counselor
Credentialed School Psychologists
Diplomates in Clinical Social Work (DCSW)
Endorsement
First licensing law for counselors
International Association of Marriage and Family Counselors (IAMFC)
License
Licensed Clinical Social Workers (LCSWs)
Licensed Counselor
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselors (LPCs)
Licensed Psychologists
Licensure
Licensure Committee
Lobbying
Master Addictions Counselor (MAC)
National Association of School Psychologists (NASP)
National Board for Certified Counselors (NBCC)
National Certified Counselor (NCC)

*Please see Table 8.1 for the names and websites for most of the credentials.

National Certified School Counselor (NCSC)
National Certified School Psychologist (NCSP)
National Clinical Mental Health Counselor Exam (NCMHCE)
National Counselor Certification
National Counselor Exam (NCE)
National Credentialing Academy (NCA)
Portability
Protection of a title
Psychiatric-Mental Health—Advanced Practice Registered Nurses (PMH—APRN)
Psychiatric-Mental Health Nurse Credentialing
Psychiatry Credentialing
Psychology board certifications
Psychology Credentialing
Qualified Clinical Social Workers (QCSWs)
Reciprocity
Registered Art Therapist (ATR)
Registration
Scope and practice
Specialty certifications
Specialty credentials in social work
Specific state certifications
State-approved school counseling program
State boards of education
Third-party reimbursement
Types of credentialing



Ethics in Counseling

CHAPTER 9

LEARNING OBJECTIVES

LO 1 Understand the difference between values, ethics, morals, and legal issues.

LO 2 Learn about the development of ethical codes in the mental health professions.

LO 3 Learn the major points of the ACA ethics code, highlight ethics codes of a few of ACA's divisions, and note the ethics codes of related mental health professions.

LO 4 Examine ethical "hot spots" and consider how a counselor might respond to them.

LO 5 Review and learn how to implement models of ethical decision-making, including problem-solving, moral, social constructionist, and developmental models.

LO 6 Learn the procedures for reporting ethical violations.

LO 7 Learn about four important areas relative to the law and ethics: civil and criminal liability, the role of ethical codes in lawsuits, the importance of having malpractice insurance, and the use of best practices to avoid ethical violations.

One time, I had a suicidal client leave her session saying she was going to kill herself. Upon hearing what happened, my supervisor looked at me and said, "Get in my car." We chased her down, stopped her, and had her involuntarily committed. Another time, a 14-year-old client told me he was having an incestuous relationship with his step-sister. I had to break confidentiality, tell his parents, and have child protective services get involved. Another time, I was testing a high school girl. Based on her responses to some questions, I thought she had been molested. When I asked her, she began to sob. Soon after, I had to break confidentiality and tell school officials. One other time I was working with a colleague who was misrepresenting his credentials. I had to sit down and talk with him and let him know that

what I thought he was doing was unethical, and that if he did not change, I would report him. These are some of the difficult ethical dilemmas we face as counselors, and I'm sure, if you have not yet faced some difficult dilemmas in your career, you will. This chapter discusses values, morality, ethics, best practices, and the law. Let's take a look.

LO 1

Defining Values, Ethics, Morality, and Their Relationship to the Law

> *Always do what is right. It will gratify half of mankind and astound the other. (Mark Twain)*

Although we are not constantly faced with situations such as the ones just described, in our work as counselors we are periodically confronted with complicated and sometimes delicate ethical dilemmas. In these moments, we need to respond in the best manner possible, and it helps if we know the difference between our moral, ethical, and legal obligations.

Morality is generally concerned with individual conduct and often reflects the values from an individual's family, religious sect, culture, or nationality. In contrast, **ethics** usually describes the collectively agreed-upon correct behaviors within the context of a professional group (Remley & Herlihy, 2014). Therefore, what might be immoral behavior for a minister might be ethical behavior for a counselor. For instance, relying on his or her sect's religious writings, a minister might oppose abortion. On the other hand, relying on ethical guidelines that suggest clients have the right to control their own lives, a counselor might support a client's decision to have an abortion. Sometimes a counselor's moral beliefs will conflict with his or her professional ethics (e.g., when a counselor's religious beliefs concerning abortion are in conflict with his or her ethical obligation to foster the client's right to direct her own life). At times, trying to make sense of one's values and what is personally right or wrong, while trying to stay ethically on-target, can be quite an undertaking! And to make things even more confounding, sometimes the law will contradict one's values, sense of morality, and even professional ethics:

> *When legislatures pass laws requiring conduct incompatible with ethical codes, professional associations first try to change the laws. If that fails, they modify the ethical codes to fit the new laws. (Swenson, 1997, p. 58)*

Finally, despite the fact that ethical codes guide our professional behaviors, perceptions of what is or is not ethical can vary greatly. For instance, when 535 members of the American Counseling Association were asked to rate whether or not 77 potential counselor situations were ethical, Neukrug and Milliken (2011) found a great deal of disparity on a number of items (see Activity 9.1 and Table 9.1).

Activity 9.1 Discussing Controversial Ethical Behaviors

Review the counselor behaviors in Table 9.1 and identify four or five you think are particularly controversial. Write down your thoughts about the behavior. If your instructor suggests, discuss the items you chose and compare them to the items chosen by other students in the class. Are there any items that a number of students chose? If so, while referring to the ACA (2014a) ethics code (go to www.counseling.org and click "knowledge center" and then "ethics"), see if you are able to come to a consensus on how to work with that dilemma.

TABLE 9.1 What Is Ethically Correct Behavior?

Counselor Behavior	Percentage of Counselors Who Viewed Behavior as Ethical
1. Being an advocate for clients	99
2. Encouraging a client's autonomy and self-determination	98
3. Breaking confidentiality if the client is threatening harm to self	96
4. Referring a client due to interpersonal conflicts	95
5. Having clients address you by your first name	95
6. Making a diagnosis based on *DSM*	93
7. Using an interpreter to understand your client	89
8. Self-disclosing to a client	87
9. Counseling an undocumented worker (illegal immigrant)	87
10. Consoling your client through touch (e.g., hand on shoulder)	84
11. Publicly advocating for a controversial cause	84
12. Keeping client records on your office computer	74
13. Attending a client's formal ceremony (e.g., wedding)	72
14. Counseling a terminally ill client on end-of-life decisions including suicide	69
15. Providing counseling over the Internet	68
16. Hugging a client	67
17. Not being a member of a professional association	66
18. Counseling a pregnant teenager without parental consent	62
19. Telling your client you are angry at him or her	62
20. Sharing confidential information with an administrative supervisor	59
21. Guaranteeing confidentiality for couples and families	58
22. Refraining from making a diagnosis to protect a client from a third party (e.g., an employer who might demote a client)	55
23. Bartering (accepting goods or services) for counseling services	53
24. While completing a dissertation, using the title Ph.D. Candidate in clinical practice	48
25. Withholding information about a minor despite parents' request	48
26. Selling clients counseling products (e.g., books, videos, etc.)	47
27. Using techniques that are not theory- or research-based	43

(*Continued*)

Counselor Behavior	Percentage of Counselors Who Viewed Behavior as Ethical
28. Pressuring a client to receive needed services	43
29. Becoming sexually involved with a former client (at least 5 years after the counseling relationship ended)	43
30. Not allowing clients to view your case notes about them	43
31. Referring a client, unhappy with his or her homosexuality, for reparative therapy	38
32. Accepting only clients who are male or clients who are female	37
33. Guaranteeing confidentiality for group members	37
34. Charging for individual counseling although seeing a family	35
35. Accepting clients only from specific cultural groups	32
36. Breaking the law to protect your client's rights	32
37. Reporting a colleague's unethical conduct without first consulting the colleague	30
38. Sharing confidential client information with a colleague	29
39. Not reporting suspected spousal abuse	29
40. Not having malpractice coverage	28
41. Counseling a client engaged in another helping relationship	27
42. Seeing a minor client without parental consent	25
43. Viewing a client's web page (e.g., Facebook) without consent	23
44. Counseling diverse clients with little cross-cultural training	22
45. Having sex with a person your client knows well	22
46. Setting your fee higher for clients with insurance	22
47. Counseling without training in the presenting problem	20
48. Not allowing clients to view their records	17
49. Trying to change your client's values	13
50. Kissing a client as a friendly gesture (e.g., greeting)	13
51. Accepting a client's decision to commit suicide	12
52. Accepting a gift from a client that's worth more than $25	12
53. Revealing confidential information if a client is deceased	11
54. Counseling a colleague with whom you work	11
55. Having dual relationship (e.g., client is your child's teacher)	10
56. Telling your client you are attracted to him or her	10
57. Not having a transfer plan should you become incapacitated	9
58. Trying to persuade a client to not have an abortion	8
59. Treating homosexuality as a pathology	6
60. Making grandiose statements about your expertise	6
61. Giving a gift worth more than $25 to a client	5
62. Keeping client records in an unlocked file cabinet	5
63. Not participating in continuing education	5
64. Engaging in a counseling relationship with a friend	5

Counselor Behavior	Percentage of Counselors Who Viewed Behavior as Ethical
65. Terminating the counseling relationship without warning	5
66. Not offering a professional disclosure statement	3
67. Referring a client satisfied with his/her homosexuality for reparative therapy	3
68. Lending money to your client	3
69. Sharing confidential information with a significant other	3
70. Not reporting suspected abuse of an older client	1
71. Not informing clients of legal rights (e.g., HIPAA, FERPA, confidentiality)	1
72. Stating you are licensed when you are in the process of obtaining a license	1
73. Revealing a client's record to his or her spouse without permission	<1
74. Not reporting suspected abuse of a child	<1
75. Attempting to persuade a client to adopt a religious belief	<1
76. Implying that a certification is the same as a license	<1
77. Not revealing the limits of confidentiality to your client	<1

LO 2

The Development of and Need for Ethical Codes

Ethical codes in the mental health professions are a modern day development. For instance, in 1953, the **American Psychological Association (APA)** published its first code of ethics, and in 1960, the **National Association of Social Workers (NASW)** adopted its code. Soon after, in 1961, the **American Counseling Association (ACA)** developed its ethical code. Codes are always undergoing revisions (see ACA, 2014a; APA, 2010; NASW, 2008) and serve multiple purposes (Corey, Corey, & Callanan, 2015; Dolgoff, Loewenberg, & Harrington, 2009; Remley & Herlihy, 2014). For instance, they:

- protect consumers and further the professional standing of an organization;
- are statements about the maturity and professional identity of a profession;
- guide professionals toward certain types of behaviors that reflect the underlying values considered desirable in the profession;
- offer a framework for the sometimes difficult ethical decision-making process; and
- can be offered as one measure of defense if a professional is sued for malpractice.

However, there are limitations to ethical codes, as they:

- do not address some issues and offer no clear way of responding to other issues;
- sometimes conflict within themselves, with related codes (e.g., ASCA and ACA), with the law, and with counselors' value systems;

- are sometimes difficult to enforce;
- do not always involve the public in the code construction process or take into account the public's interests; and
- do not always address cutting-edge issues.

LO 3

Codes of Ethics in the Helping Professions

The following offers a brief overview of ACA's (2014a) ethics code, highlights ethics codes of a few of ACA's divisions, and notes the ethics codes of related mental health professions.

ACA's Ethics Code: A Brief Overview

To keep up with the changing values of society and of the counseling profession, **ACA's ethical code** changes every 10 years or so (Daniel-Burke, 2014; Ponton & Duba, 2009). Table 9.2 summarizes the eight sections of ACA's most recent ethical code (ACA, 2014a). You are strongly encouraged to read the whole code, which can be found at www.counseling.org (click "knowledge center" and then "ethics").

TABLE 9.2 A Summary of ACA's Ethical Code

Section A: The Counseling Relationship. Highlighting important issues within the counseling relationship, this section stresses (1) the importance of respecting and looking out for the client's welfare and, to this end, keeping good records, having a plan for counseling, and supporting client networks (e.g., family, community, and religious) when appropriate; (2) obtaining informed consent prior to and during treatment; (3) consulting with others who are working with your client; (4) avoiding harm and not imposing one's own values; (5) not engaging in romantic or sexual relationships or personal virtual relationships with clients and those close to them; (6) maintaining appropriate boundaries and professional relationships with clients and documenting boundary extensions (e.g., attending a graduation ceremony); (7) knowing how to advocate for clients at various levels (e.g., individual, group, institutional, and societal); (8) understanding the importance of identifying roles when working with clients who may have a relationship with one another (e.g., individual, group, and family counseling); (9) knowing how to screen and protect clients participating in groups; (10) knowing how to establish fees, when bartering is justified, and whether to receive or give gifts; and (11) knowing how to effectively terminate and refer clients, and not abandoning or neglecting clients in counseling (e.g., vacations, illnesses, and terminations).

Section B: Confidentiality and Privacy. Section B examines the importance of (1) respecting clients' rights to confidentiality and privacy; (2) knowing when to keep and break confidentiality (e.g., when there is foreseeable harm, during end-of-life decision making, when a client has a contagious, life-threatening disease, or court-ordered clients); (3) knowing when and how to share confidential information; (4) understanding the nature of confidentiality relative to group and family work; (5) understanding the nature of confidentiality when working with clients who lack the capacity to give informed consent (e.g., children, incapacitated adults); (6) preserving the confidentiality of records; and (7) making reasonable efforts at protecting a client's confidentiality when consulting with a colleague.

Section C: Professional Responsibility. This section discusses the importance of (1) knowing the ethical code; (2) practicing within one's professional competence and knowing what to do when one is professionally or psychologically impaired; (3) accurately advertising and promoting oneself; (4) accurately representing one's credentials and qualifications; (5) not discriminating against clients; (6) knowing one's public responsibilities, including not engaging in sexual harassment, accurately reporting information to third parties (e.g., insurance companies, courts), being accurate when using the media (e.g., radio talk shows), and not making unjustifiable treatment

claims; (7) providing services that are empirically based or, if using a new procedure, explaining its potential risks and benefits to clients, and (8) ensuring the public can distinguish personal from professional statements.

Section D: Relationships with Other Professionals. This section highlights the importance of (1) maintaining mutually respectful relationships with colleagues, employers, and employees, forming strong, interdisciplinary relationships with others, and addressing unethical situations and negative working conditions when they arise; and (2) when acting as a consultant, ensuring that one is competent, understands the needs of the consultee, and obtains informed consent from the consultee.

Section E: Evaluation, Assessment, and Interpretation. This section highlights the importance of (1) using assessment tools to determine client welfare and ensuring the proper use and interpretation of assessments; (2) being competent in assessment instruments and appropriately using information gained; (3) obtaining informed consent from clients; (4) releasing data only to those identified by clients; (5) making accurate diagnoses and taking into account cross-cultural issues; (6) choosing instruments based on good reliability, validity, and cross-cultural fairness; (7) ensuring proper testing conditions; (8) ensuring nondiscrimination; (9) knowing proper ways to score and interpret instruments; (10) ensuring test security; (11) ensuring test information is up to date; (12) ensuring that sound, scientific knowledge is used assessment development; and (13) ensuring objective results when conducting forensic evaluations.

Section F: Supervision, Training, and Teaching. This section examines the importance of (1) supervisors being responsible for the welfare of their supervisees' clients; (2) supervisors obtaining ongoing training; (3) supervisors maintaining ethical relationships with supervisees, including respect for nonsexual boundaries; (4) supervisors obtaining informed consent from supervisees, ensuring supervisee access to consultation when supervisors are not available, and ensuring that supervisees know standards and are familiar with proper procedures for termination; (5) students and supervisees knowing the ACA code of ethics, monitoring themselves to ensure that they are not impaired, and providing clients with a professional disclosure statement about their status as a counseling student or supervisee and how it affects confidentiality; (6) providing ongoing evaluation, assisting supervisees in securing remediation when necessary, and endorsing a supervisee only when they believe that the individual is qualified; (7) counselor educators being competent, infusing multicultural issues, integrating theory and practice, teaching ethics to students, using case examples, ensuring the ethics of student-to-student supervision, promoting procedures grounded in theory, and ensuring clear roles and responsibilities in field placements. (8) counselor educators providing adequate program information and orientation, advising, providing self-growth experiences, and addressing personal concerns; (9) counselor educators identifying what is expected of students and working with students who may need referrals for remediation or counseling; (10) counselor educators knowing that they are prohibited from having a sexual relationship with current students or otherwise misusing the power they hold over students; and (11) counselor educators actively infusing multicultural competency into their training and working toward recruiting and retaining diverse faculty and students.

Section G: Research and Publication. A wide range of ethical areas are discussed in this section, including (1) research responsibilities, such as the appropriate use of human research participants; (2) the rights of research participants, such as offering informed consent, ensuring confidentiality, and understanding the use of deception in research; (3) standards for maintaining appropriate boundaries and relationships with research participants; (4) methods for accurately reporting results; and (5) guidelines for accurately publishing results.

Section H: Distance Counseling, Technology, and Social Media. Although distance counseling, technology, and social media issues are infused throughout the code, this new section highlights: (1) having knowledge of these areas and knowing the law; (2) conducting proper procedures for informed consent, confidentiality, and security of information; (3) making sure that the client you are corresponding with is actually the client; (4) in distance counseling, knowing the benefits and limitations, the boundaries, ensuring that clients are up to speed technologically, and knowing how to identify other services if distance counseling services are not effective; and educating clients on misunderstandings that might arise due to distance issues (e.g., mistaken nonverbals); (5) maintaining appropriate records in light of laws and informing clients about maintenance of records; maintaining links to information about credentials; providing accessibility for individuals with disabilities or those for whom English is not their first language; and (6) maintaining separate professional and personal social media websites; explaining to clients the benefits and drawbacks of social media; respecting the privacy of clients' social media unless given consent; and avoiding the disclosure of clients' confidential information on social media.

Section I: Resolving Ethical Issues. This final section of the ethical code explains the proper steps to take in the reporting and resolution of suspected ethical violations. It addresses (1) possible conflicts between ethical codes and the law and using ethical decision-making models when dealing with ethical dilemmas; (2) how to deal with suspected violations, such as first addressing the individual informally, and then, if no resolution is forthcoming or if the violation has caused harm to another, how to approach the appropriate ethics committee; and (3) the importance of working with ethics committees.

TABLE 9.3 Websites for the Ethical Codes or Best Practice Statements of Select Counseling Organizations

Association	Website or Reference
American Mental Health Counselors Association (AMHCA) 2010 ethics code	www.amhca.org/ (click "Publications" and then "Code of Ethics")
American School Counselor Association (ASCA) 2010 ethics code	www.schoolcounselor.org (click "School Counselors & Members" and then "Legal and Ethical")
International Association of Marriage and Family Counselors (IAMFC) 2011 ethics code	www.iamfconline.com (click "Ethical Codes")
Association for Specialists in Group Work (ASGW) 2007 Best Practices Guidelines	www.asgw.org (then click "ASGW Standards and Practices" and then "Best Practices")
Counselors for Social Justice (CSJ) 2010 Ethics Code	Counselors for social justice (CSJ). Code of Ethics. (2011). *Journal of Social Action in Counseling and Psychology, 3,* 1–21.
National Board for Certified Counselors (NBCC) 2012 Ethics Code	www.nbcc.org/ethics
Commission on Rehabilitation Counselor Certification (CRCC) 2010 Ethics Code	www.crccertification.com (then click "CRC/CCRC Code of Ethics")

Related Ethical Codes and Standards

Some of ACA's divisions and affiliated groups have established ethical codes in lieu of ACA's, or standards of best practices that supplement ACA's code (see Table 9.3). Sometimes, one must choose the code to which one will adhere. For instance, a counselor who is a member of **American School Counseling Association (ASCA)** and ACA, and is also a **National Certified Counselor (NCC)**, has to decide which of the three related codes to follow. Although reviewing all three codes can offer multiple perspectives, differences among them can be confusing when one is faced with a thorny ethical dilemma. As a counselor, you probably should adhere to the code of the counseling organization that best fits your work situation.

In addition to the counselor codes listed in Table 9.2, ethical codes in related mental health professions that you might find interesting include those of the American Psychological Association (APA, 2010), the National Association of Social Workers (NASW, 2008), the **American Association for Marriage and Family Therapy (AAMFT**, 2015), the **American Psychiatric Association (APA**, 2013b), and the **National Organization of Human Services (NOHS**, 2015b).

LO 4

Ethical Hot Spots for Counselors

By examining complaints filed against counselors, inquiries made by helpers regarding ethical problem areas, and research that examines ethical concerns with which counselors most struggle (Daniel-Burke, 2014; Francis & Dugger, 2014; Herlihy & Dufrene, 2011; Neukrug & Milliken, 2011), a number of **ethical hot spots** can be identified. Table 9.4 groups some of these issues into logical categories. After reviewing Table 9.4, do Activity 9.2.

TABLE 9.4 Ethical "Hot Spots" Grouped into Logical Categories

The Counseling Relationship

- Bartering (accepting goods or services) for counseling services
- Using techniques that are not theory or research based
- Pressuring a client to receive needed services
- Dealing with client issues related to medical advances (e.g., genetic testing for diseases)
- Diagnosing clients
- Working with a client in danger of harming self or others
- Trying to have a client adopt the counselor's values
- Not working with or referring a client due to values differences

Legal Issues

- Refraining from making a diagnosis to protect a client from a third party (e.g., employer who might demote a client)
- Breaking the law to protect your client's rights
- Whether to report suspected child abuse
- Whether to report suspected spousal abuse
- Whether to report suspected abuse of an older person

Social and Cultural Issues

- Referring a gay or lesbian client for sexual orientation change efforts (e.g., reparative or conversion therapy)
- Based on personal preference, accepting clients who are only male or only female
- Based on personal preference, accepting clients only from specific cultural groups
- Being competent in multicultural counseling
- Serving emerging populations with little knowledge of those groups

Boundary Issues

- Attending a client's wedding, graduation ceremony, or other formal ceremony
- Hugging a client
- Selling a product to your client related to the counseling relationship (e.g., book, audiotape, etc.)
- Having sex with a current or former client
- Self-disclosing your feelings to your clients
- Counseling a client (e.g., individual counseling) while the client is in another helping relationship (e.g., family counseling)

Confidentiality

- Understanding and managing the nature of confidentiality
- Guaranteeing confidentiality for groups, couples, and families
- Withholding information about a minor despite a parent's request for information
- Not allowing clients to view case notes about them
- Sharing confidential client information with a colleague who is not your clinical supervisor

Informed Consent

- Seeing a minor client without parental consent
- Not obtaining informed consent
- Counseling a pregnant teenager without parental consent

Professional Issues

- Not being a member of a professional association in counseling
- Inappropriate fee assessment
- Managing the changing nature of mental health
- Reporting a colleague's unethical conduct without first consulting the colleague
- Not having malpractice coverage (on your own or through your agency/setting)
- Measuring the effectiveness of counseling
- Misrepresenting credentials

Technology

- Supervising over the Internet
- Counseling over the Internet
- Security of client records on computers
- Transmitting client information over the Internet

Activity 9.2 The Tarasoff Case and Foreseeable Harm

In this case, a client named Prosenjit Poddar, who was being seen at the counseling center at the University of California at Berkeley, told his psychologist that as a result of his girlfriend's recent threats to break up with him and date other men, he intended to kill her. As a result, his psychologist informed his supervisor and the campus police of his client's threat, at which point the campus police detained him. The supervisor reprimanded the psychologist for breaking confidentiality; and, finding no reason to detain Poddar further, the campus police released him. Two months later, he killed his girlfriend, Tatiana Tarasoff. Tarasoff's parents sued the university, the therapist, the supervisor, and the police and won their suit against all but the police. The decision, which was seen as a model for duty to warn (now called **foreseeable harm**), was interpreted by courts nationally to mean that a therapist must make all efforts to prevent danger to another or to self.

Write down what you would have done if faced with a situation such as this one. What efforts would you have made to ensure that the person who is being threatened by your client is safe? In this case, talking with one's supervisor was not enough. What else can you do? In general, what do you believe are your responsibilities regarding forseeable harm and ensuring that a client does not harm self or others? After you write down your responses, share them in small groups.

LO 5

Resolving Ethical Dilemmas: Models of Ethical Decision-Making

In view of the practical limitations of ethical guidelines noted earlier, and in search of an approach to ethical decision-making that is not as prescriptive as the sole use of an ethics code, models of ethical decision-making have been devised (Cottone & Claus, 2000; Welfel, 2013). Four such types of models of ethical decision-making include problem-solving, moral, social constructionist, and developmental. These models are not exclusive of each other; that is, they can be used in conjunction with one another and with an ethics code. As you review these models, also consider the fact that when making difficult ethical decisions, the cultural, religious, and worldview (CRW) of the counselor and of the client should be taken into account (Luke, Goodrich, & Gilbride, 2013).

Problem-Solving Models

Problem-solving models provide a step-by-step approach to making ethical decisions. Hands-on and practical, they are particularly useful for the beginning counselor (Brennan, 2013). One such approach, developed by Corey et al. (2015), includes eight steps: (1) identifying the problem or dilemma, (2) identifying the potential issues involved, (3) reviewing the relevant ethical guidelines, (4) knowing the applicable laws and regulations, (5) obtaining consultation, (6) considering possible and probable courses of action, (7) enumerating the consequences of various decisions, and (8) deciding on the best course of action.

Moral Models (Principle and Virtue Ethics)

Two **moral models** that have taken on prominence in recent years are called **principle ethics** and **virtue ethics** (Levitt & Aligo, 2013). Stressing inherent principles to which the counselor should subscribe, and often viewed as foundational to the development of ethics codes, **Karen Kitchener's** principle ethics model describes the role of six principles in ethical decision-making (1984, 1986; Urofsky, Engels, & Engebretson, 2008). The first

principle, **autonomy**, has to do with protecting the independence, self-determination, and freedom of choice of clients. **Nonmaleficence**, the second principle, is the concept of "do no harm" when working with clients, while **beneficence** is related to promoting the good of society, which can be at least partially accomplished by promoting the client's well-being. The fourth principle, **justice**, refers to providing equal and fair treatment to all clients, while **fidelity** is related to maintaining trust (e.g., keeping conversations confidential) in the counseling relationship and being committed to the client within that relationship. Finally, **veracity** has to do with being truthful and genuine with the client, within the context of the counseling relationship. The clinician who employs this model will use these principles to guide his or her decision-making process.

Whereas principle ethics focuses on **foundational rules** when making ethical decisions (e.g., protecting the autonomy of the client; promoting the good of society) virtue ethics focuses on the moral character of the counselor making the ethical decision (Kleist & Bitter, 2009). In other words, principle ethics is focused on duties or how one should act when faced with ethical dilemmas; virtue ethics suggests ideals of behavior that counselors should strive for throughout their careers (Wilczenski & Cook, 2011). In this context, Meara, Schmidt, and Day (1996) suggest that virtuous helpers are **prudent**, or careful and tentative, in their decision-making; maintain **integrity**; are **respectful**; and **benevolent**. In addition, virtuous counselors strive to make wise decisions based on their understanding of their profession and the community. They do this by being self-aware, being compassionate, understanding cultural differences, being motivated to do good, and having vision concerning decisions that are made.

Social Constructionist Perspective

The **social constructionist** perspective to ethical decision-making sees knowledge (e.g., knowledge in codes) as intersubjective, changeable, and open to interpretation (Cottone, 2001, 2004; Guterman & Rudes, 2008). This approach suggests that reality is socially constructed, constituted through language, and organized and maintained through narrative (stories), and that there are no essential truths. Taking a **postmodernist** perspective, this approach views traditional ways of understanding ethical dilemmas to be problematic at times and the result of the language used and embedded in one's culture and in society. Those who adhere to a social constructionist approach view language as subtly, and sometimes not so subtly, oppressing others, particularly those from nondominant groups. These individuals question what is often taken for granted. For instance, they might question the reality or truthfulness of diagnosis, of the theoretical assumptions of counseling theories, and even of concepts and guidelines that are sometimes taken for granted in ethical codes. Those who take on a postmodernist perspective look for dialogue with others to develop new ways of understanding situations.

Those who embrace a social constructionist perspective don't expect answers to come from a code, from within themselves, or from within other people. Instead, they view solutions to problems as emerging out of dialogue between clients, counselors, and others (e.g., supervisors and others in the client's world) (Van Rooyen, Durrheim, & Lindegger, 2011). These individuals approach clients with humility and wonder, as equals, and as collaborators with whom solutions to ethical problems can be jointly worked out.

Developmental Models

Developmental models suggest that counselors at lower levels of development tend to believe there are correct and specific answers to the complex ethical dilemmas they may face (Ametrano, 2014; Lambie, Hagedorn, & Ieva, 2010; Lambie, Smith, & Ieva, 2009; McAuliffe & Eriksen, 2010). These counselors often adhere to rigid views of the truth, are uncomfortable with ambiguity, and expect and hope that formal documents, such as ethical codes, hold the answers to complex ethical dilemmas. They are also likely to look at those in positions of authority and power (e.g., supervisors) as being able to quickly tell them the correct answers when faced with thorny ethical dilemmas. These counselors can be said to be making meaning from what **William Perry** (1970) calls a **dualistic** perspective, in that they view the world in terms of black-and-white thinking, concreteness, rigidity, oversimplification, stereotyping, self-protectiveness, and authoritarianism. In contrast, higher-level counselors, sometimes called individuals **committed in relativism**, are more complex thinkers, flexible, empathic, sensitive to the contexts of ethical dilemmas, nondogmatic and have viewpoints but are open to differing opinions. Although few adults (or counselors) reach the highest levels of this development, these models suggest that, if afforded the right opportunities, most adults can.

You can see that individuals who are at lower levels would make ethical decisions in very different ways from individuals at higher levels. Counselor education programs often offer opportunities to support and challenge students to move toward these higher levels of development.

Summarizing and Integrating the Models

Let's review the decision-making models so that when you are faced with real world dilemmas, you will have one or more approaches to rely on in your decision-making process. After you review the different models in Table 9.5, read Reflection 9.1.

TABLE 9.5 Summary of Ethical Decision-Making Models

	Theoretical Assumptions	Principles/Key Points	Role of Counselor
Problem-Solving Model	Step-by-step, practical, pragmatic hands-on approach	Eight steps (see p. 134)	Go through the steps, one by one.
Moral Models			
Principle Ethics	Moral principles, sometimes called rules, play a major role in ethical decision-making. Six principles are the foundation of ethical codes. Decisions are based on these principles and on what should be done.	One example: Kitchener's six principles of autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity	Consider principles or rules in making an ethical decision.
Virtue Ethics	Moral character plays a major role in ethical decision-making. Throughout his or her professional career, the counselor strives to make ideal decisions based on his or her moral character.	One example: Meara, Schmidt, and Day's four virtues of being prudent, integrity, respectfulness, and benevolence	A counselor has a sense of moral character throughout his or her work life and tries to follow the values that reflect that character. Some values might be self-awareness, compassion, cultural astuteness, consideration of doing good, having a vision, and embracing the making of ethical decisions.

	Theoretical Assumptions	Principles/Key Points	Role of Counselor
Social Constructionist Model	Knowledge in codes is intersubjective, changeable, and open to interpretation. Realities are socially constructed, constituted through language, and organized and maintained through narrative (stories). There are no essential truths. Ethical dilemmas may be the results of inequities in society subtly supported through language	Solutions to ethical dilemmas come out of dialogue between a counselor, his or her clients, his or her supervisor, and others	Approach clients with humility and wonder, as equals, and as collaborators with whom solutions to ethical problems can be jointly worked out. Use dialogue with clients, colleagues, and supervisors to jointly work through ethical dilemmas.
Developmental Model	Counselors at lower levels of development have less of some qualities effective in ethical decision-making than do those who are at higher levels. All individuals can increase their levels of development	**Dualistic counselors**: Black-and-white thinking, concreteness, stereotyping, oversimplification, self-protectiveness, and authoritarianism. **Relativistic counselors**: Complex thinking, openness to differing opinions, flexibility, empathy, sensitivity to the context of the ethical dilemma, and nondogmaticness.	Embody the qualities of a relativist in an effort to work through ethical dilemmas.

Reflection Activity 9.1 Models Versus Personal Values

Despite the fact that the models just described, or similar ones, are generally taught in counselor education programs, some evidence indicates that counselors do not actively use this models, instead they make decisions based on their personal values, what they perceive as the client's best interest, consulting with others, and reliance on their ethics code (Levitt, Farry, & Mazaarella, 2015).

Take a moment and consider if you would use these models. Are they too profound? Are they not helpful in the moment? Would you use these models if faced with a thorny ethical decision? Why or why not? Might non-adherence to models result in poor ethical decision-making?

LO 6

Reporting Ethical Violations

Section H of ACA's (2014a) **Code of Ethics** provides guidelines on how to proceed if one suspects a counselor is violating an ethical guideline. It states that if a counselor believes that another counselor is in violation of the ethics code, the counselor should usually try to resolve the issue informally by discussing the situation directly with the counselor suspected of violating the guideline. If no resolution is found, or if substantial harm is suspected, then counselors are asked to take further action, which could include any or all of the following: "referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities" (ACA, 2014a, Standard I.2.b). (See Reflection Activity 9.2.)

Reflection Activity 9.2 The Importance of an Informal Resolution of an Ethical Violation

A friend of mine reported a psychologist to the psychology licensing board for writing inferior assessment reports. However, she did not go directly to the psychologist. She, who was also a psychologist, ended up being reprimanded by the licensing board because she had not first gone to the professional she was accusing. The accusations against the professional were never addressed.

If you had a colleague who was acting unethically, would you be able to talk to him or her directly? Would it depend on the seriousness of the ethical violation? What would prevent you from talking to him or her?

When a complaint is received, ethics committees examine whether they have the jurisdiction to address the complaint. For instance, if a complaint concerning a licensed counselor is brought to the ACA ethics committee and the counselor is not an ACA member, then the committee would likely refer the complainant to the ethics committee of the state in which the counselor is licensed. One study that examined complaints made against Licensed Professional Counselors (LPCs) found that only about 10% of complaints were seen as justified and/or within the jurisdiction of the licensing board. Of those that were adjudicated, over one-third had their licenses revoked, about one-fifth had their licenses suspended, and smaller numbers were asked to undergo supervision, received letters of reprimand, were fined, or had some other action taken against them (Neukrug, Milliken, & Walden, 2001).

LO 7

Legal Issues Related to Ethical Violations

Although many legal issues impact ethics and ethical decision-making, four important areas you should know about include civil and criminal liability, the role of ethical codes in lawsuits, the importance of having malpractice insurance, and the use of best practices to avoid ethical violations.

Civil and Criminal Liability

Whereas, "**criminal liability** is the responsibility under the law for a violation of federal or state criminal statute, **civil liability** is the responsibility one has as a result of having violated a legal duty to another" (personal communication, C. Borstein, Esq. April 22, 2015). In instances of alleged malpractice, complainants most often result in **civil suits** against counselors, although counselors can also be charged with **criminal violations** in the criminal courts. For example, if a counselor is alleged to have had sex with a client and if sex with a client is in violation of a state statute, a prosecuting attorney (e.g., District Attorney) could bring criminal charges against the counselor in criminal court while the client (the alleged victim) pursues a civil court action against the counselor by seeking monetary damages. Anyone can bring a civil lawsuit alleging virtually anything; however, outlandish cases are generally dismissed in a timely manner and some states have even set up procedures to penalize individuals for arbitrary and capricious acts of malicious prosecution. Finally, because ethical guidelines are not legal documents, they tend to hold more weight in civil courts than in criminal courts, because the burden of proof is less demanding in civil cases.

The Role of Ethical Codes in Lawsuits

Although ethical codes are not legal documents, they can be powerful pieces of evidence in a court of law. For instance, a counselor would have difficulty defending having had sex with a client, as the ethical code asserts that sex with a client is inappropriate. However, cases are often not clear-cut. For example: A counselor has sex with a former client whom she had seen as a client six years earlier. Feeling abused, the former client seeks out a prosecutor who determines that the statute is unclear about when a client stops being a client and files criminal charges against the counselor. The

counselor brings the ACA ethical code to court, which states that "Sexual or romantic counselor-client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact" (ACA, 2014a, Standard A.5.c.). However, the prosecutor retorts with the following statement, also found in the ethical code: "Counselors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship" (ACA, 2014a, Standard A.5.c.). Although ethical codes can clearly support one's professional behavior, you can see how they can sometimes also be used against a counselor.

Malpractice Insurance

In today's litigious society, there is little doubt that counselors need to be particularly careful, for even when they are doing everything correctly, they might still get sued. Remember, anyone can be sued by anybody! Certainly, this does not mean a counselor will lose a frivolous suit; however, if a counselor finds himself or herself in the dubious position of not having **malpractice insurance** and subsequently loses a civil suit, that counselor may be haunted by the monetary settlement for the rest of his or her life.

Although most schools and agencies generally purchase an umbrella malpractice insurance policy, it is still prudent to own additional insurance protection. And, always make sure that you review your malpractice policy. Review it carefully, study its monetary limits, and examine any possible exclusion to the policy. For instance, if a client sues you after you resign from a job at an agency or school, or after you give up your private insurance, are you still covered? Or, if your employer lets you run a workshop for your own personal profit at the agency on the weekend, are you covered?

The ACA insurance trust has partnered with **Healthcare Providers Service Organization (HPSO)** to offer professional liability insurance. As of the writing of this text, depending on the state where one practices, HPSO offers $1,000,000 worth of malpractice insurance at about $38 per year for students, $113 for part-time employment at an agency/school, between $138 and $488 if full-time employed at an agency/school, and between $181 and $925 if self-employed (HPSO, personal communication, April 22, 2015). In addition, new master's level students receive 50% off the price from HPSO, and ACA master's level student members receive free malpractice insurance (ACA, 2015h).

Avoiding Lawsuits: Best Practices

As you can see from this chapter, ethical decision-making can be an arduous and potentially career-threatening process. If you are ever sued, it is essential that you show the court that you were equipped with the clinical knowledge and tools necessary to make the best decisions possible and that you followed **best practices** in your profession. Following one's professional association's code of ethics is one piece of evidence showing

that best practices have been followed. In addition, Corey et al. (2015) suggest additional ways to ensure that one has been following best practices:

- Know relevant laws
- Maintain good records
- Keep your appointments
- Ensure security of records
- Stay professional with clients
- Document treatment progress
- Have a sound theoretical approach
- Maintain the confidentiality of records
- Preserve appropriate confidentiality
- Obtain informed consent from clients
- Report cases of abuse as required by law
- Treat only within your area of competence
- Avoid imposing your values or influence on clients
- Obtain written permission when working with minors
- Refer when it is in the best interest of your client to do so
- Be attentive to your clients' needs and treat them with respect
- Avoid engaging in sexual relationships with current or former clients
- Make sure that clients understand information that you present to them
- Obtain permission from a client to consult with others, whenever possible
- Ensure that clients understand that they can terminate counseling at any point
- Assess clients and explain diagnoses and treatment plans and their risks and benefits
- Monitor your reactions to clients, especially when countertransference is involved
- Know cultural and clinical issues related to bartering and accepting or giving gifts
- Provide a professional disclosure statement and obtain informed consent regarding course of treatment
- Keep appropriate boundaries and know limitations of multiple relationships (e.g., counseling a person who is a neighbor)
- Know how to appropriately assess for clients who may pose a danger of harming self or others, and know what to do if you think a client poses a threat

Case Study 9.1 Using the Ethical Decision-Making Models

Angela, an 84-year-old great grandmother, has 4 children and 13 grandchildren and is dying of pancreatic cancer. Her disease is debilitating and she is in quite a bit of pain. Therefore, as her counselor, you have agreed to see her periodically in her home. You know that she only has a few precious months to live. At one point, during a counseling session, she tells you that her pain is getting the best of her and that the morphine that is given to her barely takes the pain away. She is a proud woman and does not want her children or her grandchildren to see her suffer. She asks you whether you could expedite her death by giving her a dose of morphine that she knows will kill her. Although you refuse, she tells you that if you don't help her out,

she'll do it on her own. She tells you that she wants her children and grandchildren to remember her as a healthy strong woman, not sickly. You leave thinking she is likely going to kill herself. What should you do?

1. Consider the four ethical decision-making models, as well as the ACA code of ethics, and come to a decision about what should you do.
2. Do your morals play a role in the decision you make?
3. What place do your values play in any decision you make?
4. What does the ACA ethics code state about the role of values in the counseling relationship and how might that role impact this situation?
5. What place might the legal system play in your decision?

Summary

We began this chapter by distinguishing between ethics and morality, and by under scoring the importance of our values, our professional ethics, and the role that legal issues may play when making important ethical decisions. We then identified 77 potential counselor situations and highlighted whether a random sample of counselors viewed each situation as ethical or unethical. We suggested that you examine those behaviors and discuss the more controversial ones in class.

As the chapter continued, we noted the relatively brief history of the development of ethical codes and identified a number of purposes and limitations of codes. We then summarized the nine sections of the ACA code (Sections A through I) and provided the names and websites of ethical codes of other counseling affiliates and organizations. We also identified related mental health professions' ethical codes (e.g., APA, NASW, AAMFT, APA, and NOHS).

The chapter then went on to identify a number of ethical hot spots, grouped into the categories of counseling relationship, legal issues, social and cultural issues, boundary issues, confidentiality, informed consent, professional issues, and technology. We highlighted one hot spot regarding foreseeable harm and the Tarasoff case and asked you to consider how you might respond in a similar situation. Next, we presented ethical decision-making models, including a problem-solving model, two types of moral models—principle ethics and virtue ethics, a social constructionist model, and a developmental model. We then gave you a chance to reflect on the models and asked you if you would use them when faced with an ethical dilemma. We also asked you to consider what the consequences of not using them might be.

Next in the chapter, we discussed the reporting of ethical violations, noting that ACA's ethical code suggests that when possible, and if no harm is likely to occur to clients or to society, an informal resolution should be attempted. We then noted that only a small percentage of complaints are actually investigated, but that the consequences to licensed professional counselors who are found to have violated an ethical guideline can be great. The chapter concluded with a discussion of legal issues related to ethical violations, in which we pointed out that counselors can be sued in civil or criminal court, highlighted the important role that ethical codes can play in lawsuits, brought up the importance of carrying malpractice insurance, and noted how critical it is to use best practices to avoid lawsuits.

Key Terms

ACA's Ethical code
American Association for Marriage and Family Therapy (AAMFT)
American Counseling Association (ACA)
American Psychiatric Association (APA)
American Psychological Association (APA)
American School Counseling Association (ASCA)
Autonomy
Beneficence
Benevolent
Best practices
Civil liability
Civil suits
Code of ethics
Committed in relativism
Criminal liability
Criminal violations
Developmental models
Dualistic
Dualistic Counselors
Ethics
Ethical code
Ethical hot spots
Fidelity
Foreseeable harm
Foundational rules
Healthcare Providers Service Organization (HPSO)
Integrity
Justice
Kitchener, Karen
Malpractice insurance
Models of ethical decision-making
Moral models
Morality
National Association of Social Workers (NASW)
National Organization of Human Services (NOHS)
National Certified Counselor (NCC)
Nonmaleficence
Perry, William
Postmodernist
Principle ethics
Problem-solving models
Prudent
Relativistic counselors
Reporting ethical violations
Respectful
Section A: The Counseling Relationship
Section B: Confidentiality and Privacy
Section C: Professional Responsibility
Section D: Relationships with Other Professionals
Section E: Evaluation, Assessment, and Interpretation
Section F: Supervision, Training, and Teaching
Section G: Research and Publication
Section H: Distance Counseling, Technology, and Social Media
Section I: Resolving Ethical Issues
Social constructionist
Tarasoff case
Veracity
Virtue ethics



Culturally Competent Helping: Multicultural Counseling and Social Justice Work

CHAPTER 10

LEARNING OBJECTIVES

LO 1 Define multicultural counseling and social justice work.

LO 2 Understand the importance of culturally competent helping.

LO 3 Review some critical definitions related to culturally competent helping.

LO 4 Learn about major conceptual models related to becoming a culturally competent helper including the RESPECTFUL model, the tripartite model of personal identity, and developmental models of cultural/racial identity.

LO 5 Learn about the role of the multicultural counseling competencies and advocacy competencies in becoming a culturally competent helper.

LO 6 Offer final thoughts about how multicultural counseling and social justice work have become known as the fourth and fifth movement in the history of counseling as they increasingly change the landscape of counseling and mental health services.

… cultural competency is more than a promise; it is a mandate for the counseling profession. As was the case decades ago when social activists stood up for civil rights and social justice against the forces of oppression, counselors are encouraged to stand up now for better training, more resources, less bias, and greater levels of professional proficiency.
(Arredondo, Tovar-Blank, & Parham, 2008, p. 267)

Can counselors understand a client who is from a different culture from their own? Can anyone truly understand the experience of another? Is it possible to connect with a client who is from a different culture or ethnic background? What additional skills must one acquire to work effectively with clients from nondominant groups? As counselors, what is our responsibility to stand up against biases we see in our own profession and to advocate against

oppressive actions that negatively impact our clients and people in general? These are some of the important questions being asked when discussing multicultural counseling and social justice work. Just as refinements to accreditation, credentialing, and ethical standards have increased our professional standing and our ability to work effectively with some clients, identifying and embracing the attitudes, knowledge, and skills necessary to being culturally competent will increase our ability to work with all people.

LO 1

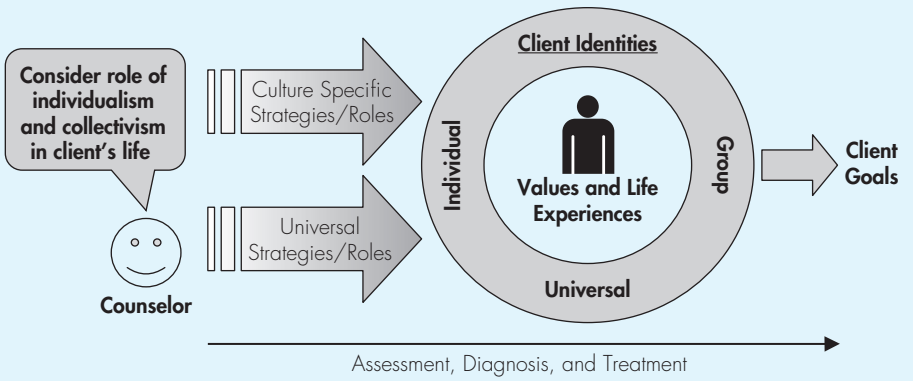
Defining Multicultural Counseling and Social Justice Work

The importance of **multicultural counseling** has been stressed for over 25 years, and more recently there has been a similar emphasis on **social justice work**. Although multicultural counseling and social justice work are intimately linked and share many of the same goals related to helping clients from traditionally oppressed groups, they are not the same (Sheely-Moore & Kooyman, 2011; Ratts, 2011). The following defines these two important, related concepts.

Multicultural counseling has been seen as the development of counselor skills in an effort to maximize counselor effectiveness in the counselor's work with all clients (McAuliffe, 2013). From this context, Sue and Torino (2005) suggest that counselors should understand the unique issues and concerns of clients (**individual identity**), the cultural background that clients share with some (e.g., sexual orientation, race, gender, etc.) (**group identity**), and the common experiences that clients share with all (**universal identity**). While gaining knowledge about client identity, the culturally competent counselor determines if the client relies more on an **individualistic perspective** (focus more on self) or a **collective perspective** (focuses more on extended family and the community) and sets goals for the helping relationship. Finally, the effective culturally competent counselor is versed in both **culture-specific skills** and **universal skills** when working toward these goals (see Figure 10.1).

In contrast to multicultural counseling, social justice work focuses on (1) empowering clients so that they can take action against oppression in their lives, (2) when needed,

FIGURE 10.1 One Way of Understanding Multicultural Counseling



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taking action for clients who are faced with oppressive forces, and (3) taking steps to change society to assist those who are marginalized (Crethar & Winterowd, 2012).

Whereas a large part of this chapter will examine how we can broaden our *knowledge, skills, and attitudes* so that we can be better at multicultural counseling, near the end of the chapter we will examine the *Advocacy Competencies*, which suggest ways that counselors can operationalize social justice work.

LO 2

Why Cultural Competent Helping?

There is little doubt that we live in a pluralistic country and are thus called to offer counseling services to clients from many diverse backgrounds (see Table 10.1).

Unfortunately, our work with diverse clients has not been stellar, as often minority clients are misunderstood, misdiagnosed, spoken down to or patronized, have the impact

TABLE 10.1 Number and Percentage of Individuals from Select Racial, Ethnic, Religious, and Sexual Identity Groups in the United States

Ethnicity/Race*	Number (millions)	%	Religion***	Number (millions)	%
White, Not Hispanic	199.16	63.0	*Christian*	247.74	78.4
Hispanic	53.43	16.9	Protestant	162.11	51.3
Black or African American	41.41	13.1	Evangelical	83.11	26.3
Asian	16.12	5.1	Mainline churches	57.20	18.1
American Indian and Alaska Native (AIAN)	3.79	1.2	Historical Black churches	21.80	06.9
			Catholic	75.52	23.9
Native Hawaiian and other Pacific Islander (NHPI)	0.63	0.2	Mormon	5.37	01.7
			Jehovah's Witness	2.21	00.7
Two or more races	7.59	2.4	Orthodox†	1.90	00.6
White alone	246.26	77.9	*Jewish*†	5.37	01.7
			Buddhist†	2.21	00.7
			Muslim†	1.90	00.6
			Hindu	1.26	00.4
Sexual Orientation**			*Other World Religions/Faiths*	4.74	01.5
Bisexual†		1.8	*Unaffiliated*	50.88	16.1
Gay or Lesbian†		1.7	Atheist or agnostic	12.64	04.0
Transgender		0.3	Nothing in particular†	38.23	12.1

*Source: U.S. Census Bureau (2014). State and county quick facts. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html.
**Source: Gates, G. J. (2011). How many people are lesbian, gay, bisexual, and transgender? Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf.
***Source: Pew Research (2015). Religion and public life project: Religious landscape survey. Retrieved from http://religions.pewforum.org/reports (note: numbers based on 316 million).
†Numbers of bisexual, gay, or lesbian change dramatically from study to study; "Orthodox" includes Greek Orthodox (<.03%), Russian Orthodox (<0.3%), and Other Orthodox (<0.3%); "Jews," "Buddhists," and "Muslims" include various sects; Muslims are often undercounted as many mosques do not officially register; "Other World Religions/Faiths" include 0.7% Unitarians and other liberal faiths, 0.4% New Age, and < 0.3$ Native American religions; "Nothing in particular" includes secular (6.3%) and religious unaffiliated (5.8%).

of social forces minimized by the helper, find the helping relationship less helpful than Whites, and seek mental health services at lower rates than Whites (National Alliance on Mental Illness, 2015; Sewell, 2009; U.S. Department of Health and Human Services, 2001; Vogel, Wester, & Larson, 2007; Williams, 2013). It should not be surprising that many clients from nondominant groups are distrustful of helpers, confused about the helping process, feel worlds apart from their helper, and terminate the counseling relationships prematurely. Why is the helping relationship unappealing to so many clients from nondominant groups? Oftentimes it is due to helper incompetence because the helper holds one or more of the following viewpoints (Buckley & Franklin-Jackson, 2005; Constantine & Sue, 2005; Leong, 2011; McAuliffe, Goméz, & Grothaus, 2013; Sue & Sue, 2013; Suzuki, Kugler, & Aguiar, 2005):

1. **The melting pot myth.** Some helpers view the United States as a *melting pot*, when, it is actually more of a **cultural mosaic.** Such counselors are less likely to honor their clients' unique cultural heritage.

   Example: The helper who challenges a client to move to a "better" ("Whiter") community because she believes the client's children will gain a better education. This "advice" ignores the client's comfort level in his own community.
2. **Incongruent expectations about the helping relationship.** The helping relationship tends to be based on Western values and consequently stresses the importance of expression of feelings, self-disclosure, cause-and-effect thinking, open-mindedness, and internal locus of control. A client who does not embrace these characteristics might be treated as having a mental disorder, or as or being resistant, and end up feeling disappointed, angry, or guilty when he or she does not live up to the counselor's expectations.

   Example: The counselor who does not realize that many Asian clients pride themselves in their ability to restrict their emotions pushes an Asian client to express her feelings. The Asian client ends up leaving the helping relationship and feels like she has disappointed her helper.
3. **De-emphasizing social forces.** Some helpers attribute most problems to internal conflicts and de-emphasize environmental issues. By de-emphasizing social forces, they are likely to have a difficult time building a relationship with a client who has been considerably harmed by external factors.

   Example: The client who has been illegally denied jobs because of his disability becomes discouraged when the counselor says, "What have you done to prevent yourself from obtaining a job?"
4. **Ethnocentric worldview.** Culturally incompetent helpers who are *ethnocentric* tend to view the world through the lens of their own culture. They falsely assume clients view the world in a similar manner or believe that when clients present a differing view, they are emotionally disturbed, culturally brainwashed, or just simply wrong.

   Example: A counselor inadvertently turns off a Muslim client when she says to her, "Have a wonderful Christmas."
5. **Ignorance of one's own racist attitudes and prejudices.** The helper who has not spent time examining his or her own racist attitudes and prejudices will unconsciously project negative and harmful attitudes onto clients.

   Example: The heterosexual counselor who unconsciously believes that being gay is a disease but consciously states he is accepting of all sexual orientations tells an antigay joke to a colleague. The colleague walks out of his office angry and upset.

6. **Inability to understand cultural differences in the expression of symptomatology.** What may be seen as abnormal in the United States may be considered usual in another culture. The helper's lack of knowledge about cultural differences in the expression of symptoms can damage a helping relationship and result in misdiagnosis, mistreatment, and early termination of culturally diverse clients from the helping relationship.

   Example: A Latina client describes a series of bodily complaints (somatic problems) to her helper. The counselor assumes that the client is a hypochondriac. In actuality, the client's mother had recently passed away, and like many Latino/Latina clients, she is dealing with her grief through somatizations.
7. **Unreliability of assessment and research procedures.** Over the years, assessment and research instruments have been notoriously culturally biased. Although advances have been made, helpers who are not familiar with these biases may utilize instruments that may be inappropriate for certain clients or make assumptions about test results and research results that may be incorrect.

   Example: A counselor encourages a child to take a self-esteem inventory, not realizing that the instrument was normed on a sample of White children and that children of color often score lower on it. In actuality, they don't have lower self-esteem; they simply interpret the questions differently.
8. **Institutional racism.** Because institutional racism is embedded in society, and some would argue, even within the professional organizations, counselors and others who work in institutions may end up holding unconscious bias that can impact individuals from nondominant groups in a large variety of ways.

   Example: A counselor education program has a very large percentage of White students in it. Students of color are wary of applying to it because all of their recruiting materials almost exclusively show White students in the pictures (see Reflection Activity 10.1).

Reflection Activity 10.1 Examples of Why Counseling Is Not Working

Now that you've read the eight reasons why counseling may not be effective for some clients from nondominant groups as well as some examples of each, see whether you can come up with additional examples that illuminate each of the reasons. Share those in class. What do you think we can do as a profession to eliminate these issues?

LO 3

Some Definitions

To help understand differences and to communicate effectively with others, it is important to understand words and terms commonly used. The following describes some of the more important ones.

Culture

Shared values, symbols, language, and ways of being in the world are some of the words associated with **culture.** Culture is expressed through common values, habits, norms of behavior, symbols, artifacts, language, and customs (McAuliffe, 2013; Sewell, 2009; Spillman, 2007).

Discrimination and Microaggressions

Active, harmful, conscious, and unconscious acting out, such as unfair hiring practices that result in differential treatment of individuals, describes **discrimination** (Law, 2007; Lum, 2004). In recent years **microaggressions,** which are brief, subtle, sly, and common putdowns or indignities, have been identified as a type of discrimination (Nadal, 2011; Sue, 2010). Some examples include statements like "You don't seem gay (or Black, etc.)," and "My ancestors made it in this country without anything; I don't see why your family can't."

Ethnicity

Heritage, ancestry, and tradition are some of the words associated with **ethnicity.** When a group of people shares a common ancestry, which may include specific cultural and social patterns such as a similar language, values, religion, foods, and artistic expressions, those people are said to be of the same ethnic group (Jenkins, 2007).

Minority and Nondominant Groups

Those who are not privileged, have fewer opportunities, are viewed as different, and are systematically oppressed by people in power due to their cultural or physical characteristics are usually said to be a **minority** group. A minority group can be the numerical majority of a population, as was the case for Blacks in South Africa and as is the situation with women in the United States (Atkinson, 2004; Macionis, 2014). The counseling profession has increasingly used the term **nondominant group** because of negative connotations of the word *minority* and because the word *nondominant* suggests there are social reasons for discrimination and racism.

Power Differentials

Potential abuse, force, control, and superior/underling roles are associated with the term **power differential,** which, much like differences in culture, ethnic group, race, or social class, can result in the oppression of people (Kuriansky, 2008). Power differentials can trump race or other differences so should be considered in understanding the dynamics between people. Power, which can be real or perceived, can be a function of race, class, gender, occupation, and a host of other factors.

Race

Defined as permanent physical differences as perceived by an external authority (Arthur, 2007), **race** has traditionally been viewed as a function of genetics. However, research on the human genome shows that our genetic heritage is 99.9% the same (1/1000 different) (National Human Genome Research Project, 2012), and it is now clear that gene pools have become increasingly mixed due to migration, exploration, invasions, systematic rape as a result of wars and oppression of minorities, and intermarriage. With some sociologists saying there are no races, others saying there are three, and still others concluding there are 200, the issue of race is cloudy and perhaps doesn't matter (see Reflection Activity 10.2).

Reflection Activity 10.2 What Race Are You Anyway?

Although most people tend to think of themselves as one race or another, take a look at what happened in one study that examined the genetic heritage of a group of students at Pennsylvania State University:

> … about 90 students took complex genetic screening tests that compared their samples with those of four regional groups. Many of these students thought of themselves as "100 percent" white or black or something else, but only a tiny fraction of them, as it turned out, actually fell into that category. Most learned instead that they shared genetic markers with people of different skin colors. ("Debunking the Concept of Race," 2005)

Reflect on your "race." Are you sure that what you think you are, you are? How might your assumptions about your race be right or wrong? How might your assumptions of your race have affected your understanding of yourself and others? How might your assumptions about your race be a social construction; that is, it is developed through conversations we have with others?

Religion and Spirituality

Prayer, belief systems, meditation, and inner peacefulness are sometimes associated with religion and spirituality. Whereas a **religion** is an organized or unified set of practices and beliefs that has moral underpinnings and define a group's way of understanding the world (Cipriani, 2007; Eriksen, Jackson, Weld, & Lester, 2013), **spirituality** resides in a person and defines the person's understanding of self, self in relationship to others, and self in relationship to a self-defined higher power or lack thereof.

Sexism, Heterosexism, and Sexual Prejudice

When a person denigrates, discriminates, stigmatizes, and consciously puts down another person because of his or her gender, that person is said to be **sexist**. When the same is done because of nonheterosexual behaviors, that person is said to be **heterosexist,** a term now widely used instead of **homophobic,** which implies that the negative behaviors are within the homophobic person and negates the role society plays in fostering these behaviors (Adam, 2007). Finally, **sexual prejudice** refers to negative attitudes targeted toward any individual due to his or her sexual orientation (Herek, 2000).

Sexual Orientation and Gender Identity

Szymanski (2013) suggests that **sexual orientation** (in contrast to **sexual preference**) is the gender toward which a person consistently has sexual feelings, longings, and attachments. Therefore, common words describing a person's sexual orientation include **lesbian, gay**, **bisexual, heterosexual, asexual,** or **questioning.** Words sometimes confused with these words include transgender, transsexual, cross-dresser, and intersex (National Center for Transgender Equality, 2014). **Transgender** refers to a person who does not identify with his or her birth sex and lives in congruence with the gender to which he or she does identify. A **transsexual** strongly disidentifies with his or her birth sex and uses hormones, surgery, or both to realign his or her birth sex with his or her gender identity. A **cross-dresser** is an individual who enjoys wearing clothes of the opposite sex (formerly called **transvestite,** but that is now considered derogatory by some). An **intersex** person, formerly called a **hermaphrodite,** is a person born with a combination of male and female genitalia. Most important, as with any individual, those who are transgender, transsexual, cross-dressers, or intersex may be gay, lesbian, bisexual, or heterosexual.

In 1975 the American Psychological Association stated homosexuality was not a disorder, and these days, the concept of normality has been expanded to all individuals,

regardless of their sexual orientation or gender identity. Recently, the **Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC)** endorsed **Competencies for Counseling LGBTQQIA (Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, and Ally) Individuals** as well as **Competencies for Counseling Transgender Individuals** (ALGBTIC LGBQQIA Competencies Taskforce, 2013; ALGBTIC Transgender Committee, 2009) (see Reflection Activity 10.3).

Reflection Activity 10.3 Sexual Orientation Change Efforts (Conversion and Reparative Therapy)

In recent years, guidelines developed by our professional associations regarding **sexual orientation change efforts**, referred to in the past as **conversion therapy** or **reparative therapy**, state that counselors should avoid referring clients to such approaches as they are often harmful (Goodrich, 2015). ACA suggests that clients who seek to change their sexual orientation should be clearly told of the lack of scientific evidence of such counseling practice, the potential harm they can do, and offer the client questions to ask any practitioner who might be practicing such approaches. Counselors who practice such treatments are ethically bound to inform clients of the lack of scientific evidence, the purpose of practicing the approach, and offer referrals to gay-, lesbian-, and bisexual-affirming counselors (Whitman, Glosoff, Kocet, & Tarvydas, 2013). Recognizing its negative impact on clients, the Obama administration has sought to ban such therapies (Shear, 2015).

If you were to have a client who was seeking to change his or her sexual orientation, how might you handle that situation? How would the above statements by ACA drive what you do?

Social Class (Class)

Money, power, status, and hierarchy are all associated with **social class. Class** is based on a person's education, income, and wealth and represents the perceived ranking of an individual within society and the amount of power an individual wields (Macionis, 2014; Goodspeed-Grant & Mackie, 2013). An individual's social class may cut across a person's ethnicity, cultural identification, and/or race.

Prejudice, Stereotypes, and Racism

Generalizing, falsehoods, irrational fears, and anger are all associated with these words. **Prejudice** has to do with judging a person or a group based on preconceived notions or attitudes (e.g., "I hate James because he's Muslim, and Muslims are all terrorists"). **Stereotyping** is holding the belief that most or all members of a group share certain characteristics, behaviors, or beliefs (e.g., "Asians are intelligent people" or "American Indians are alcoholics") (Jennings, 2007; Lum, 2004). **Racism** has to do with believing one race is superior to another (e.g., "Whites are better than Blacks") (McAuliffe et al., 2013).

LO 4

Conceptual Models Toward Understanding Cultural Identity

> *Every person is in certain respects is like all other people, like some people, and like no other person. (Kluckhohn & Murray, 1948, p. 35)*

A number of models have been developed to help us understand a client's cultural identity as well as our own cultural development. The following describes four such

models which can help us understand how individuals come to make sense of the world relative to their cultural identities. Here, we will describe the **RESPECTFUL model,** the **tripartite model of personal identity,** and **developmental models of cultural/racial identity.**

The RESPECTFUL Acronym

If you remember, in Chapter 3 we suggested that one method of understanding clients is to address a number of areas as represented by the *RESPECTFUL* acronym. Thus, effective multicultural counselors feel comfortable asking their clients about the following: religious/spiritual identity, economic class background, sexual identity, psychological development, ethnic/racial identity, chronological disposition, trauma and other threats to their personal well-being, family history, unique physical characteristics, and the clients' language and location of residence (Lewis, Lewis, Daniels, & D'Andrea, 2011).

Tripartite Model of Personal Identity

Perhaps borrowing from what has been called the existential model of cultural identity development (see Binswanger, 1963; van Deurzen, 2002), Sue and Sue (2013) suggest that we understand our clients through a tripartite model of personal identity. Here, clients' personal identities can be seen in three spheres: the **individual level,** which represents the clients' uniqueness; the **group level,** which is related to aspects of the person that can vary based on the cultural and ethnic groups to which the clients belong; and the **universal level,** which is related to common experiences, such as "(a) biological and physical similarities, (b) common life experiences (birth, death, love, sadness, etc.), (c) self-awareness, and (d) the ability to use symbols such as language" (p. 43) (see Figure 10.2).

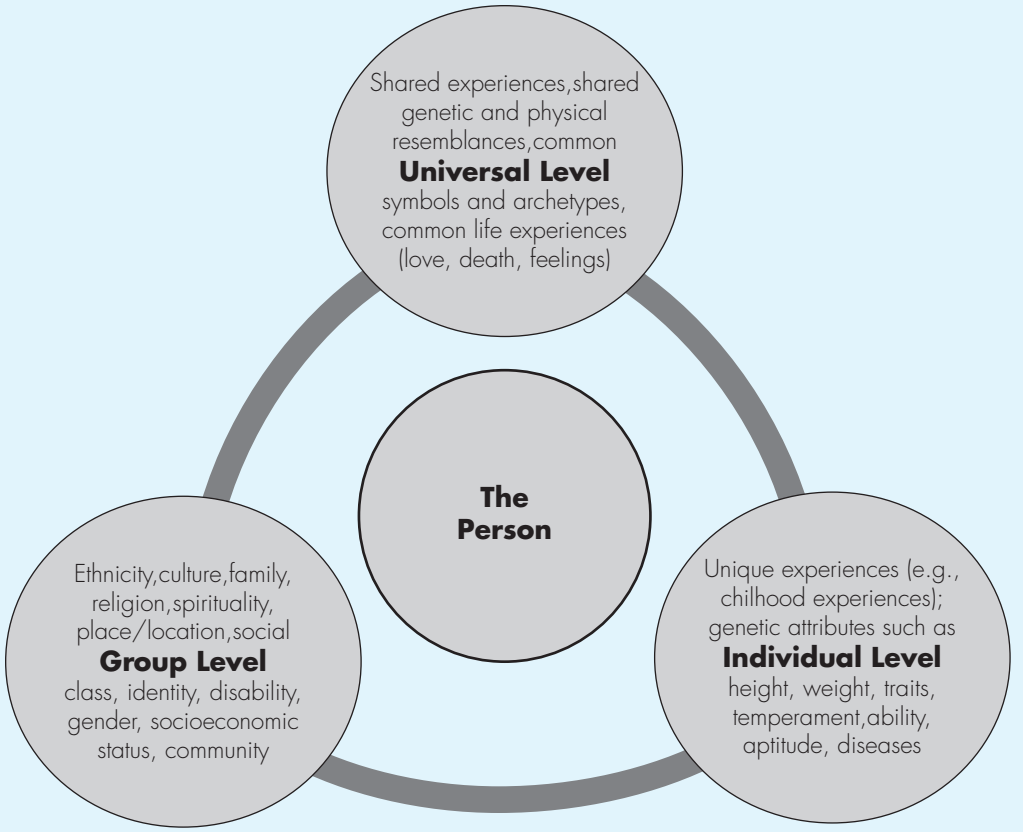
Developmental Models of Cultural/Racial Identity

In contrast to the more static RESPECTFUL and Tripartite models of cultural identity, **developmental models** examine how individuals from various cultural/racial groups pass through unique stages of development as they become increasingly aware of their cultural selves (Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue & Sue, 2013).The following presents the **Racial Identity Development for People of Color (RIDPOC)** model and then contrasts two White developmental models, one of Whites in general and one of White graduate students. The section concludes with how some White graduate students might progress through the White models.

Racial Identity Development for People of Color (RIDPOC).

Although culture-specific models of cultural/racial identity development have been created (e.g., African American development, Native American development, and so forth), McAuliffe, Goméz, and Grothaus (2013) offer a generic five-stage model of racial/cultural identity that synthesizes some of the more popular culture/racial specific models. Called the Racial Identity Development for People of Color (RIDPOC), McAuliffe et al. note that each stage in the model represents a general tendency, or overall focus of behavior,

FIGURE 10.2 Tripartite Model of Personal Identity

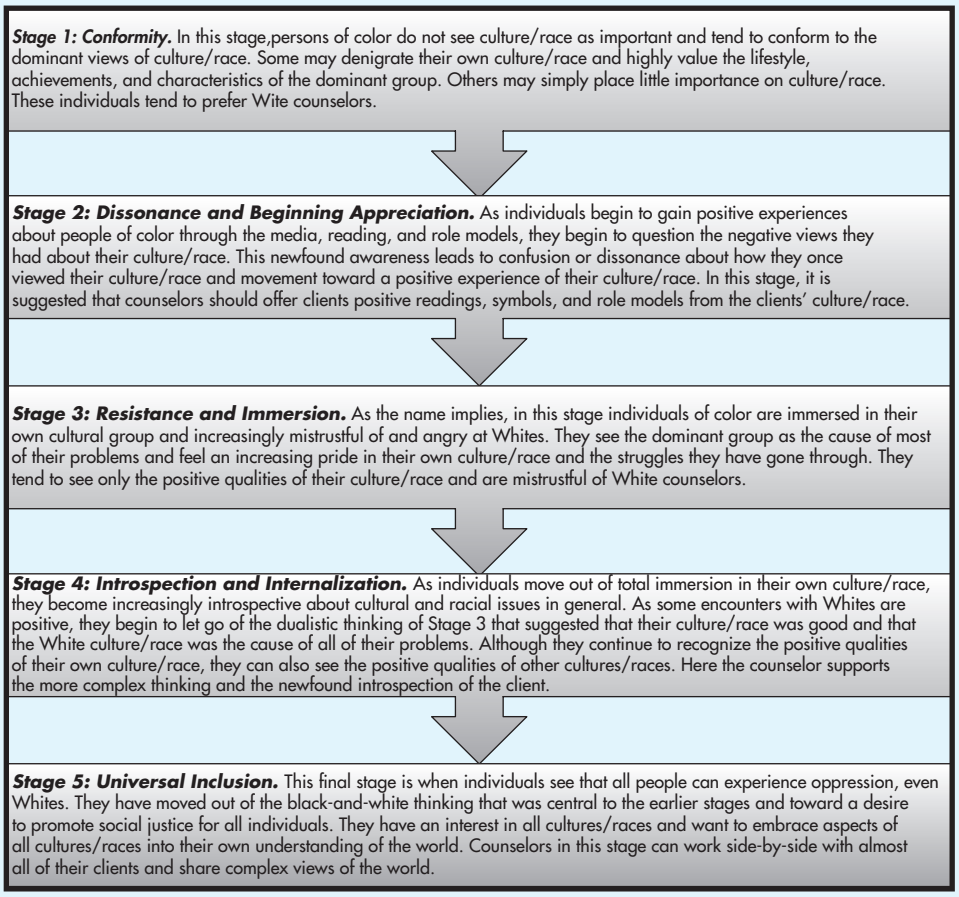


Source: Adapted from Sue, D. W. & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York, NY: John Wiley & Sons.

relative to an individual's culture or race (see Figure 10.3). If you are a person of color, see whether the model resonates with you as you read through the stages.

White Identity Development. As with cultural/racial identity development models, **White identity development** models also propose specific stages that Whites are likely to pass through as they become increasingly cross-culturally aware (D'Andrea & Daniels, 1991, 1999; Helms, 1984, 1999; Helms & Cook, 1999; Sabnani, Ponterotto, & Borodovsky, 1991). Two such models presented in Table 10.2 include Helms's White Identity Model, which speaks to Whites in general, and the model of Sabnani et al., which speaks to White graduate students in counseling. Research has supported the notion that such models reflect the deepening awareness and understanding of multicultural issues that individuals gain as they are exposed to

FIGURE 10.3 Racial Identity Development for People of Color (RIDPOC)



experiences that increase their understanding of multiculturalism (Hays, Chang, & Havic, 2005; Middleton et al., 2005). If you are White, see whether the models resonate with you as you read through the stages.

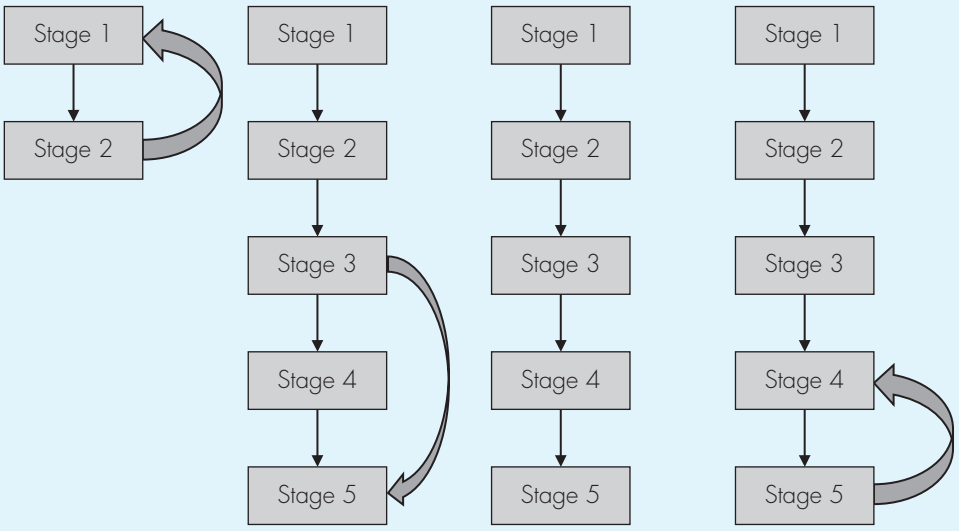
Sabnani and associates (1991) describe a number of variations in the ways students can move through the stages. A few examples are shown in Figure 10.4. For instance, Student A begins to move from Stage 1 to Stage 2. However, as the student is confronted with multicultural issues, perhaps in a course on multicultural counseling, he or she retreats back to Stage 1 behavior, preferring denial about racism and prejudice in society. The change process is too fearful for him or her. Student B moves through the first three stages, does not feel a strong need to retreat into his or her own culture in Stage 4, and moves on to Stage 5, where the student can feel good about his or her own culture while having an understanding of and appreciation for others. Student C, on the other hand, feels a need to retreat as he or she is rejected by some minority individuals (Stage 4). This student becomes angry,

TABLE 10.2 White Identity Models

Helms (Helms, 1984, 1999, 2005; Helms & Cook, 1999)	Sabnani, Ponterotto, & Borodovsky (1991)
Stage 1: Contact. Here, Whites are unaware of themselves as racial beings, oblivious to social and cultural issues and White privilege, and naïve concerning how race impacts themselves and others.	***Stage 1: Pre-exposure.*** White graduate students show naiveté and ignorance about multicultural issues and sometimes believe that racism does not exist or that, if it does, it exists only to a limited degree. Racism is generally thought of as over, and students in this stage do not understand more subtle, embedded racism.
Stage 2: Disintegration. In this stage, Whites begin to acknowledge that racism exists. Believing that society is unjust leads to a sense of confusion and disorientation as past beliefs are being challenged. Some may feel anxiety and guilt over racism and may overly identify with those from other cultures, while others may act paternalistically toward them.	***Stage 2: Exposure.*** Students enter this stage when first confronted with multicultural issues, such as when students discuss in class, or take a course on, multicultural counseling. Increasing awareness of embedded racism in society leads to feelings of guilt over being White and/or depression and anger over the current state of affairs. This stage is highlighted by conflict between wanting to maintain majority views and the desire to uphold more humanistically oriented non-prejudicial views.
Stage 3: Reintegration. This stage is a backlash to the confusion and disorientation in Stage 2, and many Whites retreat back to protecting their privileged status and maintaining the status quo. Feelings of anxiety and guilt are now transformed to anger and fear of individuals from nondominant groups.	***Stage 3: Prominority/Antiracism.*** Here students often take a strong prominority stance, are likely to reject racist and prejudicial beliefs, and sometimes will reject their own Whiteness in an effort to assuage the guilt felt in stage 2. Students in this stage tend to have an intense interest in diverse cultural groups and are likely to have an increasing amount of contact with individuals from different cultures.
Stage 4: Pseudoindependence. Not comfortable with racism, these individuals have an intellectual acceptance and curiosity regarding individuals from nondominant groups. However, these individuals have not taken personal responsibility regarding their own racism and tend to see others as responsible for racism.	***Stage 4: Retreat to White Culture.*** Students retreat into their own culture as they experience rejection from some individuals from nondominant groups. Intercultural contact is ended because they feel hostile toward and fearful of those from nondominant groups. The cozy home of the student's culture of origin is feeling quite safe at this point in time.
Stage 5: Immersion. Individuals in this stage have a need for more information about others and are eager to gain a deeper understanding of how they have been socialized to embrace racist attitudes. These individuals have a need to find a new and more compassionate definition of *White*.	***Stage 5: Redefinition and Integration.*** Students develop a worldview of multiculturalism and are integrating this into their identity. They are able to feel good about their own identity and roots, and also have a deep appreciation of the culture of others. Here, they are able to expend energy toward deeply rooted structural changes in society.
Stage 6: Emersion. Here individuals reach out and embrace a new community of Whites that can move toward a deeper understanding of race and White identity.	
Stage 7: Autonomy. This person is cognitively complex, able to understand life from multiple perspectives, able to understand his or her White privilege, is humane and humanistic, and willing to fight all forms of racism and oppression. This person has a multicultural or multiracial transcendent world view.	

upset, and discouraged; moves away from cross-cultural contact; and needs time to reflect on his or her experiences. This student does not understand that individuals from diverse backgrounds are dealing with their own identity issues, which leads some of them to reject Whites, even Whites with good intentions. Some Stage 4 students will eventually move out of their shells and have an easy transition to Stage 5. Others, however, such as Student D, may poke their heads out as they consider moving on to Stage 5, but because they continue to struggle with feelings of rejection and anger, they quickly move back to Stage 4. Keep in mind that because this is a developmental model, it is assumed that any White student, if given a conducive environment, can move to the higher stages.

FIGURE 10.4 Examples of Students' Movement through Stages of White Racial Identity



LO 5

Multicultural Counseling and Social Justice Competencies

In recent years, two standards have helped to drive our work with clients from nondominant groups: the **Multicultural Counseling Competencies** and the **Advocacy Competencies.** Let's take a brief look at each of them.

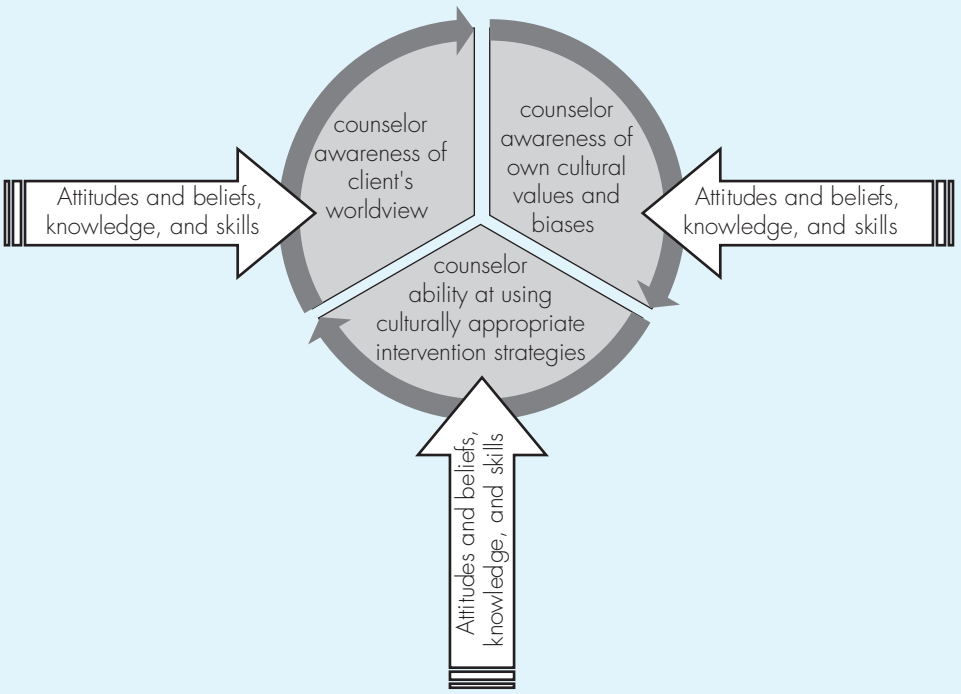
The Multicultural Counseling Competencies

Developed by the **Association for Multicultural Counseling and Development (AMCD)** and endorsed by the **American Counseling Association (ACA)** in 2002 the **Multicultural Counseling Competencies** delineate **attitudes and beliefs, knowledge, and skills** in three areas: the **counselor's awareness of the client's worldview**, the **counselor's awareness of his or her own cultural values and biases**, and the **counselor's ability to use culturally appropriate intervention strategies** (Arredondo, 1999; Sue & Sue, 2013) (see Figure 10.5) (see Appendix C for a full description of the Multicultural Counseling Competencies).

Attitudes and Beliefs.

The effective cross-cultural counselor has awareness of his or her own cultural background and has actively pursued understanding his or her own biases, stereotypes, and values. Differing worldviews between the counselor and client are not seen as deviant, or pathological, and are even embraced by this counselor (Sue & Sue, 2013). Sensitivity to differences and being attuned to one's own biases allows the culturally competent counselor to seek supervision or consultation when differences between worldviews may negatively impact the client.

FIGURE 10.5 Focus of Multicultural Counseling Competencies



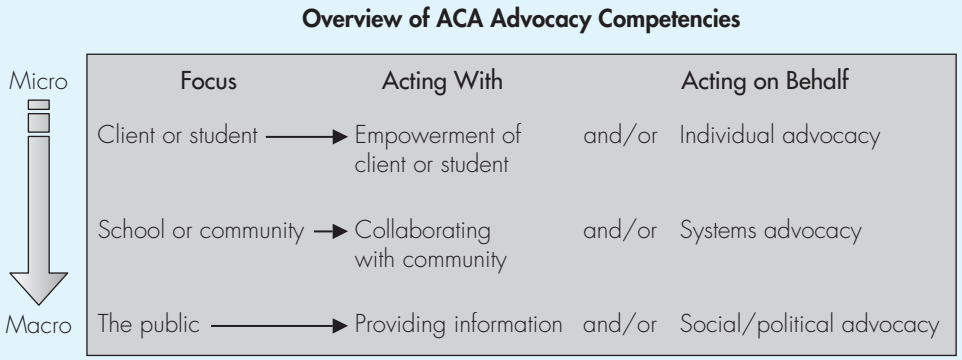
Knowledge. The culturally competent counselor has knowledge of a client's cultural group and does not jump to conclusions about a client. In addition, he or she shows a willingness to gain a greater depth of knowledge of various cultural groups. This counselor is aware of the impact of racism, sexism, heterosexism, and other sociopolitical issues on clients from nondominant groups. In addition, this counselor knows that different counseling theories carry values that may be detrimental for some clients. Finally, this counselor understands how institutional barriers affect the willingness of minority clients to use mental health services.

Skills. The culturally competent counselor is able to apply, when appropriate, generic interviewing and counseling skills and also has knowledge of and is able to employ specialized skills and interventions that might be effective with specific clients. This counselor has knowledge of and understands the verbal and nonverbal language of his or her clients and can communicate effectively with clients. In addition, the culturally skilled helper understands the importance of having a systemic perspective, such as understanding of the impact of family and society on clients; being able to work collaboratively with community leaders, folk healers, and other professionals; and advocating for clients when necessary.

The Advocacy Competencies

> *Working towards the liberation of society's most vulnerable, marginalized, and discarded people—not on a one person crusade of charity, but with the people, seeking justice together—is according to the [philosopher] Freire, the historical vocation of human beings. (Marchand, 2010, p. 52)*

FIGURE 10.6 The Advocacy Competencies



Adapted from Toporek, R. LO., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling and Development*, *87*, p. 267.

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As I noted when we began this chapter, multicultural counseling used to focus solely on *counseling* diverse clients. However, as the multicultural paradigm unfolded, it became clear that to help clients fully, mental health professionals needed to add advocacy to their repertoire of behaviors (Snow, 2013). With this in mind, during the 1990s and early 2000s, current and past ACA presidents focused on the importance of advocacy as a critical means of assisting clients, especially those who have been historically oppressed. Counselors could no longer idly stay in their offices and do nothing while clients, and others, were being mistreated, oppressed, and harassed. As a result, a task force was formed to develop Advocacy Competencies, and in 2003 they were endorsed by ACA (see Goodman, 2009).

The **Advocacy Competencies** encompass three competency areas (**client/student**, **school/community**, and **public arena**), each of which is divided into two levels: whether the counselor is **acting with** the competency area or **acting on behalf** of the competency area (see Figure 10.5). For instance, in the client competency area, a counselor might *act with* a client to help the client identify his or her strengths and resources so that he or she can feel empowered and advocate for himself or herself, or, *on behalf* of the client, the counselor might assist the client in accessing needed services (Toporek, Lewis, & Crethar, 2009). The competencies run from the **microlevel** (focus on the client) to the **macrolevel** (focus on the system). In Figure 10.6 you can view the three competency areas, each divided into two levels.

The advocacy movement shows heightened awareness among counselors of the real world effects of oppression, racism, and prejudice on a large segment of society. It is only through social justice efforts that many of our clients can overcome some of the external and oppressive barriers they face if they are to feel empowered in their lives (Crethar & Winterowd, 2012; Niles, 2009; Ratts, 2011; Ratts & Hutchins, 2009) (see Reflection Activity 10.4). (See Appendix D for a full description of the Advocacy Competencies.)

Reflection Activity 10.4 Counseling versus Advocacy

It used to be that one would rarely advocate for a client outside of the counseling session. Today, it is sometimes suggested as the appropriate and ethical way to respond.

When do you think such advocacy may be appropriate? Be specific. How might advocating for a client detract from the counseling relationship? How might it increase the mental health of the client?

LO 6

Final Thoughts: The Emergence of the Fourth and Fifth Forces

> *Multiculturalism is not competing with humanism, behaviorism, or psychodynamic perspectives but rather demonstrates the importance of making the cultural context central to whichever psychological theory is being applied. (Pedersen, Crethar, & Carlson, 2008, p. 233)*

Historically, psychodynamic approaches, behaviorism, and humanism were called the first, second, and third forces in counseling. With the more recent focus on multicultural counseling and on social justice, two new forces have emerged (Ratts, 2009). These **fourth and fifth forces** suggest that counseling theory alone cannot drive our work with our clients. Multicultural counseling and social justice work challenge counselors to understand their attitudes, knowledge, and skills relative to all people. And they dare counselors to understand their own biases and how these might affect their work with clients. In addition, they urge counselors to gain an understanding of their clients' cultures and aspects of society that actively oppress nondominant groups. Finally, they exhort counselors to advocate for their clients by empowering them, by helping them find resources, by advocating for them locally, and by advocating for systemic change nationally and internationally.

Multicultural counseling and social justice work are *not* fly by night concepts. They're *not* some new theories that are being applied and then will take a back seat. They *are* part of a movement that has and will continue to change the nature of counseling and mental health services.

Case Study 10.1 Counselor Insensitivities

The following offers a few examples of how a counselor's biases, prejudices, or insensitivities can lead to a rupture in the helping relationship. Reflect on whether you think you might ever make a similar error.

1. The counselor jokingly says to a client who is having trouble focusing, "I'll have to get you on some Ritalin." Although distasteful at any point, this statement is particularly inappropriate with this client, whose son is a child who struggles with a learning problem. The client ends up feeling as if the helper is insensitive.
2. The counselor encourages his client to be "more manly" so that he could have a more satisfying relationship with his wife. Meanwhile, the client secretly identifies as a female, and now he feels as if he cannot share this secret with his helper.
3. The counselor has pro-life or pro-choice literature in his or her office. When a woman comes in with a difficult pregnancy, this literature makes her feel like she cannot share her dilemma.
4. The atheistic counselor who dismisses her client's conflict between her religious beliefs and her same-sex attractions. Instead the helper suggests the client change her religion. This, in effect, shuts down the client's desire to talk about her problem.
5. The counselor who has a client whose parent is in the last stages of hospice care and the client is considering assisting his parent with suicide due to the pain she is in. The helper says to the client, "I cannot discuss that, as it is against the law." This has the effect of ending the conversation and leaving the client feeling as if she has no one to talk to.

Summary

This chapter examined multicultural counseling and social justice work, the fourth and fifth forces in the history of counseling. The chapter began by describing one definition of multicultural counseling that suggests that multicultural counseling is the development of counselor competencies to maximize counselor effectiveness in the counselor's work with all clients, and a second definition that suggests that multicultural counseling involves the counselor considering the role of individualism and collectivism in the client's life and in the assessment, diagnosis, and treatment process, considering the client's identities (individual, group, and universal) while applying cultural specific and universal strategies when working toward client goals.

We then went on to note that multicultural counseling and social justice work both focus on helping clients from traditionally oppressed groups, but do so in somewhat different ways. Multicultural counseling is mostly focused upon the development of counselor competencies in their work with all clients, whereas social justice work focuses on counselors empowering clients so that they can take action against oppression in their lives, and counselors taking action for clients and in society in an effort to assist those who are marginalized.

As the chapter continued, eight reasons why counseling is not effective for nondominant clients were listed, including the fact that some counselors believe we are a melting pot, have incongruent expectations about counseling, de-emphasize the role of social forces, hold ethnocentric worldviews, are ignorant of their racist attitudes and prejudices, misunderstand cultural differences in the expression of symptomatology, misjudge the accuracy of assessment and research procedures, and are ignorant of institutional racism.

We next gave definitions of a number of words and terms, including culture; discrimination and microaggressions; ethnicity; minority and nondominant groups; power differentials; race; religion and spirituality; sexism, heterosexism, and sexual prejudice; sexual orientation and gender identity; social class (class); and prejudice, stereotypes, and racism. We highlighted the negative outcome of sexual orientation change efforts (conversion and reparative therapies) and suggested ways of responding to clients who seek such therapies.

In the interest of being effective with all clients, we examined a number of models to help us understand how individuals come to make sense of their world relative to their cultural identity, including: the RESPECTFUL acronym, the tripartite model of personal identity, the Racial Identity Development for People of Color (RIDPOC) model, Helms's White Identity Model, and the White Identity Model of Sabnani et al., who specifically looked at graduate students in counseling.

As the chapter neared its conclusion, we discussed two relatively recent standards that have helped to drive our work with clients from nondominant groups. The Multicultural Counseling Competencies delineate attitudes and beliefs, knowledge, and skills in three areas: the counselor's awareness of the client's worldview, the counselor's awareness of his or her own cultural values and biases, and the counselor's ability to use culturally appropriate intervention strategies. Then we examined the recent advocacy competencies, noting that they encompass three areas (client/student, school/community, and public arena), each of which are divided into two levels, depending on whether the counselor is acting with the client or on behalf of the client. We stressed that the roots of this new advocacy movement are found in the awareness among counselors of the real world effects of oppression, racism, and prejudice on a large segment of society. We

pointed out that multicultural counseling and advocacy are sometimes called the fourth and fifth forces, as their importance follows that of psychodynamic counseling, behaviorism, and humanism.

Key Terms

Acting on behalf
Acting with
Advocacy competencies
Ally
American Counseling Association (ACA)
Asexual
Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC)
Association for Multicultural Counseling and Development (AMCD)
Attitudes and beliefs, knowledge, and skills
Bisexual
Class
Client/student
Collectivist perspective
Competencies for Counseling LGBTQQIA Individuals
Competencies for Counseling Transgender Individuals
Conversion therapy
Counselor's ability to use culturally appropriate intervention strategies
Counselor's awareness of his or her own cultural values and biases
Counselor's awareness of the client's worldview
Cross-dresser
Cultural mosaic
Culture
Culture-specific skills
De-emphasizing of social forces
Developmental models
Developmental models of cultural/racial identity
Discrimination
Ethnicity
Ethnocentric worldview
Fourth and fifth forces
Gay
Group identity
Group level
Helms's White Identity Model
Hermaphrodite
Heterosexist
Heterosexual
Homophobic
Ignorance of one's own racist attitudes and prejudices
Inability to understand cultural differences in the expression of symptomatology
Incongruent expectations about counseling
Individual identity
Individualistic perspective
Individual level
Institutionalism racism
Intersex
Lesbian
LGBTQQIA (Lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual)
Macrolevel
Melting pot myth
Microaggressions
Microlevel
Minority
Multicultural Counseling
Multicultural Counseling Competencies
Nondominant group
Power differential
Prejudice
Public arena
Queer
Questioning
Race
Racial Identity Development for People of Color (RIDPOC)
Racism
Religion
Reparative therapy

RESPECTFUL model
School/community
Sexist
Sexual orientation
Sexual orientation change efforts
Sexual preference
Sexual prejudice
Social class
Social justice work
Spirituality
Stereotyping
Transgender
Transsexual
Transvestite
Tripartite model of personal identity
Universal identity
Universal level
Universal skills
Unreliability of assessment and research procedures
White Identity Development

Afterword

Applying to Graduate School and Finding a Job

The good news is that for a career in school counseling, mental health counseling, college counseling, substance abuse counseling, rehabilitation counseling, and even genetic counseling, jobs are predicted to grow faster or much faster than average U.S. Department of Labor (n.d.). But is this what you want to do?

Now that you've read this book, you probably have a pretty good sense of who the counselor is and what the counselor does. But maybe you need a little more information—like, how much does the average counselor earn? After all, although counselors are usually pretty selfless, they do need to make a living. So Table 1 gives you median salaries and the projected job growth for a number of different kinds of counselors, so you can make an informed decision about your future.

Still interested in the counseling profession? If you are, and if you are not already in a graduate program, this chapter will help you find one. If you are in a graduate program and may be interested in a doctoral program, this chapter will help you find such a program also. If you're in a graduate program and you're soon to be looking for a job, this chapter will also help you find a job.

Select Items to Consider When Choosing a Program or Finding a Job

Although there are dozens of items to consider when selecting a graduate program or finding a job, the following pinpoints some critical elements. For instance, when making

TABLE 1 Number of Counselors/Projected Increase and Salaries

Type of Counselor	Number of Counselors Today*	Projected Number of Additional Counselors by 2022	Percent Increase	Median Salaries*
School and Career Counselors	262,300	31,200	12	$53,610–$56,040
Mental Health Counselors and Marriage and Family Therapists	166,300	48,200	29	$41,500–$43,990
Rehabilitation Counselor	103,890–117,500	36,6000	20	$33,880 $37,890
Substance Abuse and Behavioral Disorder Counselors	89,600	28,200	31	$38,520

Source: U.S. Department of Labor, Bureau of Labor Statistics (n.d.). Search: Counselors. Retrieved from http://data.bls.gov/search/query/results?q=counselors

*Estimates vary depending on source with U.S. Department of Labor.

an informed decision about going on to graduate school, one should probably consider the following:

1. Whether the program is accredited
2. The kinds of counseling specialties and degrees offered
3. The philosophical orientation of the program
4. Entry requirements
5. The size of the program and university
6. Faculty–student ratios
7. Diversity of the student body and of the faculty
8. The cost and number of available scholarships
9. Location
10. Job placement possibilities
11. Whether the program is online and negative or positive ramifications of that

Similarly, the job seeker should know the following:

1. The minimum credentials needed for the job
2. Specific requirements necessary to fulfill the job
3. The philosophical orientation of the setting
4. The number and type of clients one is expected to see
5. Other job roles and functions
6. Salary
7. Diversity of co-workers
8. Possibilities for job advancement

The Application Process

Having sat on selection committees for graduate schools and for counseling jobs in the public and private sector, I have been amazed at the number of applicants who miss the basics in their application process. The following represent some items one should address when completing such applications:

1. Complete all necessary forms, and meet all application deadlines.
2. Make sure you address each item asked of you in the graduate application or in the job advertisement.
3. Do not submit "cookie-cutter" applications to different jobs or different graduate schools. Ensure your application speaks to the school or job to which you are applying.
4. Take and be prepared for any necessary tests (e.g., GREs for graduate schools, personality tests for some jobs).
5. Write a great essay or statement of philosophy. Have some review it.
6. Find out whether an interview is required, and prepare for it.
7. Find out about faculty members' research or be knowledgeable about your employer's background, and find an opportunity to ask questions about what they have accomplished.
8. Provide a well-written résumé.
9. Consider submitting a portfolio.
10. Use spell-check, and check your grammar.
11. Be positive, focused, and prepared.
12. Don't be negative or cynical.

The Résumé

Some programs and most potential employers will ask you to submit a résumé. Good résumés present a well-rounded picture of who you are, so it's usually a good idea to submit one even if it is not requested. Some general guidelines when developing your résumé include:

1. Make it readable, attractive, grammatically correct, and to the point.
2. Do not use gender-biased words or phrases.
3. Do not be overly concerned about length. There has been a tendency in recent years to keep résumés under two pages. I don't agree. Whatever you decide the length of your résumé needs to be, make sure major points stand out and it is easy for the reader to ascertain who you are and what you have accomplished.
4. Do not make the résumé too wordy or too chaotic.
5. Tailor your résumé to the requirements of the program or job being pursued.
6. Do not add detail that could eliminate you from the selection process. For instance, sometimes individuals include career goals that are at odds with the goals of the program or the job at hand.
7. Do not sell yourself short. For example, I have seen many individuals not list jobs they have had because those jobs were not in the counseling field. Don't forget that all experience is good experience and that jobs have transferable skills.
8. Brag about yourself, but don't sound narcissistic.

For a more detailed look at résumés, get a good book on résumé writing, such as *The Perfect Résumé* (Quillen, 2014) or look at the résumé section of the classic book *What Color Is Your Parachute* (Bolles, 2015). In addition, today, there are some great websites that you can use to help you build a résumé, just Google "build a résumé."

Activity 1 Building Your Résumé

First, update your résumé at home, then bring it to class. In small groups, share what you have developed and give some critical feedback to others. Is it readable? Is it too long, too short, unkempt, or ugly? Is it factual? Does it include information that could prevent you from obtaining a job? Is it grammatically correct, and so forth?

The Portfolio

In addition to a résumé, a *portfolio* may increase your chances of being admitted to graduate school or obtaining a job (Cobia et al., 2005). A portfolio includes materials that demonstrate the ability of the student or counselor and can be used when applying for graduate school or for jobs. Competencies highlighted through accreditation processes (e.g., by the Council for the Accreditation of Counseling and Related Educational Programs [CACREP]) or goals highlighted in job advertisements will often drive what is included in the portfolio.

As an example of what may be placed in a portfolio, a student who has completed a degree in school counseling may have developed a portfolio that could be used for potential employment purposes and includes a résumé, transcripts or videos of the student's work with clients (client's identities are hidden), a supervisor's assessment of the

student's work, a paper that highlights the student's view of human nature, examples of how to build a multicultural school environment, ways that the student shows a commitment to the school counseling profession, a test report written by the student, and a project that shows how the student would build a comprehensive school counseling program. Although portfolios have, in the past, been paper projects, today's portfolios are often placed on CDs or jump drives or made available online (Andrade, 2013; Willis & Wilkie, 2009).

Locating a Graduate Program/Finding a Job

You're ready to apply to a program or find a job. So where do you look? There are some specific places you can contact to find the graduate program of your choice, and there are ways to increase your chances of obtaining your dream job. The following section provides some resources for your school- or job-selection process.

Finding a Graduate Program

A number of resources are available to assist potential graduate students in locating graduate schools. Some of these include the following:

Master's and doctoral programs in counseling:

Council for Accreditation of Counseling and Related Educational Programs
1001 North Fairfax St., Suite 510
Alexandria, VA 22314
Phone: 703-535-5990
Website: www.cacrep.org
Related association: American Counseling Association

Counselor Preparation: Programs, Faculty, Trends (13th ed.) (2013).
Authors: Schweiger, W. K., Henderson, D. A., McCaskill, K., Clawson, T., & Collins, D. R.
Routledge, C/O Taylor and Francis, Inc.
7625 Empire Dr.
Florence, KY 41042-2919
Phone: 800-634-7064
Website: http://www.routledge.com
E-mail: orders@taylorandfrancis.com

Doctoral programs in counseling and clinical psychology:

American Psychological Association (APA)
Graduate and Postdoctoral Education
750 First St. NE
Washington, DC 20002
Phone: 800-374-2721
Website: www.apa.org/education/grad/index.aspx
Related association: American Psychological Association (www.apa.org)

Master's programs in rehabilitation counseling:

National Council on Rehabilitation Education
1099 E. Champlain Dr., Suite A

PMB 137
Fresno, CA 93720
Phone: 559-906-0787
Website: http://www.ncre.org/directory.html
Related associations: American Rehabilitation Counseling Association (www.arcaweb.org)
National Rehabilitation Counseling Association (http://nrca-net.org)

Master's programs in marriage and family therapy:

Commission on Accreditation for Marriage and Family Therapy Education
112 South Alfred St.
Alexandria, VA 22314-3061
Phone: 703-838-9808
Website: www.aamft.org/imis15/content/coamfte/coamfte.aspx
Related association: American Association for Marriage and Family Therapy (www.aamft.org)

Council for Accreditation of Counseling and Related Educational Programs
1001 North Fairfax Street, Suite 510
Alexandria, VA 22314
Phone: 703-535-5990
Website: www.cacrep.org
Related association: International Association of Marriage and Family Counselors (www.iamfc.org)

Clinical pastoral programs:

Association for Clinical Pastoral Education, Inc.
1549 Clairmont Rd., Suite 103
Decatur, GA 30033
Phone: 404-320-1472
Website: www.acpe.edu

Master's programs in social work:

Council on Social Work Education
1701 Duke St., Suite 200
Alexandria, VA 22314
Phone: 703-683-8080
Website: www.cswe.org/Accreditation.aspx
Related associations: Council on Social Work Education (www.cswe.org)
National Association of Social Workers (www.naswdc.org)

Master's programs in art therapy:

American Art Therapy Association
4875 Eisenhower Ave., Suite 240
Alexandria, VA 22304
Phone: 888-290-0878
Website: www.arttherapy.org/aata-educational-programs.html
Related association: American Art Therapy Association (www.arttherapy.org)

Finding a Job

There are a number of things you can do to increase your chances of finding a job. Some of these include networking, going on informational interviews, responding to ads in professional publications, interviewing at national conferences, using the services of college and university job placement services, and more.

Networking. You've finished your training and now are ready to find a job. What do you do? Well, if you want to get a head start on the process, you should join your local, state, and national professional associations prior to finishing your training. Networking in this manner is one of the most widely used and best methods of obtaining a job. When people see you and are impressed with you, you have gained a foot in the door. And sometimes you even get a job offered on the spot (see Reflection Activity 1).

Reflection Activity 1 Networking

Randy was a former student of mine who was enthusiastic about the counseling field. He joined his professional associations, worked with me on research, and participated in professional activities whenever possible. Because Randy was so involved, he had the opportunity to co-present a workshop with me at a state professional association conference. His enthusiasm and knowledge so impressed one of the participants that at the end of one workshop she offered him a job—right there.

What are your thoughts about conducting a workshop at a conference or becoming involved with your professional associations? Why would you not want to do this?

Going On Informational Interviews. You have your résumé and have developed a portfolio, you're networked, you look good and sound good—now what do you do? Well, you've probably identified a few different types of jobs in the counseling field. Now it's time to find some people who have these jobs and go on some informational interviews. These interviews will allow you to get a closer look at exactly what people do and will help you make a decision regarding whether or not you really want to pursue a particular job. In fact, sometimes people will let you shadow them on the job, and once in a while informational interviews can lead you to a specific job opening.

Responding to Ads in Professional Publications. Today, there are a number of professional publications that list jobs locally, statewide, and nationally. An active counseling association in your community or state may have a job bank and list jobs in its newsletter. *Counseling Today*, the monthly ACA magazine, lists a variety of counseling-related jobs throughout the country. So does the APA magazine, *The Monitor.* Similarly, the *Chronicle of Higher Education* lists jobs nationally, although most listed jobs are confined to the area of student affairs or doctoral-level jobs.

Interviewing at National Conferences. Often, the large national conferences, such as the annual counselor conference sponsored by ACA, will offer a process whereby individuals who are looking for jobs can interview with prospective employers at the conference. Although this is generally focused on doctoral-level counselor-educator jobs, some master's-level jobs are also available.

College and University Job Placement Services. Job placement services and career management centers at colleges and universities will often have listings of

local community agencies that can be helpful when conducting a job search. Sometimes these placement services will offer job fairs that are relevant for graduate students in counseling.

Other Job-Finding Methods. Remember the tried-and-true methods for finding jobs— such as applying directly to an employer, responding to a newspaper ad, contacting a private or state employment agency, and placing an ad in a professional journal. These methods sometimes do work!

Being Chosen, Being Denied

Counselor educators avoid saying a person is rejected from a program or a job, suggesting instead that the individual was denied admission or given other opportunities. Nevertheless, most people who are not admitted to their first-choice school or not offered their dream job often do feel rejected. If you are denied admission or not offered a desired job, ask for feedback about your application and/or the interview process. Although it is sometimes hard not to take a denial personally, this can be an opportunity to discover what you can do to improve your application. Once you know what was amiss, you can increase the chances of obtaining your next chosen graduate program or job.

Moving Ahead

For many of you, this is your first step toward a lifetime in the counseling profession. And, if it's anything like my career has been, it may end up a little bit like a roller coaster ride. However, whether you spend the rest of your years doing counseling, teaching counseling, or as a lawyer, teacher, doctor, or computer programmer, make the best of it. Remember, this is your life and you choose what you want to do. Work hard, love others, have a good support system, and have fun. A friend of mine once said, "Your life will not be complete until you have had a child, planted a tree, and written a book." So I had two children, planted a few trees, and wrote a number of books. And guess what? He was wrong, because I keep learning that my life will never be complete. I continue to find new and wondrous things to keep me interested and to keep me moving ahead!

Appendix A

Web Addresses of Select Professional Associations

American Counseling Association and Its Divisions		
ACA	American Counseling Association	www.counseling.org
	Divisions of ACA	
AADA	1. Association for Adult Development and Aging	www.aadaweb.org
AARC	2. Association Assessment and Research in Counseling	www.aarc-counseling.org
ACAC	3. Association for Child and Adolescent Counseling	www.acachild.com
ACC	4. The Association for Creativity in Counseling	www.creativecounselor.org
ACCA	5. American College Counseling Association	www.collegecounseling.org
ACES	6. Association for Counselor Education and Supervision	www.acesonline.net
AHC	7. Association for Humanistic Counseling	www.afhc.camp9.org
ALGBTIC	8. Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling	www.algbtic.org
AMCD	9. Association for Multicultural Counseling and Development	www.multiculturalcounseling.org
AMHC	10. American Mental Health Counselors Association	www.amhca.org
ARCA	11. American Rehabilitation Counseling Association	www.arcaweb.org
ASCA	12. American School Counselor Association	www.schoolcounselor.org
ASERVC	13. Association for Spiritual, Ethical, and Religious Values in Counseling	www.aservic.org
ASGW	14. Association for Specialists in Group Work	www.asgw.org
CSJ	15. Counselors for Social Justice	www.counseling-csj.org
IAAOFC	16. International Association of Addictions and Offender Counselors	www.iaaoc.org
IAMFC	17. International Association of Marriage and Family Counselors	www.iamfconline.org
MCGA	18. Military and Government Counseling Association	www.acegonline.org
NCDA	19. National Career Development Association	www.ncda.org
NECA	20. National Employment Counseling Association	www.employmentcounseling.org

Affiliated Associations to ACA		
CCE	Center for Credentialing and Education	www.cce-global.org
CACREP	Council for Accreditation of Counseling and Related Educational Programs	www.cacrep.org
HPSO	Health Providers Service Organization	www.hpso.com
NBCC	National Board for Certified Counselors	www.nbcc.org
Accreditng/Approval Bodies in the Helping Professions		
AACN	American Association of Colleges of Nursing	www.aacn.nche.edu
ACPE	Association for Clinical Pastoral Education	www.acpe.edu
APA	American Psychological Association	www.apa.org/ed/accreditation
APNA	American Psychiatric Nurses Association	www.apna.org
CACREP	Council for Accreditation of Counseling and Related Educational Programs	www.cacrep.org
ACPE	Association for Clinical Pastoral Education	www.acpe.edu
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education	www.aamft.org/imis15/content/coamfte/coamfte.aspx
CSHE	Council for Standards in Human Service Education	www.cshse.org
CSWE	Council on Social Work Education	www.cswe.org
NCRE	National Council on Rehabilitation Education	www.ncre.org
Related Professional Associations in the Helping Professions		
AATA	American Art Therapy Association	www.americanarttherapyassociation.org
AAMFT	American Association of Marriage and Family Therapists	www.aamft.org
ACPE	Association for Clinical Pastoral Education	www.acpe.edu
APA	American Psychological Association	www.apa.org
APA	American Psychiatric Association	www.psych.org
APNA	American Psychiatric Nurses Association	www.apna.org
NASP	National Association of School Psychologists	www.nasponline.org
NASW	National Association of Social Workers	www.naswdc.org
NOHS	National Organization of Human Services	www.nationalhumanservices.org
NRCA	National Rehabilitation Counseling Association	www.nrca-net.org

Appendix B

Summary of Diagnostic Categories from the Diagnostic and Statistical Manual-5 (DSM-5)

Section II of *DSM-5* offers an in-depth discussion of 20 diagnostic categories, an additional cateogry called medication-induced disorders as well as a focus on "other conditions that may be a focus of clinical attention." The following offers a brief description of these disorders and is summarized from *DSM-5* (APA, 2013). Please refer to the *DSM-5* for an in-depth review of each disorder.

- *Neurodevelopmental Disorders.* This group of disorders typically refers to those that manifest during early development, although diagnoses are sometimes not assigned until adulthood. Examples of neurodevelopmental disorders include intellectual disabilities, communication disorders, autism spectrum disorders (incorporating the former categories of autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder), ADHD, specific learning disorders, motor disorders, and other neurodevelopmental disorders.
- *Schizophrenia Spectrum and Other Psychotic Disorders.* The disorders that belong to this section all have one feature in common: psychotic symptoms, that is, delusions, hallucinations, grossly disorganized or abnormal motor behavior, and/or negative symptoms. The disorders include schizotypal personality disorder (which is listed again, and explained more comprehensively, in the category of Personality Disorders in the *DSM-5*), delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, substance/medication-induced psychotic disorders, psychotic disorders due to another medical condition, and catatonic disorders.
- *Bipolar and Related Disorders.* The disorders in this category refer to disturbances in mood in which the client cycles through stages of mania or mania and depression. Both children and adults can be diagnosed with bipolar disorder, and the clinician can work to identify the pattern of mood presentation, such as rapid-cycling, which is more often observed in children. These disorders include bipolar I, bipolar II, cyclothymic disorder, substance/medication-induced disorder, bipolar and related disorder due to another medical condition, and other specified or unspecified bipolar and related disorders.
- *Depressive Disorders.* Previously grouped into the broader category of Mood Disorders in the DSM-IV-TR, these disorders describe conditions where depressed mood is the overarching concern. They include disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (also known as dysthymia), and premenstrual dysphoric disorder.

- *Anxiety Disorders.* There are a wide range of anxiety disorders, which can be diagnosed by identifying a general or specific cause of unease or fear. This anxiety or fear is considered clinically significant when it is excessive and persistent over time. Examples of anxiety disorders that typically manifest earlier in development include separation anxiety and selective mutism. Other examples of anxiety disorders are specific phobia, social anxiety disorder (also known as social phobia), panic disorder, and generalized anxiety disorder.
- *Obsessive-Compulsive and Related Disorders.* Disorders in this category all involve obsessive thoughts and compulsive behaviors that are uncontrollable and the client feels compelled to perform them. Diagnoses in this category include obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (or hair-pulling disorder), and excoriation (or skin-picking) disorder.
- *Trauma- and Stressor-Related Disorders.* A new category for *DSM-5*, trauma and stress disorders emphasize the pervasive impact that life events can have on an individual's emotional and physical well-being. Diagnoses include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder, acute stress disorder, and adjustment disorders.
- *Dissociative Disorders.* These disorders indicate a temporary or prolonged disruption to consciousness that can cause an individual to misinterpret identity, surroundings, and memories. Diagnoses include dissociative identity disorder (formerly known as multiple personality disorder), dissociative amnesia, depersonalization/derealization disorder, and other specified and unspecified dissociative disorders.
- *Somatic Symptom and Related Disorders.* Somatic symptom disorders were previously referred to as somatoform disorders and are characterized by the experiencing of a physical symptom without evidence of a physical cause, thus suggesting a psychological cause. Somatic symptom disorders include somatic symptom disorder, illness anxiety disorder (formerly hypochondriasis), conversion (or functional neurological symptom) disorder, psychological factors affecting other medical conditions, and factitious disorder.
- *Feeding and Eating Disorders.* This group of disorders describes clients who have severe concerns about the amount or type of food they eat to the point that serious health problems, or even death, can result from their eating behaviors. Examples include avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, pica, and rumination disorder.
- *Elimination Disorders.* These disorders can manifest at any point in a person's life, although they are typically diagnosed in early childhood or adolescence. They include enuresis, which is the inappropriate elimination of urine, and encopresis, which is the inappropriate elimination of feces. These behaviors may or may not be intentional.
- *Sleep-Wake Disorders.* This category refers to disorders where one's sleep patterns are severely impacted, and they often co-occur with other disorders (e.g., depression or anxiety). Some examples include insomnia disorder, hypersomnolence disorder, restless legs syndrome, narcolepsy, and nightmare disorder. A number of sleep-wake disorders involve variations in breathing, such as sleep-related hypoventilation, obstructive sleep apnea hypopnea, or central sleep apnea. See the *DSM-5* for the full listing and descriptions of these disorders.

- *Sexual Dysfunctions.* These disorders are related to problems that disrupt sexual functioning or one's ability to experience sexual pleasure. They occur across sexes and include delayed ejaculation, erectile disorder, female orgasmic disorder, and premature (or early) ejaculation disorder, among others.
- *Gender Dysphoria.* Formerly termed *gender identity disorder,* this category includes those individuals who experience significant distress with the sex they were born and with associated gender roles. This diagnosis has been separated from the category of sexual disorders, as it is now accepted that gender dysphoria does not relate to a person's sexual attractions.
- *Disruptive, Impulse Control, and Conduct Disorders.* These disorders are characterized by socially unacceptable or otherwise disruptive and harmful behaviors that are outside of the individual's control. Generally, more common in males than in females, and often first seen in childhood, they include oppositional defiant disorder, conduct disorder, intermittent explosive disorder, antisocial personality disorder (which is also coded in the category of personality disorders), kleptomania, and pyromania.
- *Substance-Related and Addictive Disorders.* Substance use disorders include disruptions in functioning as the result of a craving or strong urge. Often caused by prescribed and illicit drugs or the exposure to toxins, with these disorders the brain's reward system pathways are activated when the substance is taken (or in the case of gambling disorder, when the behavior is being performed). Some common substances include alcohol, caffeine, nicotine, cannabis, opioids, inhalants, amphetamine, phencyclidine (PCP), sedatives, hypnotics or anxiolytics. Substance use disorders are further designated with the following terms: intoxication, withdrawal, induced, or unspecified.
- *Neurocognitive Disorders.* These disorders are diagnosed when one's decline in cognitive functioning is significantly different from the past and is usually the result of a medical condition (e.g., Parkinson's or Alzheimer's disease), the use of a substance/medication, or traumatic brain injury, among other phenomena. Examples of neurocognitive disorders (NCD) include delirium, and several types of major and mild NCDs such as frontotemporal NCD, NCD due to Parkinson's disease, NCD due to HIV infection, NCD due to Alzheimer's disease, substance-or medication-induced NCD, and vascular NCD, among others.
- *Personality Disorders.* The 10 personality disorders in *DSM-5* all involve a pattern of experiences and behaviors that are persistent, inflexible, and deviate from one's cultural expectations. Usually, this pattern emerges in adolescence or early adulthood and causes severe distress in one's interpersonal relationships. The personality disorders are grouped into three following clusters based on similar behaviors:
  - Cluster A: Paranoid, schizoid, and schizotypal. These individuals seem bizarre or unusual in their behaviors and interpersonal relations.
  - Cluster B: Antisocial, borderline, histrionic, and narcissistic. These individuals seem overly emotional, are melodramatic, or unpredictable in their behaviors and interpersonal relations.
  - Cluster C: Avoidant, dependent, and obsessive-compulsive (not to be confused with obsessive-compulsive disorder). These individuals tend to appear anxious, worried, or fretful in their behaviors.

In addition to these clusters, one can be diagnosed with other specified or unspecified personality disorder, as well as a personality change due to another medical condition, such as a head injury.

- *Paraphilic Disorders.* These disorders are diagnosed when the client is sexual aroused to circumstances that deviate from traditional sexual stimuli *and* when such behaviors result in harm or significant emotional distress. The disorders include exhibitionistic disorder, voyeuristic disorder, frotteuristic disorder, sexual sadism and sexual masochism disorders, fetishistic disorder, transvestic disorder, pedophilic disorder, and other specified and unspecified paraphilic disorders.
- *Other Mental Disorders.* This diagnostic category includes mental disorders that did not fall within one of the previously mentioned groups and do not have unifying characteristics. Examples include other specified mental disorder due to another medical condition, unspecified mental disorders due to another medical condition, other specified mental disorder, and unspecified mental disorder.
- *Medication-Induced Movement Disorders and Other Adverse Effects of Medications.* These disorders are the result of adverse and severe side effects to medications, although a causal link cannot always be shown. Some of these disorders include neuroleptic-induced parkinsonism, neuroleptic malignant syndrome, medication-induced dystonia, medication-induced acute akathisia, tardive dyskinesia, tardive akathisia, medication-induced postural tremor, other medication-induced movement disorder, antidepressant discontinuation syndrome, and other adverse effects of medication.
- *Other Conditions That May Be a Focus of Clinical Assessment.* Reminiscent of Axis IV of the previous edition of the DSM, this last part of Section II ends with a description of concerns that could be clinically significant, such as abuse/neglect, relational problems, psychosocial, personal, and environmental concerns, educational/occupational problems, housing and economic problems, and problems related to the legal system. These conditions, which are not considered mental disorders, are generally listed as V codes, which correspond to ICD-9, or Z codes, which correspond to ICD-10.

Appendix C

AMCD Multicultural Counseling Competencies

I. Counselor Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential.
2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes.
3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.
4. Culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity and culture.

B. Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/abnormality and the process of counseling.
2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism as outlined in White identity development models.
3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A, B and C, Dimensions, and how to anticipate the impact it may have on others.

C. Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or

education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.
2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

II. Counselor Awareness of Client's Worldview

A. Attitudes and Beliefs

1. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.
2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

B. Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.
2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness or inappropriateness of counseling approaches.
3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self esteem and self concept in the counseling process.

C. Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.
2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g., community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

III. Culturally Appropriate Intervention Strategies

A. Beliefs and Attitudes

1. Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.
2. Culturally skilled counselors respect indigenous helping practices and respect helping networks among communities of color.
3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

B. Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various cultural groups.
2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.
3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.
4. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.
5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

C. Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping, but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.
2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately personalize problems.
3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
4. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor

do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.

5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.
6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.
7. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.

SOURCE: Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). *Operationalization of the multicultural counseling competencies*. Alexandria, VA: Association of Multicultural Counseling and Development. Retrieved from http://www.counseling.org/docs/competencies/multcultural_competencies.pdf?sfvrsn=3

Appendix D

Advocacy Competencies

(Endorsed by the ACA Governing Council March 20–22, 2003)

Client/Student Empowerment

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

Empowerment Counselor Competencies

In direct interventions, the counselor is able to:

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

Client/Student Advocacy

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

Client/Student Advocacy Counselor Competencies

In environmental interventions on behalf of clients and students, the counselor is able to:

8. Negotiate relevant services and education systems on behalf of clients and students.
9. Help clients and students gain access to needed resources.
10. Identify barriers to the well-being of individuals and vulnerable groups.

11. Develop an initial plan of action for confronting these barriers.
12. Identify potential allies for confronting the barriers.
13. Carry out the plan of action.

Community Collaboration

- Their ongoing work with people gives counselors a unique awareness of recurring themes.
- Counselors are often among the first to become aware of specific difficulties in the environment.
- Advocacy-oriented counselors often choose to respond to such challenges by alerting existing organizations that are already working for change and that might have an interest in the issue at hand.
- In these situations, the counselor's primary role is as an ally. Counselors can also be helpful to organizations by making available to them our particular skills: interpersonal relations, communications, training, and research.

Community Collaboration Counselor Competencies

14. Identify environmental factors that impinge upon students' and clients' development.
15. Alert community or school groups with common concerns related to the issue.
16. Develop alliances with groups working for change.
17. Use effective listening skills to gain understanding of the group's goals.
18. Identify the strengths and resources that the group members bring to the process of systemic change.
19. Communicate recognition of and respect for these strengths and resources.
20. Identify and offer the skills that the counselor can bring to the collaboration.
21. Assess the effect of counselor's interaction with the community.

Systems Advocacy

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

Systems Advocacy Counselor Competencies

In exerting systems-change leadership at the school or community level, the advocacy-oriented counselor is able to:

22. Identify environmental factors impinging on students' or clients' development.
23. Provide and interpret data to show the urgency for change.
24. In collaboration with other stakeholders, develop a vision to guide change.
25. Analyze the sources of political power and social influence within the system.
26. Develop a step-by-step plan for implementing the change process.
27. Develop a plan for dealing with probable responses to change.

28. Recognize and deal with resistance.
29. Assess the effect of counselor's advocacy efforts on the system and constituents.

Public Information

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

Public Information Counselor Competencies

In informing the public about the role of environmental factors in human development, the advocacy-oriented counselor is able to:

30. Recognize the impact of oppression and other barriers to healthy development.
31. Identify environmental factors that are protective of healthy development.
32. Prepare written and multimedia materials that provide clear explanations of the role of specific environmental factors in human development.
33. Communicate information in ways that are ethical and appropriate for the target population.
34. Disseminate information through a variety of media.
35. Identify and collaborate with other professionals who are involved in disseminating public information.
36. Assess the influence of public information efforts undertaken by the counselor.

Social/Political Advocacy

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

Social/Political Advocacy Counselor Competencies

In influencing public policy in a large, public arena, the advocacy-oriented counselor is able to:

37. Distinguish those problems that can best be resolved through social/political action.
38. Identify the appropriate mechanisms and avenues for addressing these problems.
39. Seek out and join with potential allies.
40. Support existing alliances for change.
41. With allies, prepare convincing data and rationales for change.
42. With allies, lobby legislators and other policy makers.
43. Maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals.

Source: Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2003). *ACA advocacy competencies*. Retrieved from http://www.counseling.org/docs/default-source/competencies/advocacy_competencies.pdf?sfvrsn=9

Glossary[1]

[1]Italicized words within definitions can be found in the glossary. Glossary developed by Mike Kalkbrenner.

AACN See *American Association of Colleges of Nursing.*

AADA See *Association for Adult Development and Aging.*

AAMFT See *American Association for Marriage and Family Therapy.*

AAPC See *American Association of Pastoral Counselors.*

AARC See *Association Assessment and Research in Counseling.*

AATA See *American Art Therapy Association.*

ABAP See *American Board for Accreditation in Psychoanalysis.*

ability to deliver one's theoretical approach Along with the ability to build a *working alliance*, one of the two *common factors* to effective helping relationships. As defined in this book, it includes *compatibility with and belief in your theory, competence,* and *cognitive complexity.* See also *common factors.*

ACA See *American Counseling Association.*

ACAC See *Association for Child and Adolescent Counseling.*

ACA Code of Ethics The ethical code of the *American Counseling Association,* which guides the ethical practice of counselors. The last revision was in 2014.

Academic Unit See *learning environment.*

Academy of Certified Social Workers (ACSW) This association sets standards of practice in the field for master's-level social workers.

ACAF See *American Counseling Association Foundation.*

ACC See *Association for Creativity in Counseling.*

ACCA See *American College Counseling Association.*

acceptance Respecting people's ideals, thoughts, and emotions unconditionally. Also called *positive regard* and *unconditional positive regard.* One of the nine *common factors.* See also *common factors.*

acceptance and commitment therapy (ACT) Therapeutic approach that views behaviors and cognitions as a complex web of relational associations and uses a mixture of cognitive therapy, behavioral techniques, and Eastern philosophy.

Accreditation Council for Genetic Counseling Accredits programs in genetic counseling.

accredited Accredited counselor training programs have been determined to meet minimal standards in addressing important competencies in a professional field. The Council for Accreditation of Counseling and Related Programs (CACREP) accredits counseling programs.

ACES See *Association for Counselor Education and Supervision.*

ACPA See *American College Personnel Association.*

Addams, Jane A social activist who established *hull house* in Chicago in 1899 and who organized group discussions to help people with daily living skills. These groups are viewed as early group treatment.

addiction counseling A CACREP specialty area that focuses on working with individuals who are struggling with addictions (e.g., substance abuse, eating disorders, and sexual addiction).

addiction counselor Although not all addiction counselors have their master's degree, in reference to *CACREP*, this refers to a person who has obtained his or her master's degree in addiction counseling.

ADTA See *American Dance Therapy Association.*

advanced practice registered nurse See *psychiatric-mental health nurse.*

advocacy One aspect of social justice work in which the helper empowers the client to advocate for self and/or when the helper advocates for broader social issues which can benefit clients. See also *Advocacy Competencies.*

advocacy competencies Competencies that describe advocacy in terms of three domains: the client, community, and public. Each of these domains is divided into two levels that include a focus on whether the helper is "acting on behalf" of

the domain "or acting with" the domain. The competencies run from the microlevel (focus on client) to the macrolevel (focus on system).

AHC See *Association for Humanistic Counseling.*

ALGBTIC See *Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling.*

AMCD See *Association for Multicultural Counseling and Development.*

American Art Therapy Association (AATA) An association that approves programs that offer curricula in creative and expressive therapies.

American Association for Counseling and Development (AACD) Formerly referred to as the *American Personnel and Guidance Association (APGA),* and currently *ACA.*

American Association for Marriage and Family Therapy (AAMFT) A professional association for couple and family counselors.

American Association of Colleges of Nursing (AACN) Along with the National League for Nursing An accreditation organization for psychiatric-mental health nurses.

American Association of Marriage and Family Counseling (AAMFC, now AAMFT) See *American Association for Marriage and Family Therapy.*

America Association of Pastoral Counselors (AAPC) A professional association for pastoral counselors. Offers a *certification* process for those who are interested in becoming Certified Pastoral Counselors (CPCs).

American Association of State Counseling Boards (AASCB) This association is a resource for counselor licensing information, and more recently has been helping in designing initiatives that would allow for the *reciprocity* and *portability* of counselors' licenses.

American Board for Accreditation in Psychoanalysis (ABAP) Accredits psychoanalytic institutes.

American Board of Genetic Counseling (ABGC) Offers a credential as a *Certified Genetic Counselor* (CGC) to any individual who has gone through a program accredited by the *Accreditation Council for Genetic Counseling.*

American Board of Professional Psychology (ABPP) Established in 1947, today ABPP offers certifications in 14 specialty areas for psychologists.

American College Counseling Association (ACCA) A division of ACA that focuses on counseling issues in college settings.

American College Personnel Association (ACPA) One of *ACA's* founding divisions, disaffiliated from the *ACA* in 1992. See *College Student Educators International.*

American Counseling Association (ACA) The main professional association for counselors that provides a wide range of benefits for counselors and offers twenty divisions, or specialty areas, in counseling.

American Dance Therapy Association (ADTA) A professional association for creative and expressive helpers who focus on dance and movement when helping.

American Distance Counseling Association (ADCA) A professional association that is focused on supporting the training and practice of online counseling.

American Mental Health Counselors Association (AMHCA) A professional association for clinical mental health counselors. A division of ACA.

American Music Therapy Association (AMTA) A professional association for creative and expressive therapists that focuses on music when helping.

American Personnel and Guidance Association (APGA) Formed out of four associations during the 1950s and a forerunner of *ACA.*

American Psychiatric Association (APA) The main professional association for psychiatrists.

American Psychiatric Nurses Association (APNA) The main professional association for *psychiatric nurses*.

American Psychoanalytic Association (APsaA) The professional association for individuals interested in the practice of psychoanalysis.

American Psychological Association (APA) The major professional association in psychology.

American Rehabilitation Counseling Association (ARCA) A division of ACA for rehabilitation counselors that focuses on issues related to disabilities and rehabilitation issues.

American School Counselor Association (ASCA) A division of ACA for school counselors.

AMHCA See *American Mental Health Counselors Association.*

A Mind That Found Itself Written in the early 1900s by *Clifford Beers,* helped to establish the *National Committee for Mental Hygiene,* which lobbied the U.S. Congress to pass laws that would improve the deplorable conditions of mental institutions.

AMTA See *American Music Therapy Association.*

analytic neutrality Used in psychoanalysis, it includes taking a nonjudgmental disposition and not expressing one's values, beliefs, or biases during a helping relationship.

APA See *American Psychiatric Association and American Psychological Association.*

APA Commission on Accreditation (APA-CoA) An affiliate of the *American Psychological Association,* this commission accredits psychology programs.

APNA See *American Psychiatric Nurses Association.*

approved clinical supervisor (ACS) Administered by the *Center for Credentialing and Education* (CCE), this credential indicates a counselor has expertise as a clinical supervisor and is required in some states for those who supervise counselors wishing to become licensed.

APsaA See *American Psychoanalytic Association.*

APT See *Association for Play Therapy.*

Aquinas, Thomas During the Middle Ages, Aquinas highlighted consciousness, self-examination, and inquiry as philosophies that dealt with the human condition.

ARCA See *American Rehabilitation Counseling Association.*

Aristotle Has been termed the first psychologist because of his use of objectivity and reason in studying information.

Army Alpha One of the first large-scale use of tests of ability by the army in 1917 and was a test used for literates to determine placement of recruits.

Army Beta One of the first large-scale use of tests of ability by the army in 1917 and was a test used for illiterates to determine placement of recruits.

Art Therapy Credentials Board Offers a credential as a *registered art therapist* (ATR). See *registered art therapist.*

ASCA See *American School Counselor Association.*

ASCA National Model A model for the training of school counselor, which provides a comprehensive school counseling program that focuses on the academic, career, and social and emotional development of children.

ASERVIC See *Association for Spiritual, Ethical, and Religious Values in Counseling.*

asexual A type of *sexual orientation* in which one does not have sexual attraction to anyone or who has little interest in sexual activity.

ASGW See *Association for Specialists in Group Work.*

Association for Adult Development and Aging (AADA) A division of ACA focused on all aspects of development with adults.

Association for Assessment and Research in Counseling (AARC) A division of ACA for those interested in testing, assessment, and research.

Association for Assessment in Counseling and Education (AACE) The original name of the *Association of Assessment and Research in Counseling (AARC).*

Association for Child and Adolescent Counseling (ACAC) A division of ACA focused on child and adolescent counseling.

Association for Counselor Education and Supervision (ACES) A division of *ACA* focused on issues critical to counselor educators and supervisors.

Association for Creativity in Counseling (ACC) A division of *ACA* focused on creative and expressive counseling.

Association for Humanistic Counseling (AHC) A division of *ACA* for those interested in humanistic counseling and education.

Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC) A division of *ACA* focused on a wide range of issues related to gender and sexual orientation.

Association of Marital and Family Therapy Regulatory Boards (AMFTRB) Regulatory body that helps states regulate the licensing process for *marriage, couple, and family counselors.*

Association for Multicultural Counseling and Development (AMCD) A division of *ACA* focused on cultural competence and other multicultural counseling issues.

Association for Play Therapy (APT) A professional association for creative and expressive helpers who focus on play and related activities.

Association for Specialists in Group Work (ASGW) A division of *ACA* that focuses on working in groups by focusing on such things as group counseling, group therapy, and pyschoeducational groups.

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) A professional association for those interested in values, ethics, or religion in counseling. A division of *ACA.*

Association of Social Work Boards (ASWB) Regulatory body that oversees the licensing process for *social workers.*

Atkinson, Donald Author of some of the seminal works published in the area of cross-cultural counseling.

Augustine During the Middle Ages, around 400. Augustine highlighted consciousness, self-examination, and inquiry as philosophies that dealt with the human condition.

autonomy One of *Kitchener's principle ethics* that has to do with protecting the independence, self-determination, and freedom of choice of clients.

Bandura, Albert Behavioral researcher who was the originator of social learning theory, sometimes called modeling. Through his research, he showed that people have the capacity to repeat behaviors that they have observed even at a much later time. One of the many theorists that fueled the diversity of counseling therapies during the 1950s and 1960s.

Basic Psychiatric-Mental Health Nurses (PMHN) *Psychiatric nurses* who generally do not have advanced degrees and can work with clients and families doing entry-level psychiatric nursing.

Beers, Clifford A Yale graduate who had been hospitalized for years due to schizophrenia, wrote *A Mind That Found Itself.* In 1909, he helped to establish the *National Committee for Mental Hygiene,* which lobbied the U.S. Congress to pass laws that would improve the deplorable conditions of mental institutions.

behavioral approaches Methods and approaches to counseling, which share the underlying assumption that behaviors are learned from a process of conditioning. Some of the major theorists include *Albert Bandura, Joseph Wolpe,* and *John Krumboltz.*

beneficence One of *Kitchener's principle ethics* that is related to promoting the good of society, which can be at least partially accomplished by promoting the client's well-being.

benefits of accreditation Advantages of counselor training programs that have obtained *CACREP* accreditation include better programs, better faculty, better students, a stronger professional identity, more field experiences, an easier time becoming credentialed, the maintenance of high standards, the possibility of having an easier time getting third-party reimbursements, and an easier time getting a job or getting into a doctoral program.

benefits of credentialing Credentialing offers many benefits including increased professional identity, increased sense of professionalism, demonstrating expertise within a profession, gaining parity, protecting the public, and more.

benevolent A characteristic of virtuous helpers which involves a genuine kindness and compassion. See also *moral models of ethical decision-making.*

best practices Practices, procedures, and techniques used by counselors that have been established as effective for particular populations or clients' presenting concerns.

Binet, Alfred Developed the first individual intelligence test. Late 1800s.

bisexual A type of *sexual orientation* in which one is attracted to more than one sex or gender.

board certification Qualification that demonstrates an individual has had additional experience in a specialty area. Board certification exists for the purpose of protecting of the consumer.

board certifications in psychology in 14 areas 14 specialty areas in the field of psychology in which one can become certified in.

board-certified coach Working with clients in a nontherapeutic manner that focuses on working toward goals. Coaching has become its own specialty area and individuals with a master's degree or higher in counseling can now become board-certified coaches through the *Center for Credentialing and Education.* See also *life-coaching.*

board certified in psychiatry A certification which demonstrates that a psychiatrist has had additional experience in the specialty area and has taken and passed a rigorous exam in that area.

board-certified physicians A certification which demonstrates that a physician has had additional experience in the specialty area and has taken and passed a rigorous exam in that area.

branches and regions of ACA The *American Counseling Association* has 56 chartered branches that include the 50 states, the District of Columbia, Puerto Rico, Latin America, the Virgin Islands, the Philippines, and Europe. ACA

also has four regional associations that support counselors throughout the United States: the North Atlantic Region, Western Region, Midwest Region, and Southern Region.

Brewer, John In 1932, he suggested that guidance be seen in a total educational context.

CACREP See *Council for Accreditation of Counseling and Related Educational Programs.*

career counseling A *CACREP* specialty area that focuses on helping an individual navigate the career development process.

career counselor A counselor who has obtained his or her master's degree in career counseling and focus on vocational and career issues.

Cattell, James Early philosopher who opened one of the first experimental psychology laboratories in the late 1800s.

CCE See *Center for Credentialing and Education*.

CCMHC See *Certified Clinical Mental Health Counselor.*

Center for Credentialing and Education (CCE) A credentialing body that offers a variety of credentials in the helping professions, including the *approved clinical supervisor* (*ACS*), *Human Services—Board-Certified Professional* (*HS—BCP*), and *Board-Certified Coach* (*BCC*).

cerebral electric stimulation A *neurological therapy* that involves electric stimulation of the brain to improve clients' functioning.

certification Usually set by states or by national organizations, this type of credential is more rigorous than registration but less rigorous than licensing. It often provides protection of a "title" (e.g., *certified counselor*), but generally does not define scope of practice. See also *licensure.*

Certified Clinical Mental Health Counselor (CCMHC) A specialty certification for mental health counselors that is offered through the *National Board for Certified Counselors* (*NBCC*).

Certified Family Therapist (CFT) A national certification developed by the International Association of Marriage and Family Counselors and sponsored by the *National Credentialing Academy* (*NCA*). This credential is open to those who have a master's in counseling or a related degree and a specialty in couples and family counseling.

certified genetic counselor (CGC) A credential obtained by individuals who have gone through a program accredited by *the Accreditation Council for Genetic Counseling.* Genetic counselors hold graduate degrees in any number of areas including law, medicine, and counseling.

certified pastoral counselors (CPCs) A professional certification for pastoral counselors offered by the *American Association for Pastoral Counselors.*

certified rehabilitation counselors (CRCs) A national credential for rehabilitation counselors offered by the *Commission on Rehabilitation Counselor Certification* (*CRCC*).

characteristics of the effective counselor Based on the *common factors,* includes attributes that counselors should strive for. See also *common factors.*

Charcot, Jean Martin One of the seminal theorists who practicing a new scientific technique called *hypnosis.* Mid 1800s.

Charity Organization Society (COS) Arising in the United States in the 1800s, an organization of volunteers who tried to alleviate the conditions of poverty by entering the poorer districts of cities and helping the residents there.

child development *Developmental theories* which emphasize the notion that children face predictable tasks as they passed through the inevitable developmental stages and that knowledge of such tasks could greatly aid counselors in their work with children.

child guidance clinics Clinics that were organized by the *National Committee for Mental Hygiene* in the early 1900s to improve the quality of services for children and their families.

Chi Sigma Iota (CSI) *CSI* is an honor society that promotes and recognizes scholarly activities, leadership, professionalism, and excellence in the profession of counseling.

Choosing a Career A booklet written by *Eli Weaver* in the early 1900s and helped to establish vocational guidance in New York.

Choosing a Vocation A book written by *Frank Parsons* that was used to establish *vocational guidance* in schools.

civil liability The responsibility one has as a result of having violated a legal duty to another.

Civil Rights Act One of a number of legislative acts during the 1960s that provided opportunity to minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

civil suits In counseling, lawsuits involving clients making legal allegations of alleged malpractice by counselors.

class See *social class.*

classical conditioning Behavior change brought about by pairing a conditioned stimulus (such as the sound of a bell) with an unconditioned stimulus (such as the sight of food) until the conditioned stimulus alone evokes a response (such as salivation). Developed by *Ivan Pavlov,* and expanded by *John Watson* and *Joseph Wolpe,* among others.

classifications of mental diseases A mechanism to understand and differentiate different mental disorders One of the original classification systems for *mental disorders* was developed by *Emil Kraepelin* in the mid-1800s.

client-centered theories Developed by *Carl Rogers* and part of the *existential-humanistic approach* to counseling, this approach was developed during the 1940s and its humanistic client-centered focus was a major shift from the psychoanalytic approach of Freud.

client-centered therapy: Its current practice, implications, and theory The second book that was published by *Carl Rogers* in the 1950s that impacted the shift in the counseling field toward a *humanistic, nondirective orientation*.

client/student One of the three areas that encompass the *Advocacy Competencies.*

clinical mental health counseling A *CACREP* specialty area that focuses on conducting mental health counseling in agencies or in private practice.

clinical mental health counselor A person who has obtained his or her master's degree in *clinical mental health counseling.*

clinical psychologist See *psychologist.*

clinical rehabilitation counseling A 60 credit *CACREP* specialty area that involves helping clients manage the physical, emotional, and social effects of disabilities. See also *rehabilitation counseling.*

COAMFTE See *the Commission on Accreditation for Marriage and Family Therapy Education.*

cognitive-behavioral therapy A conceptual orientation that involves a client and counselor investigating the relationship between the client's thoughts, feelings, and behaviors. Cognitive therapy is based on learning theory and focuses on the counselor helping the client to reframe thoughts or cognitions to influence the related emotions and behaviors when assisting clients in the change process.

cognitive complexity The ability to understand the world (and for counselors, to understand clients) in complex and multifaceted ways. One of the nine *common factors.*

collectivist perspective See *culturally competent helping.*

college counselors Generally, counselors who have graduated from a student affairs and college counseling master's program and who focus on helping at the postsecondary level.

College Student Educators International This organization was formerly the American College Personnel Association and has kept the acronym ACPA. It tends to focus on administration of student services.

Commission on Accreditation (CoA) This commission of the *American Psychological Association* currently sets standards for doctoral-level programs in counseling and clinical psychology.

Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) This association is affiliated with the *American Association of Marriage and Family Therapy* (*AAMFT*) and sets guidelines for marriage and family therapists and is often contrasted with couples, marriage, and family guidelines set by *CACREP.*

Commission on Rehabilitation Counselor Certification (CRCC) CRCC credentials rehabilitation counselors as *certified rehabilitation counselors* (*CRC*s).

committed in relativism Counselors who are more complex thinkers, flexible, empathic, sensitive to the contexts of ethical dilemmas, nondogmatic, and have viewpoints but are open to differing opinions.

common-core curriculum Eight areas that *CACREP* requires in the curriculum. Includes professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation.

common factors Elements in all counseling relationships that helpers should strive for in order to increase the likelihood of positive outcomes when working with clients and consumers. Includes having a working alliance (e.g., *empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence,* and *the it factor),* and *being able to deliver one's theoretical approach effectively* (*compatibility with and belief in your theory, competence,* and *cognitive complexity*).

community-based mental health centers Typically outpatient treatment facilities for clients who are living with a variety of *mental disorders.* Community mental health centers flourished in the 1960s as a result of the *deinstitutionalization* of hundreds of thousands of hospitalized patients who now needed to be seen in community-based clinics.

Community Mental Health Centers Act Passed in 1963, this legislative act provided federal funds for the creation of comprehensive mental health centers across the country, which greatly changed the delivery of mental health services.

community organizing During the early 1900s, this was part of the activities of early social workers who would join together, with community members, and focus on social justice and advocacy work in poorer communities in order to improve the lives of those who lived in those communities.

compatibility with and belief in a theory The degree to which counselors are drawn to particular theories based on similarity between worldview of the theory and attitudes and beliefs of the counselor. One of the nine *common factors.* See also *common factors.*

competence Being knowledgeable of the most recent professional research and trends and being able to apply it with clients. Having a thirst for knowledge. Knowing the limits of one's professional capabilities. One of the nine *common factors.* See also *common factors.*

competences for counseling LGBTQQIA Competencies endorsed by *ALGBTIC* for counseling individuals who identify as lesbian, gay, bisexual, transgender, questioning, queer, intersex, and ally.

competencies for counseling transgender individuals Competencies endorsed by *ALGBTIC* for counseling individuals who identify as transgendered.

complementary, alternative, and integrative therapies Therapeutic approaches which use a holistic approach that focuses on all aspects of a person's wellness, such as wellness assessment instruments, body awareness therapy, and scented oils to help people heal and become whole.

computers and related technologies Counselors now use computers and other technologies (e.g., interactive videos, CDs, DVDs) in *case management,* record keeping, *diagnosis, case conceptualization,* testing and assessment, *career counseling,* billing, marketing, and assisting clients in the learning of new skills (e.g., parenting skills, assertiveness training, *vocational skills training, counseling online,* online supervision, and more.

confidentiality The ethical guideline that stresses discretion and the knowledge of ethical, professional, and legal issues when retaining client information and knowing when confidentiality should be breached. See also *privileged communication.*

congruence/congruent See *genuineness.*

conversion therapy See *sexual orientation change efforts.*

coping self One of the five factors of the *individual self model* that includes having satisfactory leisure time, being able to deal with stress, feeling a sense of self-acceptance, being real with the self and others, absence of irrational beliefs, seeing reality in an accurate way.

CORE See *Council on Rehabilitation Education.*

Council for Accreditation of Counseling and Related Educational Programs (CACREP) The accreditation body for counseling programs, this council accredits master's programs in school counseling; clinical mental health counseling; marriage, couple, and family counseling; addiction counseling; career counseling; clinical rehabilitation counseling; and student affairs and college counseling as well as doctoral programs in counselor education and supervision.

Council for Standards in Human Service Education (CSHSE) The accreditation body for human service programs.

Council on Rehabilitation Education (CORE) An accrediting body for a rehabilitation counseling program accreditation. Recently, *CORE* and *CACREP* have developed a joint accreditation in clinical rehabilitation counseling.

Council on Social Work Education (CSWE) The accreditation body for social work programs.

counseling As defined by the *20/20 vision*, "counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals."

Counseling Association for Humanistic Education and Development Professional association for humanistic education now the *Association for Humanistic Counseling* (*AHC*).

counseling curriculum See *professional counseling identity.*

counseling men A type of gender aware therapy that focuses on men's issues in counseling. See also *gender aware counseling.*

counseling online Providing counseling services to clients online, through e-mail or live through Skype and related technologies. Increasingly, counselors may no longer sit directly across from the client; instead, they will be connected with the client electronically.

counseling psychologists See *psychologist.*

counseling skills Verbal and nonverbal communication skills that are used to enhance the *working alliance* between the client and counselor and help clients gain self-awareness while empowering them to make positive changes in their lives.

Counseling Today The monthly magazine that is a benefit of joining the *American Counseling Association*.

counselor A person who has a master's degree in counseling in one of a number of specialty areas including *school counseling; clinical mental health counseling; marriage, couple, and family counseling; addiction counseling; career counseling; clinical rehabilitation counseling;* and *student affairs and college counseling.*

Counselors for Social Justice A division of *ACA* for those interested in advocacy and other issues related to social justice.

COUNSGRADS The *American Counseling Association's* electronic mailing lists for graduate students.

countertransference The process in which the helper's own issues interfere with effectively helping his or her clients. The unconscious transferring of thoughts, feelings, and attitudes onto the client.

CRC See *certified rehabilitation counselors.*

CRCC See *Commission on Rehabilitation Counselor Certification.*

creative and expressive therapists Art therapists, play therapists, dance/movement therapists, poetry therapists, music therapists, and others who use creative tools to work with individuals who experience trauma or emotional problems in their lives.

creative self One of the five factors of the *individual self model* including the combination of elements that regulate one's responses to life events and provide a means to transcend the negative effects of these events.

credentialed school counselor Set by *State Boards of Education* who determine what *State-approved School Counseling Programs* need to offer for individuals to become certified, licensed, or endorsed in each state, with each state determining what word to use.

credentialing The process of becoming *registered, certified,* or *licensed* in one's professional field with licensure being the most rigorous and certification being more rigorous than registration.

criminal liability The responsibility under the law for a violation of federal or state criminal statute.

crisis, disaster, and trauma counseling This specialized area of training for counselors became mandatory with *CACREP's* 2009 standards.

cross-dresser An individual who enjoys wearing clothes of the opposite sex, formerly called *transvestite,* which is now considered derogatory by some.

cross-cultural counseling The practice of counseling that emphasizes the ability and readiness of a counselor to understand the cultural identity of a client and to be cognizant of how the client's cultural heritage as well as the counselor's attitudes, knowledge, and skills may impact the helping relationship.

Cross, William An author of seminal publications in the area of *cross-cultural counseling,* during the 1980s.

CSHSE See *Council for Standards in Human Service Education.*

CSI See *Chi Sigma Iota.*

CSJ See *Counselors for Social Justice.*

CSW See *Council on Social Work Education.*

cultural competence The gaining of the necessary attitudes, skills, and knowledge to be able to work with a wide variety of ethnically and culturally diverse clients. One of the *nine common factors.* See also *common factors.*

culturally competent helping The ability and readiness to understand the cultural identity of a client and to be cognizant of how the client's cultural heritage may impact the helping relationship. Also, understanding the unique issues of clients (*individual identity*), how *culture* impacts them (*their group identity*), shared human experiences (*the universal identity*), and determining if a client relies more on an *individualistic perspective* (focus more on self) or a *collective perspective* (focus more on the group).

cultural mosaic A society that has many diverse values and customs.

culture The common values, habits, norms of behavior, symbols, artifacts, language, and customs that people may share.

culture-specific skills Counseling skills and approaches that are unique to working with individuals from specific cultural backgrounds.

Davis, Jesse Developed one of the first guidance curriculums in Grand Rapids, Michigan, schools in 1907.

DCSW See *Diplomate in Clinical Social Work.*

de-emphasizing of Social Forces The false assumption by counselors that all problems are intrinsically created, and one reason why some clients from nondominant groups are dissatisfied with the helping relationship.

deinstitutionalization A social change occurring in the late 1970s whereby patients who had been held against their will and were not in danger of hurting themselves or others were released from psychiatric hospitals. See also *Donaldson v. O'Connor.*

delusive perceptions Misinformed thoughts and ideas that lead to problematic and negative consequences.

Descartes Philosopher who postulated that knowledge and truth were derived through deductive reasoning.

developmental counseling and therapy Counseling approaches which assume that matching interventions to clients' developmental levels will help them make progress in counseling and develop new neurological connections.

developmental models of cultural/racial identity A variety of models that examine how individuals from various cultural/racial groups pass through unique stages of development as they become increasingly aware of their cultural selves.

developmental models of ethical decision-making Models that examine the manner in which an individual views an ethical dilemma, which generally can be seen on a scale from being dualistic, or rigid and concrete, to relativistic, flexible, and open. See also *dualistic, relativistic.*

developmental theories Theories that emphasize the notion that individuals would face predictable tasks as they passed through the inevitable developmental stages of life and that knowledge of such tasks could greatly aid counselors in their work with clients.

diagnosis The process of identifying a *mental disorder,* which is typically done through counselors using the *Diagnostic and Statistical Manual (DSM).*

Diagnostic and Statistical Manual (DSM) Developed by the *American Psychiatric Association*, a manual that details the different types of mental disorders and emotional problems. See also *mental disorders.*

Diagnostic and Statistical Manual-5 (DSM-5) The fifth edition of the *Diagnostic and Statistical Manual.* See also *Diagnostic and Statistical Manual.*

dialectical behavior therapy (DBT) Therapeutic approach that uses a mixture of mindfulness, behavioral analysis, and cognitive techniques.

Diplomate in Clinical Social Work (DCSW) See *licensed clinical social worker.*

directive theories Theories of counseling that emphasize that clients require guidance from counselors to make changes in their lives.

discrimination An active behavior that negatively affects individuals of ethnic, cultural, and racial groups.

diverse grad-L The *American Counseling Association's* electronic mailing lists for those who are interested in diversity issues.

division expansion and autonomy Some of *ACA's* 20 divisions, such as *ASCA* and *AMHCA,* have

become increasingly autonomous and no longer required membership in *ACA* to be a member of their division.

division 17 of the APA A division of the *American Psychological Association* that focuses on counseling psychology.

division 16 of the APA (School Psychology) A division of the *American Psychological Association* for school psychologists.

divisions of ACA The *American Counseling Association* currently sponsors 20 divisions, all of which maintain newsletters and journals and provide a wide variety of professional development activities.

division 12 of the APA (the Society of Clinical Psychology) A division of the *American Psychological Association* for clinical psychologists.

Dix, Dorothea Fought for humane treatment of the mentally ill in the mid-1800s.

doctoral degree in counselor education and supervision An advanced degree in *counseling* that typically prepare counselors for faculty positions in counselor training programs and leadership positions in counseling practice.

Donaldson v. O'Connor The 1975 U.S. Supreme Court decision that stated that a person who is not dangerous to self or others could not be confined in a psychiatric hospital against his or her will.

DSM See *Diagnostic and Statistical Manual.*

DSM-5 See *Diagnostic and Statistical Manual-5.*

dualistic A perspective in which one views the world in terms of black-and-white thinking, concreteness, rigidity, oversimplification, stereotyping, self-protectiveness, and authoritarianism.

Economic Opportunity Act One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

Education for All Handicapped Children Act (PL94-142) Ensured the right to an education within the least restrictive environment for all children identified as having disabilities that interfered with learning in 1975.

ego According to Freudian theory, the conscious portion of the psyche that is the mediator between the person and reality, especially in the functioning of the person's perception of and adaptation to reality.

electroconvulsive therapy A treatment approach that involves stimulating the brain with electric shock in an effort to provide relief from certain *mental disorders,* particularly major depression.

Elementary and Secondary Education Act An act that was passed in the late 1960s allocated funding to promote improvement in the quality of elementary and secondary education. One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

Elizabethan Poor Laws During 1500s, established legislation for the Church to help the destitute in England.

Ellis, Albert Founder of *rational emotive behavior therapy* (*REBT*). One of the many theorists that fueled the diversity of counseling theories during the 1950s and 1960s.

emotional intelligence The ability to monitor one's emotions, seems to be related to knowing the appropriate time to share one's feelings and thoughts (be genuine) with the client.

empathy Originally derived from the German word Einfühlung, empathy has become a core counseling skill. Popularized by *Carl Rogers* and listed as one of his three core conditions of helping along with *genuineness* (*congruence*) and *unconditional positive regard,* it is today viewed as the ability to understand another person's feelings and situation in the world. High-level empathic responses are seen as helping a client see hidden parts of himself or herself. One of the nine *common factors.* See also *common factors.*

end-of-life care Providing counseling services to clients who are living with terminal illness or other end of life issues. The *ACA Code of Ethics* states that when counselors have values conflicts with their clients (e.g., differences on end-of-life suicide decisions, abortion, sexual orientation), they should seek out supervision, consultation, and/or further education as opposed to exiting the situation. However, counselors can refer someone due to incompetence or lack of training.

endorsement One of the most basic ways a professional can be acknowledged is through an endorsement by a professional association or other professional body. Does little more than acknowledging that the professional has met basic standards.

Eriksen's psychosocial theory One of the *postpsychoanalytic models* that moved significantly away from stressing the role *instincts* play in the formation of the *ego* and toward the importance of relationships in ego formation. Ericksen's theory focuses on eight developmental stages that individuals pass through from birth to death. In each stage, one must resolve a conflict before progressing to the subsequent stage.

essential self One of the five factors of the *individual self-model* that includes essential meaning-making processes in relation to life, self, and others.

ethical decision-making models A number of models that assist a helper when faced with difficult and complex ethical decisions. See also the following models of ethical decision-making: developmental, moral, problem-solving, and social constructionist.

Ethical Standards of Practice Developed by professional associations to guide the professional conduct of professionals.

ethnicity When a group of people share long-term patterns of behavior that include specific cultural and social patterns such as a similar language, values, religion, foods, and artistic expressions.

ethics Principles and guidelines that specify how professional should act.

Ethics Code of the American Counseling Association A code that helps guide counselors toward the appropriate ways of responding when making ethical decisions. The sections include the following: Section A: The Counseling Relationship; Section B: Confidentiality and Privacy; Section C: Professional Responsibility; Section D: Relationships with Other Professionals; Section E: Evaluation, Assessment, and Interpretation; Section F: Supervision, Training, and Teaching; Section G: Research and Publication; Section H: Distance Counseling, Technology, and Social; and Section I: Resolving Ethical Issues.

ethnocentric The potentially harmful assumption that one's view of the world is the same as his or her client's.

ethnocentric worldview Those who view the world through the lens of their own culture and falsely assume clients view the world in a similar manner or believe that when clients present a differing view, they are emotionally disturbed, culturally brainwashed, or just simply wrong.

evaluation in the program The fourth area that CACREP evaluates in master's level training programs; this includes assessment of the following: program mission and objectives, curricular offerings, and characteristics of program students and applicants. See also *master's-level standards.*

evidence-based practice The matching of treatment approaches or methods with clients' presenting problems.

existential psychology A subspecialty of psychology that is based loosely on some of the early existential philosophers and humanistic theorists, focuses on struggles of living, how individuals construct meaning, the subjective reality of the client.

experimental psychologists Psychologists who typically work laboratories and conduct research to attempt to understand the psychophysiological causes of behavior.

eye movement desensitization response (EMDR) A type of therapy that focuses on how rhythmic stimulation (e.g., rapid eye movements, tapping) can lessen symptoms associated with traumatic events.

eye movement integration therapy (EMIT) Similar to *eye movement desensitization therapy,* this new neurophysiological approach attempts to help individuals adapt new neuropathways.

Eysenck Researcher who conducted a controversial and flawed study suggesting counseling was not effective, subsequent research has demonstrated overwhelming evidence that counseling is helpful.

faculty and staff See *Learning environment.*

Family Systems An early focus of social workers which influenced the counseling profession's focus on couples and families work.

Feminist Therapy A type of therapy that focuses on women's issues. See also *gender-aware therapy.*

fidelity One of *Kitchener's principle ethics* that is related to maintaining trust (e.g., keeping conversations confidential) in the counseling

relationship and being committed to the client within that relationship.

first comprehensive theory of counseling Developed by *E. G. Williamson* (1900–1979) Also known as the *Minnesota point of view* or *trait and factor theory.* Williamson's approach initially grew out of the ideas of Frank Parsons.

first licensing law for counselors In 1976, Virginia passed the first law that granted *licensure* for *counselors,* and other states soon followed suit.

foreseeable harm Circumstances and situations in which there is a predictable and probable chance that a client or someone else is at risk for being harmed.

foundational rules Guidelines and regulations for practicing counseling or when making ethical decisions (e.g., protecting the autonomy of the client; promoting the good of society).

foundation of the program See *Professional Counseling Identity.*

founder of guidance See *Frank Parsons.*

founder of the counseling field See *Frank Parsons.*

fourth and fifth forces Multicultural counseling and advocacy are sometimes called the fourth and fifth forces, as their importance follows that of psychodynamic counseling, behaviorism, and humanism.

Frankl, Viktor An *existential-humanistic* theorist who is considered one of the founders of *existential therapy.* One of the many theorists that fueled the diversity of counseling theories during the 1950s and 1960s.

Freud, Sigmund Founder of *Psychoanalysis,* the first comprehensive approach to psychotherapy. Freud developed his theory in the late 1800s to mid 1900s after dabbling with hypnosis at which point he realized that many of his patients' symptoms had psychological, not physical origins. His psychosexual model of development offered one perspective on how personality is formed.

friendly visitors Volunteers who worked with the poor and deprived for *Charity Organization Societies.* Frequently stressed moral judgment and religious values while helping these individuals.

Galton, Sir Francis Around 1859, an early experimental psychologist.

gay Usually referring to men who have a same-sex attraction. Sometimes used to refer to lesbians.

gender aware therapy Approaches to counseling that focus on the ways that men and women are impacted by cultural stereotypes and how each gender can develop new, more adaptive roles.

Genetic Counseling Counseling individuals for problems associated with having, or potentially have, a genetic disorder.

genuineness The quality of expressing one's true feelings. Being congruent or in sync with one's feelings, thoughts, and behaviors. Popularized by Carl Rogers and listed as one of his three core conditions of helping along with empathy and unconditional positive regard. One of the nine *common factors* sometimes called *congruence.* See also *common factors.*

Gestalt Psychology Founded by *Fritz Perls* who postulated that we are born with the capacity to embrace an infinite number of personality dimensions. With the mind, body, and soul operating in unison, the individual is in a constant state of need identification and need fulfillment. However, parental dictates, social mores, and peer norms prevent a person from attaining a need and results in resistances or blockages to the experiencing of the person's needs. Needs therefore get pushed out of awareness. Stated that experience = awareness = reality.

Glasser, William Founder of *reality therapy.* One of the many theorists that fueled the diversity of counseling field during the 1960s.

globalization The international expansion of the counseling expansion. See also *International Registry of Counselor Education Programs (IRCEP).*

Globalization of Counseling The fact that counseling has become international as countries develop counseling programs, develop their own counseling styles, and adapt credentialing processes.

Great Society The term given to the numerous social programs generated by President Lyndon Johnson.

group identity See *culturally competent helping.*

group level Aspects of a person that can vary based on the cultural and ethnic groups to which he or she identifies with. See *culturally competent helping* and *tripartite model of personal identity.*

group work Although group work includes a wide range of group counseling and related activities.

It was an early focus of social workers that came out of the work of those in *Charity Organization Societies* and the *Settlement Movement.*

guidance The word *guidance* first appeared around the 1600s and was defined as "the process of guiding an individual."

Guidance Counselor A word formerly used to describe what today is known as *school counselor.*

Hall, G. Stanley Late 1800s, he founded the *American Psychological Association;* early American experimental psychologist.

Head Start A federally funded program, started in the 1970s that provides an intellectually stimulating and nurturing environment to disadvantaged preschool children. One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

health care management The overarching administration of health care issues. Counselors will increasingly be dealing with a wide variety of health care issues related to the Affordable Care Act, and their ability to be providers for a wide range of insurance and health care management systems (e.g., HMOs, TRICARE, VA Hospitals).

Healthcare Providers Service Organization Organization that has partnered with the *ACA insurance trust* to offer professional liability insurance.

Helms's White Identity Model A model for increasing counselors' competency for working with clients from diverse cultures.

hermaphrodite A person born with a combination of male and female genitalia. Now called an *intersex* person.

heterosexist Formerly referred to as *homophobic,* this is a person who views those who are not heterosexual as behaving wrongly.

Hippocrates Wrote the first "modern-day" reflections on the human condition. Around 400 BCE.

History of CACREP See *Standards for the preparation of counselors and other personnel service specialists.*

homophobic See *heterosexist.*

HS—BCP See *Human Services Board Certified Practitioner.*

Hull House A Settlement House established by *Jane Addams* in Chicago in 1899.

humanistically oriented therapies Classification of helping therapies that emphasize the importance of focusing on the present, free will, and creating Egalitarian relationships with clients.

Human Service Professional An individual who has received an associate's, a bachelor's, or an advanced degree in human services, or has the equivalent, and who practices based on the guidelines of the *Council for Standards in Human Services Education* and the *National Organization of Human Services.*

Human Services Board Certified Practitioner (HS—BCP) A national certification for human service professionals developed by the *Center of Credentialing in Education* (*CCE*).

Hypnosis/Hypnotherapy Counseling technique where the counselor induces his or her client into a trancelike state of consciousness. In this state, it is believed that clients can gain self-awareness, make progress, and develop neuropathways.

IAAOC See *International Association of Addictions and Offender Counselors.*

IAMFC See *International Association of Marriage and Family Counselors.*

ignorance of one's own racist attitudes and prejudices A person who has not spent time examining his or her own racist attitudes and prejudices and will unconsciously project negative and harmful attitudes onto others.

incongruent expectations about counseling The helping relationship tends to be based on Western values and consequently stresses the importance of expression of feelings, self-disclosure, cause-and-effect thinking, open-mindedness, and internal locus of control.

individual identity See *culturally competent helping.*

individual level See *culturally competent helping* and *tripartite model of personal identity.*

individualistic perspective See *culturally competent helping.*

indivisible self One model that views wellness as the conglomeration of five factors: *creative self, coping self, social self, essential self,* and *physical self* as well as the individual's context.

institution See *Learning environment.*

Institutional Racism When an agency or organization purposely, or out of ignorance, supports policies or behaviors that are racist.

integrity A characteristic of *virtuous helpers* that involves being honest.

International Association of Addictions and Offender Counselors (IAAOC) A division of *ACA* that focuses on substance use and abuse and counselors who tend to work in the criminal justice system.

International Association of Marriage and Family Counselors (IAMFC) A professional association for marriage and family counselors. A division of *ACA*.

International Registry of Counselor Education Programs (IRCEP) An organization that was created by *CACREP* in 2009 to assist in the approving of international counseling programs and the creation of standards.

intersex Formerly referred to as *hermaphrodite,* is a person born with a combination of male and female genitalia.

irrational thinking Patterns of thought or cognitions that are illogical and are often related to the subsequent development of negative emotions.

it factor The unique characteristics of a counselor that contribute to special ways of working with and ultimately building alliances with their clients. One of the nine *common factors.*

James, William Late 1800s, he came up with the idea of philosophical pragmatism which states that reality is continually constructed as a function of its utility or practical purpose.

Janet, Pierre A French psychologist who saw a relationship between certain psychological states and disorders that were formerly considered only organic in nature. Around 1900.

Job corps One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

joining A term that *Salvadore Minuchin* used to describe the manner in which individuals build relationships with clients. Related to the *it factor*.

Journals of ACA Divisions Professional journals that are available based on membership in *ACA* and its division.

Journal of Counseling and Development The professional journal of the *American Counseling Association*. Free subscriptions are available to *ACA* members.

justice One of Kitchener's *principle ethic*s that involves counselors providing equal and fair treatment to all clients.

Kitchener, Karen Established a *principle ethics model* that describes the role of six principles in ethical decision-making including *autonomy, nonmaleficence, beneficence, justice, fidelity,* and *veracity.*

Kraepelin, Emil Developed one of the first classifications of mental diseases. Around 1900. See also *classifications of mental diseases.*

Krumboltz, John A behavioral theorist who had many of his ideas adapted to the career counseling process. One of the many theorists that fueled the diversity of counseling theories during the 1950s and 1960s.

Laboratory Science A focus of psychology that grew out of the work of the early experimental psychologists and influenced the use of tests and research in the practice of psychology and counseling.

LCSW See *licensed clinical social worker.*

learning environment One of the four primary areas that CACREP examines in accrediting master's program. This aspect of the accreditation process sets minimal standards for the institution as a whole (the college or university), the academic unit (the counseling program), and for faculty and staff.

lesbian Women who have a same-sex attraction.

lesbian, gay, bisexual, transgender, intersex, and asexual (LGBTIA) A term that refers to a variety of *sexual orientations* and *gender identities.*

Licensed clinical social worker (LCSW) A state-sponsored credential for licensed social workers. Two other, more advanced credentials that generally require a license in social work include the *qualified clinical social worker* and the *Diplomate in Clinical Social Work.*

Licensed Marriage and Family Therapist (LMFT) A state-sponsored credential for licensed marriage and family therapists that generally follows *COAMFTE* or *CACREP* curriculum standards. See also *COMAFTE and CACREP*

licensed professional counselor (LPC) Credential for licensed counselors.

licensed psychologist Credential for licensed *psychologists.*

licensure This most rigorous form of *credentialing* is generally set by the state and requires a minimum educational level, usually a state or national exam, and additional documentation of expertise such as evidence of post education supervision. Often protects the title and the scope of practice of the professional. See also *certification.*

Licensure Committee The original committee, established in 1974 by the *American Counseling Association*, to assist in state licensure of counselors.

licensure portability Sometimes called *reciprocity,* this is the idea that one can easily "move" their license from one state to another. Currently, licensed counselors often have difficulty with moving their license and ACA and other associations are currently assisting states in developing license portability.

life-coaching Life-coaching is a helping relationship where most time is spent finding solutions and goals are emphasized. This is viewed as a partnership rather than as a therapeutic relationship, is strength-based, does not require diagnosis or third-party payments, and is often conducted in a less-structured environment than counseling.

lifespan development Models of understanding the development of the person that stress that individuals continue to grow throughout their lives.

LMFT See *licensed marriage and family therapist.*

Lobbying Advocacy efforts that professional associations take to introduce and/or defeat legislation. Lobbying has become crucial to the survival of the counseling profession, through such efforts as the establishment of state licensure and elementary school counseling.

Locke, John Believed the mind is a blank slate upon which ideas are generated. Around 1750.

LPC See *licensed professional counselor.*

MAC See *master addictions counselor.*

macrolevel A perspective that focus on the larger system when conceptualizing professional counseling topics.

malpractice insurance Insurance policies for counselors that provide coverage if a counselor is sued for *malpractice.*

Manpower Development and Training Act One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

marriage, couple, and family counseling A *CACREP* or *COAMFTE* specialty area that focuses on marriage, couples, and family counseling.

marriage, couple, and family counselors An individual who has obtained his or her master's degree in counseling or marriage and family therapy

master addictions counselor (MAC) Specialty certification for addiction counselors that is offered by the National Board for Certified Counselors (NBCC).

Master's in Psychology and Counseling Accreditation Council (MPCAC) A new accrediting body for master's level training programs in psychology and counseling. This accreditation body competes with CACREP, but currently only has accredited a handful of programs.

master's in social work (MSW) Graduate degree for social workers.

master's-level standards Standards set by *CACREP* for earning a master's degree in counseling that include four primary areas: *learning environment, professional counseling identity, professional practice,* and *evaluation in the program.*

May, Rollo Influential *existential* theorist who contributed to the diversity of the counseling field during the 1950s and 1960s.

MCGA See *Military and Government Counseling Association*.

media See *social media.*

melting-pot myth The misnomer that various values and customs of different cultures become integrated and subsumed into the larger culture. See also *cultural mosaic.*

membership benefits of ACA Membership in *ACA* provides a number of unique opportunities and benefits, including subscriptions to professional journals, professional development opportunities, networking opportunities, consultation on ethical issues and ethical dilemmas, legislative updates and policy setting for counselors, links to *ACA* listservs and interest networks, computer-assisted

job search services, professional liability insurance, graduate student scholarships, and more.

mental disorder A condition that influences one's thoughts, feelings, or behaviors that causes suffering or inhibits one's ability to function. See also *Diagnostic and Statistical Manual-5.*

Mesmer, Anton A contemporary of *Sigmund Freud* who influenced him to practice hypnosis. The name from which the word *mesmerized* was derived. Around 1800.

Mesmerize See *Mesmer, Anton*.

microaggressions Conscious or unconscious *discrimination* that includes brief, subtle, and common putdowns or indignities directed toward individuals from diverse cultures.

microcounseling skills training Based on many of the skills deemed critical by *Carl Rogers* and other humanistic counselors and psychologists, these packaged ways of training counselors showed that basic counseling skills, such as attending behaviors, listening, and empathic understanding, could be learned in a relatively short amount of time and that the practice of such skills would have a positive impact on counseling outcomes.

microlevel A perspective that focus on the *individual level* when conceptualizing professional counseling topics.

Military and Government Counseling Association (MCGA) A division of *ACA* that mostly focuses on military counselors and other counselors and educators in government.

Mill, James Around 1800. Believed the mind is a blank slate upon which ideas are generated.

Minnesota Point of View See *first comprehensive theory of counseling.*

minority Any group of people who are being singled out because of their cultural or physical characteristics and who are being systematically oppressed by those individuals who are in a position of power. See also *nondominant group.*

Minuchin, Salvador Developed structural family therapy and highlighted the importance of *joining* in when working systemically with families. See also *joining.*

Mirror of Men's Lives First job classification system was developed in 1468 by *Sanchez de Arevalo.*

morality Generally concerned with individual conduct and often reflects the values from an individual's family, religious sect, culture, or nationality. In counseling, related to some types of ethical decision-making. See also *moral models of ethical decision making.*

moral models of ethical decision-making *Ethical decision-making models* that stress moral principles in ethical decision-making, such as *principles* that can guide the helper or *virtues* the helper should consider. *See* also *Kitchener, principle ethics model,* and *virtue ethics model.*

motivational interviewing An approach to counseling that uses empathy, change talk, collaboration, and gentle nudging to induce change in clients.

MSW See *master's in social work.*

Multicultural counseling The application of culturally relevant theories and interventions including a counselor's ability and readiness to understand the cultural identity of a client and to be cognizant of how the client's cultural heritage may impact the helping relationship.

multicultural counseling competencies Delineate attitudes and beliefs, knowledge, and skills in three areas: the counselor's awareness of the client's worldview, the counselor's awareness of his or her own cultural values and biases, and the counselor's ability to use culturally appropriate intervention strategies.

multimodal therapy An approach to counseling that assesses a wide range of client domains.

NASP See *National Association of School Psychologists.*

NASW See *National Association of Social Workers.*

National Academy for Certified Mental Health Counselors (NACMHC) NACMHC, during the 1970s, offered one of the first certifications for counselors. Today, this certification is subsumed by the *National Board for Certified Counselors* and is called a *Certified Clinical Mental Health Counselor (CCMHC).*

National Association of School Psychologists (NASP) A professional association for school psychologists.

National Association of Social Workers (NASW) Professional association for social workers.

National Board for Certified Counselors (NBCC) An organization that sponsors certification of counselors as *National Certified Counselors* (*NCCs*) and in three specialty areas: *National Certified School Counselor, Clinical Mental Health Counselor,* and *Master Addiction Counselor.*

National Career Development Association (NCDA) A division of *ACA* that focuses on vocational and career assessment and counseling.

National Certified Counselor (NCC) Certification as a counselor that requires a master's degree and additional training and supervision offered by the *National Board for Certified Counselors* (*NBCC*). Requires passing the *National Counselor Exam* (*NCE*).

National Certified School Counselor (NCSC) Subspecialty certification for school counselors that is offered by the *National Board for Certified Counselors* (*NBCC*).

National Certified School Psychologist (NCSP) A certification that one gains after having successfully graduated from a state-approved school psychology program.

National Clinical Mental Health Counselor (NCMHC) A credential for clinical mental health counselors that one obtains through the *National Board for Certified Counselors* after having become a *National Certified Counselor.*

National Clinical Mental Health Counselor Exam (NCMHCE) The examination that one must pass to become a *National Clinical Mental Health Counselor.*

National Committee for Mental Hygiene National Defense Education Act (NDEA) An act that was passed in 1958 and allocated funds for training institutes that would quickly graduate secondary school counselors. These counselors, it was hoped, would identify students gifted in math and science who could be future scientists. Was critical to the spread of school counselors.

National Counselor Certification Certification as a counselor that requires a master's degree and additional training and supervision. Offered by the *National Board for Certified Counselors.*

National Counselor Exam (NCE) Examination that one must pass to become a *National Certified Counselor* (*NCC*).

National Credentialing Academy (NCA) The organization that offers credentialing as a *certified family therapist*, sponsored by the *International Association of Family Counselors.*

National Employment Counseling Association (NECA) A division of *ACA* focused on issues related to employment and career counseling.

National League for Nursing Along with the American Association of Colleges of Nursing An accreditation association for psychiatric-mental health nursing programs.

Nationally Certified School Psychologists (NCSP) A credential for school psychologist.

National Organization for Human Services (NOHS) The professional organization for human service professionals.

National portability See *portability.*

National Rehabilitation Counseling Association (NRCA) A professional association for rehabilitation counselors.

National Vocational Guidance Association (NVGA) Founded in 1913 as a professional association for vocational guidance counselors, it is considered to be the forerunner of the *American Counseling Association.*

NBCC See *National Board for Certified Counselors*

NCC See *National Certified Counselor.*

NCDA See *National Career Development Association.*

NCE See *National Counselor Exam.*

NCSC See *National Certified School Counselor.*

NCSP See *National Certified School Psychologist.*

NECA See *National Employment Counseling Association.*

neurofeedback See *neurological and psychophysiological therapies.*

neurological and psychophysiological therapies Called by some the final frontier of counseling, these include a wide range of approaches that are based on the *neuroplasticity* of the brain, involve *neuroprocessing, neurofeedback,* and assume that there is an intimate relationship between psychological and neurological change.

neuroplasticity The ability of the brain to change neural pathways and develop new neural pathways.

neuroprocessing The ability to take in and understand information and how such information impacts the neural pathways.

NOHS See *National Organization for Human Services.*

nondirective approach Usually credited to Carl Rogers, this process involves a clinical process in which the counselor trusts the client's ability to develop the strategies for change in the helping process. This view is in opposition to *directive approaches.*

nondominant group A term used instead of the word *minority* due to negative conations sometimes associated with that word.

nonmaleficence One of *Kitchener's principle ethics* regarding the concept of "do no harm" when working with clients.

NVGA See *National Vocational Guidance Association*.

organizations that partner or support ACA Affiliates and organizations that partner with *ACA* and contribute to the betterment of the counseling profession in unique ways. Some of these include *NBCC, CACREP, CORE, CSI,* and *ACAF.*

Parsons, Frank Founder of *vocational guidance* and an important figure in the subsequent development of the counseling profession. Parsons has been referred to as the *founder of the counseling field* and the *founder of guidance*.

pastoral counselors Religious counselors or counselors with spiritual orientations.

Pavlov, Ivan Behavioral researcher who was the originator of *classical conditioning* through his research showed that a hungry dog that salivated when shown food would learn to salivate to a tone if that tone were repeatedly paired or associated with the food. Around 1900.

Pedersen, Paul An author of some of the seminal works on *cross-cultural counseling*.

Perls, Fritz An *existential-humanistic* theorist who developed *Gestalt Therapy.* One of the many theorists that fueled the diversity of counseling theories during the 1950s and 1960s.

Perry, William An adult development theorist who emphasized the learning process and cognitive development of college students. See also *dualism, relativism, and commitment to relativism.*

phenomenological psychology Emphasizes the nature of existence and the study of reality. See also *existential psychology.*

philosophical pragmatism Belief system emphasizes that reality is continually constructed as a function of its utility or practical purpose.

physical self One of the five factors of the *individual self model* that includes engaging in sufficient physical activity to keep in good physical condition; maintaining flexibility through stretching and eating a nutritionally balanced diet; maintaining a normal weight and avoiding overeating.

Pinel, Philippe Founder of the field of psychiatry; viewed insanity from scientific perspective; advocated for humane treatment of the mentally ill. Around 1800.

Plato Influential philosopher who believed introspection and reflection to be the road to knowledge. Around 350 BCE.

Plotinus Believed in dualism or the concept that the soul is separate from the body. Around 250 AD.

portability Sometimes called *reciprocity,* the process of transferring credentials from state to state.

positive psychology Approach that helps clients (and non-clients) focus on their strengths and assists them in developing a positive framework so they can live more fulfilling lives.

positive regard Being nonjudgmental and accepting of clients. See also *acceptance.*

postmodernist Questions many of the basic assumptions taken for granted as a result empiricism and the scientific method and suggests there is no one way to understand the world, no foundational set of rules to make sense of who we are, and no one way of understanding a person. These individuals question "truth" and question many of the basic tenets of popular therapies that suggest certain structures cause mental health problems

postpsychoanalytic models Models that have moved significantly away from stressing the role *instincts* play in the formation of the *ego* and toward the importance of relationships in ego formation. Some of the more popular approaches include *Eriksen's psychosocial theory, relational psychoanalysis, self-psychology,* and *relational-intersubjectivity approaches.*

Posttraumatic stress disorder (PTSD) A *mental health disorder* induced by an exposure to a traumatic event that involves a recurrence of trauma-related symptoms such as nightmares, flashbacks, and severe anxiety.

power differential Differing degrees of control, authority, or influence over others that can be real or perceived and are a function of such things as race, class, gender, occupation, socioeconomic status, or a host of other factors.

prejudice Judging a person or a group based on preconceived notions about the group.

principle ethics Ethical decision-making that revolves around *moral* principles. See also *moral models of ethical decision-making*.

privileged communication As determined by the state, the legal right of a professional (lawyer, priest, physician, or licensed therapist) to not reveal information about a client.

problem-solving models of ethical decision-making *Ethical decision-making models* that provide a step-by-step approach to making

ethical decisions. Hands-on and practical, they are particularly useful for the beginning counselor.

professional associations In the mental health fields, organizations that support the philosophical beliefs of a particular discipline and offer a wide range of professional activities and benefits.

professional counseling identity The second primary area that *CACREP* reviews, professional counseling identity, focuses on the *foundation of the program* and the *counseling curriculum.* See also *master's-level standards.*

professional practice The third primary area that *CACREP* requires for program accreditation that focuses on the students' development of counseling theory and skills while under supervision. See also *master's-level standards.*

protection of a title The protection of professional credentials that attest to a person's attainment of a certain level of competence, but does not speak to the scope of practice.

prudent A characteristic of virtuous helpers that involves being careful and tentative in their decision-making.

psyche The totality of one's conscious and unconscious experience.

psychiatric-mental health nurse A nurse who has received specialized training as a mental health professional. The advanced psychiatric-mental health nurse is called an *Advanced Practice Registered Nurse* (*APRN*).

psychiatric-mental health nurse credentialing A professional credential for *Psychiatric-Mental Health Nurses.*

psychiatry credentialing The credentialing process for psychiatrists that involves becoming a licensed physician and usually a *board-certified* psychiatrist.

psychoanalysis Developed by *Freud,* the belief that instincts (e.g., hunger, thirst, survival, aggression, and sex) are strong motivators of behavior and satisfying them is mostly an unconscious process. Defense mechanisms (e.g., rationalizing, repression) are developed to manage instincts. Early child-rearing practices, as applied through the oral, anal, and phallic psychosexual stages in the first six years of life, are responsible for how defenses are developed and result in normal or abnormal personality development. Effects of early childhood practices are observed in adolescence and adulthood in what are called the latency and genital psychosexual stages.

Psychoanalytic Movement The first comprehensive psychotherapeutic system. Developed by *Sigmund Freud* psychoanalysis was influenced by the new emphasis on the scientific method.

Psychobiology A focus on the interaction of psychology and biology and related to the early roots of psychoanalysis and of psychiatry.

psychodynamic approaches A conceptual orientation that includes *psychoanalysis,* analytical therapy (jungian therapy), individual therapy (adlerian therapy), and other approaches to the helping relationship. To some degree, all suggest an unconscious and a conscious effect of the functioning of the person in some deeply personal and dynamic ways, all look at early child-rearing practices as important in the development of personality, and all believe that the past and the dynamic interaction of the past with conscious and unconscious factors are important in the therapeutic process.

psychological and educational tests The beginning of the twentieth century saw the first use of school achievement tests, vocational assessment, and some of the first modern day personality tests.

Psychology Board Certifications Established by the *American Board of Professional Psychology (ABPP)* one of 14 *board certifications* for psychologists, including clinical child and adolescent psychology, clinical health psychology, clinical neuropsychology, clinical psychology, cognitive and behavioral psychology, counseling psychology, couple and family psychology, forensic psychology, group psychology, organizational and business consulting psychology, police and public safety psychology, psychoanalysis, rehabilitation psychology, and school psychology.

psychology credentialing Credentials in psychology that most commonly include licensed psychologist, psychology board certifications, credentialed school psychologist, certified school psychologist.

psychopharmacology The scientific study of the effects that drugs have on the mind, body, and behavior.

psychologist Generally, a person who holds a doctoral degree in counseling psychology, clinical psychology, or a *Psy.D.*; has completed

an internship at a mental health facility; and has passed specific state requirements to obtain licensure as a *psychologist.*

psychopharmacological drugs Medications that are used to treat the signs and symptoms of *mental disorders.*

psychotropic medications Medications that affect psychological functioning, which are often classified into five groups: antianxiety agents, antidepressants, antipsychotics, mood-stabilizing drugs, and stimulants.

psychotherapist Although generally not licensed by states, on a practical level, a person who has an advanced degree in psychology, social work, or counseling and who works in a mental health setting or in private practice, providing individual, marital, or group counseling.

psychotherapy Generally seen as the practice of working long-term with a client in the "there and then" and focusing on life stories, deep-seated issues, personality reconstruction, the unconscious, deep client revelations, which can be painful for the client. Contrast with *counseling.*

Psy.D See *Psychologist.*

public arena One of the three areas that are covered in the *Advocacy Competencies.*

QCSW See *qualified clinical social worker.*

qualified clinical social worker (QCSW) See *licensed clinical social worker.*

queer Traditionally seen as a derogatory word to describe gays and lesbians, in recent years this word has been embraced by the *LGLBT* community as a means of regaining power and not buying into existing ways of seeing the world.

questioning A type of *sexual orientation* in which one is questioning his or her identity.

race Traditionally, a division of people who share common genetic and biological characteristics. With gene pools having been mixed for a variety of reasons over the centuries, and with recent genetic research showing that genetic differences between any two people is extremely small, the concept of races has been challenged in recent years.

Racial Identity Development for People of Color (RIDPOC) A generic five-stage model of racial/cultural identity that synthesizes some of the more popular culture/racial specific models.

racism The belief that one race is superior to another.

radical new approaches New approaches to counseling that have significantly impacted the manner that counseling is delivered. Some of these approaches include *neuroprocessing, neurofeedback, hypnotherapy, eye movement integration therapy, cerebral electric stimulation, neurological and psychophysiological therapies,* and *eye movement desensitization response.*

rational emotive approach Developed by *Albert Ellis,* rational emotive approach suggests we are born with the potential for rational or irrational thinking, and it is the belief about an event that is responsible for one's reaction to the event. Thus, an *A*ctivating event (A) precedes the *B*eliefs about the event, and it is the beliefs that result in the *C*onsequences or the feelings and behaviors that follow (A B C). Irrational beliefs (iB) result in negative feelings and behaviors and rational beliefs (rB) result in appropriate and reasonable feelings and behaviors. Ellis offers three core irrational beliefs that many people buy into. Helpers assist clients in Disputing irrational beliefs by changing their thoughts and by having them practice new behaviors. Today called rational emotive behavior therapy.

reality therapy approach Developed by *William Glasser,* reality therapy suggests we are born with five needs: survival, love and belonging, power, freedom, and fun—which can be satisfied only in the present. These needs are said to drive one's behavior and are sometimes satisfied in dysfunctional ways. The role of the counselor is to understand the pictures in the client's world that drive the client toward the satisfaction of these needs and to assist the client in developing new pictures and new behaviors that can help the client find more functional ways of acting.

reciprocity Sometimes called *portability,* the process of transferring credentials from state to state.

Reed, Anna Established guidance services in the Seattle school system in the late 1800s and by 1910, 35 cities had plans for the establishment of vocational guidance in their schools.

registered art therapist (ATR) A type certification for *art therapist.*

registered nurse—psychiatric mental health nurse A psychiatric nurse who is a registered

nurse and works with individuals with psychosocial disorders.

registration The least vigorous type of *credentialing.* See also *certification* and *licensure.*

Rehabilitation Act An act passed in 1973 that ensured vocational rehabilitation services and counseling for employable adults who had severe physical or mental disabilities that interfered with their ability to obtain and/or maintain a job.

rehabilitation counseling A 48-credit counseling specialty area, accredited by *CORE*, that involves helping clients manage the physical, emotional, and social effects of disabilities. See also *clinical rehabilitation counseling.*

rehabilitation counselor A person who has obtained a master's degree in rehabilitation counseling from a *CORE*-accredited counseling program.

relational psychoanalysis An adaptation to traditional *psychoanalysis* that involves focusing on the client's internalized relationships with others.

religion Organized or unified set of practices and beliefs that have moral underpinnings and define a group's way of understanding the world.

reparative therapy See *sexual orientation change efforts.*

reporting ethical violations Refers to a counselors' obligation to follow a series of procedures for reporting an ethical violation of a colleague.

Repressed memories The idea that certain memories are too painful to bring into consciousness and are hidden in one's unconscious. Freud originally used *hypnosis* to uncover such memories but later turned to other techniques.

RESPECTFUL model Developed by D'Andrea and Daniels, an acronym that speaks to the ingredients needed by the culturally competent mental health professional. Includes understanding religion, economic class, sexual identity, psychological development, ethnicity, chronological disposition, trauma, family history, unique physical traits, and language.

restrictions on romantic and sexual relationships The ban of sex with clients or the family members or friends of clients until a minimum of 5 years has transpired. Other restrictions in addition to the 5 years are also placed upon counselors.

Rochester Guidance Center Location in upstate New York, one of the first clinics where *Carl Rogers* worked. Here, he worked from a psychodynamic perspective but soon adapted his approach and became one of the most known existential-humanistic theorists.

Rogers, Carl One of the founders of the field of humanistic counseling and education as well as the person who developed *person-centered counseling.* Proponent of the importance of *empathy, congruence* (*genuineness*), and *unconditional positive regard* (*acceptance*) in the helping relationship. See also *common factors.*

Rush, Benjamin Founder of American psychiatry, advocated for more humane treatment of the mentally ill. Around 1880.

Sanchez de Arevalo Author, in 1648, of *Mirror of Men's Lives* that was credited as the *first job classification system.*

Satir, Virginia A social worker who was instrumental in popularizing a systemic approach to counseling. Developed the communication approach to family counseling. Mid 1900s.

school/community One of the three areas included in the *Advocacy Competencies.*

school counseling A specialty area accredited by *CACREP* that focuses on counseling in the schools. See also *school counselor.*

school counselor A person who has obtained his or her master's degree in school counseling

school psychologist An individual who holds a master's degree in school psychology and has expertise in conducting testing and assessment and in assisting in the development and implementation of behavior plans for children.

scope and practice Designates what a credentialed, usually licensed professional can do and where he or she can do it.

self-psychology An adaptation to traditional *psychoanalytic* approaches that involve focusing on a client's inner subjective experience.

self-study report A written report that specifies how a counselor training program meets each of the sections of the CACREP program standards. This report is then sent, with an application, to the *CACREP* office, which has independent readers review the report.

Settlement Movement Arising in the United States in the 1800s, the attempt by social activists, while

living with the poor, to change communities through community action and political activities.

sexist Discrimination, denigration, or stigmatizing of another due to his or her gender.

sexual orientation The gender toward which a person consistently has sexual feelings, longings, and attachments.

sexual orientation change efforts Any treatment, such as *conversion* or *reparative therapy,* that is aimed at changing one's *sexual orientation.* Evidence suggests that these approaches are harmful to clients and it is recommended counselors should avoid referring clients to such approaches.

sexual preference The former belief that *sexual orientation* was a choice or preference.

sexual prejudice Negative attitudes targeted toward homosexual, bisexual, heterosexual, or transgender individuals.

social casework An early focus of social workers that came out of the work of those in *charity organization societies* and the *settlement movement.*

social class The grouping of people according to such things as wealth, ancestry, position, and the ranking and subsequent perception of an individual's worth to society based on this grouping.

social constructionist model of ethical decision-making A perspective to ethical decision-making sees knowledge (e.g., knowledge in codes) as intersubjective, changeable, and open to interpretation. This approach suggests that reality is socially constructed, constituted through language, and organized and maintained through narrative (stories), and that there are no essential truths.

social justice Impacting the broader system (e.g., agencies, cities, country) to affect positive change for clients. See also *advocacy.*

social justice work Counseling-related activities that involve advocating for clients by empowering them, by helping them find resources, by advocating for them locally, and by advocating for systemic change nationally and internationally.

Social psychiatry A focus on the social causes of mental health issues which some psychiatrists took up during the first half of the twentieth century.

social self One of the five factors of the *individual self model* that includes one's social support through connections with others in friendships and intimate relationships, including family ties.

Social systems An early focus of social workers which influenced the counseling profession's focus on how culture and society can impact the person.

social worker A social worker can have an undergraduate or a graduate degree in social work or a related field (e.g., human services). More recently the term has become associated with those who have acquired a *master's degree in social work (MSW).*

Soul The very early spiritualists were considered the first mental health practitioners and they focused on the soul in healing individuals. This focus later morphed into a focus on the psyche.

specialty area domains Specialty areas in counseling that are accredited by *CACREP* include clinical mental health counseling, school counseling, student affairs and college counseling, career counseling, addiction counseling, clinical rehabilitation counseling, and marriage, couple, and family counseling.

specialty credentials in social work Specialty areas in which *social workers* can earn additional certifications including, in clinical work, gerontology, hospice and palliative work; youth and family; military, leadership, health care; addictions; case management; and education.

specific state certifications States often offer a variety of specialty certifications in which they decide the level of education and experience needed to obtain said certification (e.g., state-certified substance abuse counselor).

spirituality Seen as residing in a person, not a group, spirituality defines the person's understanding of self, self in relationship to others, and self in relationship to a self-defined higher power or lack thereof. See also *religion.*

standards for the preparation of counselors and other personnel service specialists Requirements that set the minimal standards for training programs in counselor education and related fields. Unofficially used as early as 1973, it was not until 1979 that the *American Personnel and Guidance Association (APGA),* now the *American Counseling Association (ACA),* officially adopted

them, and in 1981 *APGA* created the *Council for the Accreditation of Counseling and Related Educational Programs (CACREP).*

state-approved school counseling program Programs, approved by *State Boards of Education,* for the training of school counselors.

state boards of education These are professional bodies in education, in each state, that set the standards for the credentialing of teachers, school counselors, and other school personnel.

stereotypes Rigidly held beliefs about a group of people based on the false assumption that most or all members of the group have certain behaviors or beliefs that tend to be unique to that group.

strong vocational interest blank One of the first major interest inventories, in 1927. This test, which in its revised form is still one of the most widely used instruments of its kind, was to revolutionize *vocational counseling.*

student affairs and college counseling A specialty area accredited by *CACREP* that focuses on student affairs and college counseling.

student affairs and college counselor A person who has obtained his or her master's degree in *student affairs and college counseling.*

Sue, Derald One of the seminal authors of publications in the area of *cross-cultural counseling.*

***Tarasoff* Case** The landmark court case that set a precedent for the responsibility that mental health professionals have regarding confidentiality and acting to prevent a client from harming self or others.

technology and online counseling Innovative ways that are now used to teach and supervise counselors and to conduct counseling.

third-party reimbursement Insurance reimbursement for helping services that are usually provided by licensed helping professionals.

total educational context Suggested by *John Brewer* who believed that guidance counselors (now school counselors) should be involved in a variety of functions in the schools, including adjustment counseling, assistance with curriculum planning, classroom management, and, of course, occupational guidance.

trait and factor theory The *first comprehensive theory of counseling* also known as *Minnesota point of view,* which was developed by *E. G. Williamson.* This theory initially grew out of the ideas of Frank Parsons. Although originally vocationally oriented, the approach was modified and became a generic approach to counseling and psychotherapy and involved five steps: analysis, synthesis, diagnosis, counseling, and follow-up.

transactional analysis Approach to counseling that was developed by *Eric Berne* and involves the investigation of how a client is influenced and changed through interactions with others.

transgender A person who does not identify with his or her birth sex and lives in congruence with the sex to which he or she identifies.

transsexual An individual who strongly disidentifies with his or her birth sex and uses hormones, surgery, or both to realign his or her birth sex with his or her gender identity.

trasnvestite See *cross-dresser.*

trends in health management See *health care management.*

tripartite model of personal identity A model for helping counselors increase their multicultural competence. Includes individual, group, and universal levels.

20/20 Vision The coming together of 31 counseling associations to develop a common definition and vision of counseling.

unconditional positive regard Accepting a person without strings attached. One of *Carl Rogers'* core conditions of helping along with *empathy* and *congruence.*

unconscious Proposed by early psychodynamic theorists, the idea that there is a hidden part of all individuals that motivates behavior in complex ways. The goal of many counseling approaches today is to make parts of the unconscious conscious.

universal identity See *culturally competent helping.*

universal level See *culturally competent helping* and *tripartite model of personal identity.*

universal skills Generic counseling skills and techniques that are believed to be effective at working with diverse groups of clients.

unreliability of assessment and research procedures In relationship to cultural competence, the idea that some assessment and research instruments might hold cultural bias.

veracity One of *Kitchener's principle ethics* that has to do with being truthful and genuine with the client, within the context of the counseling relationship.

virtue ethics Any of a number of models that suggests ethical decision making should be based on the helper's character.

Vocational Bureau Established by *Frank Parsons* during the turn of the twentieth century, this bureau assisted individuals in choosing an occupation, preparing themselves for it, finding an opening in it, and building a career of efficiency and success.

vocational guidance The process of assisting a client in finding a career.

vocational guidance counselors Term for the first counselors who provided vocational guidance and counseling during the turn of the twentieth century. Eventually expanded into other types of counseling.

vocational guidance movements In the early 1900s, they became a major focus on vocational and occupational counseling that set the stage for the establishment of the counseling profession.

vocational rehabilitation centers During the 1950s these centers became increasingly popular as they addressed the physical and psychological needs of individuals, especially those who had been seriously injured during World War II. Today, vocational rehabilitation centers continue to be important settings for occupational and psychological counseling.

Voting Rights Act Federal legislation in the United States that forbids racial discrimination in voting. One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

Wagner O'Day Act Established the U. S. Employment Service.

Ward, Julea A precedent setting case that suggests that counselors must counsel all clients regardless of clients' values. In Julea Ward's case, she was a graduate student who refused to counsel a client who was gay and was subsequently dismissed from her program. The *Julea Ward* case was the driving force behind the statement in ACA's current ethics code that stresses that one should not refer a client due to differences in values.

Weaver, Eli A New York City principal who had written a booklet called *Choosing a Career,* and is considered an early *vocational guidance advocate*.

Wellness (embracing a wellness perspective) Ensuring individuals attend to their personal issues and examine all aspects of their lives. One of the nine *common factors.* See also *common factors* and *indivisible self*.

White identity development Proposes specific stages that White individuals are likely to pass through as they become increasingly cross-culturally aware.

White, Michael One of the persons who developed narrative therapy.

Williamson, E. G. Credited with developing the *First Comprehensive Theory of Counseling*, also known as the *Minnesota point of view* or *trait and factor theory.* Williamson's approach initially grew out of the ideas of *Frank Parsons.*

Wolpe, Joseph One of the first to apply the concepts of classical conditioning to the clinical setting. One of the many theorists that fueled the diversity of counseling therapies during the 1950s and 1960s.

Woodworth's Personal Data Sheet An early personality instrument used by the military to screen out emotionally disturbed individuals.

Work Incentive Program One of a number of legislative acts during the 1960s that provided opportunity for minorities and the poor and helped to reshape attitudes toward social problems. Resulted in increased job opportunities for counselors.

working alliance Along with the *ability to deliver one's theoretical approach,* one of the two *common factors* to effective helping relationships. As defined in this book, it includes empathy, *acceptance, genuineness, embracing a wellness perspective, cultural competence,* and the *it factor.* See also *common factors.*

Wundt, Wilhelm One of the first *experimental psychologists.* Around 1875.

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