THE WORLD OF THE

COUNSELOR

An Introduction to the Counseling Profession

ED NEUKRUG

The World of the Counselor

An Introduction to the Counseling Profession

Ed Neukrug
Old Dominion University

This is an electronic version of the print textbook. Due to electronic rights restrictions, some third party content may be suppressed. Editorial review has deemed that any suppressed content does not materially affect the overall learning experience. The publisher reserves the right to remove content from this title at any time if subsequent rights restrictions require it. For valuable information on pricing, previous editions, changes to current editions, and alternate formats, please visit www.cengage.com/highered to search by ISBN#, author, title, or keyword for materials in your areas of interest.

To my mom,
my first counselor

About the Author

Born and raised in New York City, Dr. Ed Neukrug obtained his B.A. in psychology in from SUNY Binghamton, his M.S. in counseling from Miami University of Ohio, and his doctorate in counselor education from the University of Cincinnati.

After teaching and directing a graduate program in counseling at Notre Dame College in New Hampshire, he accepted a position at Old Dominion University, in Norfolk, Virginia where he currently is a Professor of Counseling and former Chair of the Department of Educational Leadership and Counseling. In addition to teaching, Dr. Neukrug has worked as a counselor at a crisis center, an outpatient therapist at a mental health center, an associate school psychologist, a school counselor, and as a private practice psychologist and licensed professional counselor.

Dr. Neukrug has held a variety of positions in local, regional, and national professional associations in counseling and human services. In addition, he has published numerous articles and has received a number of grants and contracts with school systems and professional associations.

Books he has written include: (1) *Counseling Theory and Practice*, (2) *The World of the Counselor* (4th ed.), (3) *Experiencing the World of the Counselor: A Workbook for Counselor Educators and Students* (4th ed.), (4) *Theory, Practice and Trends in Human Services: An Introduction to An Emerging Profession* (4th ed.), (5) *Skills and Techniques for Human Service Professionals*, (6) *Skills and Tools for Today's Counselors and Psychotherapists*, and (7) *Essentials of Testing and Assessment for Counselors, Social Workers, and Psychologists* (2nd ed.) Look for his upcoming new book tentatively called, *Professional Orientation to the Counseling Profession*.

Dr. Neukrug is currently collecting oral and video stories of the great therapists of the world. If you would like to hear these stories and compare your view of human nature to these theorists, go to: www.odu.edu/sgt.

Dr. Neukrug is married to Kristina Williams-Neukrug, who is an elementary school counselor. They have two children, Hannah and Emma.

Brief Contents

* Chapters 16, 17, and 18 are co-written by Tim Grothuas, Kathleen Levingston, and Hannah Bayne, respectively.

Contents

CHAPTER 3
Standards in the Profession: Ethics, Accreditation, Credentialing, and Multicultural/Social Justice Competencies   65

SECTION II
The Helping Relationship I: Theories and Skills   97

CHAPTER 4
Individual Approaches to Counseling   98

CHAPTER 10
Abnormal Development, Diagnosis, and Psychopharmacology   322

Preface

■ *Purpose of Text*

They brought the fireman (now firefighter) to my school. I wanted to be just like him. They brought the policeman (now police officer)—that's a pretty fun job, I thought. My father, a building contractor, came and talked about building bridges. I was very proud. Maybe I would be a building contractor. The doctor, of course, was very impressive also. But they didn't bring the counselor. In fact, few of us knew about counselors—what they did, who they were. Despite this, I became one. And now, I want the world to know who they are and what they do. That is what this book is about.

After teaching for over thirty years, I have found that new students have a deep desire and longing to be counselors. I have also found their knowledge of the counseling profession to be minimal. It has been my experience that most students understand the importance of listening to a person who is experiencing distress, but know little about the broad knowledge needed to be a counselor or about the important professional, ethical, and cross-cultural issues that underlie so much of what counselors do. Thus, the purpose of this book is to enlighten students concerning the depth of the counseling profession so they can make an informed decision about whether they want to enter it and to help them begin their journey as a professional counselor with important knowledge and skills.

Since publication of the first three editions of *The World of the Counselor*, many reviewers, faculty, and students have remarked that the text is one of the most comprehensive, yet readable, of its kind. Often, faculty and students have suggested that it is a book that could be used when studying for comprehensive exams or when taking a certification or licensing exam. In revising the text I have attempted to maintain its comprehensiveness. In addition, I have updated information to ensure accuracy and relevance and have increasingly added ways for you to electronically access information (e.g., "URLs").

■ *Organization of the Text*

The text presents an overview of the counseling profession by offering relevant content, vignettes, and think pieces for students to ponder. The book loosely follows the common-core curriculum guidelines of the *Council for Accreditation of Counseling and Related Programs* (CACREP): (1) professional orientation and ethical practice, (2) social and cultural diversity, (3) human growth and development, (5) career development, (2) helping relationships, (4) group work, (6) assessment, (7) research and program evaluation, and (8) professional orientation (see www.cacrep.org). The text also offers specific content in the specialty areas of clinical mental health counseling, school counseling, and student affairs and college counseling. Adhering to the CACREP-accredited common-core areas ensures that the text is in compliance with a standard in the profession and offers the student a broad knowledge base.

The book is separated into seven sections and an Afterword. In writing the text, I have attempted to weave all of the eight common-core areas listed above into the first six sections, with the seventh section spotlighting the three specialty areas that students commonly enter: school counseling, clinical mental health counseling, and student affairs and college counseling. The Afterword offers tips for applying to master's or doctoral programs and for applying for a job.

Sections and Afterword

Section I, Professional Orientation. The section encompasses much of the content highlighted in the CACREP common-core curriculum guideline, "Professional Orientation," and more. There are three chapters in this section:

> *Chapter 1: The Counselor's Identity: What, Who, and How?*
> *Chapter 2: The Counseling Profession's Past, Present, and Future*
> *Chapter 3: Standards in the Profession: Ethics, Accreditation, Credentialing, and Multicultural/Social Justice Competencies*

Section II, The Helping Relationship I: Theories and Skills. Section II loosely follows the CACREP common-core curriculum guideline entitled, "Helping Relationships," although consultation, which is listed under this guideline, is covered in Section III. The two chapters in this section are:

> *Chapter 4: Individual Approaches to Counseling*
> *Chapter 5: Counseling Skills*

Section III, The Helping Relationship II: The Counselor Working in Systems. This section draws from a number of CACREP curriculum guidelines that in some fashion address

counseling within systems, including couples and family counseling (from CACREP specialty guidelines called "Marriage, Couple, and Family Counseling"), group work (from CACREP common-core curriculum guideline "Group Work"), and consultation and supervision (drawn from CACREP common-core curriculum guideline "Professional Orientation and Ethical Practices"). The three chapters in this section are:

Chapter 6: Couples and Family Counseling
Chapter 7: Group Work
Chapter 8: Consultation and Supervision

Section IV, The Development of the Person. The broad spectrum of human development issues in counseling are examined in Section IV. Loosely following two of the CACREP common-core curriculum guidelines of "Human Growth and Development" and "Career Development," this section includes the following three chapters:

Chapter 9: Development across the Lifespan
Chapter 10: Abnormal Development, Diagnosis, and Psychopharmacology
Chapter 11: Career Development: The Counselor and the World of Work

Section V, Research, Program Evaluation, and Assessment. This section is based on the two CACREP common-core curriculum guidelines: "Research and Program Evaluation," and "Assessment." The two chapters in this section are:

Chapter 12: Testing and Assessment
Chapter 13: Research and Evaluation

Section VI, Social and Cultural Foundations in Counseling. Section VI loosely follows the CACREP common-core curriculum guideline entitled, "Social and Cultural Diversity." The two chapters included in this section are:

Chapter 14: Theory and Concepts of Multicultural Counseling
Chapter 15: Knowledge and Skills of Multicultural Counseling

Section VII, Select Specialty Areas in Counseling. This final section examines the three most popular specialty areas in counseling: School Counseling, Clinical Mental Health Counseling, and Student Affairs and College Counseling. Each of these chapters provides history, defines roles and functions, presents theory and practice issues, and provides the counselor with specific examples of what it's like to work in each of these specialty areas. Places of employment and potential salaries are also given. The section includes the following chapters:

Chapter 16: School Counseling
Chapter 17: Clinical Mental Health Counseling
Chapter 18: Student Affairs and College Counseling

Afterword. The Afterword provides students with tips on how to get into a master's and doctoral program in counselor education and related fields and how to apply for jobs in the helping professions.

A Focus on Multicultural and Social Justice Issues; Ethical, Professional, and Legal Issues, and "The Counselor in Process"

The counseling profession has zeroed in on the importance of understanding the critical knowledge and skills related to multicultural counseling and social justice and has also focused on the importance of acting ethically, professionally, and legally. Thus, at the end of each chapter, you will find a special section that highlights multicultural and social justice issues and another section that focuses on important ethical, professional, and legal issues related to that chapter's content. Finally, I conclude each chapter with a segment entitled "The Counselor in Process," which stresses how the self-reflective counselor who is willing to risk change might deal with issues related to the chapter content.

Pedagogical Aids

The *World of the Counselor* is filled with material that highlights the content of each chapter in the text. These include:

1. Personal vignettes from the author and co-authors concerning their experiences in the field of counseling and in related professional fields
2. Vignettes that highlight specific chapter content
3. Testimonials from individuals in the field about their work
4. Experiential exercises that are peppered throughout the text that students can do in class or at home
5. References to Web sites that can highlight specific course content
6. Tables and graphs that elaborate what is in the chapter content
7. For the instructor, there are numerous instructional aids (see "Ancillaries to Text" near end of this preface)

In addition, there is a companion workbook, entitled "*Experiencing the World of the Counselor: A Workbook for Counselor Educators and Students*" that can be used in addition to the text. This manual is filled with experiential exercises that highlight each chapter's content.

Specific Changes to This Edition

If you've seen past revisions of this text, you'll know that I do not take a revision lightly. Thus, in an effort to keep the content updated and to better the quality of the text, there have been numerous changes to each chapter in the book. Each chapter has updated

references, and each chapter has expanded the section on multicultural issues to include a social justice focus. Many changes were made in each chapter, but some of the more substantive changes are listed below:

Chapter 1: The Counselor's Identity: What, Who, and How?: In addition to the various types of counselors and related helping professionals discussed in previous editions, I have added information about addiction counselors and human service professionals. As usual, based on the research, I have updated the list of characteristics most important for counselors to embody. The list now includes: empathy, acceptance, genuineness, being wellness oriented, being culturally competent, having the "it" factor, being compatible with and believing in your theory, being competent, and being cognitively complex.

Chapter 2: The Counseling Profession's Past, Present, and Future: In addition to fine-tuning the history, in this chapter I've added information on recent events in the field, including: the most recent changes in credentialing; expansion of divisions of the American Counseling Association (ACA); an updated view of evidence-based practice; the current emphasis on multicultural and social justice advocacy; the importance of obtaining training in crisis, disaster, and trauma work; the changes in the recent ACA ethical code; and the ACA 20/20 Standards, which focus on the shared professional vision that various counseling associations have adopted.

Chapter 3: Standards in the Profession: Ethics, Accreditation, Credentialing, and Multicultural/Social Justice Competencies: The most important change to this chapter is the addition of a fourth standard—multicultural and social justice competencies. In adding this standard, I have focused on the multicultural counseling competencies and *Advocacy Competencies* that ACA has adopted and which are now infused into most counseling programs.

Chapter 4: Individual Approaches to Counseling: I have completed a major re-write of this chapter, which includes the addition of some new theories and the removal of some former ones. The chapter now covers: the psychodynamic approaches of psychoanalysis, analytical therapy, and individual therapy; the existential-humanistic approaches of existential therapy, gestalt therapy, and person-centered counseling; the cognitive-behavioral approaches of behavior therapy, rational emotive behavior therapy, cognitive therapy, and reality therapy; and the post-modern approaches of narrative therapy and solution-focused brief therapy. Also new to this chapter is a brief overview of a number of extensions, adaptations, and spinoffs of the theories noted.

Chapter 5: Counseling Skills: This chapter has added an important method of writing case notes: the Subjective, Objective, Assessment, and Plan (SOAP). In addition, I have included important information on crisis, disaster, and trauma counseling, an area in which CACREP and ACA are now strongly suggesting counselors obtain training.

Chapter 6: Couples and Family Counseling: Like Chapter 4, this chapter underwent an important re-write. First, I expanded the history of couples and family counseling. I also added a section on the "view of human nature" to which most couples and family therapists adhere. This chapter now includes a focus on key concepts of couples and family therapy such as: general systems theory, cybernetics, boundaries and information flow, rules and hierarchy, communication theory, scapegoating and identified patients, stress, developmental issues, and social constructionism. Finally, some theories were added, others deleted, and all updated. The theories highlighted in this edition include: human validation process model, structural family therapy, strategic family therapy, multigenerational approaches, experiential family therapy, psychodynamic family therapy, behavioral and cognitive–behavioral family therapy, narrative family therapy, and solution-focused family therapy.

Chapter 7: Group Work: In this chapter, I added information about the Association for Specialists in Group Work's (ASGW) *Best Practice Guidelines* and *Professional Standards for the Training of Group Workers*. I reorganized the section on theory in group work and now discuss psychoanalysis group therapy, person-centered group counseling, cognitive–behavioral group therapy, and solution-focused group therapy. I've also added information on Tuckman's classic stages of forming, storming, norming, performing, and adjourning.

Chapter 8: Consultation and Supervision: In this chapter, I've updated and simplified the definition of consultation. I also added social constructionism to the different theories of consultation and added information on the "cube" model of college counseling. Relative to supervision, I've expanded the information on parallel process and updated the definitions of supervision, supervisor, and supervisee. I've expanded the discussion on countertransference (there's a great "cartoon" that shows this process) and added a discussion on triadic supervision. The models of supervision offered now include: developmental, psychotherapy-based, and integrative. In general, I believe the chapter is now an easier read and offers other additional information important to the consultation and supervision processes.

Chapter 9: Development across the Lifespan: This chapter offers an expanded coverage of Kohlberg's theory by adding information on the "Heinz dilemma" in moral development. Also, I've expanded the section on Carol Gilligan's understanding of women's development. In addition, I re-wrote and updated the section on Erikson's eight lifespan stages. I kept Levinson's information on male development, but also included information he and his wife wrote on female development. In addition, I added a section on cross-cultural bias in developmental models.

Chapter 10: Abnormal Development, Diagnosis, and Psychopharmacology: In this chapter, I changed some of the information on Maslow's hierarchy and how it might be used to understand abnormal development. I also added a section on the post-modernist's and

social constructionist's perspective on abnormal development. I offer an expanded summary, in Table 10.1, of the different developmental theories, and although I still describe DSM-IV-TR, I note some of the likely upcoming changes in DSM-5. As always, the section on psychotropic medication needed to be revised greatly to keep up with changing medications. I also offer an alternative way of framing diagnosis from a humanistic and anti-deterministic perspective and have added a discussion relative to diagnosis and insurance fraud.

Chapter 11: Career Development: The Counselor and the World of Work: I've tried, in this chapter, to streamline and simplify some of the basic definitions used in the area of career development. Based on recent research, I've completed a re-write of the section on social cognitive career theory. Near the end of the chapter, I offer the National Career Development Association's (NCDA) *Multicultural Career Counseling and Developmental Competencies.* Here, I also offer a new social justice focus that assumes forces outside the person affects their career decision-making process.

Chapter 12: Testing and Assessment: This chapter offers a new and expanded definition of assessment procedures. Also, under aptitude testing, I have added a section on neuropsychological assessment and under informal assessment I have added information on performance-based assessment and environmental assessment. In this chapter, I offer a new section on the importance of counselors taking a stand when they see tests being used inappropriately.

Chapter 13: Research and Evaluation: This chapter has updated information on quantitative and qualitative research. For instance, the section formerly called "single-subject design" is now called "one-shot case study and one group pretest/post-test design" and has been re-written accordingly. The section on qualitative research has been expanded and now includes information on grounded theory, phenomenological approach, ethnographic research, and historical research. In understanding data analysis, I have added a section on effect size. In addition, I have expanded a table that summarizes quantitative and qualitative research as well as evaluation. There is also a new discussion on bias in counseling research. Throughout the chapter, you will find new and updated examples of different kinds of research and evaluation techniques.

Chapter 14: Theory and Concepts of Multicultural Counseling: In Chapter 14, I added a new definition of multicultural counseling offered by Sue and Torino (2005). I've updated statistics about diversity in the United States and added or expanded upon the following definitions: culture; discrimination and microaggressions; ethnicity; minority and nondominant group; power differentials; race; religion and spirituality; sexism, heterosexism, and sexual prejudice; sexual orientation; social class ("class"); and stereotypes, prejudice, and racism. In understanding client racial/ethnic identity development, I now offer an existential model of identity, the tripartite model of personal

identity, the interpersonal model of racial identity, developmental models of cultural and racial identity, and the White identity development model. At the end of the chapter, I added a section on whether one can have multicultural counseling without social justice or action. I also added a section on the ACA (2005) ethics code and how it focuses on multicultural counseling. Finally, I've added information about ACA's advocacy standards.

Chapter 15: Knowledge and Skills of Multicultural Counseling: As in Chapter 14, in this chapter, I update many of the graphs and figures that reflect changing demographics in the United States and elsewhere. I also added the competencies needed when working with clients around religion and spirituality, which was developed by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC). The chapter offers a major re-write of the section on gender-aware therapy. Also, many other changes can be found throughout, as I changed wording and phrasing to ensure that this chapter keeps up with current trends in multicultural counseling.

Chapters 16, 17, and 18: School Counseling, Clinical Mental Health Counseling, and Student Affairs and College Counseling: Although I kept the basic shell of these chapters, I asked experts in each of the three specialty areas to review and revise these chapters to ensure current accuracy. Although you will find much of these chapters sounding similar in flavor to the last edition, you will also find many specific details changed and updated.

Afterword: The previous edition of the text had a Chapter 19 that included future trends in the field and information about applying to graduate school and applying for jobs. Because future trends were discussed in previous chapters (especially Chapter 2: The Counseling Profession's Past, Present, and Future), I removed this from the chapter and converted it into an Afterword that offers tips for applying to graduate school and for applying to jobs. If you think you will be applying to a master's program, doctoral program, or for a job in the near future, I think you will find this Afterword a useful resource.

Ancillaries to the Text

For students:

Some of you may be using the companion manual to this text, *Experiencing the World of the Counselor: A Workbook for Counselor Educators and Students*. For you who do use this manual, you will find dozens of exercises to enhance your learning. Many of these can be completed on your own, while others may be facilitated by your instructor and completed with others in class.

Also, your instructor can point out how to find sample test questions located on the instructor's companion site of the book on the Brooks/Cole website. These questions, and

answers, are based on chapter content and will give you a feel for the types of questions that might be asked on an exam.

For the instructor

There are a number of ancillaries to ensure student learning. All of the ancillaries, with the exception of the workbook: *Experiencing the World of the Counselor: A Workbook for Counselor Educators and Students*, can be found on the instructor's companion site of the book on the Brooks/Cole Website (www.brookscole.com; then search for "World of the Counselor"). Some of the ancillaries include:

1. *Experiencing the World of the Counselor.* This companion book can be purchased by students. In it, you will find exercises and activities that can enhance student learning. If you do not already have a desk copy, please consider obtaining one from Brooks/Cole to see if it might benefit student learning in your class (call 1-800-477-3692, or type in "World of the Counselor" on the search engine found at www.brookscole.com).
2. *PowerPoint Slides:* Extensive PowerPoint slides that summarize each chapter's content are available from the Brooks/Cole Web site.
3. *Test Bank:* An extensive test bank is available through the Brooks/Cole Web site.
4. *Teaching Tips:* These suggestions, found on the Brooks/Cole Web site, are based on the way I teach this course and may provide you with possible pedagogical methods as you navigate through the chapters.
5. *Sample Syllabus:* A sample syllabus is available in the instructor's manual, which can be found on the Brooks/Cole Web site.

◼ *Acknowledgments*

This book could not have been completed without the help of a number of people from Cengage. I had a particular treat in writing this edition of the book because of the help of Nic Albert, Associate Development Editor. Although across the country, it seemed as if he was at my side, reading and giving me comments about every chapter of the book. His help was enormous, and "beyond the call of duty." Thanks so much, Nic. A special thanks to Seth Dobrin, Acquisitions Editor, whose support and continual good sense has made the process of writing this edition particularly easy.

A number of other people from Cengage were instrumental in getting this edition of the book completed. They include: Matt Ballantyne, Production Manager; Dean Dauphinais, Rights Acquisition Specialist; Naomi Dreyer, Assistant Editor; Suzanna Kincaid, Editorial Assistant; Judy Inouye, Manufacturing Buyer; Bob Kauser, Rights Acquisition Director; Marcia Locke, Manufacturing Director; Elizabeth Momb, Associate

Professional Orientation

Overview

*T*his first section offers an overview of important professional issues in the field of counseling. A common theme running through Chapters 1 through 3 is how the counseling profession has developed its unique professional identity. This topic is explored by looking at how we are the same as well as how we are different from other mental health professionals, by examining our unique history, and by describing the standards of our profession.

Chapter 1 defines counseling and distinguishes it from related fields such as guidance and psychotherapy. This chapter compares different kinds of mental health professionals who do counseling, and it concludes by examining the characteristics of an effective counselor. Chapter 2 reviews the history of the counseling profession, tracing it from the distant past, through the beginnings of the mental health field, to the current status of the profession. It also offers us a glimpse into its future. Chapter 3 explores the development and implementation of four important standards in the counseling profession: ethics, accreditation, credentialing, and multicultural/social justice competencies.

At the conclusion of every chapter in the book, chapter content is tied in with important multicultural/social justice issues; ethical, professional, and legal issues; and, in a section called "The Counselor in Process," issues involving how the counselor lives as a person and professional in the world.

The Counselor's Identity: What, Who, and How?

. . . 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 label counselor. *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, those services have little in common with . . . [psychological counseling].* (Hackney & Cormier, 2009, p. 2)

Sometimes as a child, I would have a temper tantrum, and my mother would say, "I just don't understand why you get so angry; maybe I should take you to see a counselor." This threat intimated that there was something terribly wrong with me, and perhaps, in some way, also showed her love for and desire to understand and help me.

I used to wonder what it would be like to see a counselor. It couldn't be a good thing if my mom was using it as a threat, I thought! On the other hand, maybe counseling would be a place where I could talk to someone who understood me, someone who could understand my moods, moods that felt normal to me yet were being defined as being wrong, or kind of abnormal. Maybe seeing a counselor would be okay. In fact, maybe a counselor would say I was normal! But what exactly would a counselor do, I wondered?

Thankfully, over the years I've had the opportunity to be in counseling. And, irony of all ironies, I became a counselor. Well, maybe my mom intuited early that I was going to be intimately involved in counseling in one way or another!

This chapter is about defining the words *counseling* and *counselor*. First, I will highlight the word *counseling* and distinguish it from related words such as *guidance* and *psychotherapy*. Then I will compare and contrast counselors with other mental health professionals who do counseling. Next, I will examine characteristics of an effective helper.

As we near the end of the chapter, I will provide an overview of the various professional associations in the counseling field, with particular emphasis on the American Counseling Association (ACA). I will conclude the chapter by highlighting

the importance of multicultural issues in the field of counseling and by focusing on ethical, professional, and legal issues that apply to counselors.

◼ *Guidance, Counseling, and Psychotherapy: Variations on the Same Theme?*

Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. (ACA, 2010a)

This statement, recently endorsed by a wide range of counseling associations, took a long time coming, as over the years, the word *counseling* has not been easily defined. In fact, for years there have been differing opinions about what counseling is and how to distinguish it from guidance and psychotherapy. Let me offer some of my own associations with these words, and see if they match your own. For instance, when I hear the word *psychotherapy*, I think of the following words: *deep, dark, secretive, sexual, unconscious, pain, hidden, long-term*, and *reconstructive*. The word *counseling* makes me think of *short-term, facilitative, here-and-now, change, problem solving, being heard*, and *awareness*. And lastly, *guidance* makes me think of *advice, direction, on the surface, advocacy*, and *support*. Did these associations ring true for you? Now, let's look at how the literature has defined these words.

Over the years there have been a plethora of definitions of counseling that suggest it 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, 2005); to an approach that suggests that there is no essential difference between the two (Neukrug, 2011; Patterson, 1986).

Some of the confusion among these words rests in their historical roots. The word *guidance* first appeared around the 1600s and was defined as "the process of guiding an individual." Early guidance work involved individuals giving moralistic and direct 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*. Meaning "caring for the soul," the word was derived from the Greek words *psyche*, meaning spirit or soul, and *therapeutikos*, meaning caring for another (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 the psychoanalysts who practiced psychotherapy, dealt with social and emotional issues. 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) stated 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).

In the training of counselors today, the word guidance has tended to take a back seat to the word counseling, while the words counseling and psychotherapy are generally

FIGURE 1.1
Guidance, Counseling, and Psychotherapy Continuum

	Guidance →	Counseling →	Psychotherapy →	
Short-term	→	→	→	Long-term
Modifying behavior	→	→	→	Personality reconstruction
Surface issues	→	→	→	Deep-seated issues
Here and now	→	→	→	There and then
Preventive	→	→	→	Restorative
Conscious	→	→	→	Unconscious
Helper-centered	→	→	→	Helpee-centered
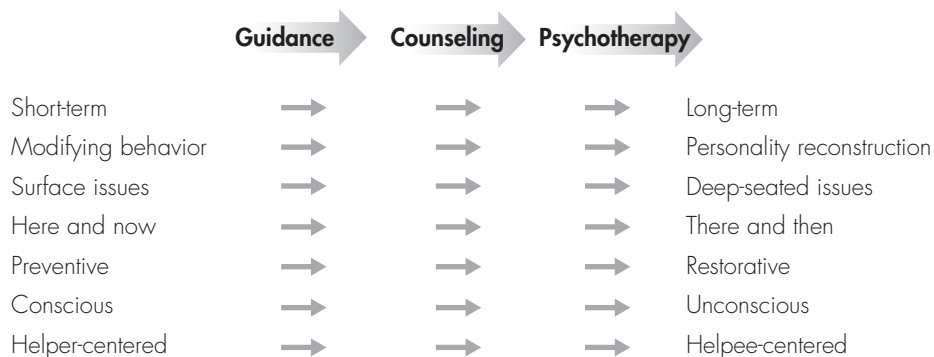
used interchangeably in textbooks. Examine most texts that describe theories of counseling and compare them to a text that describes theories of psychotherapy, and you will find them to be nearly identical. In other words, theories of counseling and psychotherapy are indistinguishable. In fact, often both words are in the title. For example, C. H. Patterson noted in his very popular text, *Theories of Counseling and Psychotherapy*, that ". . . counseling and psychotherapy are both used in the title of this book because it appears to be impossible to make any clear distinction between them" (Patterson, 1986, p. xvii). In a similar vein, Corey (2009), the author of the best-known text on theories of counseling and psychotherapy, simply does not address the issue, choosing to use the words interchangeably.

Despite the lack of distinction made in most texts, a differentiation between counseling and psychotherapy is likely to be made by the average person, perhaps by many counseling students, and even by professors of counseling. Acknowledging this common usage, one model of understanding these terms would place guidance and psychotherapy on opposite extremes, with counseling falling somewhere midway on the continuum (see Figure 1.1).

Comparison of Mental Health Professionals

Whether we call it guidance, counseling, or psychotherapy, in today's world we find a number of professionals practicing it. In fact, although differences in the training of mental health professionals exist, over the years their professional duties have begun to overlap (Todd & Bohart, 2006). For instance, today, some school counselors do therapy, counseling and clinical psychologists act as consultants to the schools, psychiatrists are social advocates, social workers and others can be psychoanalysts, mental health counselors do family therapy, and psychologists vie for the right to prescribe psychotropic medications (Johnson, 2009). Let's examine some of the similarities and differences among various professionals, including counselors, social workers, psychologists, psychiatrists, psychoanalysts, psychiatric mental health nurses, psychiatrists, human service practitioners, and psychotherapists.

Counselors

For many years, the word *counselor* simply referred to any "professional who practices counseling" (Chaplin, 1975, p. 5). However, today, most individuals who call themselves counselors will have a master's degree in counseling. These days, counselors are found in many settings and perform a variety of roles. For instance, they may serve as school counselors, college counselors, mental health counselors, private practitioners, rehabilitation counselors, and counselors in business and industry. The counselor's training is broad, and we find counselors doing 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 guidance activities for individuals of all ages. Even though counselors do not tend to be experts in psychopathology, they do have knowledge of mental disorders and know when to refer individuals who need more in-depth treatment.

Although there are many different kinds of counselors, all tend to have had common coursework in professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, the helping relationship, group work, assessment, and research and program evaluation. In addition to these common core areas, counselors generally have had coursework in a counseling specialty area, which might include classes 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.

Today, most counseling programs at the master's level will offer degrees in one or more of the specialty areas as recognized by the accrediting body for counseling programs, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) (see Chapter 3). These include school counseling; clinical mental health counseling; marriage, couple, and family counseling; addiction counseling; career counseling; and student affairs and college counseling. Rehabilitation counseling is accredited by a separate accreditation body, the Council on Rehabilitation Education (CORE), and follows similar curriculum guidelines to those above with an added emphasis on courses related to working with individuals with disabilities. Not all programs use the exact names that CACREP suggests and some programs offer specialty areas outside of those delineated by CACREP. However, most programs will offer a core curriculum and field work similar to that noted in the previous paragraph.

All counselors can take an exam to become a National Certified Counselor (NCC) that is offered by the National Board for Certified Counselors (NBCC, 2009a). NBCC also offers subspecialty certifications in clinical mental health counseling, school counseling, and addiction counseling. In addition, today, all 50 states, Puerto Rico, and the District of Columbia have established licensing laws that allow a counselor who has a master's degree in counseling, additional training, and supervision to practice as a Licensed Professional Counselor (LPC) (some states use a related term) (ACA, 2010c). 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 3). The professional association for counselors, which is called the American Counseling Association (ACA), currently has 19 divisions that focus on a variety of counseling concerns (a further discussion of ACA and its divisions is provided later in this chapter).

While keeping in mind that a person with a master's degree in counseling is primarily a counselor and secondarily a school counselor, mental health counselor, or a counselor in some other specialty area, the following are brief descriptions of some of the more prevalent counseling specialty areas.

School Counselors

A *school counselor* has a master's degree in counseling and 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 twelfth grade (K–12). Today, the majority of school counseling programs are CACREP accredited, which requires a minimum of 48-credit hours for the degree. 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 (see Chapter 16). 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). If they so choose, school counselors can become NCCs, and, in most states, LPCs.

Clinical Mental Health Counselors (Agency Counselors)

A *clinical mental health counselor* is an individual who has obtained his or her degree in clinical mental health counseling or a closely related degree in counseling (e.g., agency counseling). Although in the past CACREP had included standards for 48-credit agency (or community counseling) programs, CACREP's 2009 standards have done away with those specialty areas and now support a 54-credit clinical mental health counseling degree, which, in 2013, will be increased to 60 credits. However, some master's programs may still be operating, and accredited, under the older 48-credit standards. As these programs' accreditation periods expire, they will have to either expand their master's degrees to the new 54 or 60-credit requirement, or disband their programs. Although not all programs are CACREP accredited, individuals who obtain a degree in clinical mental health counseling, or related degrees, are generally trained to conduct counseling or psychotherapy 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.

Marriage, Couple, and Family Counselors

Marriage, couple, and family counselors are specifically trained to work with couples and with family systems 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 American Association of Marriage and Family Therapists (AAMFT) is one professional association for marriage

and family counselors; another is the International Association of Marriage and Family Counselors (IAMFC, n.d.). IAMFC is a division of ACA, although one can join IAMFC without joining ACA.

Although all 50 states have some requirement for marriage and family licensure, the requirements can vary dramatically (*Occupational Outlook Handbook*, 2010–2011). While some states license marriage and family counselors who have studied from programs that follow the curriculum guidelines set forth by AAMFT'S Commission on the Accreditation of Marriage and Family Therapy (COAMFTE), other states prefer licensing counselors who have studied from programs that follow the 60-credit CACREP guidelines, and still others have set their own curriculum guidelines for credentialing. Most states that offer marriage and family counselor credentialing allow helping professionals with related degrees (e.g., counseling, social work, psychology) to also practice marriage and family counseling, as long as they follow the curriculum guidelines set forth by the state and abide by any additional requirements for credentialing.

Student Affairs and College Counselors

Student affairs and college counselors work in a variety of settings in higher education, including college counseling centers, career centers, residence life, advising, multicultural student services, and other campus settings where counseling-related activities occur. Usually, these counselors will have taken specialty coursework in college student development and student affairs practices and may have attended a 48-credit CACREP-accredited program. If they so choose, counselors who work in college settings can become NCCs, and, in most states, LPCs. 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.

Addiction Counselors

Addiction counselors study a wide range of addiction disorders, such as substance abuse (drugs and alcohol), eating disorders, and sexual addictions. They are familiar with diagnosis, treatment planning, and understand the importance of psychopharmacology in working with this population. Today, CACREP offers a 60-credit accreditation in addiction counseling. Many addiction counselors can become certified through their state. In addition, NBCC offers a certification as a Master Addiction Counselor (MAC). Because CACREP-accredited programs offer the basic curriculum in counseling in addition to specialized courses in substance abuse, addiction counselors can almost always become Licensed Professional Counselors (LPCs). 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.

Rehabilitation Counselors

Rehabilitation counselors offer a wide range of services to people with physical, emotional, and/or developmental disabilities. "Rehab" counselors work in state vocational rehabilitation agencies, unemployment offices, or private rehabilitation agencies. The Council on

Rehabilitation Education (CORE) is the accrediting body for rehabilitation counseling programs. Although the curricula in rehabilitation counseling programs largely parallel those in CACREP-approved programs, rehab 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. Although CORE and CACREP attempted to merge, these efforts have failed and merger talks, for now, been been placed on hold (The CACREP Connection, 2007). Although rehabilitation counselors can become NCCs or LPCs, many choose to become Certified Rehabilitation Counselors (CRCs) through a separate certification process offered by the Commission on Rehabilitation Counselor Certification (CRCC). 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 or even just a master's degree in religion or divinity. Pastoral counselors sometimes work in private practice or within a religious association. Pastoral counselors, religious counselors, or counselors with a spiritual orientation 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 (CPC).

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), the term has recently become more associated with those who have acquired a master's degree in social work (MSW). Whereas social workers traditionally have been found working with the underprivileged and with family and social systems, today's social workers provide counseling and psychotherapy for all types of clients in a wide variety of settings, including child welfare services, government-supported social service agencies, family service agencies, private practices, and hospitals. Social workers usually have extensive training in counseling techniques but less preparation in career counseling, assessment techniques, and quantitative research methods.

Even though theoretical distinctions exist between the MSW and the master's degree in counseling, the two degrees probably have more similarities than differences. With additional training and supervision, social workers can become nationally certified by the Academy of Certified Social Workers (ACSW). In addition, most states have specific requirements for becoming a Licensed Clinical Social Worker (LCSW). The professional association for social workers is the National Association of Social Workers (NASW).

Psychologists

Many different types of *psychologists* practice in a wide range of settings, including agencies, private practice, health maintenance organizations, universities, business and industry, prisons, and schools. Psychologists are often found running agencies, consulting with

business and industry, or serving in supervisory roles for all types of mental health professionals. Some of the many different kinds of psychologists include clinical, cognitive, counseling, developmental, educational, engineering, evolutionary, experimental, forensic, health, industrial/organizational, neuro, quantitative, rehabilitation, school, social, and sports. Today, each state determines the types of psychology licenses it authorizes as well as the requirements for obtaining those licenses (American Psychological Association, [APA], 2003).

Relative to the practice of psychotherapy, all states offer licensure in counseling and/or clinical psychology, and many states now allow individuals with a "Psy.D.," a relatively new clinical doctorate in psychology, to become licensed as clinical or counseling psychologists. Licensed counseling and clinical psychologists have obtained a doctoral degree in psychology, acquired extensive supervised experience after graduate school, and passed a licensing exam. The professional association for psychologists is the American Psychological Association (APA). Counselors are likely to have more contact with clinical, counseling, and school psychologists than with other types of psychologists. These specialty areas are described below.

Clinical Psychologists

Clinical psychologists have a strong background in science, theory, and practice, which enables them to alleviate maladjustment and promote psychological well-being (APA, 2003). To obtain a license as a clinical psychologist, one must graduate from an APA-accredited doctoral program in clinical psychology and complete additional requirements identified by state licensing boards. The professional association for clinical psychologists is Division 12 of the APA.

Counseling Psychologists

Historically, *counseling psychologists* have worked with relatively healthy populations, whereas clinical psychologists have worked with seriously impaired populations. Today, however, the differences between counseling and clinical psychologists are nominal (APA, 2003). To become a counseling psychologist, one must obtain a doctoral degree from an APA-approved program and complete additional requirements identified by the state licensing board. The professional association for counseling psychologists is Division 17 of the APA.

School Psychologists

School psychologists have a master's or doctoral degree in school psychology and are licensed by state boards of education. Their work involves children, families, and the schooling process and their training tends to focus on consultation, evaluation and assessment, intervention, prevention, and research and planning (National Association of School Psychologists, n.d.). Many school psychologists today are found working closely with students with learning programs, their parents, and their teachers. Although most school psychologists work in schools, you can sometimes 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.

Psychiatrists

A *psychiatrist* is a licensed physician who generally 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 some states have granted psychologists prescription privileges for psychotropic medication (Johnson, 2009), 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 a number of recognized psychoanalytical institutes. Although the American Psychoanalytical Association (APsaA), the professional association of psychoanalysts, formerly would only endorse psychiatrists for training at psychoanalytical institutes (Turkington,1985), they now allow other mental health professionals to undergo training (APsaA, 2008). Because states do not license psychoanalysts, clients who are seeing a psychoanalyst should make sure that the analyst was trained at an institute sanctioned by the American Psychoanalytical Association and that he or she has a license in a mental health field (e.g., licensed psychiatrist, psychologist, counselor [LPC], or social worker [LCSW]).

Psychiatric-Mental Health Nurses

Primarily trained as medical professionals, *psychiatric-mental health nurses* are also skilled in the delivery of mental health services (American Psychiatric Nurses Association, n.d.). Most psychiatric-mental health nurses work in hospital settings, with lesser numbers working in community agencies, private practice, or educational settings. Psychiatric-mental health nursing is practiced at two levels. The RN psychiatric-mental health nurse does basic mental health work related to nursing diagnosis and nursing care. The Advanced Practiced 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 (Phillips, 2007), APRNs provide an important service in many mental health settings. Because of their training in both medicine and basic counseling skills, they 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, 2010). The professional

association of psychiatric-mental health nurses is the American Psychiatric Nurses Association (APNA).

Expressive Therapists

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 are experiencing significant trauma or emotional problems in their lives (Malchiodi, 2006). 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. 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 expressive therapists obtain degrees in counseling or social work and later pick up additional coursework in expressive therapy. However, there are programs that offer a curriculum in the expressive therapies, such as those approved by the American Art Therapy Association (AATA). Other expressive therapy 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 certification exists for some kinds of expressive therapies (e.g., see Art Therapy Credentials Board, 2007), states generally do not license expressive therapists, although they can become licensed if their degree was in a field credentialed by the state (e.g., counseling or social work) and sometimes can become licensed if they take additional courses so their course work matches the curriculum requirements of the existing state licenses (Wadeson, 2004).

Human Service Practitioners

Individuals who serve as *human service practitioners* 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. Recently, CSHSE, in consultation with the National Organization of Human Services (NOHS) and the Center for Credentialing and Education (CCE), created a certification in human services, called the Human Services–Board Certified Practitioner (HS-BCP).

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., LPCs, LCSWs, psychologists). The bottom line is that in most states, anyone can claim to be a psychotherapist, but only licensed practitioners can practice psychotherapy.

Professional Associations in the Social Services

In order to protect the rights of their members and support the philosophical beliefs of their membership, professional associations have arisen over the years for each of the social service professionals discussed in this chapter. A few of the many benefits that these associations tend to offer include:

- National and regional conferences to discuss training and clinical issues
- Access to malpractice insurance
- Lobbyists to protect the interests of the membership
- Newsletters and journals to discuss topics of interest to the membership
- Opportunities for mentoring and networking
- Information on cutting-edge issues in the field
- Codes of ethics and standards for practice
- Job banks

Most of you who are reading this text are likely to be interested in joining the American Counseling Association (ACA) and its divisions, which will be discussed in detail shortly. However, to broaden your professional knowledge and acquaint you with related associations you might want to join, some of the other major associations within the social service fields will also be highlighted. Keep in mind that there are dozens of professional organizations in the social services, and this section of the text features only a few of the more popular ones.

The American Counseling Association

The beginnings of the American Counseling Association (ACA) can be traced back to the 1913 founding of the National Vocational Guidance Association (NVGA). After undergoing many changes of name and structure over the years, today's ACA is the world's largest counseling association. This 45,000-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, 2010c, para 4).

Divisions of ACA

ACA currently sponsors 19 divisions, all of which maintain newsletters and most of which provide a wide variety of professional development activities. Many of these divisions also publish journals. ACA's divisions, along with the year they were founded and the journal(s) they publish, follow. (See http://www.counseling.org and click on "divisions" for more information.)

- AACE: Association for Assessment in Counseling and Education (1965)
  Journal: *Measurement and Evaluation in Counseling and Development*
- AADA: Association for Adult Development and Aging (1986)
  Journal: *Adultspan*

- ACC: Association for Creativity in Counseling (2004)
  Journal: *Journal of Creativity Mental Health*
- ACCA: American College Counseling Association (1991)
  Journal: *Journal of College Counseling*
- ACEG: Association for Counselors and Educators in Government (1984)
  Journal: None published
- ACES: Association for Counselor Education and Supervision (1952)
  Journal: *Counselor Education and Supervision*
- AGLBIC: Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (1997)
  Journal: *Journal of LGBT Issues in Counseling*
- AMCD: Association for Multicultural Counseling and Development (1972)
  Journal: *Journal of Multicultural Counseling and Development*
- AMHCA: American Mental Health Counselors Association (1978)
  Journal: *Journal of Mental Health Counseling*
- ARCA: American Rehabilitation Counseling Association (1958)
  Journal: *Rehabilitation Counseling Bulletin*
- ASCA: American School Counselor Association (1953)
  Journal: *Professional School Counseling*
- ASERVIC: Association for Spiritual, Ethical & Religious Values in Counseling (1974)
  Journal: *Counseling and Values*
- ASGW: Association for Specialists in Group Work (1973)
  Journal: *Journal for Specialists in Group Work*
- C-AHEAD: Counseling Association for Humanistic Education and Development (1952)
  Journal: *Journal of Humanistic Counseling, Education, and Development*
- CSJ: Counselors for Social Justice (2002)
  Journal: *Journal for Social Action in Counseling and Psychology*
- IAAOC: International Association of Addictions and Offender Counselors (1974)
  Journal: *The Journal of Addictions and Offender Counseling*
- IAMFC: International Association of Marriage and Family Counselors (1989)
  Journal: *The Family Journal: Counseling & Therapy for Couples & Families*
- NCDA: National Career Development Association (1952 as NVGA, 1985 as NCDA)
  Journal: *The Career Development Quarterly*
- NECA: National Employment Counseling Association (1964)
  Journal: *The Journal of Employment Counseling*

Associations Related to ACA

ACA supports a number of affiliates and organizations that contribute to the betterment of the counseling profession in unique ways. Brief descriptions follow.

- **The ACA Insurance Trust (ACAIT).** This organization provides liability insurance as well as a wide range of other kinds of insurance for its members (see http://www.acait.com/).

- **The American Counseling Association Foundation (ACAF).** ACAF offers support and recognition for a wide range of projects, including scholarships for graduate students, recognition of outstanding professionals, enhancement of the counseling profession, and support for those in need (see http://www.acafoundation.org/).
- **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 (see http://www.cacrep.org/).
- **The Council on Rehabilitation Education (CORE).** CORE develops standards and provides accreditation processes for rehabilitation counseling programs (see http://www.core-rehab.org/).
- **The National Board for Certified Counselors (NBCC).** NBCC provides national certification for counselors (National Certified Counselor; NCC); mental health counselors (Certified Clinical Mental Health Counselor; CCMHC), school counselors (National Certified School Counselor; NCSC), and substance abuse counselors (Master Addiction Counselor; MAC) (see http://www.nbcc.org/certifications/).
- **Chi Sigma Iota (CSI).** CSI is an honor society that promotes and recognizes scholarly activities, leadership, professionalism, and excellence in the profession of counseling.

Branches and Regions of ACA

In addition to its 19 divisions, ACA has 56 branches, which consist of state associations, associations in Latin America, and associations in Europe. Four regional associations support counselors throughout the United States: the North Atlantic Region, Western Region, Midwest Region, and Southern Region.

Membership Benefits of ACA

Membership in ACA provides a number of unique opportunities and benefits, including the following:

- Professional development programs, such as conferences and continuing education workshops
- Counseling resources, including books, ethical codes, video and audiotapes, electronic news, and journals
- Computer-assisted job search services
- Professional liability insurance
- Consultation on ethical issues and ethical dilemmas
- Assistance in lobbying efforts at the local, state, and national levels
- A counselor directory
- Networking and mentoring opportunities
- Graduate student scholarships
- Subscriptions to the *Journal of Counseling and Development* and other professional journals, based on division membership

- A variety of discount and specialty programs (e.g., rental cars, auto insurance, hotels, discounts on books, etc.)
- Links to ACA listservs for graduate students, international counseling issues, public policy issues, and counselor educators
- Links to ACA divisions and other relevant professional associations
- Legislative updates and policy setting for counselors

The American Art Therapy Association (AATA)

The American Art Therapy Association (AATA) was founded in 1969 and is open to any individual interested in art therapy. AATA is "dedicated to the belief that the creative process involved in art making 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, 2010, Mission section). 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 the journal *Art Therapy*.

The American Association for 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 for Marriage and Family Therapy (AAMFT), with its 24,000 members, has become another important 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, What We Do section, para 1). AAMFT publishes the *Journal of Marital and Family Therapy*, sponsors a yearly conference, and offers professional activities related to family counseling and family development.

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* (which has the same acronym as the American Psychological Association, APA) has over 38,000 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, 2010, 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.*

The American Psychiatric Nurses Association (APNA)

Founded in 1986 with 600 members, today the American Psychiatric Nurses Association (APNA) has over 7,000 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, n.d., Welcome to APNA section). 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 150,000. 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, 2010, Mission statement section). 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.

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. Servicing both undergraduate- and graduate-level social workers, NASW has nearly 150,000 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, 2010, About NASW section). The association publishes five journals and other professional publications. It has 56 chapters that include every state as well as additional chapters in New York City, District of Columbia, Puerto Rico, Virgin Islands, Guam, and an International 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, promoting professional and organizational identity through certification, enhancing internal and external communications, advocating and implementing a social policy and agenda, and nurturing the financial sustainability and growth of the organization" (NOHS, 2009, Our Mission section). 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* (formerly, *Human Service Education*)

◼ *Characteristics of the Effective Helper*

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* [italics added]" (p. 322). Although found to have serious methodological flaws, Eysenck's research did lead 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 evidence-based medical practices. . . . (Wampold, 2010a, pp. 65–66)

But what is it that makes counseling effective? First and foremost, some client factors such as readiness for change, psychological resources, and social supports may affect how well a client does in counseling (Asay & Lambert, 1999; Clarkin & Levy, 2004; Wampold, 2010a). However, these factors are intimately related to the counselor's ability to work with the client. When looking specifically at the counselor, there has been some emphasis in recent years on the importance of matching treatment methodologies to presenting problems. Called *evidence-based practice* (Norcross, Beutler, & Levant, 2006; Hayes, 2005; Stout & Hayes, 2005), this approach has become commonplace in training clinics. However, it has also become clear that specific counselor qualities, sometimes called *common factors*, seem to be even more important to positive counseling outcomes than matching a treatment approach to a presenting problem (Wampold, 2010a, 2010b, 2010c). For instance, the counselor's ability at developing a strong *working alliance* with the client may be the most significant factor in creating client change (Baldwin et al., 2007; Beutler et al., 2004; Marmarosh et al., 2009; Orlinsky, Ronnestad, & Willutzki, 2004). 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, additional common factors seem to be related to the counselor's ability to deliver his or her theoretical approach (Wampold, 2010a), which I view as containing 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 (see Figure 1.2).

FIGURE 1.2
**The Nine Characteristics
of the Effective Counselor**

Empathy
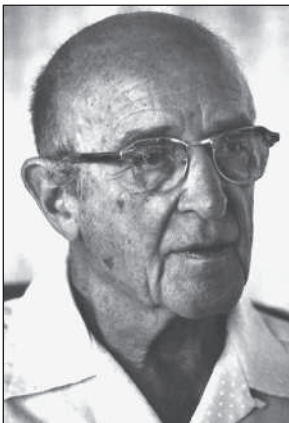
Natalie Rogers

Carl Rogers

More than any 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 (Bohart, Elliot, Greenberg, & Watson, 2002; Norcross, 2010). Understanding our clients, or being empathic,

> *. . . 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)

Whether or not one could 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, 2010; Neukrug & Schwitzer, 2006). Because empathy is seen as an important personal attribute as well as a critical counseling skill to learn, it will be discussed in more detail in Chapter 5.

Acceptance

Acceptance, sometimes called positive regard, is another component likely related to building a strong working alliance (Norcross, 2010). Acceptance is an attitude that suggests that regardless of what the client says, within the context of the counseling relationship, he or she will feel accepted. Just about every counseling approach stresses the importance of acceptance (see Neukrug, 2011). 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 counselor or by themselves. Solution-focused brief 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, suggests in his rational emotive behavioral approach that clients be shown unconditional acceptance and not be berated for thinking, feeling, and acting in a certain manner.

Genuineness

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 his or her 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). Genuineness may also be related to *emotional intelligence*, which is the ability to monitor one's emotions, a quality that counselors and counseling students seem to have more than others (Martin, Easton, Wilson, Takemoto, & Sullivan, 2004). Rogers (1957) popularized the term *genuineness* (or *congruence*) and noted that it was a core condition in the counseling relationship, along with empathy and unconditional positive regard.

Research by Gelso (Gelso & Carter, 1994; Gelso et. al., 2005) suggests that regardless of one's theoretical orientation, there exists an ongoing "real relationship" in which the client, to some degree, will see the counselor realistically. This real relationship has at its core the ability of the client to recognize the genuine (or nongenuine) self of the counselor. Genuineness has been shown to be one more quality that is sometimes related to positive outcomes in counseling (Beutler et al., 2004; Klein, Kolden, Michels, & Chisholm-Stockard, 2002; Norcross, 2010).

Embracing a Wellness Perspective

Counselor stress, burnout, compassion fatigue, vicarious traumatization, and unfinished psychological issues can all hinder the counselor's ability to have a working alliance (Lawson, 2007; Norcross, 2010; Roach & Young, 2007). Such concerns can prevent a counselor from being empathic, lower the ability to show acceptance, lead to incongruence, and increase *countertransference*, or "the unconscious transferring of thoughts, feelings, and attitudes onto the client by the therapist" (Neukrug, 2011, p. 50).

Counseling students and counselors in general all need to attend to their own wellness by *embracing a wellness perspective* if they are to be effective counselors. 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 (creative self, coping self, social self, essential self, and physical self) and contexts are described in Table 1.1.

You may want to complete an informal assessment on each of the factors and context to determine what areas you might want to address in your life. For instance, score yourself from 1 to 5 on each of the factors, with 5 indicating you most need to work on that area. Then, find the average for each of the five factors. Next, write down the ways you can better yourself in any factor where your scores seem problematic (probably scores of 3, 4, or 5). You may also want to consider how the contextual elements affect your ability to embrace a wellness perspective.

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
- 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, 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?

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 diverse clients. In fact, it is now assumed that when clients from nondominant groups work with majority helpers, there is a possibility that the client will frequently be misunderstood, often misdiagnosed, find counseling and therapy less helpful than their majority counterparts, attend counseling and therapy at lower rates than majority clients, and terminate

TABLE 1.1

Abbreviated Definitions of Components of the Indivisible Self Model	
WELLNESS FACTOR	DEFINITION
Total Wellness	The sum of all items on the 5F-Wel; a measure of one's general well-being or total wellness
Creative Self	The combination of attributes that each of us forms to make a unique place among others in our social interactions and to positively interpret our world
Thinking	Being mentally active, open-minded; having the ability to be creative and experimental; having a sense of curiosity, a need to know and to learn; the ability to solve problems
Emotions	Being aware of or in touch with one's feelings; being able to experience and express one's feelings appropriately, both positive and negative
Control	Belief that one can usually achieve the goals one sets for oneself; having a sense of planfulness in life; being able to be assertive in expressing one's needs
Work	Being satisfied with one's work; having adequate financial security; feeling that one's skills are used appropriately; the ability to cope with workplace stress
Positive Humor	Being able to laugh at one's own mistakes and the unexpected things that happen; the ability to use humor to accomplish even serious tasks
Coping Self	The combination of elements that regulate one's responses to life events and provide a means to transcend the negative effects of these events
Leisure	Activities done in one's free time; satisfaction with one's leisure activities; having at least one activity in which "I lose myself and time stands still"
Stress Management	General perception of one's own self-management or self-regulation; seeing change as an opportunity for growth; ongoing self-monitoring and assessment of one's coping resource
Self-Worth	Accepting who and what one is, positive qualities along with imperfections; valuing oneself as a unique individual
Realistic Beliefs	Understanding that perfection and being loved by everyone are impossible goals, and having the courage to be imperfect
Social Self	Social support through connections with others in friendships and intimate relationships, including family ties
Friendship	Social relationships that involve a connection with others individually or in community, but that do not have a marital, sexual, or familial commitment; having friends in whom one can trust and who can provide emotional, material, or informational support when needed
Love	The ability to be intimate, trusting, and self-disclosing with another person; having a family or family-like support system characterized by shared spiritual values, the ability to solve conflict in a mutually respectful way, healthy communication styles, and mutual appreciation
Essential Self	Essential meaning-making processes in relation to life, self, and others
Spirituality	Personal beliefs and behaviors that are practiced as part of the recognition that a person is more than the material aspects of mind and body
Gender Identity	Satisfaction with one's gender; feeling supported in one's gender; transcendence of gender identity (i.e., ability to be androgynous)
Cultural Identity	Satisfaction with one's cultural identity; feeling supported in one's cultural identity; transcendence of one's cultural identity
Self-Care	Taking responsibility for one's wellness through self-care and safety habits that are preventive in nature; minimizing the harmful effects of pollution in one's environment
Physical Self	The biological and physiological processes that compose the physical aspects of a person's development and functioning
Exercise	Engaging in sufficient physical activity to keep in good physical condition; maintaining flexibility through stretching
Nutrition	Eating a nutritionally balanced diet, maintaining a normal weight (i.e., within 15% of the ideal), and avoiding overeating
Contexts	
Local context	Systems in which one lives most often—families, neighborhoods, and communities—and one's perceptions of safety in these systems
Institutional context	Social and political systems that affect one's daily functioning and serve to empower or limit development in obvious and subtle ways, including education, religion, government, and the media
Global context	Factors such as politics, culture, global events, and the environment that connect one to others around the world
Chronometrical context	Growth, movement, and change in the time dimension that are perpetual, of necessity positive, and purposeful

NOTE: 5F-Wel = Five Factor Wellness Inventory

SOURCE: Myers, J., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development*, 86, p. 485.

counseling more quickly than majority clients (Evans, Delphin, Simmons, Omar, & Tebes, 2005; Sewell, 2009; United States Department of Health and Human Services, 2001). Unfortunately, it has become abundantly clear that many counselors have not learned how to effectively build a bridge—form 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 rightfully 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, cross-cultural competence is a theme we will visit and revisit throughout this text, and I will offer a number of ways for you to lessen the gap between you and your client. One model that can help bridge that gap is D'Andrea and Daniels's (2005) RESPECTFUL Counseling Model, which highlights ten factors that counselors should consider addressing with clients:

R – Religious/spiritual identity

E – Economic class background

S – Sexual identity

P – Psychological development

E – Ethnic/racial identity

C – Chronological disposition

T –Trauma and other threats to their personal well-being

F – Family history

U – Unique physical characteristics

L – Language and location of residence, which may affect the helping process. (p. 37)

The RESPECTFUL model offers one mechanism through which you can think about clients as you develop your skills as a counselor. Throughout the text, you will find other ways of assuring that you have a strong sense of *cultural competence*.

The "It" Factor

I worked at a suicide crisis center where 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. 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 have their own *it factor*, although more often than not these great theorists want <u>us</u> to use <u>their</u> *it factor*. So, Carl Rogers, who was great at showing empathy, unconditional positive regard, and genuineness, suggested we all use these core conditions; and Albert Ellis, who was a master at showing how irrational one can be, suggested we all show our clients their irrational thinking; and

Michael White, who believed that social injustices fueled mental illness, wanted all counselors to look at how individuals are oppressed by language; and of course Freud, who believed in the unconscious, told us to show analytic neutrality to allow the unconscious to be projected onto the therapist. I believe Salvadore Minuchin's (1974) described this *it factor* best. A family counselor, Minuchin 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. There 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 Box 1.1)

Compatibility with and Belief in a Theory

There are many theories to choose from when I do counseling, but most don't fit me. For one reason or another, I am simply not compatible with them. 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—for whatever 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) says 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). Wampold (2010a, 2010b) 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, will you likely see positive counseling outcomes. So, what theories are you drawn to? And, if you aren't sure yet, you'll have an opportunity to explore this more in Chapter 4 and in other courses where you will examine your own theoretical orientation to counseling. Hopefully, over, time, you will feel an increased sense of *compatibility with and belief in a theory*.

BOX 1.1

What Is Your "It"?

Write down your unique personality characteristics that allow you to build a bond with others. Then the instructor can make a master list on the board. After reviewing the list, discuss whether the characteristics are inherent and which may be learned. Is it possible for a counselor to acquire new ways of bonding with clients as he or she develops?

Competence

Counselor expertise and mastery (*competence*) has been shown to be a crucial element for client success in counseling (Wampold, 2010a, 2010c; Whiston & Coker, 2000). Competent counselors have a thirst for knowledge. They continually want to improve and expand their expertise at delivering their theory. Such counselors exhibit this thirst through their study habits, their desire to join professional associations, through mentoring and supervision, by reading their professional journals, through their belief that education is a lifelong process, and through their ability to view their own approach to working with clients as something that is always broadening and deepening.

Counselors have both an ethical and legal responsibility to be competent (Corey, Corey, & Callanan, 2011). For instance, the ACA (2005) ethical guidelines elaborate 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, (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 (ACA, 2005, Standard C.2). The legal system reinforces these ethical guidelines because "one function of lawsuits is to encourage competent therapy" (Swenson, 1997, p. 166).

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

Cognitive Complexity

The best helpers believe in their theory, but are willing to question it. This apparent contradiction makes sense. You have a way of working, but are also willing to constantly examine if your way *is* working. Deal (2003) describes such a counselor as person who is as a critical thinker who is good at examining problems from multiple perspectives and good at analyzing and evaluating situations. Counselors who view the world with a fair amount of *cognitive complexity* are likely to be more empathic, more open-minded, more self-aware, more effective with individuals from diverse cultures, able to examine a client's predicament from multiple perspectives, and better able to resolve "ruptures" in the counseling relationship (Deal, 2003; Eriksen & McAuliffe, 2006; Granello, 2002; Milliken, 2004; McAuliffe & Eriksen, 2010; Norcross, 2010). 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 his or her theory holds the "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.

Now that we've looked at all nine characteristics, ask yourself, are you empathic, accepting, genuine, wellness oriented, and culturally competent? Do you have the "it"

factor? Are you compatible with and do you believe in your theory? Are you competent and cognitively complex? As we start on our journey to help others, let's not forget to help ourselves, because clearly, helping ourselves will significantly improve the manner in which we help others.

Multicultural/Social Justice Focus: Inclusion of Multiculturalism in the Profession

With relatively small numbers of persons from culturally diverse groups entering the counseling profession (ACA, 2009), it is imperative that the helping professions develop an environment that attracts more counselors of color. Increased cultural diversity among counselors along with better training in multicultural counseling are essential if culturally diverse clients are to feel comfortable seeking out and following through in counseling.

In addition, if counseling is to be an equal opportunity profession, counselors must graduate from training programs with more than a desire to help all people. As a profession, we will have achieved competence in counseling diverse clients when every graduate from each training program has (1) learned counseling strategies that work for a wide range of clients, (2) worked with clients from diverse backgrounds, (3) gained a deep appreciation for diversity, and (4) acquired an identity as a counselor that includes a multicultural perspective (see D'Andrea & Heckman, 2008). As you read through this text, you will see considerable emphasis placed on multicultural and social justice issues. As you reflect on the issues, consider what the counseling profession can do to foster a more welcoming professional culture that will attract more individuals of color and what training programs can do to assure that all individuals feel comfortable with the counseling process.

Ethical, Professional, and Legal Issues

Knowing Who We Are and Our Relationship to Other Professional Groups

Our professional identity is based on a specific body of knowledge unique to our profession. By knowing who we are, we also have a clear sense of who we are not. It is by having a strong sense of our identity that we are able to define our limits, know when it is appropriate to consult with colleagues, and recognize when we should refer clients to other professionals (Gale & Austin, 2003). The ACA *Code of Ethics* (ACA, 2005) highlights the importance of knowing our professional boundaries:

> *Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.* . . . (Standard C.2.a.)

and

> *Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice.* (Standard C.2.e.)

and

> *If counselors determine an inability to be of professional assistance to clients, they avoid entering or immediately terminate the counseling relationship. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. . . .* (Standard A.11.b.)

Impaired Mental Health Professionals

> *For a counselor to set themselves up as a helper to others, without having resolved major difficulties of their own, would appear to be farcical.* (Wheeler, 1991, p. 199)

An older quote, but still a poignant point—to avoid working on your own issues while trying to help others—simply does not make sense. As noted earlier, mental health professionals have a responsibility to be aware of the pressures and stresses that impinge on their lives and how these might affect their relationship with clients. This is stressed in the ACA (2005) *Code of Ethics:*

> *Counselors are alert to the 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 such time it is determined that they may safely resume their work . . . .* (Standard C.2.G)

A professional who is not attending to his or her own needs is likely to be ineffective in the counseling relationship. Professional incompetence is not only unethical; it can lead to malpractice suits (Neukrug, Milliken, & Walden, 2001; Remley & Herlihy, 2010). But, perhaps even more importantly, impaired practice can result in our clients ending up with deeper wounds than the ones they had when they initially entered counseling.

■ The Counselor in Process: Personal Therapy and Related Growth Experiences

As you begin your journey in the counseling profession, I hope you have the opportunity to engage in growth experiences that will help you embody the counselor characteristics highlighted in this chapter. What kind of experiences should you seek out? First, I hope that you strongly consider undergoing your own personal counseling, for the many reasons noted earlier. In addition to counseling, you might want to consider other related growth

experiences, such as prayer and/or meditation, relaxation exercises and stress reduction, discussion and support groups, exercise, journaling, and readings.

I also hope that you are afforded experiences in your educational program that will challenge you to grow intellectually and personally. I am hopeful that the philosophy of your program is that students need a supportive environment in which they can feel safe enough to share, while at the same time, be challenged to grow. This "constructive development" philosophy has become an important model for many counselor education programs, as it is built on the belief that if afforded a nurturing environment, students can develop increased flexibility and relativist thinking in their ways of understanding the world (Eriksen & McAuliffe, 2006; McAuliffe & Eriksen, 2010). Such students gain a strong sense of self, can listen to feedback about self from others, and are genuine, more empathic, and more accepting of others. Not surprisingly, these are also the qualities we look for in an effective counselor!

◼ *Summary*

In this chapter, we attempted to define the somewhat elusive word counseling and distinguish it from the words guidance and psychotherapy. We then compared and contrasted some of the training, credentialing, and roles and functions of counselors, social workers, psychologists, psychiatrists, psychoanalysts, psychiatric mental health nurses, expressive therapists, human service practitioners, and psychotherapists. In addition, we also identified some of the benefits of professional associations, with a special emphasis on the American Counseling Association (ACA), and identified some of the more prominent professional associations in related fields.

Next, we discussed the recent move toward evidence-based practice, but noted that even more important were the characteristics of the counselor, sometimes called the "common factors" that are critical in counseling outcomes. We highlighted six components of building an effective working alliance followed by three components to the counselor's ability to deliver his or her theoretical approach. These nine components included empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence, something that I call the "it" factor, compatibility with and belief in your theory, competence, and cognitive complexity.

Examining some important multicultural and social justice issues, we noted that clients of color are frequently misdiagnosed, attend counseling at lower rates, terminate counseling more quickly, find counseling less helpful, and can be distrustful of White counselors. We talked about the importance of recruiting a more culturally diverse group of counselors to the field, as the counseling profession continues to have relatively small numbers of individuals from diverse cultures entering the profession and because clients tend to respond better to counselors of their own cultural background. We also talked about the importance of having every counseling student graduate with knowledge of how to work with diverse clients, with experience working with diverse clients, with an appreciation for diversity, and with an identity that includes a multicultural perspective.

As the chapter neared its conclusion, we discussed the importance of a number of ethical issues, including understanding our professional identity and knowing our professional limits, practicing within one's area of competence, consulting with other

professionals, and terminating or referring clients when one is unable to work effectively with them. We then discussed the importance of assuring that we are not working while impaired. Related to this topic, we ended the chapter discussing the importance of being in our own personal counseling and/or finding other related personal growth experiences. We also expressed the hope that readers of this text were in an educational program that affords personal and intellectual growth experiences in a nurturing yet challenging environment.

References

American Association of Marriage and Family Therapists. (2002). *About AAMFT.* Retrieved from http://www.aamft.org/about/index_nm.asp

American Art Therapy Association. (2010). *The mission.* Retrieved from http://aata2009.serveronline.net/aata-aboutus.html

American Counseling Association. (2005). *Code of ethics.* Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Counseling Association. (2009, August 1). *Membership report.* Alexandria, VA: Author.

American Counseling Association. (2010a). *ACA Milestones.* Retrieved from http://www.counseling.org/AboutUs/OurHistory/TP/Milestones/CT2.aspx?

American Counseling Association. (2010b). *Licensure & certification: State professional counselor licensure boards.* Retrieved from http://www.counseling.org/Counselors/LicensureAndCert/TP/StateRequirements/CT2.aspx

American Counseling Association. (2010c). *About us.* Retrieved from http://www.counseling.org/AboutUs/

American Nurses Credentialing Center. (2010). *Home page.* Retrieved from http://www.nursecredentialing.org/

American Psychiatric Association. (2010). *About APA.* Retrieved from http://www.psych.org/FunctionalMenu/AboutAPA.aspx

American Psychiatric Nurses Association. (n.d.). *Home page.* Retrieved from http://www.apna.org/

American Psychological Association. (2003). *Careers for the 21st century.* [Brochure]. Washington, DC: Author.

American Psychological Association. (2010). *About APA.* Retrieved from http://www.apa.org/about/index.aspx

American Psychoanalytic Association. (2008). *Principles and standards for education in psychoanalysis.* Retrieved from http://www.apsa.org/Portals/1/docs/Training/Standards_rv_06_08.pdf

Anderson, T., Lunnen, K. M., & Ogles, B. M. (2010). Putting models and techniques in context. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 143–166). Washington, DC: American Psychological Association.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, and S. D. Miller (Eds.). *The heart and soul of change: What works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Art Therapy Credentials Board. (2007). *Welcome to the art therapy credentials board, inc.!* Retrieved from http://www.atcb.org/

Baker, S. & Gerler, E. (2008). *School counseling for the twenty-first century* (5th ed.). Upper Saddle River, NJ: Merrill.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). *Journal of Consulting and Clinical Psychology, 75*(6), 842–852. doi: 10.1037/0022-006X.75.6.842

Baxter, N. J., Toch, M. U., & Perry, P. A. (1997). *Opportunities in counseling and development careers* (rev. ed.). Lincolnwood, IL: VGM Career Horizons.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.) (227–306). New York: Wiley.

Bike, D. H., Norcross, J. C., & Schatz, D. M. Process and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 19–31. doi: 10.1037/a0015139

Bohart, A. C., Elliot, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89–108). New York: Oxford University Press.

Chaplin, J. P. (1975). *Dictionary of psychology* (2nd ed.). New York: Dell.

Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 195–226). New York: Wiley.

Corey, G. (2009). *Theory and practice of counseling and psychotherapy* (8th ed.). Belmont, CA: Brooks/Cole.

Corey, G., Corey, M. S., & Callanan, P. (2011). *Issues and ethics in the helping professions* (8th ed.). Belmont, CA: Brooks/Cole.

Deal, H. D. (2003). The relationship between critical thinking and interpersonal skills: Guidelines for clinical supervision. *The Clinical Supervisor, 22*(2), 3–19. doi: 10.1300/J001v22n02_02

D'Andrea, M., & Daniels, J. (2005, July). A socially responsible approach to counseling, mental health care. *Counseling Today, 48*(1), 36–38.

D'Andrea, M., & Heckman, E. F. (Eds.). (2008). Multicultural counseling (Special issue). *Journal of Counseling and Development, 86*(3).

Egan, G. (2010). *The skilled helper: A problem management and opportunity-development approach to helping* (9th ed.). Belmont, CA: Brooks/Cole.

Eriksen, K. P., & McAuliffe, G. J. (2006). Constructive development and counselor competence. *Counselor Education and Supervision, 45*(3), 180–192.

Evans, A. C., Delphin, M., Simmons, R., Omar, G., & Tebes, J. (2005). Developing a framework for culturally competent systems care. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (vol. 2, pp 492–513). Hoboken, NJ: John Wiley.

Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling and Development, 81,* 3–10.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*(3), 296–306. doi:10.1037/0022-0167.41.3.296

Gelso, C. J., Kelley, F. A., Fuertes, J. N., Marmarosh, C., Holmes, S. E., Costa, C., & Hancock, G. R. (2005). Measuring the real relationship in psychotherapy: Initial validation of the therapist form. *Journal of Counseling Psychology,* 52(4), 640–649. doi: 10.1037/0022-0167.52.4.640

Gompertz, K. (1960). The relation of empathy to effective communication. *Journalism Quarterly, 37,* 535–546.

Granello, D. H. (2002). Assessing the cognitive development of counseling students: Changes in epistemological assumptions. *Counselor Education and Supervision, 41,* 279–293.

Hackney, H., & Cormier, L. S. (2009). *The professional counselor: A process guide to helping* (6th ed.). Columbus, OH: Merrill.

Hayes, R. A. (2005). Introduction to evidence-based practice. In C. E. Stout & R. A. Hayes (Eds.), *The evidence-based practice: Methods, models, and tools for mental health professionals* (pp. 1–9). Hoboken, NJ: Wiley.

International Association of Marriage and Family Counseling (n.d.). *Welcome to IAMFC.* Retrieved from http://www.provisionsconsultingcms.com/~iamfc/

Johnson, J. (2009). Whether states should create prescription power for psychologists. *Law and psychology review, 33,* 167–178.

Klein, M. H., Kolden, G.G., Michels, J. L., & Chisholm-Stockard, S. (2001). Congruence or genuineness. *Psychotherapy*, *38*(4), 396–400. doi: 10.1037/0033-3204.38.4.396

Kleinke, C. L. (1994). *Common principles of psychotherapy*. Pacific Grove, CA: Brooks/Cole.

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education and Development*, *46*(1), 20–34.

Malchiodi, C.A. (Ed.). (2006). *Expressive therapies*. New York: Guilford Press.

Marmarosh, C. L., Markin, R. D., Gelso, C. J., Majors, R., Mallery, C., & Choi, J. (2009). The real relationship in psychotherapy: Relationships to adult attachments, working alliance, transference, and therapy outcome. *Journal of Counseling Psychology*, *56*(3), 337–350. doi: 10.1037/a0015169

Martin, W. E., Easton, C., Wilson, S., Takemoto, M., & Sullivan, S. (2004). Salience of emotional intelligence as a core characteristic of being a counselor. *Counselor Education and Supervision*, *44*(1), 17–30.

McAuliffe, G., & Eriksen, K. (Eds.). (2010). *Handbook of Counselor Preparation*. Thousand Oaks, CA: Sage and Alexandria, VA: Association for Counselor Education and Supervision.

Menninger, K. (1973). *Whatever became of sin?* New York: Hawthorne Books.

Milliken, T. F. (2004). The impact of cognitive development on White school counselor interns' perspectives and perceived competencies for addressing the needs of African American students. (Doctoral dissertation, College of William and Mary, 2003). *Dissertation Abstracts International*, *65*(02A), 420.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development*, *86*(4), 482–493.

National Association of School Psychologists (n.d.). *What is a school psychologist?* [Brochure]. Bethesda, MD: Author.

National Board for Certified Counselors. (2009a). *Certified counselors*. Retrieved from http://www.nbcc.org/certifications/

National Association of Social Workers. (2010). *About NASW*. Retrieved from http://www.naswdc.org/nasw/default.asp

National Organization of Human Services. (2009). *Home page*. Retrieved from http://www.nationalhumanservices.org/

Neukrug, E. (2011). *Counseling theory and practice*. Belmont, CA: Brooks/Cole.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision*, *41*(1), 57–70.

Neukrug, E. & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional counseling*. Pacific Grove, CA: Brooks/Cole.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 113–142). Washington, DC: American Psychological Association.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health: Dialogue on the fundamental questions*. Washington, DC: American Psychological Association.

Norcross, J.C., Bike, D. H., Evans, K. L., & Schatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach? *Journal of Clinical Psychology*, *64*(12), 1368–1376. doi:10.1002/jclp.20523

Nugent, F. A., & Jones, K. D. (2005). *An introduction to the profession of counseling* (4th ed.). Upper Saddle River, NJ: Merrill.

Occupational Outlook Handbook (2010–2011). *Counselors*. Retrieved from http://www.bls.gov/OCO/ocos067.htm

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., 307–389). New York: Wiley.

Patterson, C. H. (1986). *Theories of counseling and psychotherapy* (4th ed.) New York: HarperCollins.

Phillips, S. J. (2007). A comprehensive look at the legislative issues affecting advanced nursing practice. *Nurse Practitioner, 32*(1), 14–17. doi:10.1097/00006205-200701000-00006

Remley, T. P., & Herlihy, B. (2010). *Ethical and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education and Supervision, 47*(1), 29–45.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103. doi:10.1037/h0045357

Rogers, C. R. (1989). A client-centered/person-centered approach to therapy. In H. Kirschenbaum (Ed.), *The Carl Rogers reader* (pp. 135–152). Boston: Houghton Mifflin. (Original work published 1986.)

Sewell, H. (2009). *Working with ethnicity, race and culture in mental health.* Philadelphia: Jessica Kingsley Publishers.

Stout, C. E., & Hayes, R. A. (Eds.). (2005). *The evidence-based practice: Methods, models, and tools for mental health professionals.* Hoboken, NJ: Wiley.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

The CACREP Connection. (2007, Fall). *CACREP/CORE merger fails.* Alexandra, VA: CACREP.

Todd, J., & Bohart, A. C. (2006). *Foundations of clinical and counseling psychology* (4th ed.). Long Grove, IL: Waveland Press.

Turkington, C. (1985). Analysts sued for barring non-MDs. *APA Monitor, 16*(5), 2.

Tyler, L. E. (1969). *The work of the counselor* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

United States Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report to the Surgeon General.* Retrieved from: http://downloadncadisamhsagov/ken/pdf/SMA-01-3613/sma-01-3613pdf

Wadeson, H. (2004). To be or not to be licensed: Is that the question? *Art Therapy, 21*(4), 182–183.

Wampold, B. E. (2010a). *The basics of psychotherapy: An introduction to theory and practice.* Washington, DC: American Psychological Association.

Wampold, B. E. (2010b). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates.

Wampold, B. E. (2010c). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 49–82). Washington, DC: American Psychological Association.

Wheeler, S. (1991). Personal therapy: An essential aspect of counsellor training, or a distraction from focusing on the client? *Journal for the Advancement of Counselling, 14*, 193–202. doi:10.1007/BF00119182

Whiston, S. C., & Coker, J. K. (2000). Reconstructing clinical training: Implications from research. *Counselor Education and Supervision, 39*, 228–253.

Williamson, E. G. (1950). *Counseling adolescents.* New York: McGraw-Hill.

Williamson, E. G. (1958). Value orientation in counseling. *Personnel and Guidance Journal, 37*, 520–528.

Zytowski, D. G. (1972). Four hundred years before Parsons. *Personnel and Guidance Journal, 50*, 443–450.

The Counseling Profession's Past, Present, and Future

Can you imagine a woman being hanged as a witch because she was mentally ill, or being placed in a straitjacket and thrown into a filthy, rat-infested cell for the remainder of her life? Or can you envision a man being placed in a bathtub filled with iron filings to cure him of mental illness or bled to rid him of demons and spirits that caused him to think in demonic ways? What about having a piece of your brain scraped out in order to change the way you feel? Or being placed in a box that would receive "energy" and rid you of emotional and physical problems? These examples are a part of the history of our profession.

I've taught long enough to know that when I teach history, it often is not as interesting as what you just read. In fact, my experience has been that half of the class mentally steps out. Why is this so? Unfortunately, learning names, dates, and a few facts is just plain boring for some people. I used to feel the same way, but now I have a different perspective. In 1962, Thomas Kuhn wrote a book called *The Structure of Scientific Revolutions* that changed the way I understood history and the accumulation of knowledge. What intrigued me in particular was his concept that knowledge builds upon prior knowledge, and, periodically, the time is ripe for a person to synthesize this prior knowledge and develop new, revolutionary ways of understanding what has come before. He called this process a *paradigm shift*. This concept makes learning about history more exciting for me, because I can now see how events unfold to bring us closer to the next paradigm shift.

We are all part of history in the making. Some of us take an active role through research, scholarly pursuits, or leadership in professional organizations. Perhaps you will be one of those who are instrumental in the next paradigm shift. Regardless of whether you assume the role of active participant or interested observer, you have been affected by the past, and, in your own unique way, you are affecting the future. Let's look at how history has made us what we are today, and then, later in the text, we can consider where we might be headed in the future.

Early treatment of the mentally ill–hydrotherapy

We will start our look at history by journeying into the distant past, exploring some of the precursors to the mental health field. We will then take a brief look at the history of social work, psychology, and psychiatry: three fields that dramatically affected the counseling profession. Next, we will examine the history of our profession in detail, from its early roots in vocational guidance to modern-day counseling. The chapter will conclude by examining the relatively recent impact of ethical standards, multicultural competencies, and social justice issues.

▪ *Understanding the Human Condition: From Early Antiquity to the Present*

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, 2011, p. 30)

Since the dawn of 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, 2009). Shamans, or individuals who had special status due to their mystical powers, have been considered to be caretakers of the soul and thought to have knowledge of the future. Later in history, the concept of soul has often given way to the concept of *psyche*.

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 obviously was psychologically minded wrote:

> *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 Hippocrates (460–377 BCE) who presented reflections on the human condition that were to greatly change the Western world's view of the person. Whereas many contemporaries of Hippocrates believed that possession by evil spirits was responsible for emotional ills, Hippocrates offered suggestions for the treatment of the human condition that might even be considered modern by today's standards. 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—an idea that would certainly spark the ire of many women and probably quite a few men in today's world!

With the advent of monotheistic religion, we see abundant examples of humankind's attempt to understand 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 to the pain and suffering that people carry due to what is called "delusive perceptions" (Purton, 1993), and the Old and New Testaments offer us many reflections on the concept of guilt and sin—reflections that could very well come in handy today.

. . . Is no one any longer guilty of anything? Guilty perhaps of a sin that could be
repented and repaired or atoned for? Is it only that someone may be stupid or sick or
criminal or asleep. . . . Anxiety and depression we all acknowledge, and even vague
guilt feelings; but has no one committed any sins? (Menninger, 1973, p. 13)

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 might be considered the start of the modern era; with it came the printing press and the writings of modern philosophers. Individuals like Descartes (1596–1650), who believed that knowledge and truth come through deductive reasoning, and John Locke (1632–1704) and James Mill (1773–1836), who believed that the mind is a blank slate upon which ideas become generated, set the stage for modern psychologists to study human experience. These individuals, and others, gave us the ingredients for modern psychology, the beginnings of modern-day social work and psychiatry, and the origins of the counseling field.

A Brief History of Related Helping Professions: Social Work, Psychology, Psychiatry

Originating in the nineteenth century, the professions of social work, psychology, psychiatry, and counseling had somewhat different beginnings, with the counseling profession evolving out of early vocational guidance activities, the social work field developing

FIGURE 2.1
The Coming Together of the Major Fields of Mental Health

Psychiatry

Psychology

Counseling

Social work

1850   1900   1940   2000
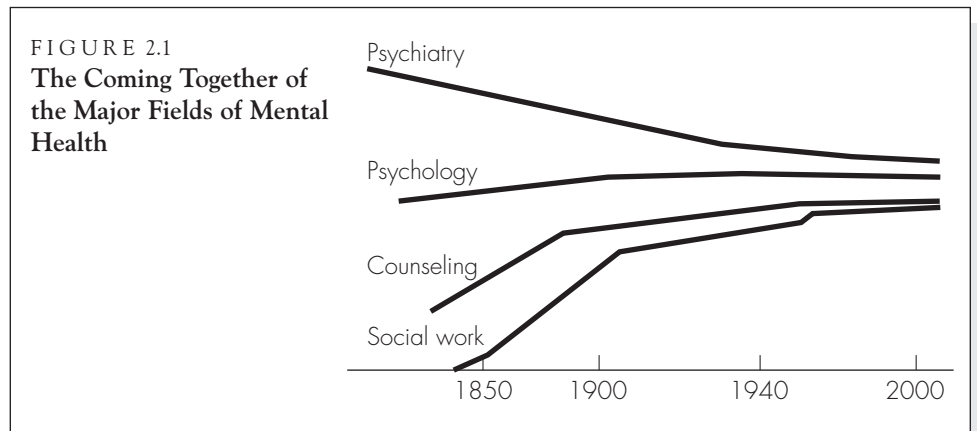
out of the desire to assist the destitute, psychology starting as both a laboratory science and an attempt to understand the nature of the person, and psychiatry growing out of modern medicine's attempt to alleviate mental illness through medical interventions. Despite their different origins, they all have slowly moved toward many of the same theoretical conclusions and today can be seen on slightly different yet parallel paths (see Figure 2.1).

The Social Work Profession

Historical Background

The field of social work can be traced to work with the poor and destitute in the United States and England. During the 1500s, the *Elizabethan Poor Laws* in England gave the Church power to oversee the raising and administering of funds for the destitute (Burger, 2011). Until then, such relief had been provided on a voluntary basis. As a carryover from this system, during the colonial period in America, local governments enacted laws to assist the poor. During this same period of history, organized charities (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 major approaches evolved: the *Charity Organization Society* (COS) and the *settlement movement*. Charity Organization Societies had volunteers who would visit the poor, aid in educating children, give economic advice, and assist in alleviating the conditions of poverty. Generally, the poor received advice, support, and small amounts of necessities from COS volunteers, along with a good dose of moral judgment and religious preaching. Sometimes these volunteers, who became known as "friendly visitors," would spend years assisting one family. The COSs are seen as the beginnings of *social casework*, the process in which a client's needs are examined and a treatment plan is designed.

In contrast to the COSs, the settlement movement had staff who actually lived 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)

The idealistic young staff of settlement houses believed in community action and tried to persuade politicians to provide better services for the poor. One of the best-known settlement houses was *Hull House*, established by social activist Jane Addams (1860–1935) in 1889 in Chicago (Addams, 1910).

Out of this involvement with the underprivileged arose articles and books concerned with methods of adequately meeting the needs of the underclass. At the turn of the twentieth century, the first social work training programs arose. Over the next 30 years, the social work field grew in many different directions, with major areas of emphasis being social casework, social group work, and community work.

During the 1940s and 1950s, an increased emphasis on understanding the dynamics of social and family systems emerged. As social workers had already been working with social systems and families, this emphasis became a natural focus for many social work programs. Such programs stressed contextual or systems thinking, as opposed to seeing the individual as an island unto him- or herself, as had many of the early philosophers and psychologists. 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 for Social Work (NASW). In 1965, 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 psychotherapy 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

The counseling profession has learned much from the field of social work. Social work, with its emphasis on understanding systems, has provided the counseling profession with an understanding of the individual from a family and social system perspective. Because many of the well-known family therapists started out as social workers, counselors have learned to apply many of their 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 emphasis 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.

The Psychology Profession

Historical Background

The origins of the psychology profession can be traced back thousands of years. For instance, during the seventh century BCE, Greek philosophers reflected on the nature of life and the universe. A few centuries later, the Greek philosopher Hippocrates offered notions on how to treat mental illness, and Plato (427–347 BCE) suggested 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. Many consider Plato's student Aristotle (384–322 BCE) to be the first psychologist because he used objectivity and reason to study knowledge, and his writings were psychological in nature (Iannone, 2001; Wertheimer, 2000).

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.

During the nineteenth century, psychology was increasingly influenced by modern-day medicine, physics, and the new theory of evolution. Wilhelm Wundt (1832–1920) and Sir Francis Galton (1822–1911), two of the first experimental psychologists, developed laboratories to examine similarities and differences in responses by individuals to sensory experiments as they attempted to understand how responses to external stimuli were related to the workings of the mind (Green, 2009). This scientific orientation to the field of psychology quickly spread to the United States, where G. Stanley Hall (1846–1924) and James Cattell (1860–1940) opened laboratories at Harvard and the University of Pennsylvania in the late 1800s (Capshew, 1992). It was also during the nineteenth century that William James (1842–1910) published his theory of *philosophical pragmatism*, which suggested that truth or reality is continually constructed as a function of the utility or practical purpose that it has for the individual who holds that reality (Leary, 1992). Thus were seen the beginnings 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 at the end of the nineteenth century. For instance, Alfred Binet (1857–1911) developed, for the Ministry of Public Education in Paris, one of the first intelligence tests, which was used to assist in classroom placement of children who were mentally retarded (Neukrug & Fawcett, 2010). The beginning of the twentieth century saw the first use of school achievement tests, tests for vocational assessment, and some of the first "modern day" personality tests. Today, tests are used everywhere and often help provide a deeper understanding of our clients.

The beginnings of the testing movement paralleled the rise of *psychoanalysis*, the first comprehensive psychotherapeutic system. Developed by Sigmund Freud (1856–1939), this movement was undoubtedly affected by the new emphasis on the scientific method. Freud had been greatly influenced by Anton Mesmer (the term mesmerize was

Sigmund Freud

derived from his name) (1734–1815) and Jean Martin Charcot (1825–1893), who were practicing a new technique called *hypnosis*. These early hypnotists showed that suggestion could greatly influence an individual's mental state. In fact, Charcot showed that some physical disorders (e.g., some forms of paralysis), whose etiology was previously thought to only be of a physical nature, could be induced under hypnosis. Freud originally used hypnosis to uncover repressed and painful 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 and mental illness were revolutionary and continue to have a profound affect on the conceptualization of client problems (Appignanesi & Zarate, 2004). Although Freud was trained as a physician, his 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. Ivan Pavlov (1849–1936) and his followers, in experiments with *classical conditioning* of dogs, developed *behaviorism*, de-emphasized the importance of introspection, and stressed the importance of stimulus–response and environmental influences. 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*, which tried to answer questions about how individuals organize experience into reality, first emerged. The early days of behaviorism, existential psychology, phenomenological psychology, and Gestalt psychology represent the roots of many of today's *cognitive–behavioral* and *humanistically oriented* therapies.

In 1892, the American Psychological Association (APA) was founded as an association mostly of experimental psychologists (Sokal, 1992). However, starting in the 1920s clinicians began to have a greater impact on the field and entered the association in large numbers. During the mid-1940s, APA underwent a great revision and assimilated many new clinical associations such as Counseling Psychology (Division 17) (Pepinsky, 2001; Routh, 2000; Schmidt, 2000). This division shared a common history and had similar goals with the counseling profession. Its assimilation by APA highlighted the fact that a vast majority of psychologists had begun to view themselves as clinicians, rather than as academics or scientists.

Today, we still find both *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

The field of psychology has affected the counseling profession more than any other related mental health 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.

The Psychiatry Profession

Historical Background

Until the late 1700s, mental illness was generally viewed as mystical, demonic, and not treatable, but this perspective gradually gave way to new approaches to the understanding and treatment of mental diseases. In the late 1700s, in France, Philippe Pinel (1745–1826), who is credited with being the founder of psychiatry, was one of the first of many to view insanity from a scientific perspective. Administering two mental hospitals, Pinel removed the chains that bound inmates in one of the first attempts to treat inmates humanely (Weissmann, 2008).

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

In the United States, Benjamin Rush (1743–1813), a physician and dedicated social reformer, is considered to be the founder of American psychiatry. An impassioned believer in the abolition of slavery, a signer of the Declaration of Independence, and an advocate for the establishment of a peace institute as an alternative to the U.S. Military Academy, Rush appealed for humane treatment of the poor and mentally ill. Rush's text *Medical Inquiries and Observations upon the Diseases of the Mind*, published in 1812, became the seminal text in the field of psychiatry for the next 70 years (Baxter, 1994).

By the early 1800s, the Pennsylvania Hospital in Philadelphia and the Publick Hospital for Persons of Insane and Disordered Minds in Williamsburg, Virginia, had been established to treat the mentally insane. Early treatments for the mentally ill hardly resembled anything we might find in today's psychiatric hospitals; however, they were an acknowledgment that psychiatric disorders were real (see Box 2.1).

In the mid-1800s, Dorothea Dix (1802–1887) and others advocated for the humane treatment of the mentally ill and suggested supportive care, encouragement and respect, removal from stressors, and vocational training as treatments of choice (Baxter, 1994). The spread of mental hospitals and the impetus towards more humane treatment of the mentally ill led to the founding of the Association of Medical Superintendents of American Institutions for the Insane in 1844. The forerunner of the American Psychiatric Association, this association sought the improvement of diagnosis, care, and the humane treatment of the mentally ill and developed standards for mental hospitals of the time.

In the first half of the twentieth century, psychiatry developed in a number of different directions. Whereas many psychiatrists became entrenched in the psychoanalytic movement, others began to drift toward psychobiology as the treatment of choice for mental disorders, while still others became increasingly involved in social psychiatry (Sabshin, 1990). During the 1950s, there was a great expansion of the use of psychotropic medications, which resulted in many individuals who had been formerly hospitalized living

BOX 2.1

The Beginnings of the Modern Mental Hospital

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 was thought to remove harmful fluids from the

individual's system (Zwelling, 1990). It was believed, at that time, that it was important to cause fear in a person, and even individuals like Dr. Benjamin Rush, known for his innovative and humane treatment of the mentally ill (Woodside & McClam, 2009), wrote of the importance of staring a person down:

> The first object of a physician, when he enters the cell or chamber of his deranged patient, should be to catch his EYE. . . .The dread of the eye was early imposed upon every beast of the field. . . . Now a man deprived of his reason partakes so much of the nature of those animals, that he is for the most part terrified, or composed, by the eye of a man who possesses his reason. (Rush cited in Zwelling, 1990, p. 17)

on their own. Then in the 1960s, the development of community-based mental health centers greatly expanded the role of psychiatrists in community agencies. The eventual deinstitutionalization of the mentally ill as a result of Supreme Court case *Donaldson v. O'Connor* (to be discussed later in the chapter) also meant that psychiatrists were needed to work at community based agencies. Increasingly, psychiatrists became disengaged from doing psychoanalysis and more involved in exploring the psychobiology of mental illness.

During the 1950s, the American Psychiatric Association was instrumental in developing the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I), the forerunner of the DSM-IV-TR and soon to be published DSM-5. The purpose of the DSM is to provide uniform criteria for making clinical diagnoses, thereby enhancing agreement among clinicians (American Psychiatric Association, 2000).

Today, with research indicating that some mental illness is predominantly or partially biologically based (Roberts, Kiselica, & Fredrickson, 2002; Schatzberg & Nemeroff, 2009; Neukrug, 2001), 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 the diagnosis and development of treatment plans for clients, which sometimes include 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.

■ *The Counseling Profession: Its History and Trends*

Precursors to the Counseling Profession: The 1800s

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)

In the 1800s, a number of forces came together that eventually led to the early beginnings of the counseling profession. Such seemingly disparate forces as social reform movements, the early days of vocational guidance, the beginning use of assessment instruments, and the first comprehensive approach to therapy all influenced the beginning of what we now call the counseling profession. Let's take a brief look at each of these forces.

Social Reform Movements of the 1800s

During the 1800s, a number of reform movements occurred simultaneously that eventually influenced the development of the counseling profession. Social workers who were working with the poor and destitute, psychiatrists who were trying to change the treatment of the mentally ill, and educators such as John Dewey (1859–1952)—who insisted on more humanistic teaching methods and access to public education—all had a common desire to help people in more humane and "modern" ways (Dewey, 1956; Dykhuizen, 1973; Neukrug, 2008). The counseling profession soon bore the fruits of these reform movements as it embraced many of their ideals and some of their basic premises. Reform movements, and their focus on caring for others, no doubt influenced the modus operandi of the first professional counselors: the vocational guidance workers.

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 beginnings of the vocational guidance movement and ultimately set the stage for the establishment of the counseling profession. This time in history saw the rise of social reform movements, the impact of the Industrial Revolution, and an increase in immigration, mostly to large northeastern cities. Perhaps for the first time, there became a 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). By the end of the century, however, 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).

The Beginnings of the Testing Movement: Turn of the 20th Century

Paralleling the rise of the vocational guidance movement was the testing movement. With the development of laboratory science in Europe and the United States came an increased interest in examining individual differences. Soon people were studying differences in intelligence, as it was then defined. For instance, Alfred Binet's intelligence test, developed in 1896, signified the beginning of the large-scale use of measurement instruments, soon to be used to assist individuals and institutions in decision-making (Neukrug & Fawcett, 2010). Most significantly for the counseling profession, a number of these assessment instruments would soon be employed in vocational counseling and would earmark the beginning of the counseling profession (DuBois, 1970; Williamson, 1964).

Testing, vocational guidance theory, and the humane treatment approaches developed from the reform movements were three crucial elements involved in the formation of the counseling profession; however, the emergence of a comprehensive approach to psychotherapy may have been the most important component for the establishment of the counseling profession.

Psychoanalysis and the Development of Psychotherapy: Turn of the 20th Century

Although for centuries, philosophers and shamans had reflected on the human condition and scholars had contributed treatises on psychological thought, it was not until the 1800s that a major paradigm shift took place in the understanding of mental illness. It was at this time that many challenged the notion that mental illness was caused by demons or that it was primarily organic in nature. Instead, there evolved a consensus that at least some emotional problems were caused by unconscious psychological factors (Ehrenwald, 1991). It is not surprising that at the end of the nineteenth century Freud's theory of psychoanalysis, which represented the first systematic and comprehensive approach to psychotherapy, erupted into the Western world.

Freud's theory ushered in a new way of viewing the development of the person. Constructs never before discussed became commonplace and continue to be accepted in today's world. Freud and his disciples made terms like id, ego, superego, the conscious, the unconscious, and psychosexual development commonplace. Soon, these constructs permeated the Western world, and this new "psychological" way of viewing the world affected the emerging field of counseling.

Early Vocational Guidance and the First 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 with-
out 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 every-
where. In some very 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. Simi-
larly, 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 voca-
tional guidance in America was Frank Parsons (1854–1908) (Briddick, 2009a; McDaniels &
Watts, 1994). Today seen as the founder of guidance in America, Parsons was greatly in-
fluenced by the reform movements of the time, such as the work of Jane Addams at Hull
House. Eventually establishing the *Vocational Bureau*, which assisted individuals in "choos-
ing 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. In 1909, his book *Choos-
ing 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 found-
ing of the National Vocational Guidance Association (NVGA) in 1913, which is generally
considered to be the distant predecessor of the American Counseling Association (ACA).

Frank Parsons was a man with a vision (Pope & Sveinsdottir, 2005; Briddick, 2009b).
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). It is clear that Parsons's principles of voca-
tional guidance greatly affected the broader field of counseling.

Parsons's main thrust toward vocational guidance was viewed as a three-part process which he described in the following manner:

(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, 1909/1989, p. 5)

However, a deeper examination of Parsons's 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. It is clear that Frank Parsons deserves the title *Founder of Vocational Guidance*, and in many ways, he can also be seen as the founder of the counseling field.

Parsons offered the beginnings of a theoretical orientation to counseling, and with the founding of the 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 America was here to stay, and it would soon have an impact on all facets of counseling.

Although vocational guidance in the schools soon took hold, 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" (now called 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. One tool used by the counselor was the test (Aubrey, 1982).

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 used to determine placement of recruits. Although particularly crude by even standards of the time (see Box 2.2), tests of ability would soon be adapted for use in vocational guidance.

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

BOX 2.2

The Army Alpha Test

As you take the test below, consider some of the obvious cross-cultural problems that are inherent within it.

The Army Alpha was used to determine placement in the armed forces during World War I. Below is an adaptation of the test, as printed in *Discover* magazine. Take the test and discuss your thoughts about it. The average mental age of the recruits who took the Army Alpha test during World War I was approximately 13. Could you do better? You have three minutes to complete these sample questions, drawn verbatim from the original exam. (McKean, 1985)

The following sentences have been disarranged but can be unscrambled to make sense. Rearrange them and then answer whether each is true or false.

1. Bible earth the says inherit the the shall meek.
   true   false

2. a battle in racket very tennis useful is
   true   false

Answer the following questions:

3. If a train goes 200 yards in a sixth of a minute, how many feet does it go in a fifth of a second?

4. A U-boat makes 8 miles an hour under water and 15 miles on the surface. How long will it take to *cross a 100-mile channel if it has to go two-fifths of the way under water?*

5. The spark plug in a gas engine is found in the:
   crank case   manifold   cylinder   carburetor

6. The Brooklyn Nationals are called the:
   Giants   Orioles   Superbas   Indians

7. The product advertised as 99.44 per cent pure is:
   Arm & Hammer Baking Soda
   Crisco   Ivory Soap   Toledo

8. The Pierce-Arrow is made in:
   Flint   Buffalo   Detroit   Toledo

9. The number of Zulu legs is:
   two   four   six   eight

Are the following words the same or opposite in meaning?

10. vesper–matin   same   opposite

11. aphorism–maxim   same   opposite

Find the next number in the series:

12. 74,   71,   65,   56,   44,   Answer:

13. 3,   6,   8,   16,   18,   Answer:

14. Select the image that belongs in the mirror:
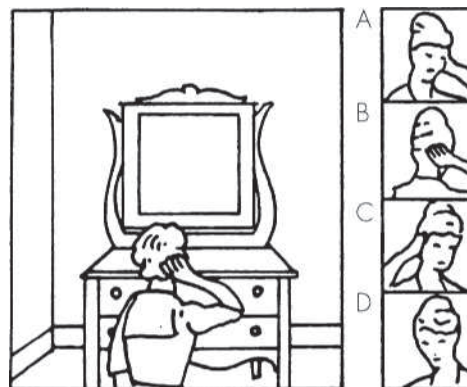
15. & 16. What's missing in these pictures?

15.

16.
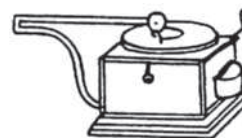
Answers: 1. true, 2. false, 3. twelve feet, 4. nine hours, 5. cylinder, 6. superbas, 7. Ivory Soap, 8. Buffalo, 9. two, 10. opposite, 11. same, 12. 29, 13. 36, 14. A, 15. spoon, 16. gramophone horn. Scoring: All item except 3, 4, 10, and 11 = 1.25 points. Items 3 and 4 = 1.875 points, Items 10 & 11 = .625 points. Add them all up, they equal your mental age.

early personality instrument used by the military to screen out emotionally disturbed individuals. The successful large-scale military use of tests led to the development and adoption of similar instruments in the schools, business, and industry (Neukrug & Fawcett, 2010). 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.

The Spread of Psychotherapy and Its Impact on the Counseling Profession: 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, 1948, p. 57)

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 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 post-traumatic stress disorder, or PTSD). Because 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 a bachelor's or master's degree, 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 started as a degree in vocational guidance. It was a natural transition for individuals with this 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 to be 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 in the psychology department), 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 soon was seen as a generic approach to counseling and psychotherapy. The trait-and-factor approach involved a series of five steps, which included (1) analysis: examining the problem and obtaining available records and testing on 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; and (5) follow-up: assuring proper support after counseling had ended (Patterson, 1973).

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 twentieth century (The Top Ten…, 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 a major impetus for the counseling field to move 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.

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, affected 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 these developmental 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 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. The NDEA 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. A natural extension of secondary school counseling, college counseling centers often started as vocational administration counseling centers initiated after World War II (Nugent & Jones, 2009). 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 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) 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 (C-AHEAD).

Changes were not only taking place in the counseling profession around this time. In 1945, the American Association of Marriage and Family Counseling (AAMFC, later to be called 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.

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) (Gladding, 2009). However, during the late 1950s and continuing into the 1960s a number of new, at the time revolutionary, approaches to counseling began to take shape, including the *rational emotive* (cognitive) approach of Albert Ellis (Ellis & Harper, 1961); the *behavioral* approaches of Bandura (1969), Wolpe (1958), and Krumboltz (1966a, 1966b); William Glasser's *reality therapy* approach (1961, 1965); the *Gestalt* approach of Fritz Perls (1969); the communication approach of *transactional analysis* (Berne, 1964); and the *existential* approaches of Frankl (1963), May (1950), and others. These counseling approaches were at least partially developed due to the demand for counselors and therapists during this time period. Can you imagine being a young mental health professional during this time? The sheer numbers 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, 2011).

Many other acts were also passed during this decade. For instance, in 1964 amendments to the 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, and diversification of the counseling profession, largely as the result of legislative actions.

With this expansion and diversification came an increased emphasis on the need for professionalism in the field. One outgrowth of this professionalization was the emergence of ethical standards of practice, such as development of the APGA's first guidelines for ethical behavior 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 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), the National Employment Counseling Association (NECA), and the recommendation in 1964 by APGA to have state branches (ACA, 1995a).

Continued Proliferation of the Counseling Field: The 1970s

During the 1970s, a number of events occurred that increased the need for counselors. For instance, the 1975 Supreme Court decision in *Donaldson v. O'Connor* led to the deinstitutionalization of tens of thousands of state mental hospital patients who had been hospitalized against their will (see Box 2.3). 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 five to twelve 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

BOX 2.3

Donaldson v. 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 even if he was, stated that 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 was 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.

6. Special services for children
7. Special services for the elderly
8. Preinstitutional court screening
9. Follow-up care for mental hospitals
10. Transitional care from mental hospitals
11. Alcoholism services
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* assured 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 of 1975* (PL94-142) assured the right to an education within the least restrictive environment for all children identified as having a disability 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 these microcounseling skills was based on many of the skills deemed critical by Carl Rogers and other humanistic 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 the counseling relationship (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 counselor education curricula. In fact, it would not

be long before some of the microcounseling techniques would be criticized as being too Western for some clients.

The 1970s was also the decade of increased professionalization in the field. For instance, the early 1970s saw the Association of Counselor Educators and Supervisors (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 and resulted 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 in 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, 1972), the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 1974), the Association for Specialists in Group Work (ASGW, 1973), the International Association of Addictions and Offender Counselors (IAAOC, 1972), and the American Mental Health Counselors Association (AMHCA, 1978) (ACA, 1995a; Goodyear, 1984).

Recent Changes in the Field: 1980–2000

The 1980s and 1990s saw a continued expansion and diversification of the field of counseling as well as a settling-in phase marked by an increased emphasis 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 increasingly evident that there was an urgent need for the standardization of training and the credentialing of counselors. Therefore, in 1981 the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was formed to delineate standards further for the profession. Today, CACREP accredits master's programs in school counseling; clinical mental health counseling; marriage, couple, and family counseling; addiction counseling; career counseling; and student affairs and college counseling (see Chapter 3 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, 2009b). In addition, in 1994, the International Association of Marriage and Family Counselors (IAMFC, n.d.), a division of ACA, began to offer certification for family therapists. 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). It is not surprising that 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 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). The 1980s and 1990s saw the founding of a number of new divisions, including the Association for Counselors and Educators in Government (ACEG, 1994), the Association for Adult Development and Aging (AADA, 1986), the International Association of Marriage and Family Counselors (IAMFC, 1989), the American College Counseling Association (ACCA, 1991), and the Association for Gay, Lesbian and Bisexual Issues in Counseling (AGLBIC, 1997). 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 one affiliate, representing the differing specialty areas in counseling, with close to 500 counselor training programs in the United States (Hollis & Dodson, 2000).

The New Millennium: 2000 and On

The first decade of the new millennium has already shown us that a number of issues from the last part of the twentieth century, as well as new emerging issues, are having an impact on the counseling profession. Here are a few of the most current issues in the counseling profession.

Certification and Licensure

National counselor certification has continued to expand, and today, there are over 45,000 National Certified Counselors (NCCs). NBCC now offers subspecialty certifications in clinical mental health counseling, school counseling, and addiction counseling (NBCC, 2009b). Meanwhile, state licensure has been approved in all 50 states as well as Puerto Rico and the District of Columbia, and today there are over 115,000 licensed counselors (ACA, 2010c). As credentialing becomes increasingly important for job attainment, third-party reimbursement, and professional recognition, we will continue to see an increase in the number of certified and licensed counselors.

Division Expansion and Division Independence

Since 2000, we saw the addition of two new divisions to ACA: the Association of Creativity in Counseling and Counselors for Social Justice. With nineteen divisions covering a vast array of counseling interests, it is clear that ACA is a diverse group. It also seems evident that 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 *ASCA National Model* (ASCA, 2005), which increase the focus of the school counselor on student learning (see Chapter 16) and AMHCA's increasing push toward a greater clinical focus (see Chapter 17), have made these differences deeper. Today, one can join many of the divisions without the former requirement of ACA membership. Although we are all counselors, whether we will all remain under one roof is a question that will be answered in the years to come.

Evidence-Based Practice

As we move into this new century, there will be increasing calls for our work to be based on scientific evidence (Hayes, 2005; Norcross, Beutler, & Levant, 2006). In this century, we will continually be asked to show that what we do is working in all realms of counseling, from school counseling to clinical counseling. This important question is also reinforced in the 2005 ACA ethical code that states:

> *Counselors use techniques/procedures/modalities that are grounded in theory and/ or have an empirical or scientific foundation. Counselors who do not must define the techniques/procedures as "unproven" or "developing" and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm.* (Section C.6.E)

Multicultural Counseling

Cross-cultural counseling, considered the *fourth force* in counseling after psychoanalysis, behaviorism, and humanism, continues to be a cutting edge topic in our profession (see D'Andrea & Heckman, 2008). ACA has now endorsed *the Multicultural Counseling Competencies*, and if you look at almost any journal in our field, you will see new research and scholarship on ways to work with clients' cultural groups other than your own. Clearly, a focus on the importance of cross-cultural counseling issues continues into this century.

Social Justice Advocacy

In recent years, there has been an increasingly loud call to the profession to include social justice advocacy in the work that we do as counselors (Niles, 2009; Ratts & Hutchins, 2009). To meet this challenge, in 2003 the ACA governing council endorsed the *Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2002). The competencies speak to three levels of advocacy: client/student, school/community, and public arena, and each level contains two domains:

> *The client/student level of advocacy involves using direct counseling to empower individuals and providing advocacy at the individual level. The school/community level of advocacy emphasizes community collaboration and systems advocacy. The public arena level of advocacy is concerned with informing the public about systemic barriers that affect human development and how helping professionals can shape public policy.* (Ratts & Hutchins, p. 269)

The roots of this new movement, which some have called the *fifth force* in counseling (Ratts 2009), is the awareness amongst counselors of the real world effects that things like oppression, racism, and prejudice have on a large segment of society. It is only through social justice efforts that many of our clients can overcome some of the barriers they face and subsequently feel empowered in their lives.

Crisis, Disaster, and Trauma Training

The horror of hurricane Katrina and the attack on the twin towers taught us that as a country, our readiness to react to a disaster was not particularly good, and it also taught us that many counselors were not adequately prepared to address crises, disasters, and trauma. Thus, there has been a particular push in recent years to have counselors trained appropriately to work with crises, disasters, and with individuals in trauma. The 2009 CACREP standards have curriculum guidelines infused throughout their standards, and today, programs cannot become accredited without showing these standards are taught.

Changes in Ethical Guidelines

The 2005 ethics code of ACA includes a number of revisions that challenge counselors to work in new ways. For instance, the code replaces the term "clear and imminent danger" with "serious and foreseeable harm," increases the restrictions on romantic and sexual relationships, softens the admissibility of dual relationships and replaces the word "dual" with "multiple," includes a statement on counseling for end-of-life care for terminally ill clients, increases attention to social and cultural issues, allows counselors to refrain from making a diagnosis, highlights the importance of having a scientific basis for treatment modalities, requires counselors to have a transfer plan for clients, adds guidelines for how and when to use technology, and includes a statement about the right to confidentiality for deceased clients (ACA, 2005; Kaplan et al., 2009). This new code will clearly affect how many counselors work as we move into this new century.

A Push toward Unity: The 20/20 Standards

ACA, along with the majority of its divisions and other related professional associations, decided it was time for the counseling profession to develop a shared vision—an understanding that would unite all counselors toward the future. Thus, at the ACA national conference in 2010, a number of counseling associations came together to develop *20/20: A Vision of the Future of Counseling*. This shared vision includes the following:

- 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. (ACA, 2010, para. 7)

◼ *Do We Have to Memorize All Those Names? A Developmental Perspective*

A student of mine recently came into my office and complained about having to memorize the names of "picayune" individuals from the counseling profession's past. "What does this have to do with me being an effective counselor?" he argued. Admittedly put somewhat on the defensive, I tried to explain the importance of knowledge building on knowledge, and that these individuals have given us a base of understanding that has affected the profession today. I believe that this explanation makes a justifiable argument concerning the need to learn such names. However, one thing I did not discuss with him was the concept of "roots." Most of us would agree that our past experience has shaped our development. Our experiences, whether negative or positive, relate strongly to the essence of who we are today. And so, it is in the life of a profession. We are what we are because of our past. Be it positive or negative, we have become what we are because of our history, and perhaps as importantly, we will become what we will become as a function of our past and what we do in the present. We are a profession in process—a living entity that develops over time. Yes, we could decide to forget our past, not look at our roots, and attempt to move forward. However, I believe that unconsciously our roots will still be directing us. Why not strive to understand from whence we came, and attempt to make smart, conscious choices about the present and the future? Let's not repress what our past has been; let's be open to understanding it and to forging a new and better path for the future for our profession and ourselves. Such understanding takes courage and work. It is not easy taking a hard look at oneself, and it is damned difficult memorizing all those names (see Table 2.1).

◼ *Multicultural/Social Justice Focus: Learning from the Past, Moving toward the Future*

Relative to the role that social justice and cross-cultural issues play in the professional identity of the counselor, we have made great strides from where we were twenty-five years ago. However, we still have a ways to go. Despite the fact that multicultural and social justice issues are now vying to be the "fourth and fifth forces" in counseling, and despite the fact that we have *Multicultural Counseling Competencies* and *Advocacy Competencies*, and even though research and scholarship on multicultural counseling pervades the counseling literature, there is much that we still must address on our journey to become social justice advocates and culturally competent counselors. Some of this includes:

1. Ensuring that all students are trained in the *Multicultural Counseling Competencies* and the *Advocacy Competencies*
2. Ensuring that all students are working on their own biases and how they might affect the counseling relationship
3. Ensuring that all students have the knowledge and skills necessary if they are to become culturally competent counselors
4. Providing vehicles for increased scholarship, especially outcome research that provides a road map for counselor best practices relative to social justice and cross-cultural counseling

TABLE 2.1

Summary of Important Historical Events Related to the Field of Counseling	
3000 BCE Ancient Egypt	"Psychological" writings found on papyrus.
400 BCE Hippocrates	Wrote 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 and self-examination, and inquiry.
1468 Sanchez de Arevalo	Wrote first job classification system in *Mirror of Men's Lives*.
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 scientifically. Advocated for humane treatment.
1800 Benjamin Rush	Founder of American psychiatry. Advocated for humane treatment of mentally ill.
1800 Anton Mesmer	Discovered first uses of hypnosis.
1800s Charity Organization Societies	Volunteers offered assistance to the poor and destitute.
1850 Jean Martin Charcot	Used hypnosis to understand disorders. Saw relationship between psychological and organic states.
1850 Dorothea Dix	Advocated for humane treatment of 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 theory of psychoanalysis.
1890s G. Stanley Hall	Founded the APA; early American experimental psychologist.
1890s James Cattell	Early American experimental psychologist.
1890s to mid-1900s John Dewey	Educational reformer who advocated for humanistic teaching methods.
1896 Alfred Binet	Developed first individual intelligence test for the French Ministry of Public Education.
1889 Jane Addams	Established Hull House in Chicago.
1900 Emil Kraepelin	Developed one of the first classifications of mental diseases.
1900 Pierre Janet	Saw a relationship between certain psychological states and organic disorders.
1900 Ivan Pavlov	Developed one of the first behavioral models of learning.
1900 William James	"Philosophical Pragmatism:" reality is continually constructed as a function of its utility or practical purpose.
1906 Eli Weaver	Developed vocational guidance in New York City schools.
1907 Jesse Davis	Developed one of the first guidance curricula in Grand Rapids, Michigan, schools.
1908 Anna Reed	Established vocational guidance in Seattle school system.
1908 Frank Parsons	Founder of vocational guidance; developed first comprehensive approach to vocational guidance.

TABLE 2.1 (*continued*)

1908 Clifford Beers	Institutionalized for schizophrenia; wrote: *A Mind That Found Itself*; Advocated for humane treatment.
1913 NVGA	National Vocational Guidance Association formed. Distant forerunner of ACA.
1917 Army Alpha Test	First large-scale use of test of ability.
1917 Woodworth Personal Data Sheet	One of first structured personality tests.
1927 Strong Interest Inventory	One of first interest inventories to assist in career counseling process.
1930 E. G. Williamson	Developed first comprehensive theory of counseling. Called "Minnesota Point of View," or "trait-and-factor approach."
1932 John Brewer	Suggested guidance be seen in total educational context.
1932 Wagner O'Day Act	Established U. S. Employment Service.
1921 American Psychiatric Association	American Psychiatric Association took current name. Originally founded in 1844.
1940s Carl Rogers	Developed 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.
1950s Virginia Satir	One of first social workers to stress contextual or systems thinking.
1950s	DSM first developed.
1952 APGA	American Personnel and Guidance Association formed out of four associations. Forerunner of ACA.
1955 NASW	National Association of Social Workers founded from merger of seven associations.
1958 NDEA	*National Defense Education Act.* Training for and expansion of school counselors.
1961 Ethical Codes	Development of first APGA guidelines for ethical behavior.
1960s Great Society Initiatives	Numerous laws passed under President Johnson: development of social service agencies nationally.
1963 *Community Mental Health Centers Act*	Federal law provided for establishment of community mental health centers nationally.
1970s	Development of "micro-counseling 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 voc rehab services for adults. Increased need for trained rehabilitation counselors.
1973 CORE	Council for Rehabilitation Education offered 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 need for school counselors.
1975 *Donaldson v. 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	Councils for Accreditation of Counseling and Related 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. New divisions of ACA founded.
1992 ACA	AACD becomes the American Counseling Association.

T A B L E 2 . 1   (*continued*)

1994 Family Therapy Certification	IAMFC offers national certification as a family therapist.
1991 Multicultural Counseling Competencies	Proposed and adopted by AMCD: Competencies suggest how to address multicultural training.
2001	New CACREP Standards.
2002	*Advocacy Competencies* endorsed by ACA.
2003	ASCA National Model.
2005	New ACA ethical code.
2009	New CACREP standards; licensure for counselors in all 50 states achieved.
2010	20/20: A vision for the future of counseling; 45,000 National Certified Counselors.
Current Issues	Evidence-based practice; crisis, trauma, and disaster counseling; independence of some ACA divisions.

Ethical, Professional, and Legal Issues: Changing over Time

With the development of the first ACA ethical code in 1961, the counseling profession made a commitment to the conscientious and principled use of counseling approaches. As with all forward-thinking professional associations, since 1961, the guidelines have been revised numerous times. Changes in ethical codes often reflect important concerns taking place in society and the profession. For instance, as a result of AIDS and other communicable life-threatening diseases, a section was added to the 1995 ethics code that spoke to the possibility of breaking confidentiality when a third party is at risk. More recently, the 2005 code made a number of dramatic changes, including the right to do counseling for end-of-life terminally ill clients, the softening of dual relationships, the proper use of technology, the use of evidence-based practice, and more (see ACA, 2005b; Kaplan et al., 2009).

As values in society and in our profession evolve and as our profession continues to develop its own professional identity, our ethical standards will continue to be revised to reflect new viewpoints. Prior ethical standards and laws tell us something about where we have been as a profession and as a country. Current standards and laws reflect the current thinking and values of our profession and country, and challenges to guidelines reflect our current struggles and point us in the direction of the future (Gale & Austin, 2003). Counselors need to be knowledgeable of the past, aware of the present, and speculative about the future if they are to feel thoroughly involved with the profession.

The Counselor in Process: Looking Back, Looking Ahead, and Embracing Paradigm Shifts

As we look back at our history, we saw the paradigm shifts that took place near the turn of the last century that led to the creation of our field. In the middle of the twentieth century, we saw the next paradigm shift, which led to the expansion of the profession as

well as the shift toward a humanistic emphasis. And now, the impact of multicultural and social justice issues seems to be indicating that we are in the midst of another paradigm shift—a shift toward more inclusivity, increased understanding of difference, culturally competent counseling, advocacy work, and a new type of counseling that doesn't always take place in the office. Sometimes it's difficult when you're in the midst of a shift to be clear that a shift is occurring, but my best guess is that we are on the outer end of this shift—and it seems like it's here to stay. Perhaps most interesting, what do you think the next shift will be?

■ *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 that the historical roots of the counseling profession can be traced back to early philosophers. We discovered that the helping professions of social work, psychology, and psychiatry had different beginnings from those of counseling, and that over the years all these professions have moved toward many of the same goals and objectives.

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 had a great impact on counselor education training and its recent trends toward increasing practicum and internship hours. We also saw that many of the philosophical roots of modern-day counseling theories arose from the early beginnings of psychology. 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.

In addition to tracing the influence of other professions, we examined the unique history of the counseling profession. With its early focus in 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 creation of ethical standards, an 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 number of credentialed counselors, the addition of divisions in ACA while at the same time the assertion of independence from some of ACA's divisions, a focus on evidence-based practice, a continued focus on multicultural counseling and the endorsement by ACA of the *Multicultural Counseling Competencies*, a relatively new focus on social justice advocacy and the endorsement by ACA of the *Advocacy Competencies*, a realization that counselors need to be better trained in crisis and trauma counseling and disaster response, a new focus on a number of ethical issues, and the recent adoption of "20/20: A vision for the future of counseling."

This chapter ended with a brief discussion of the importance of the relatively recent increased focus on multicultural counseling and social justice issues and made some suggestions regarding what still needs to be done in these areas, including: having all students trained in the *Multicultural Counselor Competencies* and the *Advocacy Competencies*, assuring all students are working on their own biases, having all students learn the knowledge and skills necessary to be culturally competent, and providing vehicles for increased scholarship in these areas. We also talked about how our ethical codes change over time and reflect changes in society and in the profession. Finally, we ended by considering whether we are currently in another paradigm shift in counseling, focused around multicultural and social justice issues, and wondered what the future will bring.

◼ *References*

Addams, J. (1910). *Twenty years at Hull House*. New York: Macmillan.

American Counseling Association. (1995a). *ACA history: 1995*. Alexandria, VA: Author.

American Counseling Association. (1995b). *Code of ethics and standards of practice* (rev. ed.). Alexandria, VA: Author.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling .org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Counseling Association. (2010c). *2010 Mental health professions statistics*. Retrieved from http://www.counseling.org/PublicPolicy/TP/ResourcesAndReports/CT2.aspx

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American School Counselor Association. (2005). *The ASCA National Model: A framework for school counseling programs* (2nd ed.). Arlington, VA: Author.

Appignanesi, R., & Zarate, O. (2004). *Introducing Freud*. Royton, England: Icon Books.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*(1), 42–78.

Aubrey, R. F. (1977). Historical development of guidance and counseling and implications for the future. *Personnel and Guidance Journal, 55*, 288–295.

Aubrey, R. F. (1982). A house divided: Guidance and counseling in twentieth-century America. *Personnel and Guidance Journal, 61*, 198–204.

Attridge, W. C. (2000). *Ethical considerations for internet counseling*. Retrieved from ERIC database. (ED 448369).

Bandura, A. T. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.

Baxter, W. E. (1994). *American psychiatry celebrates 150 years of caring. The Psychiatric Clinics of North America, 17*(3), 683–693.

Beers, C. W. (1948). *A mind that found itself* (7th ed.) Garden City, NY: Doubleday.

Belgium, D. (1992). Guilt. In M. T. Burker & J. G. Miranti (Eds.), *Ethical and spiritual values in counseling.* (pp. 53–66). Alexandria, VA: American Association for Counseling and Development.

Belkin, G. S. (1988). *Introduction to counseling* (3rd ed.). Dubuque, IA: William C. Brown.

Berne, E. (1964). *Games people play*. New York: Simon & Schuster.

Breasted, J. H. (1930). *The Edwin Smith surgical papyrus*. Chicago: University of Chicago Press.

Breasted, J. H. (1934). *The dawn of conscience*. New York: Scribner's.

Brewer, J. M. (1932). *Education as guidance*. New York: Macmillan.

Briddick, W. (2009a). Frank findings: Frank Parsons and the Parson family. *Career Development Quarterly, 57*(3), 207–214.

Briddick, W. C. (2009b). Frank Parsons on interests. *Journal of Vocational Behavior, 24*(2), 230–233.

Burger, W. (2011). *Human services in contemporary America* (8th ed.). Belmont, CA: Brooks/Cole.

Campbell, D. P. (1968). The Strong vocational interest blank: 1927–1967. In P. McReynolds (Ed.), *Advances in psychological assessment*, (vol. 1, pp. 105–130). Palo Alto, CA: Science and Behavior Books.

Capshew, J. H. (1992). Psychologists on site: A reconnaissance of the historiography of the laboratory. *American Psychologists, 47*(2), 132–142. doi:10.1037/0003-066X.47.2.132

Carkhuff, R. R. (1969). *Helping and human relations* (vol. 2). New York: Holt, Rinehart & Winston.

Carson, A. D., & Altai, N. M. (1994). 1000 years before Parsons: Vocational psychology in classical Islam. *The Career Development Quarterly, 43*, 197–206.

Claiborn, C. D. (Ed.). (1991). *Multiculturalism as a fourth force in counseling* [Special issue]. *Journal of Counseling and Development, 70*(1).

D'Andrea, M., & Heckman, E. F. (Eds.). (2008). (Eds.). Multicultural counseling [Special issue]. *Journal of Counseling and Development, 86*(3).

Dewey, J. (1956). *School and society*. Chicago: University of Chicago Press. (Original work published 1900)

Donaldson v. O'Connor, 422 U.S. 563 (U.S. Supreme Ct., 1975).

DuBois, P. (1970). *A history of psychological testing*. Boston: Allyn & Bacon.

Dykhuizen, G. (1973). *The life and mind of John Dewey*. Carbondale, IL: Southern Illinois University Press.

Egan, G. (1975). *The skilled helper: A model for systematic helping and interpersonal relating*. Pacific Grove, CA: Brooks/Cole.

Ehrenwald, J. (Ed.). (1991). *The history of psychotherapy: From healing magic to encounter*. Northvale, NJ: Aronson. (Original work published 1976)

Ellis, A., & Harper, R. A. (1961). *A guide to rational living*. Englewood Cliffs, NJ: Prentice Hall.

Ellwood, R. S., & McGraw, B. A. (2009). *Many peoples, many faiths: Women and men in the world religions* (9th ed.). Upper Saddle River, NJ: Pearson.

Erikson, E. H. (1950). *Childhood and society*. New York: Norton.

Evans, K. M., & Larrabee, M. J. (2002). Teaching the multicultural counseling competencies and revised career counseling competencies simultaneously. *Journal of Multicultural Counseling and Development, 30*(1), 21–39.

Frankl, V. E. (1963). *Man's search for meaning*. Boston: Beacon.

Gillham, N. (2001). *A life of Sir Francis Galton: From African exploration to the birth of eugenics*. New York: Oxford University Press.

Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling and Development, 81*, 3–10.

Ginzberg, E., Ginsburg, S. W., Axelrad, S., & Herma, J. (1951). *Occupational choice: An approach to a general theory*. New York: Columbia University Press.

Gladding, S. T. (2009). *Counseling: A comprehensive approach* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

Glasser, W. (1961). *Mental health or mental illness?* New York: Harper & Row.

Glasser, W. (1965). *Reality therapy: A new approach to psychiatry*. New York: Harper & Row.

Goodyear, R. K. (1984). On our journal's evolution: Historical developments, transitions, and future directions. *Journal of Counseling and Development, 63*, 3–9.

Green, C.D. (2009). Darwinian theory, functionalism, and the first American psychological revolution. *American Psychologist, 64*(2), 75–83. doi:10.1037/a0013338

Hayes, R. A. (2005). Introduction to evidence-based practice. In C. E. Stout & R. A. Hayes (Eds.), *The evidence-based practice: Methods, models, and tools for mental health professionals* (pp. 1–9). Hoboken, NJ: Wiley.

Herr, E. L. (1985). *Why counseling?* (2nd ed.). Alexandria, VA: American Association for Counseling and Development.

Herr, E. L., Cramer, S. H., & Niles, S G. (2004). *Career guidance and counseling through the life span: Systematic approaches* (6th ed.). Boston: Pearson/Allyn & Bacon.

Hollis, J. W., & Dodson, T. A. (2000). *Counselor preparation 1999–2001: Programs, faculty, trends* (10th ed.). Philadelphia: Taylor & Francis.

Iannone, A. P. (2001). *Dictionary of world philosophy*. New York: Routledge.

International Association of Marriage and Family Counseling (n.d.). *Welcome to IAMFC*. Retrieved from http://www.provisionsconsultingcms.com/~iamfc/

Ivey, A., E. & Gluckstein, N. (1974). *Basic attending skills: An introduction to microcounseling and helping*. N. Amherst, MA: Microtraining Associates.

Jones, L. K. (1994). Frank Parsons' contribution to career counseling. *Journal of Career Development, 20*(4), 287–294. doi.org/10.1177/089484539402000403

Kaplan, M., & Cuciti, P. L. (Eds.). (1986). *The Great Society and its legacy: Twenty years of U.S. social policy*. Durham, NC: Duke University Press.

Kaplan, D., M., Kocet, M. M., Cottone, R. R., Glosoff, H. L., Miranti, J. G., Moll, E. C., …Tarvydas, V. M. (2009). New mandates and imperatives in the revised ACA code of ethics. *Journal of Counseling and Development, 87*, 241–256.

Kornetsky, C. (1976). *Pharmacology: Drugs affecting behavior*. New York: Wiley.

Kottler, J. (2011). *Introduction to counseling: Voices from the field* (7th ed.). Belmont, CA: Brooks/Cole.

Krumboltz, J. D. (1966a). Promoting adaptive behavior. In J. D. Krumboltz (Ed.), *Revolution in counseling* (pp. 3–26). Boston: Houghton Mifflin.

Krumboltz, J. D. (Ed.). (1966b). *Revolution in counseling*. Boston: Houghton Mifflin.

Kuhn, T. S. (1962). *The structure of scientific revolutions*. Chicago: University of Chicago Press.

Lambie, G., & Williamson, L. L. (2004). The challenge to change from guidance counseling to professional school counseling: A historical proposition. *Professional School Counseling, 8*(2), 124–131.

Leary, D. (1992). William James and the art of human understanding. *American Psychologist, 47*(2), 152–160. doi:10.1037/0003-066X.47.2.152

Leiby, J. (1978). *A history of social welfare and social work in the United States*. New York: Columbia University Press.

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2002). ACA Advocacy Competencies. Retrieved from http://www.counseling.org/Resources/Competencies/Advocacy_Competencies.pdf

May, R. (1950). *The meaning of anxiety*. New York: Ronald Press.

McDaniels, C., & Watts, G. A. (Eds.). (1994). Frank Parsons: Light, information, inspiration, cooperation [Special issue]. *Journal of Career Development, 20*(4).

Mehr, J. J. & Kanwischer, R. (2011). *Human services: Concepts and intervention strategies* (11th ed.). Boston: Pearson.

Menninger, K. (1973). *Whatever became of sin?* New York: Hawthorne Books.

National Board for Certified Counselors. (2009b). *About Us: History of NBCC*. Retrieved from http://www.nbcc.org/whoWeAre/About.aspx

Neukrug, E. (1980). The effects of supervisory style and type of praise upon counselor trainees' level of empathy and perception of supervisor. (Doctoral dissertation, University of Cincinnati, 1980). *Dissertation Abstracts International, 41*(04A), 1496.

Neukrug, E. (2001). Medical breakthroughs: Genetic research and genetic counseling, psychotropic medications, and the mind-body connection. In T. McClam & M. Woodside (Eds.), *Human service challenges in the twenty-first century*. (pp. 115–132). Birmingham, AL: Ebsco Media.

Neukrug, E. (2008). *Theory, practice and trends in human services: An introduction to an emerging profession* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Neukrug, E., & Fawcett, R. C. (2010). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*(1), 57–70.

Niles, S. (Ed.). (2009). Special section: Advocacy competencies. *Journal of Counseling and Development, 87*(3).

Norcross, J. C., Beutler, L. E., & Levant, R. (2006). *Evidence-based practices in mental health: Dialogue on the fundamental questions*. Washington, DC: American Psychological Association.

Nugent, F. A., & Jones, K. D. (2009). *An introduction to the profession of counseling* (5th ed.). Boston: Pearson.

Patterson, C. H. (1973). *Theories of counseling and psychotherapy* (2nd ed.). New York: Harper & Row.

Pepinsky, H. B. (2001). Counseling psychology: History. In W.E. Crawford & C. B. Nemeroff (Eds.), *The Corsini encyclopedia of psychology and behavioral science* (Vol. 1, pp. 375–379). New York: Wiley.

Perls, F. (1969). *Gestalt therapy verbatim*. Moab, UT: Real People Press.

Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.

Pope, M., & Sveinsdottir, M. (2005). Frank, we hardly knew ye: The very personal side of Frank Parsons. *Journal of Counseling and Development, 83*, 105–115.

Purton, C. (1993). Philosophy and counseling. In B. Thorne and W. W. Dryden (Eds.). *Counseling: Interdisciplinary perspectives* (pp. 152–161). Philadelphia, PA: Open University Press.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *Journal of Humanistic Counseling, Education, and Development, 48*(2), 160–172.

Ratts, M. J., & Hutchins, A. M. (2009). ACA advocacy competencies: Social justice advocacy at the client/student level. *Journal of Counseling and Development, 87*, 269–275.

Roberts, S. A., Kiselica, M. S., & Fredrickson, S. A. (2002). Quality of life of persons with medical illnesses: Counseling's holistic contribution. *Journal of Counseling and Development, 80*, 422–432.

Rockwell, P. J., & Rothney, W. M. (1961). Some social ideas of pioneers in the guidance movement. *Personnel and Guidance Journal, 40*, 349–354.

Rogers, C. R. (1942). *Counseling and psychotherapy: New concepts in practice*. Boston: Houghton Mifflin.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.

Routh, D. K. (2000). Clinical psychology: History of the field. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 2, pp. 113–118). New York: Oxford University Press.

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.

Sabshin, M. (1990). Turning points in twentieth-century American psychiatry. *The American Journal of Psychiatry, 147*(10), 1267–1274.

Schatzberg, A. F., & Nemeroff, C. B. (Eds.). (2009). The American psychiatric publishing *textbook of psychopharmacology* (4th ed.). Washington, DC: American Psychiatric Press.

Schmidt, L. D. (2000). Counseling psychology: History of the field. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 2, pp. 317–320). New York: Oxford University Press.

Sokal, M. M. (1992). Origins and early years of the American Psychological Association, 1890–1906. *American Psychologist, 47*(2), 111–122. doi:10.1037/0003-066X.47.2.111

Solomon, M. (1918). The increasing importance of the biological viewpoint in psychopathology and psychiatry. *The Journal of Abnormal Psychology, 13*(3), 168–171. doi: 10.1037/h0070702

Super, D. E. (1953). A theory of vocational development. *American Psychologist, 8*(2), 185–190. doi:10.1037/h0056046

Sweeney, T. J. (1991). Counselor credentialing: Purpose and origin. In F. O. Bradley (Ed.), *Credentialing in counseling* (pp. 81–85). Alexandria, VA: Association for Counselor Education and Supervision.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

The top 10: The most influential therapists of the past quarter-century. (2007, March/April). *Psychotherapy Networker.* Retrieved from http://www.psychotherapynetworker.org/component/content/article/81-2007-marchapril/219-the-top-10

Watts, G. A. (1994). Frank Parsons: Promoter of a progressive era. *Journal of Career Development, 20*(4), 265–286. doi:10.1007/BF02106300

Weissmann,G. (2008). Citizen Pinel and the madman at Bellevue. *The Journal of the Federation of American Societies for Experimental Biology. 22,* 1289–1293. doi:10.1096/fj.08-0501ufm

Wertheimer, M. (2000). *A brief history of psychology* (4th ed.). New York: Harcourt College Publishers.

Williamson, E. G. (1964). An historical perspective of the vocational guidance movement. *Personnel and Guidance Journal, 42,* 854–859.

Woodside, M., & McClam, T. (2009). *An introduction to human services* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition.* Stanford, CA: Stanford University Press.

Zwelling, S. S. (1990). *Quest for a cure: The public hospital in Williamsburg, Virginia, 1773–1885.* Williamsburg, VA: The Colonial Williamsburg Foundation.

Zytowski, D. G. (1972). Four hundred years before Parsons. *Personnel and Guidance Journal, 50,* 443–450.

Standards in the Profession: Ethics, Accreditation, Credentialing, and Multicultural/Social Justice Competencies

*I*t was 1976, and I was working at a mental health center as an outpatient therapist seeing a client who was known to have made up to 50 somewhat serious suicide attempts. I'll never forget that at the end of one session, she looked at me and said, "I'm going to kill myself," and walked out. I immediately ran to get my supervisor, who said, "Get in my car," and the next thing I knew we were in a car chase after my client. We caught up to her, just about forced her into coming back to the center, and hospitalized her against her will. As we were doing all of this, I was wondering about the ethics of having a car chase and bringing her back to the center. I also thought about the legal ramifications if we had not done anything and risked a potential suicide, to say nothing of our moral obligation!

After receiving my doctorate in counselor education, I became a faculty member at a small college in New Hampshire. I took the national counselor certification exam and became a nationally certified counselor. A few years later, I applied for licensure as a psychologist in New Hampshire and nearby Massachusetts. Both state licensing boards gave me a hard time, saying my degree was in counseling, not psychology, and not from a school accredited by the American Psychological Association. Eventually, they did license me (which would probably be unlikely today). A few years later, I moved to Virginia, where the psychology licensing board told me I could not get licensed as a psychologist and suggested that I get licensed as a Licensed Professional Counselor (LPC). How odd, I thought, that different states view my background in different ways.

I teach at a state university in a CACREP-accredited program. Because the program is CACREP accredited, students can take the National Counselor Exam (NCE) as they near their graduation date, prior to actually graduating. Students who have graduated from a non-CACREP-accredited university must wait until they graduate before taking

the exam and must complete 3,000 hours of supervised experience within two years before they can be certified. Clearly, students from a CACREP-accredited program are at an advantage.

When I obtained my degrees, there were few if any courses in cross-cultural counseling. Some lip service was paid to the topic, but it was not really included in the curriculum. In fact, articles and books on cross-cultural counseling hardly existed. So, I've had to learn the old way, by reading on my own. And relative to social justice, well, that term didn't exist on nearly the scale that it does today. Clearly, we didn't learn how it fit into the "counseling way." This too I had to learn the old fashioned way. This field has certainly changed.

The examples above reflect some of the struggles and oddities related to four standards in the profession that will be examined in this chapter: the development and use of ethical codes and the legal issues that affect them, the history and current status of accreditation in the profession, the state of credentialing, and the recent adoption by ACA of the *Multicultural Counseling Competencies* and the *Advocacy Competencies*.

The development of standards is a symbol that a profession has matured and has taken a serious look at where it has been, where it is, and where it wants to go. As standards evolve, professions can reflect upon, revise, and sometimes even eliminate some of their standards. Despite the helping professions having been in existence for more than 100 years, the development of standards is relatively new. In this chapter, we will examine how professional standards in the helping professions have been established and how they influence the delivery of counseling services today.

Ethics

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

After meeting with a 17-year-old high school student who has been truant from school and has a history of acting-out behaviors, you find evidence that an uncle who is five years older than she, molested her when she was 12 years old. In addition, you believe that the young woman has been involved in some petty crimes, such as shoplifting and stealing audio equipment from the school. What are your moral, ethical, and legal obligations?

On a daily basis we are generally not faced with such difficult situations as the one just described, however, as counselors we are periodically confronted with complicated and sometimes delicate situations in the work that we do. In these moments, we need to know

how to respond. If we are to respond in the best manner possible, it is important that 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* generally describes the collectively agreed-upon "correct" behaviors within the context of a professional group (Remley & Herlihy, 2010). 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 assert a client's right to self-determination, a clinician might support a client's decision to have an abortion. Sometimes an individual's moral beliefs will conflict with his or her professional ethics (e.g., when a clinician's religious beliefs concerning abortion are in conflict with ethical obligations to preserve the client's right to self-determination). Clearly, trying to make sense of one's values, what is personally "right" or "wrong," and professional ethics can at times 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 behavior, perceptions of what is or is not ethical can vary greatly. For instance, when 535 ACA members 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 Table 3.1).

The Development of and Need for Ethical Codes

The establishment of ethical guidelines in the helping professions began during the midpoint of the twentieth century, when, in 1953, the American Psychological Association (APA) published its code of ethics. Not long after, in 1960, the National Association of Social Workers (NASW) adopted its code, and in 1961, the American Counseling Association (ACA) developed its ethical code. Because ethical standards are to some degree a mirror of change in society, the associations' guidelines have undergone a number of major revisions over the years to reflect society's ever-changing values (see ACA, 2005; APA, 2003; NASW, 2008). Today, codes serve a number of purposes, including all of the following (Corey, Corey, & Callanan, 2011; Dolgoff, Loewenberg, & Harrington, 2009):

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

TABLE 3.1

What Is Ethically Correct Behavior?

COUNSELOR BEHAVIOR	% ETHICAL	COUNSELOR BEHAVIOR	% ETHICAL
1. Being an advocate for clients	99	39. Not reporting suspected spousal abuse	29
2. Encouraging a client's autonomy and self-determination	98	40. Not having malpractice coverage	28
3. Breaking confidentiality if the client is threatening harm to self	96	41. Counseling a client engaged in another helping relationship	27
4. Referring client due to interpersonal conflicts	95	42. Seeing a minor client without parental consent	25
5. Having clients address you by your first name	95	43. Viewing client's Web page (e.g., Facebook) without consent	23
6. Making a diagnosis based on DSM-IV-TR	93	44. Counseling diverse clients with little cross-cultural training	22
7. Using an interpreter to understand your client	89	45. Having sex with a person your client knows well	22
8. Self-disclosing to a client	87	46. Setting your fee higher for clients with insurance	22
9. Counseling an undocumented worker ("illegal immigrant")	87	47. Counseling without training in presenting problem	20
10. Consoling your client through touch (e.g., hand on shoulder)	84	48. Not allowing clients to view their records	17
11. Publicly advocating for a controversial cause	84	49. Trying to change your client's values	13
12. Keeping client records on your office computer	74	50. Kissing a client as a friendly gesture (e.g., greeting)	13
13. Attending a client's formal ceremony (e.g., wedding)	72	51. Accepting a client's decision to commit suicide	12
14. Counseling terminally ill client on end-of-life decisions including suicide	69	52. Accepting a gift from a client that's worth more than $25	12
15. Providing counseling over the Internet	68	53. Revealing confidential information if a client is deceased	11
16. Hugging a client	67	54. Counseling a colleague who you work with	11
17. Not being a member of a professional association	66	55. Having dual relationship (e.g., client is your child's teacher)	10
18. Counseling a pregnant teenager without parental consent	62	56. Telling your client you are attracted to him or her	10
19. Telling your client you are angry at him or her	62	57. Not having a transfer plan should you become incapacitated	9
20. Sharing confidential information with administrative supervisor	59	58. Trying to persuade client to not have an abortion	8
21. Guaranteeing confidentiality for couples and families	58	59. Treating homosexuality as a pathology	6
22. Refraining from making a diagnosis to protect a client from a third-party (e.g., employer who might demote a client)	55	60. Making grandiose statements about your expertise	6
		61. Giving a gift worth more than $25 to a client	5
23. Bartering (accepting goods or services) for counseling services	53	62. Keeping client records in an unlocked file cabinet	5
		63. Not participating in continuing education	5
24. While completing dissertation, using the title "Ph.D. Candidate" in clinical practice	48	64. Engaging in a counseling relationship with a friend	5
25. Withholding information about minor despite parents' request	48	65. Terminating the counseling relationship without warning	5
26. Selling clients counseling products (e.g., book, video, etc.)	47	66. Not offering a professional disclosure statement	3
27. Using techniques that are not theory or research based	43	67. Referring a client satisfied with his/her homosexuality for "reparative therapy"	3
28. Pressuring a client to receive needed services	43	68. Lending money to your client	3
29. Becoming sexually involved with a former client (at least 5 years after the counseling relationship ended)	43	69. Sharing confidential information with significant other	3
30. Not allowing clients to view your case notes about them	43	70. Not reporting suspected abuse of an older client	1
31. Referring a client, unhappy with his or her homosexuality, for "reparative therapy"	38	71. Not informing clients of legal rights (e.g., HIPAA, FERPA, confidentiality)	1
32. Accepting clients who are only male or only female	37	72. Stating you are licensed when in process of obtaining it	1
33. Guaranteeing confidentiality for group members	37		
34. Charging for individual counseling although seeing a family	35	73. Revealing client's record to the spouse without permission	<1
35. Accepting clients only from specific cultural groups	32	74. Not reporting suspected child abuse of a child	<1
36. Breaking the law to protect your client's rights	32	75. Attempting to persuade client to adopt a religious belief	<1
37. Reporting colleague's unethical conduct without consulting colleague	30	76. Implying that a certification is the same as a license	<1
38. Sharing confidential client information with a colleague	29	77. Not revealing the limits of confidentiality to your client	<1

Adapted from: Neukrug, E., & Milliken, T. (2011). Counselors' perceptions of ethical behaviors. *Journal of Counseling and Development, 89,* 206–216.

Although ethical codes can be of considerable assistance in a professional's ethical decision-making process, there are limitations to the use of such a code (Corey et al., 2011; Dolgoff, et al., 2009; Remley & Herlihy, 2010):

- Codes do not address some issues and offer no clear way of responding to other issues.
- There are sometimes conflicts within the same code, between the code and the law, and between the code and a counselor's value system.
- It is sometimes difficult to enforce ethical violations in the codes.
- The public is often not involved in the code construction process, and public interests are not always taken into account.
- Codes do not always address "cutting edge" issues.

In the development and revision of ethical codes, deciding what might be included in a code can be a difficult task. For instance, there is often a struggle between deciding which societal values should be reflected in codes (Gert, 2005; Ponton, & Duba, 2009). In addition, even when societal values are included, they are often not reflective of all individuals within American culture. As an example, the idea of "self-determination," or the notion that we all should have the ability to decide for ourselves what is in our own best interest, is not a value held by all individuals in society, especially those who value the opinions of extended family or authority figures when making important decisions. In addition to societal values, universal truths are often reflected in a code. However, people also debate the universality of universal truths. For example, the idea that "though shall not kill" seems to be universal, yet many would hold that killing is ethical during war. Thus, deciding what principles to include in a code often involves a fair amount of debate amongst and reflection by members of professional associations as they try to develop a code that fits most counselors and can be palpable to most clients. Despite wrestling with many different values, those who developed the ethical guidelines of the three major helping professions of counseling, psychology, and social work ended up producing codes that seem fairly similar.

Codes of Ethics in the Helping Professions

ACA's Ethical Standards: A Brief Overview

ACAs ethical code has undergone a number of revisions since it was first adopted in 1961. However, because values of society and professional associations are always changing, and because codes only change periodically (e.g., every 10 years or so), the values reflected in a code sometimes lag behind the values of society and of professional associations (Kaplan et al., 2009; Kocet, 2006; Ponton & Duba, 2009). Keeping this in mind, the eight sections of ACA's ethical code are briefly summarized below (ACA, 2005). The summary highlights aspects of the code, and you are strongly encouraged to read the whole code in detail, which can be found at: http://www.counseling.org/Resources/ (then click "Ethics").

Section A: The Counseling Relationship. Highlighting important issues within the counseling relationship, this section stresses (1) the importance of respecting the client and looking out for the client's welfare by (2) keeping good records and having a plan for counseling; (3) obtaining informed consent prior to and during treatment;

(4) consulting with others who are working with your client; (5) avoiding harm and not imposing one's own values; (6) knowing role limitations when working with a client, such as not engaging in sexual relationships with clients and those close to them; (7) knowing how to advocate for clients at various levels (e.g., institutional, societal); (8) understanding the importance of identifying roles when working with multiple clients (e.g., group and family counseling); (9) knowing how to screen and protect clients participating in groups; (10) knowing how to provide effective care for terminally ill clients; (11) knowing rules related to fees and bartering; (12) knowing how to effectively terminate and refer clients; and (13) being able to navigate the intricacies of technology when working with clients.

Section B: Confidentiality, Privileged Communication, and Privacy. Section B examines the importance of (1) respecting clients' rights to confidentiality and privacy; (2) knowing the exceptions to client confidentiality (e.g., when client is in danger of harming self or other); (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; (7) protecting confidentiality in research; and (8) maintaining confidentiality when serving in a consultative role.

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; and (7) ensuring the public can distinguish personal from professional statements.

Section D: Relationships with Other Professionals. Section D highlights the importance of (1) maintaining mutually respectful relationships with colleagues, employers, and employees despite differing counseling approaches, forming strong, interdisciplinary relationships with others, and addressing unethical situations and negative working conditions when they might 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 reliable and valid assessment instruments and ensuring client welfare when assessing; (2) being competent in the use of assessment instruments and using the information gained appropriately; (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 non-discrimination; (9) knowing proper ways to score and interpret instruments; (10) ensuring test security; (11) ensuring test information is up to date and not obsolete; (12) ensuring that sound, scientific knowledge is used in the construction of ssessment instruments; and (13) ensuring objective results when conducting forensic evaluations.

Section F: Supervision, Training, and Teaching. Section F examines the importance of (1) supervisors being responsible for the welfare of supervisee's clients; (2) supervisors obtaining ongoing training; (3) supervisors maintaining ethical relationships with supervisees, including respect for nonsexual boundaries; (4) supervisors obtaining informed consent, ensuring access to consultation when they are not available, ensuring supervisees know standards and are familiar with proper procedures for termination; (5) supervisors evaluating and offering feedback to supervisees; (6) counselor educators being competent, infusing multicultural issues, integrating theory and practice, ensuring the rights of students, being careful when presenting "innovative" techniques, ensuring adequate field placements, and ensuring that students and supervisees present professional disclosure statements to clients; (7) counselor educators ensuring student welfare by offering orientations and providing self-help experiences; (8) students knowing their ethical code regarding what to do if impaired; (9) counselor educators offering ongoing feedback to students and remedial help if needed; (10) counselor educators knowing 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.

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 relationships with research participants; (4) methods for accurately reporting results; and (5) guidelines for accurately publishing results.

Section H: 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; (2) how to deal with suspected violations, such as first addressing the individual informally, and if no resolution is forthcoming, or if the violation is of such a nature to have caused harm to another, how to approach the appropriate ethics committee; and (3) the importance of working with ethics committees.

Related Ethical Codes and Standards

In addition to ACAs ethical code, a number of the divisions and affiliated groups of ACA have established ethical codes in lieu of ACA's code or standards of best practices that supplement the ACA code. Highlighting just a few of these, we find that the American Mental Health Counselors Association (AMHCA), the American School Counselors Association (ASCA), and the International Association for Marriage and Family Counselors (IAMFC) all have their own codes (AMHCA, n.d.; ASCA, 2004; IAMFC, n.d.). Also, the Association for Specialists in Group Work (ASGW) has a best practice guideline that supplements the ACA code (ASGW, 1998). In addition, the National Board for Certified Counselors (NBCC) and the Commission for Certification on Rehabilitation Counselor Certification (CRCC) both have separate codes for counselors (CRCC, 2010; NBCC, 2005). Clearly, sometimes one must choose which code to adhere to. For instance, if one is a member of ASCA, ACA, and is also a National Certified Counselor (NCC), which of the three codes does one follow? Although all three are fairly similar, there are some differences, and bouncing among codes to decide which one to follow

when faced with a difficult ethical dilemma is not the best way to make a decision. However, if time permits, reflecting on the different codes and debating the knowledge held in each might be smart when faced with a difficult situation.

Besides ACA and its divisions, related mental health fields have ethical codes. Thus we find ethical codes from the American Psychological Association (APA, 2003), the National Association of Social Workers (NASW, 2008), the American Association of Marriage and Family Therapists (AAMFT, 2001), the American Psychiatric Association (APA, 2009), and the National Organization of Human Services (NOHS, 1996). Although there is certainly much in common among the various ethical standards, differences do exist. Of course, it is important to have a clear sense of one's professional affiliation and be particularly familiar with that association's guidelines when making difficult ethical decisions.

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 (Glosoff & Freeman, 2007; APA, 2009; Neukrug & Milliken, in press; Neukrug, Milliken, & Walden, 2001), a number of ethical "hot spots" can be identified. Based on Neukrug and Milliken's (2011) research, Table 3.2 groups some of these issues into logical categories.

Resolving Ethical Dilemmas: Models of Ethical Decision-Making

In view of the practical limitations of ethical guidelines noted earlier, and in search of a more flexible and comprehensive approach to resolving ethical dilemmas, models of ethical decision-making have been devised (Cottone & Claus, 2000; Welfel, 2010). This section of the chapter examines four types of models: 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.

Problem-Solving Models

Problem-solving models provide the clinician with a step-by-step approach to making ethical decisions. They are practical, hands-on approaches that are particularly useful for the beginning clinician. One such approach, developed by Corey et al. (2011), is an eight-step practical model that consists of: (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. Corey's and other similar models can be a great aid to the clinician in the sometimes thorny ethical decision-making process.

Moral Models (Principle and Virtue Ethics)

While Corey's model emphasizes pragmatism, other models stress the role of moral principles in ethical decision-making. Two *moral models* have taken on prominence in recent years. Called *principled ethics* and *virtue ethics*, these models stress inherent principles or virtues to which the counselor should subscribe when making ethical decisions.

TABLE 3.2

Ethical "Hot Spots" Grouped into Logical Categories

The Counseling Relationship

- Counseling a terminally ill client about end-of life decisions
- Providing counseling over the internet
- Telling your client you are angry at him or her
- Using techniques that are not theory or research based
- Pressuring a client to receive needed services
- Trying to have client adopt counselor's values

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
- Reporting or not reporting child abuse
- Reporting or not reporting spousal abuse
- Reporting or not reporting elder abuse

Social and Cultural Issues

- Referring a gay or lesbian client for reparative 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

Relationships and boundary issues

- Attending a client's wedding, graduation ceremony, or other formal ceremony
- Hugging a client
- Bartering (accepting goods or services) for counseling services
- Selling a product to your client that is related to the counseling relationship (e.g., book, audiotape, etc.)
- Becoming sexually involved with a current client
- Having sex with a former client

Confidentiality

- Keeping client records on your office computer
- Sharing confidential client information with your administrative supervisor
- Guaranteeing confidentiality for couples and families
- Withholding information about a minor client despite a parent's request for information
- Not allowing clients to view case notes about them
- Guaranteeing confidentiality for group or family members
- Sharing confidential client information with a colleague who is not your supervisor

Informed Consent

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

Professional/Practice Issues

- Not being a member of a professional association in counseling
- Misrepresentation of credentials
- Inappropriate fee assessment
- Reporting a colleague's unethical conduct without first consulting with the colleague
- Not having malpractice coverage (on your own or by your agency/setting)
- Engaging in a helping relationship with a client (e.g., individual counseling) while the client is in another helping relationship (e.g., family counseling) without contacting the other counselor

Source: Neukrug, E., & Milliken, T. (2011). Counselors' perceptions of ethical behaviors. *Journal of Counseling and Development, 89*, 206–216.

Kitchener's (1984, 1986; Urofsky, Engels, & Engebretson, 2008) principle ethics model is often described as the foundation or core of ethical codes. Her model describes the role of six moral principles that individuals should consider in the process of ethical decision-making: *autonomy* has to do with protecting the independence, self-determination, and freedom of choice of clients; *nonmaleficence* is the concept of "do no harm" when working with clients; *beneficence* is related to promoting the good of society, which can be at least partially accomplished by promoting the client's well-being; *justice* refers to providing equal and fair treatment to all clients; *fidelity* is related to maintaining trust (e.g., keeping conversations confidential) in the counseling relationship and being committed to the client within that relationship, and *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.

Kleist and Bitter (2009) note that whereas the focus of principle ethics is on what should be done when making ethical decisions, the focus of virtue ethics is on the character of the counselor who is making the ethical decision. For instance, Meara, Schmidt, and Day (1996) suggest that virtuous helpers are *prudent* or careful and tentative in their decision-making, maintain *integrity*, are *respectful*, and are *benevolent*. In addition, virtuous counselors strive to make ideal 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 by having a vision concerning decisions that are made.

Social Constructionist Perspective

One of the more recent additions to ethical decision-making, the *social constructionist perspective* sees knowledge (e.g., knowledge in codes) as intersubjective, changeable, and open to interpretation (Guterman & Rudes, 2008). This perspective suggests that realities are socially constructed, constituted through language, organized and maintained through narrative (stories), and that there are no essential truths (Freedman & Combs, 1996). Taking a *post-modern* perspective, they believe that traditional ways of viewing ethical dilemmas could at times be problematic, and is often the result of the language used and embedded in one's culture and in society. Such language, they suggest, is often subtly, and sometimes not so subtly, oppressive of others, particularly those from nondominant groups. They question what we often take for granted (e.g., diagnosis, theoretical assumptions) and look for dialogue with others to develop new ways of understanding situations.

Although fully aware of ethical guidelines, those who embrace a social constructionist perspective don't expect "answers" to come from a code, within themselves, or within other people. They view solutions to problems as coming out of dialogue between counselors and their clients and others (e.g. supervisors, others in client's world). The social constructionist approaches the client with humility, as an equal, with wonder, and as a collaborator with whom solutions to ethical problems can be jointly worked out.

Developmental Models

Developmental models, created by individuals like William Perry (1970) and Robert Kegan (1982, 1994), suggest that individuals at "lower" levels of development have less of some qualities that are considered positive for counselors than those who are at

"higher" levels (Linstrum, 2005; Neukrug, Lovell, & Parker, 1996). Although not specifically developed for ethical decision-making, their models would suggest that counselors at lower levels of development would want "the answer" to complex questions that might face them, such as those involved in difficult ethical decisions. These counselors often adhere to a rigid view of the truth, and expect, or at the very least, hope that such formal documents as ethical codes hold the answer 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 answer when faced with thorny ethical dilemmas. These counselors can be said to be making meaning from what Perry 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*, would be more complex thinkers, open to differing opinions, flexible, empathic, sensitive to the context of the ethical dilemma, and nondogmatic (Cottone, 2001; Kohlberg, 1984; McAuliffe & Eriksen, 2010). Although few adults (or counselors) reach the highest levels of this development (Lovell, 1999), these models suggest that, if afforded the right opportunities, most can.

You can see that individuals who are at lower levels would make ethical decisions in very different ways than 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

Often, the models just presented are not used in isolation. After reviewing the different models in Table 3.3, read the ethical dilemma presented in Box 3.1. First, consider separately how the problem-solving, moral, and social constructionist models would approach the ethical dilemma faced in the vignette. Then, when working on the developmental model, consider how a person of higher development could integrate all the models in responding to the dilemma.

BOX 3.1

Using the Ethical Decision-Making Models

John, 82, is seriously depressed and feels that he has no reason to continue living after having been recently diagnosed with pancreatic cancer and given less than one year to live. Although he has been seeing you, his counselor, for several months, his outlook on life has not changed, and he is determined to end what he considers to be an "empty existence" before death overtakes him. John's partner of 45 years, Jim, died two years ago, and he now believes that the reality of his own mortality has become apparent. John lives in a retirement complex but has few close friends. He and Jim had isolated themselves from others, and in order to safeguard their privacy, severed all social ties years ago. John has no support system and is not interested in trying to develop one now. He tells you that he has lived long enough and has accomplished most of what he wished to do in life. He is now ready to die and wants only to get it over with as quickly and painlessly as possible. He asks you to help him decide upon the most efficient means of achieving this goal. As his counselor, what should you do?

T A B L E 3.3

Summary of Ethical Decision-Model			
	THEORETICAL ASSUMPTIONS	PRINCIPLES/KEY POINTS	ROLE OF COUNSELOR
Problem-Solving Model	Step-by-step, practical, pragmatic hands-on approach.	Eight steps (see p. 72)	Go through the steps, one by one.
Moral Models			
Principle Ethics	Moral principles 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.	*Six principles:* Autonomy, nonmaleficense, beneficence, justice, fidelity, and veracity.	Consider the six principles in making an ethical decision.
Virtue Ethics	Moral principles play a major role in ethical decision-making. The focus is on the character of the counselor who strives to make ideal decisions based on an understanding of profession and community.	*Four virtues:* Being prudent, integrity, respectfulness, and benevolence.	Counselor needs to be self-aware, compassionate, culturally astute, consider doing good, have a vision, and embrace the four virtues in making an ethical decision.
Social Constructionist Model	Knowledge in codes is intersubjective, changeable, and open to interpretation. Realities are socially constructed, constituted through language, organized, and maintained through narrative (stories). There are no essential truths. Ethical dilemmas may be result of inequities in society subtly supported through language.	Solutions to ethical dilemmas come out of dialogue between counselor, his or her clients, his or her supervisor, and others.	Approaches client with humility, as an equal, with wonder, and as a collaborator with whom solutions to ethical problems can be jointly worked out.
Developmental Model	Counselors at "lower" levels of development have less of some qualities effective in ethical-decision making than those who are at "higher" levels. All individuals can increase levels of development.	*Dualistic counselors:* Black and white thinking, concreteness, stereotyping, oversimplification, self-protectiveness, and authoritarianism. *Relativistic counselors:* Complex thinkers, open to differing opinions, flexible, empathic, sensitive to the context of the ethical dilemma, and nondogmatic.	Embody qualities of relativist in an effort to work through ethical dilemma.

Reporting Ethical Violations

The ACA Ethical Code (2005), Section H, provides guidelines on how to proceed if one suspects a counselor is violating an ethical guideline. Unless substantial harm has occurred or is likely to occur to another, the code first encourages complainants to try and resolve the issue informally by discussing the situation directly with the counselor who is suspected of violating the guideline (see Box 3.2). 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

BOX 3.2

The Importance of an Informal Resolution of an Ethical Violation

A friend of mine reported a psychologist to the 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.

ethics, voluntary national certification bodies, state licensing boards, or to the appropriate institutional authorities" (ACA, 2005, Standard H.2.e).

When a complaint is received, ethics committees will first examine whether they have the jurisdiction to address the complaint. For instance, if a complaint comes to the ethics committee of ACA concerning a licensed counselor, and the counselor in question is not a member of ACA, then the ethics 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 found that of those complaints made to licensing boards nationally, only 10% were acted upon, with the following consequences: 36% had their licenses revoked, 19% had their licenses suspended, 5% were sent letters of reprimand, 4% were required to receive supervision, and 1% were assessed a fine. Another 35% had some other action taken against them (e.g., community service, further education, or voluntary surrender of license) (Neukrug, Milliken, & Walden, 2001).

Legal Issues Related to Ethical Violations

Civil and Criminal Liability

Because some complainants consider potential suspension or expulsion from a professional group too mild a punishment, they may opt to commence a civil lawsuit, or if they suspect a possible criminal act, report it to the authorities in hopes of a criminal prosecution of the counselor. 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, Helman Brook, Esq., March 6, 2010). As was widely recognized in the O. J. Simpson lawsuits, the burden of proof in a criminal case is quite different from that in a civil case. In a criminal matter, the burden is on the state to prove guilt "beyond a reasonable doubt." In a civil matter, the burden is on the plaintiff to prove the case by a "preponderance of the evidence." To highlight these differences, imagine the scale of justice. In a criminal case, the scale needs to sharply drop to one side to establish the defendant's guilt beyond a reasonable doubt; in a civil suit, where the penalty is money rather than potential incarceration, the scale need tilt only slightly in the plaintiff's (complainant's) favor to obtain a verdict and a potential judgment (personal communication, Carole Borstein, Esq., February 25, 2010).

In instances of alleged malpractice, complainants most often initiate civil suits against counselors, although counselors could also be charged with criminal violations in the criminal courts. For example, if a counselor is alleged to have had sex with a client

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 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 an individual for arbitrary and capricious acts of malicious prosecution and abuse of process in filing unwarranted lawsuits.

The Role of Ethical Codes in Lawsuits

Although ethical guidelines are not legal documents, whether a counselor is involved in a criminal or civil suit, a professional association's code of ethics can be an important piece of evidence. For instance, a counselor would have a difficult time defending having had sex with a client because the ethical guidelines clearly assert that sex with a client is inappropriate behavior. However, cases are often not clear-cut. For example, a counselor has sex with a former client she had seen six years earlier. The former client feels abused, brings the case to a prosecutor who determines that the statute is unclear about when a client stops being a client, and decides to file criminal charges against the counselor. The counselor then brings the most recent version of the ACA ethical guidelines to court, which state 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, 2005, Standard A.5.b.). On the other hand, the prosecutor would undoubtedly retort with the following statement, also found in the ethical guidelines: "Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some 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 such an interaction or relationship" (ACA, 2005, Standard A.5.b.). Finally, because ethical guidelines are not legal documents, they are likely to hold more weight in a civil court than in a criminal court, because the burden of proof is less demanding in a civil case.

Malpractice Insurance

In today's litigious society, there is little doubt that a counselor needs to be particularly careful, and 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 him- 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. There is little question that, in today's world, malpractice insurance is almost a necessity. Although most schools and agencies generally purchase an umbrella malpractice insurance policy, it is still prudent to own additional insurance protection. And, if you do work in a setting that has purchased a malpractice policy, review it carefully, study its monetary limits, and examine any possible exclusions to the policy. For instance, are you covered if you work

after hours? What if your employer lets you run a workshop for your own personal profit at the agency on the weekend? Are you still covered?

Although colleges and universities almost always carry malpractice insurance for students doing practicum and internship, again it is always best to check and see if the school does indeed have a policy and the monetary limits of such a policy. The ACA insurance trust has partnered with Healthcare Providers Service Organization (HPSO) to offer professional liability insurance. As of the writing of this text, this program offers malpractice insurance for rates that tend to run around $29 for students and from $165 to $317 for self-employed counselors for $1,000,000 worth of coverage (ACA, 2010a).

Avoiding Lawsuits: Best Practices

As one can see from the discussion on ethics and on the importance of malpractice insurance, making ethical decisions can be an arduous and potentially career-threatening process. It is, therefore, essential that clinicians are equipped with the clinical knowledge and tools necessary to make the best decisions when working with clients. Showing a court that you have followed *best practices* in your profession can be critical in winning a lawsuit. Although ethical guidelines are not legal documents, following one's professional association's code of ethics can be one important piece of evidence in showing best practices have been followed. Gerald Corey and his colleagues describe additional ways in which a clinician can assure that he or she has been following best practices (Corey et al., 2011). Highlighting some of these ways, they note that clinicians should:

- 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 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
- Make sure that clients understand information you present to them
- Avoid engaging in sexual relationships with current or former clients
- Assure that clients understand they can terminate counseling at any point
- Obtain permission from a client to consult with others, whenever possible
- Assess clients, 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

- Keep appropriate boundaries and know limitations of multiple relationships (e.g., counseling a person who is a neighbor)
- Provide a professional disclosure statement and obtain informed consent regarding course of treatment
- 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

Accreditation

The History and Development of Professional Preparation Standards

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 & Wiederman, 2000, p. 53)

Mental health professionals often have responsibilities that heavily impact the lives of others, many of whom are exceptionally vulnerable. Shoddy or inept training could cause you, even inadvertently, to harm people. One mechanism of ensuring good training is through accreditation of programs. Some of the first programs to offer training standards that would eventually lead to accreditation 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, 2012; Sheridan, Matarazzo, & Nelson, 1995). Few then realized that today there would literally be hundreds of accredited programs offering graduate training in counseling, social work, couples and family therapy, and psychology. Although starting a little later than the fields of psychology and social work, within the past 30 years the counseling field has made great strides in its efforts toward accreditation.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP): A Short History

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)

Although the idea of having standards for counselor education programs can be traced back to the 1940s (Sweeney, 1992), 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). Soon, 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 (Altekruse & Wittmer, 1991; Sweeney, 1995). Although the Standards were being unofficially used as early as 1973, it was not until 1979 that APGA (now 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, which went into effect in January of 2009. Today they are considered to be the standard to which all counseling programs should strive (see CACREP, 2010a).

Considering the vast number of changes that most programs have to make and the amount of time that it takes to implement such changes, it is a tribute to CACREP that 242 of the approximately 500 institutions that offer counseling programs oversee 579 accredited programs in a number of specialty areas (Urofsky, personal communication, March 5, 2010). An additional 35 programs are now applying for accreditation (CACREP, 2010b), and with New York State 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 the there will be continued expansion of the number of CACREP accredited programs. It is probably not surprising that accreditation of counseling problems has quickly spread, as the benefits are many (Bahen & Miller, 1998; McGlothlin & Davis, 2004; O'Brien, 2009; Schmidt, 1999):

- Students who graduate from accredited programs study from a common curriculum, are generally more knowledgeable about core counseling issues, and usually participate in more intensive and longer field work experiences.
- Accreditation often becomes the standard by which credentialing bodies determine who is eligible to become certified or licensed.
- Accreditation bodies offer the impetus for setting and maintaining high standards.
- Accreditation almost always results in improved programs.
- Administrators and legislators are often more willing to provide money to maintain the high standards of accredited programs.
- Those who graduate from accredited programs generally have better job opportunities.
- Accredited programs will often attract better faculty.
- Accredited programs will often attract better students.

Although some have argued that accredited programs can limit creativity, are too costly, and delimit what can be offered, it is clear that CACREP is here to stay.

A Quick Overview of the CACREP Standards

Today, CACREP offers standards for the doctoral degree in counselor education and for the master's degree in clinical mental health counseling (54 credits until July 1, 2013, thereafter 60 credits), school counseling (48 credits), student affairs and college counseling (48 credits), career counseling (48 credits), addiction counseling (60 credits), and marriage, couple, and family counseling (60 credits) (CACREP, 2010c). In some counseling programs you will find accredited master's degrees in counseling listed under related names (e.g., community counseling) as those programs were accredited under previous standards. As their accreditation periods run

out, they will either become re-accredited under one of the new names or disband the program.

For all master's programs seeking CACREP accreditation, the standards delineate a variety of requirements within three primary areas: The *Learning Environment*, which sets minimal standards for structure and evaluation of the institution, the academic unit, faculty and staff; *Professional Identity*, which specifies foundations of the program (e.g., mission statement and objectives) and delineates content areas that should be learned by students (i.e. 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); and *Professional Practice*, which specifies supervisor qualifications and requirements for field work experience that include 100 hours of practicum and 600 hours of internship. Similar types of guidelines are also given for doctoral level programs in counselor education. In addition to these common standards, each specialty area has additional standards that must be met. For instance, clinical mental health counseling requires student learning in the following areas: foundations; counseling, prevention, and intervention; diversity and advocacy; assessment; research and evaluation; and diagnosis. School counseling requires all the same areas with the exception of diagnosis and with the addition of academic development, collaboration and consultation, and leadership.

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 along 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.

The CACREP accreditation process tends to be long and arduous. Despite this fact, or perhaps because of it, CACREP has become a major force in the preparation of highly trained counselors and will no doubt continue to have an impact on the counseling field.

Other Accrediting Bodies

A number of other accreditation bodies set standards in related fields. For instance, the Council on Rehabilitation Education (CORE, 2010) accredits rehabilitation counseling programs. Although CORE and CACREP had discussed the possibility of a merger, such talks fell through and are currently on hold (The CACREP Connection, 2007). In another related field, we find training centers being approved by the American Association of Pastoral Counselors (AAPC, 2005–2009). 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 American Psychological Association (APA) currently sets standards for doctoral-level programs in counseling and clinical psychology (APA, 2010). The Council on Social Work Education (CSWE, 2010) is responsible for the accreditation of both undergraduate and graduate social work programs, while AAMFT's Commission on Accreditation for Marital and Family Therapy Education (COAMFTE, 2002) is the accrediting body for marriage and family therapy programs. Although somewhat in conflict with CACREP's accreditation of marriage and family therapy counseling programs, this commission has accredited 107 marriage and family therapy programs in the United States and Canada (COAMFTE, 2010).

Credentialing

One method of ensuring that professionals are competent is through accreditation. Another means is through *credentialing*. Although credentialing in the mental health professions is a relatively new phenomenon, regulating occupations began as far back as the thirteenth century when the Holy Roman Empire set requirements for the practice of medicine (Hosie, 1991). However, it was not until the 1900s that credentialing became common, and it was not until the 1970s that credentialing in the counseling field first started to become a reality. Today, credentialing cuts across many professions and can be found in many different forms. Usually, credentialing offers many benefits to the profession, the consumer, and the counselor (Bloom, 1996; Corey et al., 2011), including the following:

- *Increased professionalization.* Credentialing increases the status of the members of a profession and clearly identifies who those members are.
- *Parity.* Credentialing helps counselors achieve parity in professional status, salary, insurance reimbursement, and other areas with closely related mental health professions.
- *Delimiting the field.* The process of passing legislation to enable counselors to obtain credentials assists the profession in clearly defining who we are and where we are going.
- *Protection of the public.* Credentials help identify to the public those individuals who have the appropriate training and skills to do counseling.

Although credentialing takes many forms, the three most common forms of credentialing 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, 2010b). Although more rigorous than registration, certification is less demanding than licensure. Generally, certification is seen as a protection of a title (Remley & Herlihy, 2010); that is, it 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 of Certified Counselors (NBCC, 2009a). 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 for an individual to maintain his or her credential.

Licensure

The most rigorous form of credentialing is *licensing*. 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, 2010b). 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 (see Chapter 4), legal regulations related to suspected violations of the law (e.g., child abuse), and other various restrictions and regulations (Virginia Board of Counseling, 2009).

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 often continuing education requirements are mandated (see Box 3.3).

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 twenty 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 in our cousin professions.

Master's Degree in Social Work Credentialing

On the national level, a number of credentials exist for the many master's-level social workers. Experienced social workers can hold a credential as an ACSW from the Academy for Certified Social Workers. Those who have more clinical experience can become a QCSW (Qualified Clinical Social Worker), and advanced clinicians can become a Diplomate in Clinical Social Work (DCSW). In addition, many clinical social workers become licensed in their states and become Licensed Clinical Social Workers (LCSWs) (NASW, 2010).

BOX 3.3

The Topsy Turvy World of Credentialing

Professional school counselors are required by law and/or regulation in every state 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, 2003, p. 5)

There are many caveats to the above definitions of registration, certification, and licensing. For instance, although I was a licensed psychologist in Massachusetts and New Hampshire, when moving to Virginia, the psychology licensing board would not license me. I was, however, quite content to obtain my license as a professional counselor. You see, state licenses are often not reciprocal.

Also, state boards of education often use the words certification or licensure for school personnel (e.g., teachers, school counselors, school psychologists). This means that the individual has successfully graduated from a state-approved program in their respective area. However, there is no rhyme or reason why one state will use the word "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 you live in. So, check on your state regulations to be sure you know how credentialing operates where you live.

Doctoral Level Credentialing as a Psychologist

The first push for credentialing of doctoral-level psychologists came during the 1950s (Cummings, 1990). Today, every state offers licensure for doctoral-level psychologists, generally in the areas of counseling and/or clinical psychology. In addition, many states now offer hospital privileges for *licensed psychologists*. Such privileges afford psychologists the right to treat those who have been hospitalized with serious mental illness. Not surprisingly, psychologists have recently sought, so far with very limited success, to gain the right to prescribe medication for emotional disorders (Johnson, 2009).

Marriage and Family Therapy Credentialing

Today, every state in the United States has enacted some credentialing laws for marriage and family counselors or therapists. In some cases, state marriage and family licensure boards are independent and have followed the guidelines set by the American Association of Marriage and Family Therapists (AAMFT). In other cases, such marriage and family licensure has been subsumed under the counseling board or the boards of other related mental health professions. 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 therapist to become a Certified Family Therapist (CFT) (NCA, n.d.).

Credentialing as a Psychiatrist

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 psychiatrists are not only *licensed physicians* within the state where they practice, but are generally board certified in psychiatry (B. Britton, M.D., personal communication, March 10, 2010).

Credentialing as a Psychiatric-Mental Health Nurse

There are two levels of *psychiatric-mental health nurses*—the basic and the advanced. Basic psychiatric-mental health nurses generally do not have advanced degrees and can work with clients and families doing entry-level psychiatric nursing. In contrast, advanced psychiatric-mental health nurses are generally registered nurses with a master's degree in psychiatric-mental health nursing. These Advanced Practice Registered Nurses (APRN) can do a wide-range of mental health services, can prescribe medication, and can receive third-party reimbursement in many states (American Psychiatric Nurses Association, n.d.).

Credentialing for Counselors

Although the first credentialing of counselors can be traced back to the certification of school counselors in the 1940s (Bradley, 1995), counselor credentialing in the form of certification and licensure did not take off until the 1970s. Below is a brief examination of some of the certification and licensure gains within the past 30 years.

Certified Rehabilitation Counselors (CRC)

In 1974, the field of rehabilitation counseling became one of the first counseling specialty areas to obtain certification for its members through the Commission on Rehabilitation Counselor Certification (CRCC, 2010; Livingston, 1979). Since its inception, CRCC has credentialed over 35,000 Certified Rehabilitation Counselors (CRCs).

National Counselor Certification (NCC)

The National Board for Certified Counselors (NBCC) was established in 1982 to "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, 2009a, para. 1). Today, over 45,000 counselors have become National Certified Counselors (NCCs). 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 two years of post-master's experience with 100 hours of supervision and 3,000 hours of work experience. Finally, 42 licensing boards have adopted the NCE, or some of its specialty certifications (see next section), as part of their licensing process (NBCC, 2009c).

Specialty Certifications in Counseling

In addition to the NCC, NBCC offers three specialty certifications: Certified Clinical Mental Health Counselor (CCMHC), National Certified School Counselor (NCSC), and the Master Addiction Counselor (MAC). The NCC is a pre- or co-requisite to these specialties (NBCC, 2009b). Finally, as noted earlier, the International Association of Marriage and Family Counselors, through the National Credentialing Academy, has developed a process of national certification for marriage and family counselors (NCA, 2005). In the past 25 years, the certification process has done much for the professionalization of the counseling field. Signifying competence in our field, the NCC and the specialty certifications demonstrate a unifying force within the profession that links all specialties. Similar to physicians, where one is first a physician and secondarily a cardiologist, pediatrician, psychiatrist, and so forth, a counselor is first a counselor and secondarily a school counselor, clinical mental health counselor, college counselor, addiction counselor, and so forth.

Counselor Licensure

The movement toward professional counselor licensure began slowly in the 1960s but picked up steam in 1976 when Virginia became the first state to pass a licensing law for counselors. Today, all 50 states, Puerto Rico, and the District of Columbia offer licensing and there are approximately 115,000 licensed counselors nationally (see ACA, 2010c). 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 just recently approved counselor licensure, this number will surely rise quickly. As noted earlier, the NCC or its subspecialty certifications are often used by states as the licensing exam. In addition to an exam, licensure generally includes a minimum of two years of post-master's-degree supervision, sometimes additional coursework, and other requirements depending on the state.

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 profession (see ACA, 2010d). 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 in all 50 states. Today, we must continue to lobby to ensure that we are included as providers for various health insurance plans. If counselors are not included, the counselor as private practitioner might no longer exist.

In today's world, the public wants to see proof that the counselor's role is necessary. Lobbyists and our grassroots efforts help to show the importance of counseling. Credentialing helps to show the public that we are experts at what we do. Who pays for these efforts? We do! A portion of our professional association membership fees goes to pay for lobbyists and legislative initiatives in which counselors find ways to support our own interests. When you refrain from joining your professional association, you reap the benefits for which others are paying!

Multicultural/Social Justice Standards: Multicultural Counseling Competencies and Advocacy Competencies

While counseling is one way to provide services to clients from oppressed groups, it is limited in its ability to foster social change. Engaging in advocacy, prevention, and outreach is critical to social justice efforts, as is grounding teaching and research in collaborative and social action processes. (Vera & Speight, 2003, p. 253)

Increasingly, *multicultural counseling* and *social justice advocacy* are viewed as one broad effort to reduce or eliminate injustices in the helping professions (Pieterse, Evans, Butner, Colins, & Mason, 2009). However, in many ways, social justice advocacy is a subset of multicultural counseling. Whereas multicultural counseling is mostly focused upon the development of counselor competencies in an effort to maximize the ability of counselors to work with all clients, social justice advocacy focuses on taking action to effect change in an effort to help marginalized clients. Although the main focus of the counseling profession was initially on multicultural competence, in recent years, social justice advocacy has taken a prominent role. Thus, it is not surprising that in 1991, Sue, Arredondo, and McDavis (1992) developed a set of skills they called the *Multicultural Counseling Competencies*, and it was not until 2002 that the *Advocacy Competencies* were developed. Let's take a look at both sets of competencies.

Multicultural Counseling Competencies

The original *Multicultural Counseling Competencies* were developed by Sue et al. (1992), and later expanded and operationalized to help guide counselor educators in the training of counselors (Arredondo, 1999; Arredondo et al., 1996; Hill, 2003). The competencies were subsequently adopted by the Association for Multicultural Counseling and Development (AMCD) and then by ACA (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003; Roysircar, Sandhu, & Bibbins, 2003). Today, the competencies reflect minimum standards needed by all counselors if they are to work effectively with diverse clients. The competencies, which can be found in Appendix A, delineate attitudes and beliefs, knowledge, and skills in three areas: the counselor's awareness of the client's worldview, the counselor's awareness of one's own cultural values and biases, and the counselor's ability to use culturally appropriate intervention strategies (see Figure 3.1).

A longer version of the competencies is available that offers strategies to achieve each competency. Today, most counselor education programs try to focus on these strategies to help students increase multicultural competence. You are encouraged to read the competencies in Appendix A and discuss them in class.

Advocacy Competencies

The development of *Advocacy Competencies* grew out of a number of parallel processes occurring within the broader counseling community (Toporek, Lewis, & Crethar, 2009). First, the *Transforming School Counseling* initiative, which sought to change the way school counselors practiced (see Chapter 16), was being developed during the 1990s and had advocacy as one of its major thrusts. Also, counselors were increasingly

FIGURE 3.1
Focus of Multicultural Counseling Competencies
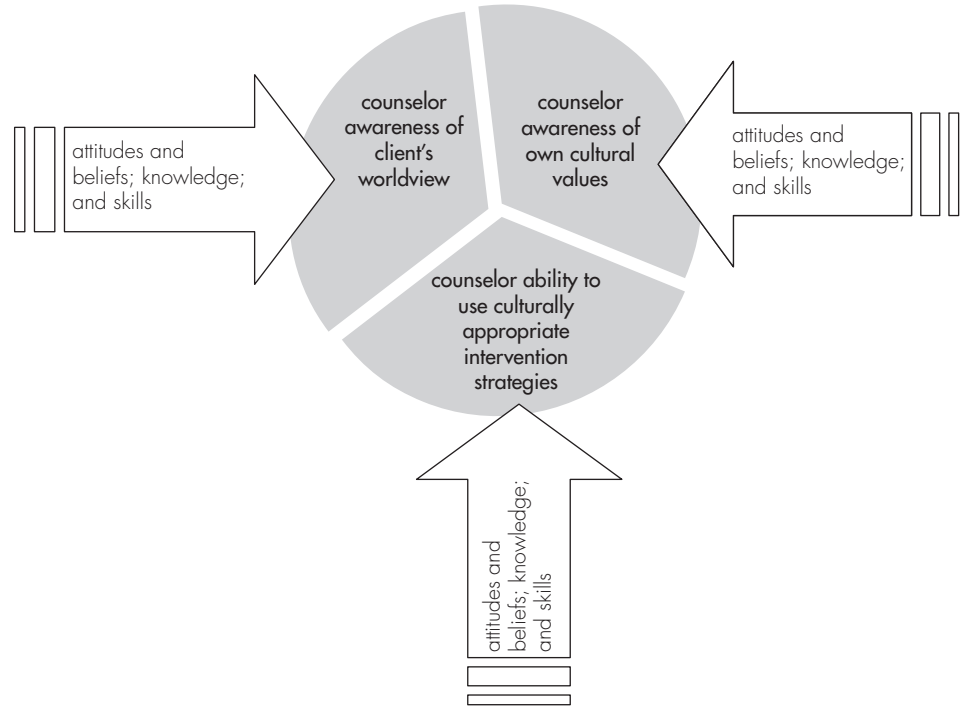
becoming more at ease with advocacy as they took on advocacy roles to obtain counselor licensure in each of the 50 states and fought for parity with other mental health professions. Third, a number of counselors gathered together during the 1990s to discuss social justice issues. Out of these discussions arose the Counselors for Social Justice (CSJ) division of ACA, which found itself in a particularly good position to conduct research and disseminate information about social justice and advocacy. Finally, during the 1990s and early part of the 2000s, ACA presidents became particularly focused on advocacy issues and a new task force was formed to examine the possibility of developing *Advocacy Competencies*. Soon the competencies were developed, and in 2003, they were endorsed by ACA.

The *Advocacy Competencies* encompass three areas of competence (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 (see Figure 3.2). For instance, with the client competency, 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 him- or herself; *or*, "on behalf" of the client, the counselor might assist the client in accessing needed services. The competencies run from the *microlevel* (focus on client) to the *macrolevel* (focus on system). In Figure 3.2, you can view the three competency areas, each divided into two levels. In Appendix B, the competencies are explained and examples of competency areas and levels are given.

FIGURE 3.2
ACA Advocacy Competencies

Source: Toporek, R. L., & Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling and Development, 87,* p. 267.
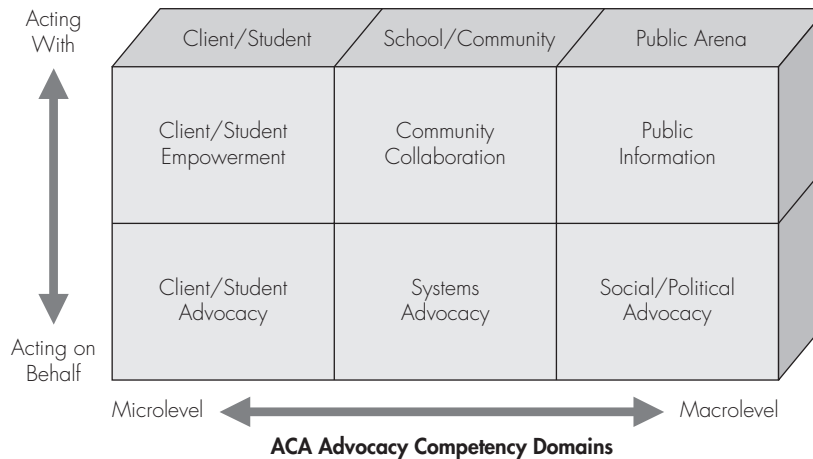
Multicultural/Social Justice Focus: Are the Competencies Research-Based?

Despite the fact that the *Multicultural Counseling Competencies* hit the road running, there has been criticism of them, with some authors citing a paucity of research that supports their efficacy (e.g., Weinrach & Thomas, 2002, 2004). Their criticism may be worth looking at, for it seems like the idea of the importance of the competencies came prior to any actual research that was conducted on the effectiveness of the competencies. However, let's pause for a moment and think about the counseling field in general. Is it not true that all of our theories of counseling, from Freud through the more recent brief counseling treatment approaches, started with an idea and only later were researched? And, is it not true that an idea precedes implementation of the idea, which only then leads to research on its effects? Although caution should always be taken whenever new theories are generated, in the counseling field it has been common practice to field test ideas prior to conducting research measuring their effectiveness. Additionally, one must wonder why the *Multicultural Counseling Competencies* seem to have received more than their share of criticism when none has been voiced for some of the more recent counseling theories that have little research to show their effectiveness?

So where do we stand now? The *Multicultural Counseling Competencies* have been around for two decades and most of the scholarship that was initially published relied on self-reports or articles that were theoretical in nature (Cartwright, Daniels, Zhang, 2008). However, in recent years this has begun to change. In fact, some of the more recent research seems to support some aspects of the competencies. Hopefully, "revisions on the basis of new research will strengthen the model, as is true with all good theoretical models" (Worthington, Soth-McNett, & Moreno, 2007, p. 360).

Now, as to the *Advocacy Competencies*—perhaps we have even more of a challenge here, for how does one measure change in clients when a large part of one's focus is not on the clients but on aspects outside of the counseling office? This will be an important challenge to the counseling profession and one that will have to be faced if the *Advocacy Competencies* are to be seen as worthwhile.

▣ *Ethical, Professional, and Legal Issues: A Plethora of Standards?*

Years ago, when asked if he believed in licensure, Carl Rogers would often assert "no," as he thought that many good counselors and therapists would be left out of the exclusive club that was slowly being developed. And, as turf battles have erupted over the years among the various professions, and as each profession has vowed to keep the other profession "out," you've got to sometimes wonder if he was right.

Today, we have counselor licensure and counselor certification, psychology licensure and psychology certification, social work licensure and social work certification, and more. We have multiple ethical codes, and sometimes we don't know which one we should follow, and we have accreditation bodies that increasingly tell programs they will not be accredited if they hire someone outside of their discipline. And now we have the *Multicultural Counseling Competencies* and *Advocacy Competencies*, and I can tell you, I've seen many a person get shunned for not being an advocate for those competencies.

There's little doubt that we have become, in a way, our own exclusive professional club. Maybe in some ways it's not so good, as we sometimes viciously vie for a position of power against our mental health cousins (e.g., psychologists and social workers), and as we proudly keep out those who do not meet or support the many standards we have developed. On the other hand, maybe our standards play a critical role for us as they provide our profession with a strong sense of where we have been, who we are, and where we are going. Look at the good and look at the bad, and you decide—has it been worth it?

▣ *The Counselor in Process: A Lifelong Commitment to Professionalism*

Embracing a professional lifestyle does not end once one finishes graduate school, obtains a job, becomes credentialed, has ten years of experience, or becomes a "master" counselor. It is a lifelong commitment to a way of being; a way that says you are constantly striving to make yourself a better person, a more effective counselor, a counselor committed to professional activities and to excellence in the field. Our profession has come a long way since the turn of the last century, as is evidenced by the increasing number of standards highlighted in this chapter. It is our job and our obligation to stay current with the most recent efforts to better ourselves as counselors and as professionals. And, despite all our efforts, 100 years from now our successors will undoubtedly say, "How naive they were." We have come very far, and yet we have far to go.

▣ *Summary*

This chapter examined four broad standards in the field of counseling: ethics, accreditation, credentialing, and multicultural/social justice standards. Starting with ethics, we distinguished morality from professional ethics. We spoke of the relatively brief history of the development of ethical codes and identified a number of purposes and limitations of codes. We summarized the eight sections of the ACA code (Sections A through H), and we also identified other codes in the counseling profession, including those of AMHCA, ASCA, NBCC, CRCC, and IAMFC. We also identified related professional codes (e.g., AAMFT, APA, NASW, NOHS). We then identified a number of ethical "hot spots" and grouped them into the categories

of: the counseling relationship, legal issues, social and cultural issues, relationship and boundary issues, confidentiality, informed consent, and professional/practice issue. 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. Then we discussed how to report ethical violations and highlighted the consequences to licensed professional counselors who violated an ethical guideline. This section concluded with a discussion of legal issues related to ethical violations, including distinguishing between civil and criminal liability, the role of ethical codes in lawsuits, the importance of malpractice insurance, and using best practices in counseling if we are to avoid lawsuits.

The chapter next moved into a discussion of accreditation. We presented the history of counseling program accreditation and noted that CACREP's original standards were adopted in 1981. We talked about the rapid spread of programs that are accredited and highlighted some of the benefits and drawbacks to accreditation. We noted that the 2009 CACREP standards address accreditation for clinical mental health counseling, school counseling, student affairs and college counseling, career counseling, addiction counseling, and marriage, couple, and family counseling. We next gave a quick overview of what is required for a program to become CACREP accredited. We concluded by noting a number of accrediting bodies in related mental health professions, including CORE, AAPC, APA, CSWE, and COAMFTE.

Credentialing was next covered in this chapter. We mentioned some of the benefits of credentialing, such as increased professionalization, parity, delimiting the field, and protection of the public. We distinguished registration from certification and from licensing but also noted there continues to be some confusion and cross-use of these words. We then examined some of the credentials in related mental health fields. For instance, for social workers we highlighted the ACSW, QSCW, DCSW, and LCSW. For psychologists, we noted that all states license doctoral level counseling and/or clinical psychologists. Marriage and family counselors, we noted, can be licensed in many states, although regulations vary, and we also noted that IAMFC offers a national certification in this area. Psychiatrists, we noted, are physicians who specialize in psychiatry, and pointed out that psychiatric-mental health nurses can be credentialed at a basic or advanced level. For counselors, we identified many types of credentials including: Certified Rehabilitation Counselor (CRC), National Certified Counselor (NCC), Certified Clinical Mental Health Counselor (CCMHC), National Certified School Counselor (NCSC), Master Addiction Counselor (MAC), and Counselor Licensure (usually called LPC). We concluded with a discussion about the importance of lobbying for credentialing and other counseling related issues.

The last main focus of the chapter was on multicultural/social justice standards, including the *Multicultural Counseling Competencies* and the *Advocacy Competencies*. We noted that the *Multicultural Counseling Competencies* were developed in the early 1990s and have become increasingly used over the years. They delineate attitudes and beliefs, knowledge, and skills in three areas: the counselor's awareness of the client's worldview, the counselor's awareness of one's own cultural values and biases, and the counselor's ability at using culturally appropriate intervention strategies. The *Advocacy Competencies* were developed recently and encompass three areas: client/student, school/community, and the public arena, each of which are divided into two levels: whether the counselor is "acting on behalf" or "acting with" the competency area.

The chapter concluded with a discussion of the efficacy of the *Multicultural Counseling Competencies* and the *Advocacy Competencies*, some reflections on the advantages and disadvantages of having so many standards, and the importance of having a commitment to the field and to the profession.

◼ *References*

Altekruse, M. K., & Wittmer, J. (1991). Accreditation in counselor education. In F. O. Bradley (Ed.), *Credentialing in counseling* (pp. 81–85). Alexandria, VA: Association for Counselor Education and Supervision.

American Association of Marriage and Family Therapists. (2001). *AAMFT code of ethics*. Retrieved from http://www.aamft.org/resources/lrm_plan/ethics/ethicscode2001.asp

American Association of Pastoral Counselors. (2005–2009). Training programs in pastoral counseling. Retrieved from https://aapc.org/content/training-programs-pastoral-counseling

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Counseling Association. (2010a). *ACA insurance trust*. Retrieved from http://www.acait.com/

American Counseling Association. (2010b). Licensure and certification. Retrieved from http://www.counseling.org/Counselors/LicensureAndCert.aspx

American Counseling Association. (2010c). Licensure & certification: State professional counselor licensure boards. Retrieved from http://www.counseling.org/Counselors/LicensureAndCert/TP/StateRequirements/CT2.aspx

American Counseling Association. (2010d). *Public policy*. Retrieved from http://www.counseling.org/PublicPolicy/

American Mental Health Counselors Association. (n.d.). *Principles for AMHCA Code of ethics*. Retrieved from https://www.amhca.org/assets/content/AMHCACodeOfEthics2010Final.pdf

American Psychiatric Association. (2009). Th*e principles of medical ethics: With annotations especially applicable to psychiatry*. Retrieved from http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMedicalEthics.aspx

American Psychiatric Nurses Association. (n.d.). *Home page*. Retrieved from http://www.apna.org/

American Psychological Association. (2003). *Ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code2002.html

American Psychological Association. (2009). Report on the ethics committee, 2008. *American Psychologist, 64,* 464–473. doi:10.1037/a0015887

American Psychological Association. (2010). *Program consultation and accreditation*. Retrieved from http://www.apa.org/ed/accreditation/

American School Counselor Association. (2004*). Ethical standards for school counselors*. Retrieved from http://www.schoolcounselor.org/content.asp?contentid=173

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling and Development, 77*(1), 102–108.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*(1), 42–78.

Association for Specialists in Group Work. (1998). *ASGW best practice guidelines*. Retrieved from http://www.asgw.org/PDF/Best_Practices.pdf

Bahen, S. C., & Miller, K., E. (1998). CACREP accreditation: A case study. *Journal of Humanistic Education and Development, 37*(2), 117–27.

Bitter, J. (2009). *Theory and practice of family therapy and counseling*. Belmont, CA: Brooks/Cole.

Bloom, J. (1996). *Credentialing Professional Counselors for the 21st Century*. Retrieved from ERIC database. (ED399498)

Bradley, L. J. (1995). Certification and licensure. *Journal of Counseling and Development, 74,* 185–186.

Brooks, D. K., & Gerstein, L. H. (1990). Counselor credentialing and interprofessional collaboration. *Journal of Counseling and Development, 68,* 477–484.

Cartwright, B. Y., Daniels, J., & Zhang, S. (2008). Assessing multicultural competence: Perceived versus demonstrated performance. *Journal of Counseling and Development, 86,* 318–322.

Commission on Accreditation for Marital and Family Therapy Education. (2002). *Commission on accreditation for marriage and family therapy education*. Retrieved from http://www.aamft.org/about/COAMFTE/AboutCOAMFTE.asp

Commission on Accreditation for Marital and Family Therapy Education. (2010). *Directory of MFT programs*. Retrieved from http://www.aamft.org/cgi-shl/twserver.exe?run:COALIST

Commission on Certification for Rehabilitation Counselors. (2010). *Code of professional ethics for rehabilitation counselors*. Retrieved from https://www.crccertification.com/filebin/pdf/CRCC_COE_1-1-10_Rev12-09.pdf

Corey, G., Corey, M. S., Callanan, P. (2011). *Issues and ethics in the helping professions* (8th ed.). Belmont, CA: Brooks/Cole.

Cottone, R. R. (2001). A social constructivism model of ethical decision making in counseling. *Journal of counseling and development, 79*(1), 39–45.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling and Development, 78*, 275–283.

Council on the Accreditation of Counseling and Related Educational Programs. (2010a). *Home page*. Retrieved from http://www.cacrep.org

Council on the Accreditation of Counseling and Related Educational Programs. (2010b). *Programs in process*. Retrieved from http://67.199.126.156/template/page.cfm?id=36

Council on the Accreditation of Counseling and Related Educational Programs. (2010c). *2009 standards*. Retrieved from http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Council on Rehabilitation Education. (2010). *Home page*. Retrieved from http://www.core-rehab.org/

Council on Social Work Education. (2010). *Home page*. Retrieved from http://www.cswe.org/

Cummings, N. A. (1990). The credentialing of professional psychologists and its implications for the other mental health disciplines. *Journal of Counseling and Development, 68*, 490.

Dolgoff, R., Loewenberg, F. M., & Harrington, D. (2009). *Ethical decisions for social work practice* (8th ed.). Belmont, CA: Brooks/Cole.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W. W. Norton and Company.

Garcia, A. (1990). An examination of the social work profession's efforts to achieve legal regulation. *Journal of Counseling and Development, 68*, 491–497.

Gert, B. (2005). *Morality* (rev. ed.). New York: Oxford University Press.

Glosoff, H., & Freeman, L. T. (2007). Report of the ACA ethics committee: 2005–2006. *Journal of Counseling and Development, 85*, 251–254.

Guterman, J. T., & Rudes, J. (2008). Social constructionism and ethics: Implications for counseling. *Journal of Counseling and Development, 52*, 136–144.

Hill, N. R. (2003). Promoting and celebrating multicultural competence in counselor trainees. *Counselor Education and Supervision, 43*, 39–51.

Hosie, T. (1991). Historical antecedents and current status of counselor licensure. In F. O. Bradley (Ed.), *Credentialing in counseling* (pp. 23–52). Alexandria, VA: Association for Counselor Education and Supervision.

International Association of Marriage and Family Counselors (n.d.). *IAMFC Ethical Code*. Retrieved from http://www.iamfconline.com/PDFs/Ethical%20Codes.pdf

Johnson, J. (2009). Whether states should create prescription power for psychologists. *Law and psychology review, 33*, 167–178.

Kaplan, D. M., Kocet, M. M., Cottone, R., Glosoff, H.L., Miranti, J. G., Moll, E. C., …Tarvydas, M. L. (2009). New mandates and imperatives in the revised "ACA Code of Ethics." *Journal of Counseling and Development, 87*(2), 241–256.

Kegan, R. (1982). *The evolving self*. Cambridge, MA: Harvard University Press.

Kegan, R. (1994). *In over our heads*. Cambridge, MA: Harvard University Press.

Keith-Spiegel, P., & Wiederman, M. W. (2000). *The complete guide to graduate school admission: Psychology, counseling and related professions* (2nd ed.). Mahwah, NJ: Erlbaum.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12*(3), 43–45. doi:10.1177/0011000084123005

Kitchener, K. S. (1986). Teaching applied ethics in counselor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development, 64*(5), 306–311. doi:10.1177/0011000084123005

Kleist, D., & Bitter, J. R. (2009). In J. Bitter, *Theory and practice of family therapy and counseling* (pp. 43–65). Belmont, CA: Brooks/Cole.

Kocet, M. (2006). Ethical challenges in a complex world: Highlights of the 2005 ACA Code of Ethics. *Journal of Counseling and Development, 84*(2), 228–234.

Kohlberg, L. (1984). *The psychology of moral development: The nature and validity of moral stages.* San Francisco: Harper & Row.

Linstrum, K. S. (2005). The effects of training on ethical decision making skills as a function of moral development and context in master-level counseling students. *Dissertation Abstracts International Section A: Humanities & Social Sciences. Vol. 65(9-A), 2005, 3289. US: Univ Microfilms International.*

Livingston, R. (1979). The history of rehabilitation counselor certification. *Journal of Applied Rehabilitation Counseling, 10*, 111–118.

Lovell, C. (1999) Empathic-cognitive development in students of counseling. *Journal of Adult Development, 6*(4), 195–203. doi:10.1023/A:1021432310030

Lum, C. (2003). *A guide to state laws and regulations on professional school counseling.* Retrieved from ERIC database. (ED 474113)

Meara, N. M., Schmidt, L. D., & Day, J. D. (1996) Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist, 24*(9), 4–77. doi:10.1177/0011000096241002

McAuliffe, G., & Eriksen, K. (Eds.). (2010). *Handbook of Counselor Preparation.* Thousand Oaks, CA: Sage and Alexandria, VA: Association for Counselor Education and Supervision.

McGlothlin, J. M., & Davis, T. E. (2004) Perceived benefit of CACREP (2001) core curriculum standards. *Counselor Education and Supervision, 43*(4), 274–285.

Morales, A. T., Sheafor, B. W., & Scott, M. E. (2012). *Social work: A profession of many faces* (12th ed.). Boston: Allyn & Bacon.

National Association of Social Workers. (2008). *Code of ethics.* Retrieved from http://www.socialworkers.org/pubs/code/code.asp

National Board for Certified Counselors. (2005). *Code of ethics.* Retrieved from http://www.nbcc.org/AssetManagerFiles/ethics/nbcc-codeofethics.pdf

National Board for Certified Counselors. (2009a). *Certified counselors.* Retrieved from http://www.nbcc.org/certifications/

National Board for Certified Counselors. (2009b). *About Us: History of NBCC.* Retrieved from http://www.nbcc.org/whoWeAre/About.aspx

National Board for Certified Counselors. (2009c). *State board information.* Retrieved from http://www.nbcc.org/directory/StateDetail.aspx?stateName=

National Credentialing Academy. (n.d.). *Overview and general information.* Retrieved from http://www.natlacad.4t.com/overview.html

National Organization of Human Services. (1996). *Ethics of human services.* Retrieved from http://www.nationalhumanservices.org/mc/page.do?sitePageId=89927&orgId=nohs

Neukrug, E., Lovell, C., & Parker, R. (1996). Employing ethical codes and decision-making models: A developmental process. *Counseling and Values, 40*, 98–106.

Neukrug, E., & Milliken, T. (2011). Counselors' perceptions of ethical behaviors. *Journal of Counseling and Development, 89*, 206–216.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*(1), 57–70.

O'Brien, P. (Ed.). (2009). Accreditation: Assuring and enhancing quality [Special issue]. *New Directions for Higher Education, 145*.

Perry, W. G. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. New York: Holt, Rinehart, & Winston.

Pieterse. A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi. *The Counseling Psychologist, 37*, 93–115. doi:10.1177/0011000008319986

Ponton, R., & Duba, J. (2009). The "ACA Code of Ethics": Articulating counseling's professional covenant. *Journal of Counseling & Development*, 87(1), 117–121.

Remley, T. P., & Herlihy, B. (2010). *Ethical, legal, and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Roysircar, G., Arredondo, P., Fuertes, J. N., Ponterotto, J. G., & Toporek, R. L. (Eds). (2003). *Multicultural counseling competencies 2003: Association for Multicultural Counseling and Development*. Alexandria, VA: Association for Multicultural Counseling and Development.

Roysircar, G. Sandhu, D. S., & Bibbins, V. E. (Eds.). (2003). *Multicultural competencies: A guidebook of practices*. Alexandria, VA: Association for Multicultural Counseling and Development.

Schmidt, J. J. (1999). Two decades of CACREP and what do we know? *Counselor Education and Supervision*, 39(1), 34–45.

Sheridan, E. P., Matarazzo, J. D., & Nelson, P. D. (1995). Accreditation of psychology's graduate professional education and training programs: An historical perspective. *Professional Psychology, Research and Practice, 26*, 386–392. doi:10.1037/0735-7028.26.4.386

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477–486.

Sweeney, T. J. (1991). Counselor credentialing: Purpose and origin. In F. O. Bradley (Ed.), *Credentialing in counseling* (pp. 81–85). Alexandria, VA: Association for Counselor Education and Supervision.

Sweeney, T. J. (1992). CACREP: Precursors, promises, and prospects. *Journal of Counseling and Development, 70*(6), 667–672.

Sweeney, T. J. (1995). Accreditation, credentialing, professionalization: The role of specialties. *Journal of Counseling and Development, 74*, 117–125.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

The CACREP Connection (2007, Fall). *CACREP/CORE merger fails*. Alexandria, VA: CACREP.

Toporek, R. L., & Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling and Development, 87*, 260–269.

Urofsky, R., Engels, D., & Engebretson, K. (2008). Kitchener's principle ethics: Implications for counseling practice and research. *Counseling and Values, 53*(1), 67.

Vera, E., M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*, 253–272. doi:10.1177/0011000003031003001

Virginia Board of Counseling. (2009). *Virginia board of counseling: Laws governing counseling*. Retrieved from http://www.dhp.virginia.gov/counseling/counseling_laws_regs.htm

Weinrach, S. G., & Thomas, K. R. (2002). A critical analysis of the multicultural counseling competencies: Implications for the practice of mental health counseling. *Journal of Mental Health Counseling, 24*, 20–35.

Weinrach, S. G., & Thomas, K. R. (2004). The AMCD Multicultural Counseling Competencies: A critically flawed initiative. *Journal of Mental Health Counseling, 26*, 81–93.

Welfel, E. R. (2010). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology, 54*, 351–361. doi:10.1037/0022-0167.54.4.351

The Helping Relationship I: Theories and Skills

CHAPTER **4**   *Individual Approaches to Counseling*

CHAPTER **5**   *Counseling Skills*

Overview

*T*his section of the text provides an orientation to the theories and skills used in individual counseling. Chapter 4 describes four broad conceptual orientations and select theories associated with them as well as a number of extensions, adaptations, and spinoffs of these approaches. Near its conclusion, we will look at integrative therapy (eclecticism). Chapter 5 examines some of the basic skills necessary for a successful counseling relationship, many of which are common to all of the theoretical approaches we use. Additional topics covered in Chapter 5 include case conceptualization, the stages of the counseling relationship, and some of the skills associated with these stages. As with all the chapters, we will highlight some important ethical, professional, and legal issues as well as some cutting edge multicultural and social justice issues related to each chapter's content.

As you read through Chapter 4, consider the similarities and differences among theories and whether or not it is feasible to combine theories. Later, as you examine the many skills discussed in Chapter 5, reflect back on the theories and consider which skills might be more applicable to each of the theories you have studied.

Individual Approaches to Counseling[1]

I've attended counseling a lot. My first counselor was able to hear the deepest parts of my being. He helped me work through some entrenched pains and hurts. He helped me look at myself and open myself up to my feelings. He was grounded in person-centered counseling but would periodically use other techniques from the existential–humanistic tradition.

My next counselor challenged me. He would ask me to close my eyes; get in touch with my thoughts, feelings, and sensations; and discuss them. He would point out inconsistencies, such as noticing that I would smile when I was angry. He would challenge me to go deeper into myself. He was a Gestalt therapist.

The third counselor I saw used to sit on his chair and listen to me, rarely responding. I would accuse him of being a psychoanalyst; he wouldn't say anything. I rarely, if ever, received feedback. I think he was a psychoanalyst, or at least psychodynamically oriented. Perhaps I didn't work with him long enough to hear some of his insights into my behaviors.

My next counselor was a good listener and would point out the choices I had in my life. He would try to understand what was important to me and helped me to redefine myself through the choices I made. He was a very well known existential therapist.

I saw a behaviorist for a short while. He helped me work on some very focused issues. He took a long history, and then we got down to work.

In recent years, a couple of counselors I saw practiced from a post-modern perspective. They were most interested in helping me understand how I come to make meaning out of my life and helped me see how certain stories, or narratives in my life, tend to be the cornerstone for how I come to define who I am. They have also helped me see that I can build new narratives to redefine who I am.

---

[1] Although some distinguish between the words counselor and therapist and counseling and therapy, throughout this chapter these words are used interchangeably.

As I've said, I've been in counseling a lot. I've seen male counselors, female counselors, short counselors, tall counselors, bad counselors, and good counselors. I believe that counseling has helped me become a better person. I know it has deepened, and I am pretty sure it has helped me become a better counselor.

This chapter will begin by defining *theory* and take a look at the close relationship between one's view of human nature and the theoretical orientation to which one ultimately adheres. After this discussion, we will present an overview of twelve counseling theories that are subsumed within four broad conceptual orientations. Thus, we will examine the psychodynamic approaches of psychoanalysis, analytical therapy, and individual therapy; the existential–humanistic approaches of existential therapy, gestalt therapy, and person-centered counseling; the cognitive–behavioral approaches of behavior therapy, rational emotive behavior therapy, cognitive therapy, and reality therapy; and the post-modern approaches of narrative therapy and solution-focused brief therapy. Next, we will provide a brief overview of a number of extensions, adaptations, and spinoffs of these approaches and then discuss what it means to be eclectic or integrative in our own theoretical approach. We will conclude the chapter with an examination of the cross-cultural biases inherent in some of the more common theories of counseling and then highlight some aspects of American Counseling Association's (ACA's) ethical code related to the counseling relationship.

■ *Why Have a Theory of Counseling?*

> *. . . theory is the road map that guides the therapist from Point A to Point B. Indeed, there can be no therapy without therapeutic actions, and the therapeutic actions emanate from theory. A cogent treatment is a fundamental element of psychotherapy. Choice of a theory involves multiple considerations on the part of the therapist and the client. . . .* (Wampold, 2010b, p. 59)

A former professor of mine would refer to the discovery of new knowledge as the virgin branch on a tree. Past knowledge leads to new discoveries, and new discoveries are only the result of all that has come before. So it was with the discovery that the Earth was round, and with Einstein's theory of relativity, and so it will be when a cure for AIDS is found or a new counseling theory is developed. New knowledge is based on sound scientific hunches, connected to all of what has come before, and only later accepted as scientific proof. As noted in Chapter 2, knowledge periodically leads to paradigm shifts. Such shifts occur infrequently and mark a change in the perception of scientific knowledge. Using our tree analogy, a paradigm shift represents a bud of the tree giving birth to a new branch. These shifts in our understanding of knowledge radically change perceptions of reality (see Box 4.1).

BOX 4.1

Paradigm Shifts and the Changing Nature of Reality?

What we have come to know as "truth" is probably our best guess of what might be truth and founded in knowledge that has come before. For instance, consider how different our world would seem if one of the newest paradigms in physics, Superstring theory, was validated and we no longer viewed the atom as a tiny kind of "solar system."

Superstring theory: The universe is composed, not of subatomic particles. . . but of tiny strings tied

together at the ends to form loops. These strings exist in a ten-dimensional universe, which some time before the Big Bang cracked into two pieces, a four-dimensional universe (ours; that's three dimensions plus time) and a six-dimensional universe that [is] so small we haven't been able to see it. What physicists have been thinking of as subatomic particles are actually vibrations of the strings, like notes played on a violin. (Jones & Wilson, 2006, p. 508)

In the arena of counseling theories, it was not until Freud put forth his theory of psychoanalysis that the first comprehensive theory of psychotherapy was formulated. Freud's theory created a shift in thinking—it brought forth a new way of understanding the person.

> *. . . his theories influence how we interpret human behavior, not only in biography, literary criticism, sociology, medicine, history, education, and ethics, but also in law. We now take for granted the basic psychoanalytic concept that our early life experiences strongly influence how we think, feel, and behave as adults. Because of the unmistakable impact of his thought, some scholars refer to the twentieth century as the "century of Freud."* (Nicholi, 2002, p. 2)

However, Freud's theory was not developed in a vacuum; it evolved because others before him pondered similar questions. Over the years, we have learned that we can discard some of Freud's theory, accept other aspects of it, and continue to examine the rest. Whether it's psychoanalysis or new age therapy, theory provides a framework to conduct research to see if the theory is effective with clients.

A counseling theory offers us a comprehensive system of doing counseling and assists us in conceptualizing our clients' problems, knowing what techniques to apply, and predicting client change (Neukrug & Schwitzer, 2006). In addition, by examining what we say to our clients, we are able to evaluate whether we are acting congruently with our theory. Theories are heuristic; that is, they are researchable and testable and ultimately allow us to discard those aspects shown to be ineffective (Wampold, 2010a; 2010b). Having a theory is an indication that we are not practicing chaotically; that there is some order in the way we approach our clients.

Probably the most important aspect of any theory is its *view of human nature*, which is critical to the formation of the theory's template. Typically, the view of human nature held by each theorist takes into account the effects of biology, genetics, and environment on the personality development of the individual. So, if I believe that an individual's behavior is determined by genetics, my theory will reflect this notion. On the other hand, if I believe that the environment holds the key to personality formation, then my theory will reflect this belief. Prior to reviewing the theories in this chapter, you may want to reflect on your view of human nature and personality formation. Then, read the chapter and consider which of the theories best aligns with your beliefs (see Box 4.2).

BOX 4.2

Your View of Human Nature
To determine your view of human nature and theoretical orientation, please take the instrument in Appendix C or online at: http://www.odu.edu/~eneukrug/therapists/survey.html

Today, it is generally agreed that there are hundreds of different kinds of psychotherapies, each with its own unique view of human nature, techniques, and process (Gabbard, 1995; O'Leary, 2006; List of psychotherapies, 2010). Based on their views of human nature, most of these theories can be categorized into four conceptual orientations: psychodynamic, existential–humanistic, cognitive–behavioral, and post-modern (Neukrug, 2011; Norcross, Bike, & Evans, 2009). This chapter is organized around these orientations and will provide a brief overview of a few theories within each of these classifications.

Four Conceptual Orientations to Counseling and Associated Theories

In this section of the chapter, we will examine the psychodynamic approaches of psychoanalysis, analytical therapy, and individual therapy; the existential–humanistic approaches of existential therapy, gestalt therapy, and person-centered counseling; the cognitive–behavioral approaches of behavior therapy, rational emotive behavior therapy, cognitive therapy, and reality therapy; and the post-modern approaches of narrative therapy and solution-focused brief therapy.

Psychodynamic Approaches

Beginning with Freud's theory of psychoanalysis in the late 1800s, many approaches to counseling and psychotherapy have been developed that are broadly considered to be in the psychodynamic school. Freud (1856–1939), who developed quite a following early in the twentieth century, dominated the psychodynamic field for almost half a century. However, because Freud tolerated little divergence from his viewpoints, many of his disciples eventually split from his rigidly held views and developed their own related theories. Today, psychodynamic approaches vary considerably but contain some common elements. For instance, they all suggest that an *unconscious* and a *conscious* affect the functioning of the person in some deeply personal and *dynamic* ways. They all look at early *child-rearing* practices as being important in the development of personality. They all believe that examining the *past*, and the dynamic interaction of the past with conscious and unconscious factors, are important in the therapeutic process. Although these approaches have tended to be long-term, in recent years some have been adapted and used in relatively brief treatment modality formats. Let's take a quick look at three of the more popular psychodynamic approaches: *psychoanalysis*, *analytical therapy* (Jungian therapy), and *individual psychology* (Adlerian Therapy).

ARCHIV/Photo Researchers, Inc.
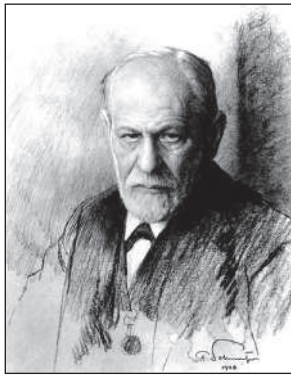
Sigmund Freud

Psychoanalysis

The first comprehensive psychotherapeutic approach, psychoanalysis dramatically changed the Western world's understanding of the individual's psychological makeup. Developed by Sigmund Freud, who was trained as a physician, psychoanalysis is steeped in *biological determinism*, or the notion that instincts and drives greatly affect behavior. However, Freud's explanation for personality formation was far more complex than just the notion of biology causing behavior, for he also believed that parenting styles within the first five years of life interact in a complex fashion with instincts and inherent personality structures to produce one's personality.

Freud suggested that we are born with raw *psychic energy* called our *instincts*. The *life instinct* (*Eros*), said Freud, meets our basic need for love and intimacy, sex, and survival for the individual and the species. It is associated with cooperation, collaboration, and harmony with others. Believing that "the aim of life is death" (Freud, 1920/1961, p. 32), Freud said the *death instinct* (*Thanatos*) seeks our own demise and dissolution and that fear, hate, self-destructive behaviors, and aggression toward others (death instinct projected outward) is a reflection of this instinct. All psychic energy that drives the life and death instincts is called the *libido*.

Freud believed three structures are involved in one's personality formation: the *id*, *ego*, and *superego*. The id houses our instincts, operates from raw, irrational impulses and is fueled by the *pleasure principle*, whose aim is to reduce tension through the simplest means possible. The ego develops soon after birth and is ruled by the *reality principle* as it tries to deal logically and rationally with the world. The superego develops during and soon after ego development and is responsible for the development of one's moral code and conscience. The ego must contend with the irrationality of the id and the morality of the superego as it attempts to mediate behaviors (see Box 4.3).

Freud postulated that all of one's psychic energy becomes focused on differing *erogenous zones* that correspond to the unfolding biological development of the child. When a child is *overindulged* or *frustrated* during a stage, his or her libido becomes locked or *fixated*, resulting in unfinished psychological issues and behaviors that are reflective of what Freud called the *psychosexual stages*. The five stages include the:

1. *Oral Stage*. Between birth and 18 months the infant's erogenous zone is the mouth, and pleasure is received through sucking and eating. Withholding the

BOX 4.3

The Hidden Nature of Man (and Woman)

In the film *The Hidden Nature of Man* (Kemeny, 1970) a young man and woman are having lunch. The young man's ego is represented by him sitting at the table as he tells her how pretty she looks. His id and superego stand behind him and exert pressure on the ego (the young woman only hears the ego talking). The id, dressed in red, is saying, "I want, I want! Warm. Breasts." The superego, dressed in white, is saying, "Honor thy mother. Be a good boy." The young man makes suggestive remarks concerning them going back to her apartment, and ultimately, the young woman notes that her roommate is away and suggests they go back to her apartment. Thus, we see the complex interaction of the id, ego, and superego. Clearly, what is not shown in this film is the woman's id and superego!

breast and/or bottle and food greatly affects the child's sense of self and sense of trust and security in the world.

2. *Anal Stage*. Obtaining control over bowel movements is the major task of this stage, which occurs between 18 months and 3 years. Here, children learn they can control their bodies as well as their environment. How parents deal with toilet training and the broader experience of how the child learns to control his or her world is crucial during this stage (think of the "terrible twos," when the child is attempting to control his or her world).

3. *Phallic Stage*. Experiencing pleasurable genital sensations is the major focus during this stage, which occurs between ages 3 and 5 or 6. Here, children self-stimulate, have a fascination with bodily functions, and are particularly affected by the moral imperatives of their parents. Relative to the phallic stage, it should be noted that Freud's ideas about childhood sexuality were revolutionary and controversial at the time and set the stage for ongoing debates about the role of sexuality in personality development.

4. *Latency Stage*. Strictly speaking, not a psychosexual stage, the latency stage occurs between the ages of 5 or 6 years and puberty, when there is a repression of the libido. During this holding pattern, children focus on peer relationships and other age-appropriate activities, such as athletics and school.

5. *Genital Stage*. Resulting patterns of behavior from the oral, anal, and phallic stages become evident as the young adult and adult exhibit behavior, which is influenced by conscious and unconscious motivations.

Based on how one is parented, the *structures of personality* (the id, ego, and super-ego) become established in the child as he or she traverses the first three psychosexual stages. In this process, the ego is in a difficult position as it attempts to mediate between the ongoing urges of the id and demands from the superego to act in a "proper" and moral fashion. Fears of the id or superego taking over can wreak havoc and create anxiety for the individual. To manage the pressures from the id and the superego, children create *defense mechanisms*. For instance, consider a child in the phallic stage who is self-stimulating (the id). Seeing the child masturbate, the parent slaps his or her hand and says, "Don't do that" (development of the superego). Subsequently, the child unconsciously fears *annihilation* and *castration* by his parent and develops a defense mechanism to deal with the impulse to masturbate in the future (e.g., sublimating the desire by getting very involved in sports or through compulsive hand-washing).

Freud, and later his daughter Anna Freud (1936–1966), identified a number of defense mechanisms that unconsciously help the individual cope with anxiety (A. Freud, 1966). Although there are many defense mechanisms, some of the more common ones are *repression*, the pushing out of awareness of threatening or painful memories; *denial*, the distortion of reality in order to deny perceived threats to the person; *projection*, viewing others as having unacceptable qualities that the individual him- or herself has; *rationalization*, the explaining away of a bruised or hurt ego; *regression*, reverting to behavior from an earlier stage of development; *sublimation*, channeling impulses into socially accepted forms of behavior; *identification*, identifying with groups or others in an effort to improve one's sense of self-worth; *compensation*, exaggerating certain positive traits in an effort to mask weaker traits; and *reaction formation*, replacing a perceived negative feeling with a positive one.

Psychoanalysis is considered a *deterministic* approach because consciousness is considered the "tip of the iceberg," which implies that most of our motivations are unconscious and are the result of the intricate relationship among how the structures of personality (id, ego, and superego) are developed as a function of different parenting styles, as children traverse the stages of development (see Figure 4.1). At best, we can become a little more conscious as small parts of the iceberg are revealed.

Traditional psychoanalysis is a long-term, in-depth process in which the client may meet with a therapist three or more times a week for five or more years. In this process, the therapist attempts to build a *transference relationship* in which the client projects past patterns from significant early relationships onto the counselor. To encourage this relationship, the counselor remains relatively aloof from the client. Psychoanalysts initially use a fair amount of *empathy* while encouraging clients to share their deepest thoughts. Revelations by clients are responded to in a nonjudgmental manner, which is encouraging of more revelations. Fairly early in the relationship they will use *free association*, where clients are encouraged to say anything that comes to their minds to allow for the uninhibited expression of unconscious desires and repressed memories. Later, the therapist will incorporate *dream analysis*, where both the *manifest* (obvious) content of dreams as well as the *latent* (hidden) meaning of dreams are interpreted in an effort to understand unconscious desires and repressed memories (Freud, 1899/1976a, p. 769). *Interpretation of client resistance*, *interpretation of defense mechanisms*, and *interpretation of parapraxes* (errors of speech, slips of tongue, or misspeaks) are also used to reveal unconscious meanings that may be symbolic of repressed wishes and desires (Freud, 1905/1976b). And, of course, *analysis of the transference relationship*, where the therapist interprets client projections, including client projections onto the therapist, are examined in terms of how they relate to past patterns in early relationships (e.g., relationships with parents) (Freud & Breuer, 1895/1974). Ultimately, the relationship ends when the client has gained increased knowledge and awareness of underlying dynamics and how this gets expressed through his or her patterns and symptoms, and when the client has made some changes based on these insights.

FIGURE 4.1
The "Tip of the Iceberg"
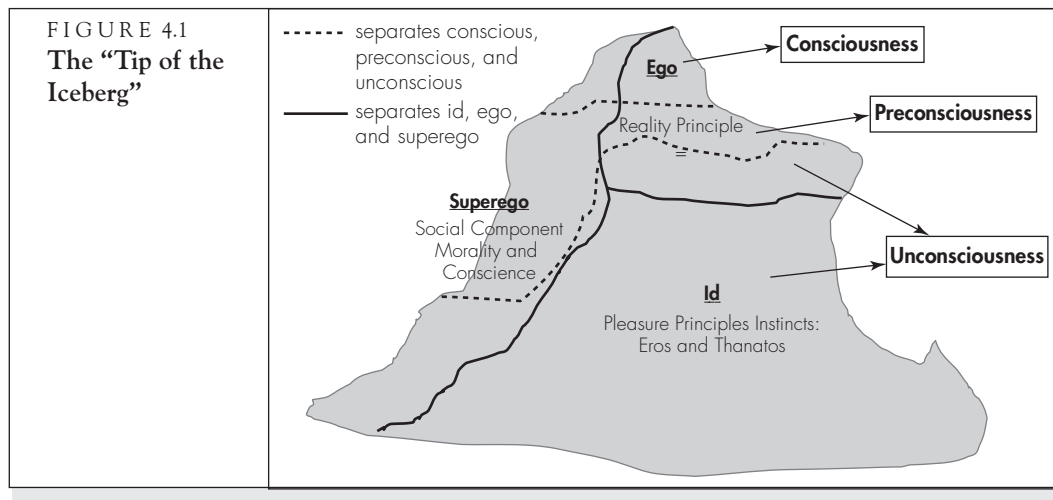
Analytical Psychology (Jungian Therapy)
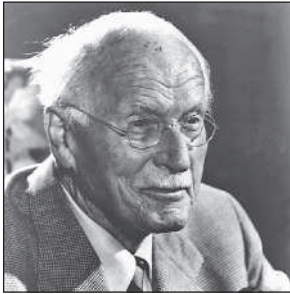
Originally a colleague of Freud's, Carl Jung (1875–1961) was trained in the psychoanalytical tradition. However, as he developed, he became disheartened by psychoanalysis, describing it "as a psychology of neurotic states of mind, definitely one-sided. . . not a psychology of the healthy mind, and this is a symptom of its morbidity. . ." (Jung, 1975, p. 227). Departing from Freud over his pessimistic, deterministic view of human nature and the psychoanalytic views on childhood sexuality, Jung optimistically believed that we could become conscious of unconscious forces and gradually integrate such knowledge into a healthier way of living.

Carl Jung

> *For my part, I prefer to look at man in the light of what in him is healthy and sound, and to free the sick man from just that kind of psychology which colours every page Freud has written.* (Jung, 1975, p. 227)

Jung believed each of us has a unique *psychological type* that includes the attitudes of *extraversion* and *introversion* (whether one is oriented to the outside objective world or to the internal subjective world) and the *mental functions* of *thinking* and *feeling*, and *sensing* and *intuiting* (which reflects how we operate in our outer or inner world). The mental functions come in pairs because if one is favored, the other is more in the background. Jung believed that people are inherently extraverted or introverted; thus, crossing extraversion or introversion with the predominant mental function that one could favor produces eight possible combinations or "types" (AFS, AFI, ATI, ATS, EFS, EFI, ETI, ETS). Thinking types evaluate information from a detached perspective and use logic, reason, and the examination of data and causal relationships in this process (consider the stereotypic scientist or behaviorist). Feeling types make decisions by evaluating situations through the use of empathy, by understanding relationships, and by considering the needs of people (think of the humanistically oriented counselor stereotype). Feeling types should not be confused with individuals who make decisions based on feelings or affect. Sensing types make sense of information through the use of the five senses: hearing, seeing, smelling, touching, and tasting, whereas intuitive types make sense of the world by listening to one's "gut" and unconscious (e.g., Sensing type: "I can smell your lover's perfume" vs. Intuitive type: "I just know that you're having an affair—I just have that gut feeling").

Jung believed our psychological type mediates our conscious experience. For instance, the extraverted person who is predominantly a thinker and sensing type would tend to see the world from that frame of reference with other experiences being pushed into what Jung called the *personal unconscious*. In addition to the personal unconscious, Jung believed that each of us has a *collective unconscious*. Almost mystical in its nature, the collective unconscious is a depository of ancient experiences—an entity from the early beginnings of civilization that has been passed down to each of us.

> *The deepest we can reach in our exploration of the unconscious mind is the layer where man is no longer a distinct individual, but where his mind widens out and merges into the mind of mankind, not the conscious mind, but the unconscious mind of mankind, where we are all the same. . . . On this collective level we are no longer separate individuals, we are all one.* (Jung, 1968, p. 46)

Jung believed the collective unconscious is inherited, identical in all of us, and contains the *archetypes*, which provide the psyche with its tendency to perceive the world in

certain ways that we identify as "human." Evidence for archetypes, said Jung, can only be inferred and is found in the similar behaviors, artwork, images, and myths that are recognized in all cultures. Some of the more well-known archetypes include: the *persona*, or the mask we wear in public life; the *anima* and *animus*, which represent the feminine and masculine characteristics that all of us have; and the *shadow*, which represents the most hidden and scariest parts of ourselves that we are afraid to reveal to self. Jung also believed that archetypes provide the energy for the development of complexes. A *complex* is created, according to Jung, when repressed experiences get pushed into the personal unconscious and become bound with one or more archetypes. For instance, a young child who is abused by his or her parents might repress the resulting feelings of hurt and shame into the personal unconscious. In an effort to protect oneself from these experiences, they become bound with the "trickster" and "power" archetypes creating a bully complex. And, this person ends up being a bully.

Believing that we could become "conscious of almost anything" (Jung, 1968, p. 48), Jung suggested that awareness of all parts of ourselves is the first step to integration, self-acceptance, and wholeness (e.g., the bully could become aware of his or her hurt and pain and how the archetypes serve a survival function for him or her). Thus, understanding our personal unconscious (e.g. our repressed attitudes and mental functions; our complexes) and our collective unconscious (our archetypes) are critical goals in analytical therapy and are achieved by examining our *dreams*, amplifying the meaning *symbols* have in our lives, participating in *creative techniques* (e.g., working with clay), and a process Jung called *active imagination*.

Individual Psychology (Adlerian Therapy)

Alfred Adler believed that every child was born with innate and unique capabilities and is inherently moving toward the future, not determined by the past. Using the word *Teleology*, from the Greek, "teleos," (meaning, "goal directed process"), Adler suggested that we move toward the future to makes ourselves whole and complete and to fulfill our one true drive, our *striving for perfection*. If unimpeded, this path would bring out our uniqueness and natural creativity, lead us towards connection and cooperation with others, a sense of wholeness and completion, and meaningfulness in life (Sweeney, 1998). Adler stated that all other drives, including our sexual or aggressive instincts, are subsumed by this drive. However, he also warned that if one's natural striving for perfection was diverted, the individual would develop neurotic or even psychotic behaviors.

Part of being human, said Adler, was dealing with inevitable *feelings of inferiority*. In attempting to overcome those feelings, Adler believed we all develop unconscious beliefs or *private logic*. Private logic leads to what Adler originally called a *fictional final goal* but was later referred to as a *subjective final goal* to emphasize its subjective nature (Watts & Holden, 1994). He also asserted that the picture in one's mind of what the individual would like to be, which was shaped by the subjective final goal, could drive a person throughout his or her life. Adler stated that the child's experiences by age 5, and the subsequent memories of those experiences, were critical factors in the development of one's private logic and subjective final goal. Thus, birth order and other factors in early childhood could play critical roles in the development of the person. However, Adler also believed that the child is not determined by his or

Alfred Adler

her early experiences. No, he believed the child could change if afforded a corrective education. And, if the child can change, so too can the adult!

Adler suggested that our drive toward our subjective final goal often results in the development of behaviors that *compensate* for feelings of inferiority (a "100 pound weakling" becomes an obsessed body builder). Ultimately, Adler stated that a person believes that his or her subjective final goal will bring a sense of mastery, superiority, and eventually, perfection, completion, and wholeness. For instance, Adler himself had feelings of inferiority as the result of a number of ailments he had as a young child. This led him to develop a subjective final goal of conquering death, and thus he was driven to become a doctor in this unconscious quest (Hoffman, 1994). Similarly, due to being bullied as a child, Olympic star Michael Phelps developed his own private logic and compensated for his feelings of inferiority by putting his all into his natural ability at swimming. Sometimes, however, feelings of inferiority can lead to a subjective final goal that results in maladaptive behaviors. For instance, consider the child who feels bad about his or her body, ends up as an adult with a body dysmorphic disorder, and becomes bulimic in his or her attempt to have the perfect body. (Subjective final goal: "If I could have the perfect body, my life would be fine.") Finally, Adler suggested that the individual develops a *style of life* that is reflective of the person's movement toward his or her subjective final goal. Whether our subjective final goal results in a lifestyle that is reflected by healthy or maladaptive behaviors, it is deeply rooted in the past, affects our present, and leads us toward our future.

Considered by some a psychodynamic theorist, Adler hypothesized that an individual's drive toward perfection could best be understood through in-depth counseling. In such work, the therapist helps the client understand how early experiences, and the memories of those experiences, have led to private logic that affects the development of one's subjective final goal and is reflected in one's style of life. However, there are also clear existential and humanistic leanings in Adler's approach (Ansbacher, 1964; Ellenberger, 1970; Stein, 2007; Maslow, 1968). For instance, Adler stressed the importance of *Gemeinschaftsgefühl*, which loosely translated means *social interest*. If unimpeded by feelings of inferiority, Adler believed one would naturally move toward meaningful relationships, empathy toward and cooperation with others, the betterment of society, and an understanding of our place in the universe (Ansbacher & Ansbacher, 1956). Called by some the first humanist (Ansbacher, 1964), Adler's theory is optimistic and anti-deterministic and impacted the development of subsequent humanistic theories of counseling.

Adler's influence over the years was widespread, with Rudolf Dreikurs (1897–1972) and Don Dinkmeyer (1924–2001) becoming particularly well known for adapting individual psychology to work with children. Dinkmeyer and Dreikurs (1963) believed that children have an inherent desire to belong and feel part of their peer groups (similar to Adler's concept of "social interest"), but due to feelings of inferiority and maladaptive parenting, some exhibit maladaptive behaviors in an unsuccessful attempt to gain this sense of belonging. Typical behaviors such children exhibit include *attention seeking* (e.g., interrupting), *the use of power* (e.g., bullying), *revenge seeking* (e.g., playing nasty practical jokes), and displaying *inadequacy* (e.g., withdrawing). Like Adler, Dinkmeyer and Dreikurs believed that children can be taught new behaviors by significant others in their lives, such as parents, counselors, and teachers (Wolfgang, 2001).

The purpose of the therapeutic relationship in individual psychology is to help clients gain insight into how their current style of life is not working for them and develop new behaviors that will lead to healthier relationships highlighted by empathy, a sense of

belonging, and cooperation (Carlson, Watts, & Maniacci, 2006). For children and adults, Adlerian therapy can be viewed through a series of four phases: *building the therapeutic relationship*; *assessing and understanding the lifestyle*; *insight and interpretation*; and *reeducation and reorientation* (Mosak & Maniacci, 1999; Oberst & Stewart, 2003; Sweeney, 1998). As clients move through the phases, they are encouraged to give up their misguided private logic, dysfunctional subjective final goals, deleterious compensatory behaviors, and dysfunctional styles of life, and adopt new values and behaviors that reflect a healthier style of life that increasingly focuses on the importance of others and the broader community. Dinkmeyer, Dreikurs, and Adler developed a wide range of techniques to help accomplish this with some of the more common ones being: *exploring the family constellation*, *examining early recollections*, *encouragement*, *democratically held discussion groups*, *limit setting*, *acting "as if"* ("fake it till you make it"), *spitting in the client's soup* (showing the client how behaviors are not working), and *setting logical and natural consequences*.

Existential–Humanistic Approaches

At the turn of the twentieth century in Europe, the writings of such existential philosophers as Kierkegaard, Tillich, Sartre, and Camus became particularly well known. American counselors and psychotherapists began to see the value in some of these thinkers' explorations of the *struggles of living* and how people *construct meaning* in their lives, eventually embracing some of their concepts and adapting them to the counseling relationship. The new theories that evolved tended to be far more *optimistic*, less *deterministic*, and more *humane* than the earlier psychodynamic approaches and became known as existential–humanistic approaches to counseling.

Today, existential–humanistic approaches embrace a *phenomenological perspective* by stressing the subjective reality of the client, de-emphasizing the role of the unconscious, and focusing on the importance of *consciousness* and/or *awareness*. Deeply opposed to the reductionistic, nonpersonal tradition of psychoanalysis, existential–humanistic therapy stresses the counselor's personal qualities and how the counselor uses him- or herself in *the relationship* to effect change. In addition, most existential–humanistic approaches believe in an inborn tendency for individuals to *self-actualize*, or fulfill their potential, if they are afforded an environment conducive to growth (Maslow, 1968, 1970). Although many modern-day approaches to counseling and psychotherapy have borrowed from the existential–humanistic schools, a few are particularly based in this tradition. Thus, in this section of the chapter we will look at *existential therapy*, which is presented here as an integration of a number of well-known existentially based therapies, examine the *person-centered counseling* approach of Carl Rogers, and then take a look at *Gestalt therapy*, originally founded by Fritz Perls.

Existential Therapy

Although Ludwig Binswanger (1881–1966) is generally acknowledged as being the first existential therapist (Cain, 2002), Viktor Frankl is seen as the person who popularized this approach through his form of existential therapy called *Logotherapy* ("meaning therapy"). Frankl, who spent years in a Nazi concentration camp, wrote his theory on scraps of paper as he watched others around him lose hope and fall into the depths of despair (see Frankl, 1968; 1946/2004; 1946/2006). Eventually deciding that we can choose how we decide to exist in the world even when faced with horrendous circumstances, he developed his

approach. Frankl was to influence others, including such famous existential therapists as Rollo May (1909–1994) (May, Angel, & Ellenberger, 1958), James Bugental (1976), and Irvin Yalom (1980). May is often considered the father of American existential therapy, while Yalom is often looked to as the person who popularized the existential approach in the United States, partly because of his bestselling novels, *Love's Executioner* and *When Nietzsche Wept* (this book was also turned into a movie).

Existential therapists believe that people are born into a world that has no inherent meaning or purpose. People are not born good or bad; they are just thrust into the cosmos. Because life has no inherent meaning, each of us is charged with the responsibility of making it meaningful through the choices we make. Existential therapists reject the notion that we are determined by early childhood development, instincts, or intrapsychic forces, although talking about the past is not avoided if the client believes it would help him or her understand self in a more meaningful way.

Central to existential therapists' beliefs is the notion that, consciously or unconsciously, people struggle throughout their lives with basic questions related to what it is to be human. Some of this struggle has to do with a few core issues, such as the fact that we are born alone, will die alone, and except for periodic moments when we encounter another person deeply, we live alone; death constantly looms over us and reminds us of the relatively brief amount of time we have; we alone are responsible for making our lives meaningful; and meaning, as well as a limited sense of freedom, comes through consciousness and the choices we make (Yalom, 1980).

Existential therapists believe that most people live a life of limited self-reflection as they put energy into avoiding the core issues related to their humanness. Such avoidance is the result of trying to maneuver around the anxiety and dread we will feel if we examine these issues head-on. After all, it is not easy to accept one's aloneness in the world, it can be frightful to be cognizant of one's ultimate demise (death), it can be humbling to examine whether one is living a meaningful existence, and it takes focused self-discipline to change the way one has been living. And, the result of living with limited self-awareness and steering clear of the inherent struggles of living is the development of neuroses and psychopathology, which from the existential perspective is the result of living inauthentically. In essence, we can live authentically, with a life that sometimes includes anxiety and dread, if we face our core issues squarely, but are doomed to an inauthentic, neurotic existence if we do not.

Existential therapists suggest that in dialogue with others, people can gain a greater awareness of the choices they have made and can begin to direct their lives toward a more personally meaningful and authentic existence by making new choices that involve facing life's struggles honestly and directly. With this awareness, however, comes a great sense of responsibility, as we come to realize that every choice we make affects ourselves, those close to us, and to some degree, all people on the planet, as each decision we make has a ripple effect throughout the world. Some of the major points of existential therapy can be found in Box 4.4.

Although there are no preset techniques that existential therapists use in applying its core philosophy, most existential therapists will stress the importance of the relationship between the therapist and the client, discuss the philosophy of existential psychotherapy and how it might apply to the individual's particular life circumstances, be authentic with the client, and view the therapeutic process as a *shared journey*. This shared journey is significant as it is only through a genuine relationship that change can occur. Therapy is not seen as a process of applying techniques but instead is viewed as a joint discussion

Viktor Frankl

JACQUELINE GODANY/REUTERS /Landov

BOX 4.4

Major Points of Existential Therapy

1. We are born into a world that has little inherent meaning.
2. We are born alone and we will die alone.
3. We alone make our lives meaningful.
4. We bring meaningfulness into our lives through the choices that we make.
5. Meaningful choices only occur if we are conscious of our aloneness and our limited time on earth.
6. Anxiety, feelings of dread, and having struggles are a natural part of living and are important messages about how we live and relate to others.
7. Limited freedom is experienced through the realization that we choose our existence.
8. With recognition that we choose our existence comes responsibility to choose wisely for ourselves and to recognize how those choices affect those close to us and all people.

concerning the meaning of life and how one can make constructive change to alter one's sense of fulfillment and meaningfulness. Therefore, inherent in existential therapy is the assumption that the client can change, has the capacity for deepening self-awareness, and can build a meaningful and real relationship with the therapist; a relationship that can have an impact on the client, the therapist, and the world.

Person-Centered Counseling

Trained as a clinical psychologist, Carl Rogers (1902–1987) was to greatly change the face of psychotherapy with the development of his nondirective approach to counseling (Rogers, 1942). First called *client-centered therapy* (Rogers, 1951), and later *person-centered counseling*, his approach was not only seen as a means of assisting clients, but as a way of living (Rogers, 1980). Considered the most influential psychotherapist of the twentieth century (Kirschenbaum & Henderson, 1989; "The top 10," 2007), Rogers believed that people had an *actualizing tendency* (Rogers, 1951), and if placed in a nurturing environment, would develop into fully aware, fully functioning selves. However, all too often, Rogers postulated, an individual's natural growth process is thwarted as others place *conditions of worth* on the person. Because the person has a strong *need to be regarded* positively by others, he or she may act in unnatural, unreal ways and develop a distorted sense of self in order to meet these conditions of worth. Therapy, Rogers said, offers the individual an opportunity to realize an increased sense of *congruence* with one's true self and achieve a more realistic sense of what Rogers called the *ideal self*, or the self we strive to be (Rogers, 1959).

Rogers felt that people can get in touch with their true selves if they are around others who are *real* (*congruent* or *genuine*), *empathic*, and exhibit *unconditional positive regard*, which he collectively called the *core conditions*, believing that these attributes alone are enough to facilitate change (Rogers, 1957) (see Box 4.5). Applying the core conditions to the therapeutic relationship, Rogers believed that personality change would occur if the therapeutic framework included what he called the *necessary and sufficient conditions*:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.

Carl Rogers

BOX 4.5

The Core Conditions

Rogers believed that congruence, unconditional positive regard, and empathy were the three core components of an effective counseling relationship and carefully described them. The following are based on Rogers's descriptions:

Congruence or Genuineness. Rogers believed that the counselor needs to be in touch with his or her feelings toward the client, regardless of what they may be (Rogers, 1957). The level of self-disclosure that the therapist shows the client, however, may vary depending on the session and whether or not the feeling was persistent, keeping in mind the impact that expression of the feeling might have on the client. Although Rogers had negative feelings toward some clients during a session, almost invariably he found that the feelings dissipated as the client opened up and unraveled his or her inner self. Thus, he warned therapists against using excessive self-disclosure. Finding the ideal balance between awareness of feelings and the expression of those feelings is one of the challenges facing the person-centered counselor.

Unconditional Positive Regard. Rogers believed that counseling relationships should be highlighted by a sense of acceptance, regardless of what feelings are expressed by the client. This unconditional acceptance allows the client to feel safe within the relationship and to delve deeper into him- or herself. As the client begins to take steps toward understanding this deepening self, the client will begin to recognize those aspects of self that have been lived for others as the result of conditions of worth that were placed upon him or her. Rogers viewed unconditional positive regard as an ideal to strive for during the totality of the session, but not always sucessfully achieved.

Empathic Understanding. Perhaps the most researched and talked-about element of the counseling relationship, empathy, or deep understanding, was Rogers's third crucial element. Such understanding can be shown in a number of ways, including accurately reflecting the meaning and affect of what the client expressed; using a metaphor, analogy, or visual image to show the client that he or she was accurately heard; or simply nodding one's head or gently touching the client during the client's deepest moments of pain. Such acknowledgment of the client's predicament tells the client that the therapist experiences the client's world "as if it were [his or her] own, but without ever losing the 'as if' quality" (Rogers, 1957, p. 99). In other words, the therapist is "with" the client, "hears" the client, understands the client fully, and is able to communicate such understanding to the client.

3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved (Rogers, 1957, p. 96).

If the counselor could exhibit the core conditions to the client, the client would begin to open up and understand past pains and hurts that were caused by conditional relationships in the client's life. In fact, such a therapeutic relationship would assist the client in his or her movement from living a life marked by nongenuineness to a life highlighted by realness and would also result in the client changing specific behaviors. Other results of therapy could include increased openness to experience, more objective and realistic perceptions, improved psychological adjustment, increased congruence, improved self-regard, movement from an external to an internal

BOX 4.6

I Guess Nobody Is Perfect—Not Even Dr. Rogers

In the late 1970s, I went to hear Carl Rogers talk for my second time. I was excited—Rogers was my hero. There were thousands of people in the audience, and as he fielded questions, I shyly raised my hand. Suddenly, he was pointing to me. I stood up and blurted something out, at which point he asked me to repeat myself. I again tried to formulate my question, and he said something like, "I can't understand what you're talking about." He moved on to another question. I was shattered, hurt, and felt like rolling up into a ball. And he—yes, Carl Rogers—had not been very caring to this young counselor. I then discovered that even our heroes are not perfect.

Hear this story (entitled "Oh My God, He Doesn't Like Me") and other stories about Carl Rogers by clicking "Carl Rogers" at the "Stories of the Great Therapists" Web site (see http://www.odu.edu/sgt).
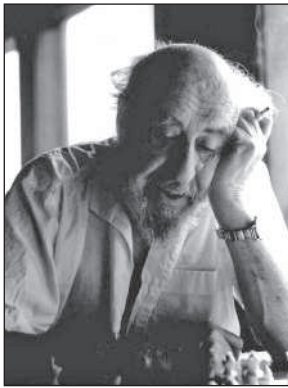
locus of control, more acceptance of others, better problem solving, and a more accurate perception of others (Rogers, 1959).

Because Rogers felt that the attributes of empathy, congruence, and unconditional positive regard were important in all interpersonal relationships, he spent much time later in his life advocating for social change and helping people understand differences among themselves (Kirschenbaum, 2009). Working with such people as Protestants and Catholics in Northern Ireland, Blacks and Whites in South Africa, and individuals in what was then the Soviet Union, he attempted to get people who held widely disparate political and philosophical points of view to hear one another and form close, long-lasting relationships (see Box 4.6).

When originally developed, person-centered counseling was considered a short-term therapy, at least in comparison to the then widely popular psychodynamic methods. However, with recent changes in the health care system and the movement toward brief treatment, what was traditionally considered short-term is now seen as long-term. Although the principles of person-centered counseling can be applied if you meet with a client one time or for five years, generally, person-centered counseling lasts from a few weeks to a year or more. Probably the most important determining factors in the length of treatment are the level of incongruence in the client and the kinds of issues the client is bringing to treatment. However, it should be noted that many counselors today have integrated the core skills of congruence, unconditional positive regard, and empathy with techniques from some of the shorter-term approaches currently used.

Gestalt Therapy

Gestalt therapy was created by Fritz Perls (1893–1970), a German Jew who fled Nazi Germany. Trained as a psychoanalyst, Perls quickly became disheartened with the approach. Borrowing ideas from *Gestalt psychology*, *phenomenology*, and *existentialism*, Perls developed a highly directive approach that pushes clients to confront their unfinished business and live a more real and sane life.

Fritz Perls

Today, most Gestalt therapists believe that from birth, the individual is in a constant state of *self-regulation* through a process of *need identification* and *need-fulfillment*. They believe that the individual's pressing need dictates his or her perceptual field (what the person sees), or, as Gestalt therapists state, the individual is only aware of the need that is in the *foreground*. Because needs can vary dramatically, this theory contrasts with the psychoanalytic view, which suggests that a limited number of instincts drive behavior (e.g., hunger, thirst, survival, sex, aggression), or the Maslowian (humanistic) idea that basic needs (e.g., hunger, thirst) are addressed prior to higher-order needs (love and belonging, self-esteem).

> *You can believe in two instincts . . . or you can believe in two million instincts, or unfinished situations, like I like to do. I believe that our organism is so complicated, that every time something happens to it, is experienced by it, we are thrown out of balance and at each moment we have to regain this balance.* (Perls, 1978, p. 58)

For the Gestalt therapist, how the individual makes contact with his or her environment in an attempt to satisfy needs is reflective of the individual's way of being in the world and determines the *self* (Perls, Hefferline, & Goodman, 1951; Polster & Polster, 1973). The healthy individual has a semi-permeable boundary that allows the individual to maintain a sense of self, while also allowing material from the environment to be engulfed, "chewed," and taken in as it becomes assimilated (Yonteff, 1976). This person has a constant free-flowing exchange between self and *other* (all that is outside of self), and this exchange causes the self, or *ego*, to be constantly changing; that is, as needs are met, self changes. For instance, when "falling in love," the boundary extends out and includes the essence of the other person. At that moment, the person's sense of self, indeed the person's ego, has changed.

Although satisfaction of needs is a natural process, need satisfaction can be thwarted by such things as parental shoulds, social and cultural dictates, and peer norms. Such influences result in the development of mechanisms that resist the experience of that pressing need. These mechanisms yield individuals who are fake, incongruent, false to their nature, and "playing" at being a self-created image, all in an effort to avoid the experience of the need. Such false behaviors result in *impasses* or *blockages* that prevent experiencing and are revealed through dysfunctional and neurotic behaviors that are called *unfinished business* by Gestalt therapists. Breaking free from these influences and the resulting impasses and dealing with one's unfinished business is one of the goals of Gestalt therapy. Successfully doing so allows individuals to live more authentic lives in which they are fully in touch with themselves and are able to have open and honest communication with others. Because unfinished business prevents a person from experiencing oneself fully, one goal of Gestalt therapy is to help the client once again experience the *now*. Experiencing fully is the basis for seeing one's reality clearly. In fact, one of Perls's famous quotes is, "To me, nothing exists except the now. Now = experience = awareness = reality. The past is no more and the future not yet. Only the now exists" (Perls, 1970, p. 14).

Because Gestalt theorists believe we can free ourselves from our impasses and blockages, the Gestalt approach is considered *anti-deterministic*. In fact, one of the greatest contributions of Gestalt therapy is that it circumvented the years of therapy that were needed in psychoanalysis to get to the raw, unconscious, hidden parts of self. Whereas psychoanalysts believed defense mechanisms should be dealt with gingerly because of their importance in maintaining ego integrity, Gestalt and related therapies viewed defenses as

something that one should break free of in an effort to fully experience the present and become sane (Hart, Corriere, & Binder, 1975).

You would probably not be surprised that Gestalt therapists use a variety of techniques to help clients access all of their feelings, thoughts, and experiences, as they are pushed to increasingly experience the "now," quickly identify and understand their impasses, and work on their unfinished business. After specific unfinished business is worked through, it leaves the foreground and allows room for new issues to arise. This process is akin to the peeling-of-an-onion metaphor: "We can open one door at a time and peel off one layer of the onion at a time. Each layer is part of the neurosis. . . " (Perls, 1973, p. 84). Some of the more popular techniques that Gestalt therapists use include:

AWARENESS EXERCISES.   With this technique, therapists ask clients to close their eyes and experience all their feelings, thoughts, and senses. This allows clients to quickly get in touch with hidden feelings or thoughts that are defended against when one uses the external world to avoid inner senses.

USE OF "I" STATEMENTS.   One frequently used defense is the projection of issues onto people or things. Thus, therapists will encourage clients to take ownership of such projections through the use of "I" statements. For example, "This world sucks," becomes "I suck; I don't take responsibility for my happiness."

THE EXAGGERATION TECHNIQUE.   Here, therapists have clients exaggerate a word, phrase, or nonverbal behavior that is believed to hold some hidden meaning. For instance, a client who is slouched over might be asked to slouch more and to attach words to what it feels like to be so slouched. One client might say, "I feel as though the world is on my shoulders," and then soon realize that the "world" represents demands the client feels placed upon him. Further exploration may reveal how the client blames others for his inability to stop taking on tasks.

EMPTY CHAIR TECHNIQUE.   This popular technique has clients imagine that a person, or a part of the client's self, is sitting in an empty chair. The therapist then facilitates a dialogue between the client and this "other person" in order to uncover underlying issues within the client. For instance, a therapist might ask a client who feels as if she has the world on her shoulders to have a conversation with the world, eventually getting to the hidden meanings "the world" holds.

PLAYING THE PROJECTION.   When an individual has strong feelings about other persons or things, a therapist may ask the client to make an "I statement" about that person or thing. Here, it is assumed that the client's strong feelings about the "other" is really a projection of strong feelings about self. Imagine a client who states that she doesn't trust men in relationships, saying, "I don't trust myself in relationships with men."

TURNING QUESTIONS INTO STATEMENTS ABOUT SELF.   Gestalt therapists assume that all questions hide a statement about self. Therefore, the therapist asks the client to change questions into statements about self. Imagine a client changing: "Why don't people care more about others?" to the following statement about self: "I feel that people don't care about me."

OTHER TECHNIQUES.   Assuming that individuals will often avoid responsibility, project onto others, and try to find ways of not dealing with hidden feelings, Gestalt therapists use a wide variety of other techniques to confront clients into awareness. For instance, they encourage clients to "stay with the feeling," to play out different parts of their dreams, to make statements asserting that they take responsibility for their behaviors, and/or to act out the opposite behavior of the one they are exhibiting.

In summary, the Gestalt therapist is an *active*, *directive* therapist who has an existential–humanistic orientation. Although the Gestalt therapist shares many similar goals with the existential and person-centered therapist, their ways of reaching those goals vary dramatically.

Cognitive–Behavioral Approaches

© AP Photo
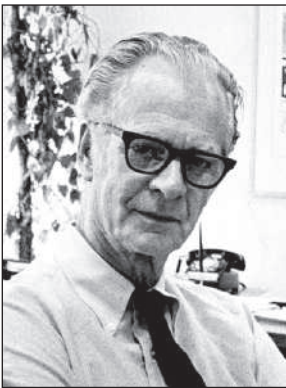
B.F. Skinner

Around the turn of the century, the Russian scientist Ivan Pavlov (1848–1936) found 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. In other words, eventually the dog would salivate when it heard the tone, regardless of whether food was present. Pavlov discovered what was later called *classical conditioning*. John Watson (1925; Watson & Raynor, 1920) and later Joseph Wolpe (1958) would eventually take these concepts and apply them in clinical settings.

During the 1930s, the psychologist B. F. Skinner (1904–1990) showed that animals would learn specific behaviors if the behavior just emitted was *reinforced* (Nye, 1992, 2000; Skinner, 1938, 1971). His *operant conditioning* procedures demonstrated that *positive reinforcement*, the presentation of a stimulus that yields an increase in behavior, or *negative reinforcement*, the removal of a stimulus that yields an increase in behavior, could successfully change behavior. Skinner also found that *punishment* was not a particularly effective means to change behavior (see Box 4.7).

During the 1940s, Albert Bandura found that children who viewed a film in which an adult acted aggressively toward a Bobo doll would act out more aggressively than did children who had not seen the film, when all the children were placed in a room together (Bandura, Ross, & Ross, 1963). This third behavioral approach, after classical and operant conditioning, and known as *social learning* or *modeling*, has shown that although we often do not immediately enact behaviors we have observed, we have the capacity to do so at a later date (Bandura, 1977).

BOX 4.7

Can a Behaviorist Be a Humanist?

During the defense of my doctoral dissertation, my advisor (who was a behaviorist) asked me if "a behaviorist can be a humanist." I went on to give what I thought at the time to be a rather esoteric response noting that the basic orientations of the approaches were philosophically different and therefore incompatible with one another. A few years later, I had the opportunity to hear B. F. Skinner talk at a church in New Hampshire.

Following his talk, I went up to him and asked, "Can a behaviorist be a humanist?" Waiting a moment, he turned to me, and with a deeply reflective look he said, "Well, I don't know about that, but he can surely be humane."

You can hear this and other stories by clicking on "B. F. Skinner" at the "Stories of the Great Therapists" Web site (see http://www.odu.edu/sgt).

In recent years, cognitive therapists have focused on how deeply embedded *cognitive structures*, or *illogical and irrational ways of thinking*, can be conditioned in a similar way as behaviors. And, like behaviors, through *counter-conditioning*, old dysfunctional cognitions can be *extinguished* and new, more functional cognitions can be adopted. Because behavior therapists and cognitive therapists tend to believe there is an intimate, sometimes seamless relationship between cognitions and behaviors, there has been a tendency for these individuals to merge the tenets of both approaches into what has become known as the cognitive–behavioral school. Some of the common assumptions underlying these approaches include the following:

1. The individual is born capable of developing a multitude of personality characteristics.
2. Significant others and cultural influences play a particularly important role in how the individual is conditioned.
3. Genetics and other biological factors may play a significant role in who we become.
4. Despite the fact that the past plays an important role in how a person is conditioned, long periods of time do not need to be spent on examining the past. Instead, one needs to determine what behaviors and thoughts need to be changed and focus on changing them.
5. Behaviors and cognitions are generally conditioned in very complex and subtle ways.
6. The kinds of behaviors and cognitions that are conditioned play a central role in the development of normal and abnormal behavior.
7. By carefully analyzing how behaviors and cognitions are conditioned, one can understand why an individual exhibits his or her current behavioral and cognitive repertoire.
8. By identifying what behaviors have been conditioned, one can eliminate undesirable behaviors and set goals to acquire more functional ways of behaving and thinking.
9. By actively disputing dysfunctional thinking and through counterconditioning, change is possible in a relatively short amount of time.

This section of the chapter will provide an overview of four cognitive–behavioral approaches: *modern-day behaviorism*, *rational emotive behavior therapy* (REBT), *cognitive therapy*, and *reality therapy*.

Modern-Day Behavior Therapy

Based on an understanding of classical conditioning, social learning or modeling, and operant conditioning, modern-day behaviorists have at their disposal a wide range of techniques that they can apply with clients. However, choosing and applying technique effectively is a careful and deliberate process that occurs through a series of stages that includes building the relationship, clinical assessment, focusing on problem areas and setting goals, choosing techniques and working on goals, assessment of goal completion, and closure and follow-up. Let's take a brief look at each of these stages.

STAGE 1: BUILDING THE RELATIONSHIP.   During this stage, the major goal is to build a strong relationship with the client and to begin to clearly define the goals of therapy. Building the relationship is done by showing an accepting attitude to the client, and today it is usual to

find behavior therapists demonstrating good listening skills and being empathic, showing concern and positive regard, and informing the client that any issue can be discussed in counseling. As a supportive, trusting relationship is developed, the therapist increasingly inquires about the how's, where's, and what's of the presenting problem.

STAGE 2: CLINICAL ASSESSMENT.   Critical to choosing the most effective technique for client change is to make a thorough assessment of client needs. Sometimes called a *functional behavior analysis* (FBA), such an assessment should minimally include an in-depth structured interview that examines a broad range of predetermined areas in the client's life and particularly focuses on events that occur prior to and directly after the problematic behavior (Alberto & Troutman, 2006; Wolpe & Lazarus, 1966). In addition, it is often wise to incorporate the use of personality instruments, observation by the clinician, interviews with significant others, and self-monitoring by the client, who will later report back observations to the clinician (Neukrug & Fawcett, 2010).

STAGE 3: FOCUSING ON PROBLEM AREAS AND SETTING GOALS.   During the second stage, the therapist has completed a thorough assessment and defined potential problem areas. Now, identified areas are further examined by obtaining a baseline of the frequency, duration, and intensity of the behaviors. Often, this is accomplished by having the client complete a journal and/or ledger of the behaviors in question. A careful analysis of problem behaviors can help to reveal their magnitude, sets parameters for how and when to change the behaviors, and is useful when assessing progress made. Completion of the baseline is also helpful in setting goals for treatment. From an examination of the baseline, clients can better understand the magnitude of various problem behaviors, decide upon which they want to focus, and collaboratively set goals with the therapist.

STAGE 4: CHOOSING TECHNIQUES AND WORKING ON GOALS.   By drawing from social learning theory, operant conditioning, and classical conditioning, therapists have a large array of techniques to assist the client through the change process (see Box 4.8). At this stage in the therapeutic process, the therapist must carefully explain various techniques to the client and collaboratively choose those techniques that would be most efficacious for the problem at hand. Now the work begins as the client and therapist together devise a plan to use the techniques to reach decided-upon goals.

STAGE 5: ASSESSMENT OF GOAL COMPLETION.   Now that goals have been decided upon, techniques chosen, and work is in progress, it becomes important to assess whether clients are reaching their stated goals. Because a baseline of the intensity, frequency, and duration of the problem behavior has usually been recorded, it is a relatively easy task to assess whether there is a lessening of the problem behavior. If no such progress is seen, it is important to reassess the problem and the techniques chosen (or recycle from Stage 3). If the problem was originally diagnosed accurately, and if appropriate techniques were chosen, the client should begin to see an amelioration of the problem.

STAGE 6: CLOSURE AND FOLLOW-UP.   Reinforcement theory suggests that *extinction* of most behaviors will usually be followed by a resurgence of the targeted behavior called *spontaneous recovery* (Nye, 1992; 2000). Therefore, it is important to remain with the client long enough to ensure success and to prepare the client for a possible resurgence of the problem

BOX 4.8

Select Techniques Used in Behavior Therapy

Modern-day behavior therapy uses a wide variety of techniques from operant conditioning, classical conditioning, and modeling in an effort to help the client change behaviors and feel better about him- or herself. Just a few of the dozens of popular behavior techniques that are used today include:

- *Reinforcement*, where basic positive and negative reinforcement contingencies are applied (e.g., use of sticker charts, saying "good job," etc.)
- *Modeling,* where the client observes a model and then practices the model's behaviors on his or her own
- *Relaxation and systematic desensitization*, where clients learn basic relaxation techniques and apply them to the alleviation of specific phobias (e.g., fear of elevators)
- *Token economies,* where tokens are given to clients when they exhibit specific targeted behaviors and are later exchanged for a reward

- *Flooding and implosion techniques,* where clients are exposed to a feared stimulus for an extended amount of time until the stimulus no longer evokes the fear response
- *Aversion therapy,* where a stimulus that is perceived to be highly noxious by a client is associated with a targeted behavior (e.g., a pedophile receives electric shock when aroused by pictures of children)
- *Stimulus control,* where a stimulus is altered or removed and a new, healthier behavior is reinforced (e.g., a binge eater places a lock on the refrigerator)
- *Self-management techniques,* where clients learn how to apply any of a number of behavioral techniques on their own and monitor their own progress

after therapy has ended. Therefore, many behaviorists build in follow-up sessions to the course of therapy. Of course, as in any therapy, when success is reached, it is important that the client experiences a sense of closure as he or she nears the end of therapy.

Behavior therapy today is a far cry from the deterministic, objectivistic, scientific behavior therapy of years ago. Whereas classical behaviorists viewed the client as an object that was experimented upon, the modern-day behaviorist understands the importance of building a relationship so that he or she can better understand the client's problem and so clients will be more amenable to the therapeutic process. The stages just described are an example of how such a process might occur.

Rational Emotive Behavior Therapy (REBT)

. . . if you have right opinions, you will fare well; if they are
false, you will fare ill. For to every man the cause of his acting
is opinion. . . . (Epictetus, c. 100 CE)

Developed by Albert Ellis (1913–2009) during the 1950s, rational emotive therapy asserts that we are fallible human beings who have the potential for rational or irrational thinking. *Rational thinking*, say REBT therapists, leads to healthy ways of living, and results in people who show unconditional acceptance of self, of others, and of the way things are. In contrast, *irrational thinking* leads to emotional distress, dysfunctional behaviors, and neurotic ways of living, as well as people who tend to be critical of others and of themselves. Although early child-rearing practices, family dynamics, societal influences, and innate biology tend to be the basis for the development of rational or irrational thinking, REBT
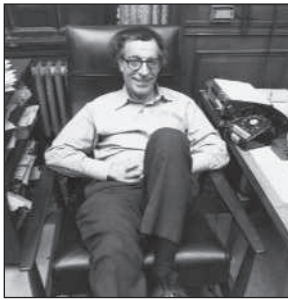
Albert Ellis

therapists believe that it is the individual who sustains his or her unique way of thinking (Ellis & MacLaren, 2005).

REBT therapists believe that there is a complex interaction between one's thinking, feeling, and behavioral states, and they view the interpretation of cognitive processes as being mostly responsible for self-defeating emotions and dysfunctional behaviors. Reactions to events, say REBT therapists, are filtered through one's belief system, and the individual responds consciously or unconsciously to the belief system, not to the event. If the belief system is irrational, the individual responds with self-defeating emotions and self-perpetuating dysfunctional behaviors. If the belief system is rational, the individual responds with emotions that perpetuate healthy ways of functioning in the world. Thus, strong emotions, such as grief after the loss of a dear friend or sadness if one's house is flooded from a hurricane, would be considered a reasonable response, whereas a deep depression after the ending of a relationship or road rage at a fellow driver would be seen as unreasonable responses and a reaction to an irrational belief system.

Although REBT therapists view an individual's belief system as generally being created early in life, they also believe it can be challenged and systematically changed by analyzing its philosophical basis and helping the individual gain awareness into the irrational beliefs that fuel maladaptive ways of living. Long-winded examination of the past is not necessary, and indeed could be harmful and inhibit progress toward change.

> *Freud was full of horseshit. He invented people's problems and what to do about them. Tell me one thing about the past. I'll prove it's not what upset you. It's how you philosophized about it that made you disturbed.* (Ellis as cited in Aviv, 2005, para. 2)

As you can see from the preceding quote, the insight-oriented approach of REBT has a strong *anti-deterministic* philosophy that suggests we can choose new ways of thinking and ultimately feel better and act in healthier ways. This optimistic view of change has an existential flavor to it, although REBT is rarely placed within the existential schools. Perhaps REBT can best be seen as a philosophy that is a mixture of learning theory and existential–humanistic philosophy: learning theory in the sense that we learned a way of thinking, feeling, and acting that is self-perpetuating and existential–humanistic because we can choose to learn new and healthier ways of thinking, feeling, and behaving.

Basic to REBT philosophy is the idea that we have adopted certain *cognitive distortions* in our lives that have led to one or more of three core *irrational beliefs* (see Box 4.9; Ellis originally suggested 11 irrational beliefs that he eventually pared down to three). As you might expect, the techniques used in REBT are based on helping the client identify and stop using cognitive distortions while also replacing irrational beliefs with rational beliefs. In addition, because the REBT therapist sees an intimate connection between thinking, behaving, and feeling, other techniques will be used to encourage new ways of responding and feeling that are aligned with the new rational way of thinking.

The REBT therapist tends to be *active* and *directive* and not overly concerned about the building of caring, empathic relationships when working with clients as he or she shows the client how cognitive distortions and irrational beliefs have led to dysfunctional ways of living in the world (see Box 4.10). They do this by demonstrating the *ABCs of feeling and behaving*. Here, the therapist shows the client how it is not the *activating event* ("A") that

BOX 4.9

Cognitive Distortions and Three Core Irrational Beliefs

Cognitive Distortions

Absolutistic musts and shoulds occur when an individual believes that he or she must or should act a certain way in life (e.g., "I must be the best parent," or "I should always be polite").

Awfulizing occurs when an individual exaggerates events by making them horrible, terrible, awful, or catastrophic (e.g., "If I don't get into that graduate program, my life will be shattered," or "It's so horrible, I can't even tell you what happened—okay, my husband abused me—I can't go on!").

I-can't-stand-it-itis occurs when an individual continually sees events as being unbearable and exaggerates the event through his or her irrational belief system (e.g., "I just can't stand my daughter's behavior any more, she's going to drive me crazy!" or, "Those immigrants are taking jobs away from us; they're going to eventually take my job!").

Demands on oneself add unnecessary stress to an individual because they assume that a person should, must, or ought to act in a certain manner ("I need to find love or my life will be ruined").

People-rating (damning oneself and others) occurs when an individual rates or views oneself, or another person, as having all or none of a quality (good, bad, worthless) (e.g., "My boss is a no-good idiot; I hate him," or "I loved that woman, she was perfect. Why did she do this to me?").

Three Core Irrational Beliefs

1. "I absolutely must under all conditions do important tasks well and be approved by significant others or else I am an inadequate and unlovable person!"

2. "Other people absolutely must under all conditions treat me fairly and justly or else they are rotten, damnable persons!"

3. "Conditions under which I live absolutely must always be the way I want them to be, give me almost immediate gratification, and not require me to work too hard to change or improve them; or else it is awful, I can't stand them, and it is impossible for me to be happy at all!" (Ellis & MacLaren, 2005, pp. 32–33)

BOX 4.10

Don't Give Me That Empathy %#@$%#

A few years after finishing my doctorate, I considered doing a postdoctoral fellowship at the Rational Emotive Behavior Institute in New York City. I sent in my resume and was called for an interview. At first, I interviewed with one of the directors; then I was told I would have to do a role-play with "Al." I was brought in to see Al, who was sitting in a big, comfortable armchair. He proceeded to ask me to role-play a counselor. He was the client, presenting a male college student who had difficulty dating. I began to listen and respond with empathy, thinking that after hearing about the problem, I would move into an REBT style of response. After about three empathic responses in a row, Al said to me, something like, "Don't give me any of that Rogerian ____! I want to see a rational emotive counselor." I proceeded to give him what he wanted, thinking to myself, "He sure is serious about the unimportance of the 'necessary and sufficient conditions.'" I decided not to pursue the fellowship.

You can hear this and other stories by clicking on "Albert Ellis" at the "Stories of the Great Therapists" Web site (see http://www.odu.edu/sgt).

has caused the *consequential* negative feelings ("C") but the *irrational belief* ("iB") about the event that has led to those feelings. For instance, look at the following scenario:

> *Activating event* (A): My lover has left me.
>
> *Cognitive self-statement or belief*: I must have a lover, otherwise I am worthless.
>
> *Underlying core irrational belief* (iB): Conditions under which I live *absolutely must* always be the way I want them to be, give me almost immediate gratification, and not require me to work too hard to change or improve them; or else it is *awful*, I *can't stand* them, and it is impossible for me to be happy *at all*!
>
> *Possible consequence* (C):
>
>> *Feelings consequence:* depression, panic
>>
>> *Behavioral consequence:* need to immediately seek out another person, even if the relationship may not be healthy or positive; or isolation if depression is particularly bad.
>
> After the client learns the basic ABCs, he or she is taught how to *dispute* ("D") the irrational belief by replacing the irrational belief with a rational belief (rB).
>
> *Activating event* (A): My lover has left me.
>
> *Rational belief* (rB): This is unfortunate, and things don't always work out in life the way that I want them to. However, I'll move on in my life and perhaps even meet someone I like more.
>
> *Possible consequence* (C): Feeling "okay" and actively trying to meet new people.

In addition to the "ABC" method, there are a number of techniques that are used in REBT to assure a new cognitive, behavioral, and emotional outlook. These include: *cognitive homework*, where the client practices disputing irrational beliefs at home; *bibliotherapy*, where clients can read about REBT philosophy; *role-playing* to try out new behaviors consistent with a rational view; *shame-attacking exercises*, where clients practice unconventional social behaviors (dressing unusually) to learn how to rid themselves of their conventional ways of being; *imagery exercises*, where clients imagine healthier ways of acting; *behavioral techniques*, where clients practice new behaviors; and *emotive techniques*, where clients are encouraged to get in touch with their feelings to help understand their underlying belief system.

The actual practice of REBT is relatively short-term and can be viewed through the following five steps:

> *Step 1:* Assessing the client's situation and hypothesizing how the ABCs apply
>
> *Step 2:* Teaching the REBT philosophy
>
> *Step 3:* Demonstrating how the client's situation fits the REBT model
>
> *Step 4:* Directing the change process through a variety of techniques
>
> *Step 5:* Reinforcing change and terminating the relationship

REBT is an active and directive therapy in which clients are challenged to take on a more rational way of living. Although REBT therapists don't tell people how to live, they do help them look at how current thinking and associated behaviors and feelings may be related to specific cognitive distortions and irrational beliefs.

Cognitive Therapy

Cognitive therapy was developed during the 1960s by Aaron Beck (1921–   ). Although similar to Ellis's approach in many ways, Beck believed more strongly than Ellis that the relationship was critical to positive therapeutic outcomes and disagreed with Ellis's use of the word "irrational." Beck's writings suggest there is a genetic and evolutionary predisposition toward certain emotional responses. Although adaptive in the distant past, in today's world their expression can sometimes be maladaptive (e.g., excessive anxiety and anger) (Beck, A., 1967, 1976, 1999, 2005). Called the *continuity hypothesis*, these older, emotional responses are seen as "continuing" into the modern world (Weishaar, 1993), and when an individual today exhibits large amounts of these emotional responses, he or she is often viewed as having a mental disorder. Beck also suggests that individuals who have a tendency toward exhibiting these maladaptive emotional responses will not express them if taught effective skills by parents and others. And, taking a rational, pragmatic, and some say "constructivist" perspective, which suggests that one can "reconstruct" their sense of who they are, Beck assumes that those who do exhibit maladaptive responses can change through therapeutic discourse with others (Beck, J., 2005; Leahy, 2003). Thus, cognitive therapy is seen as an *anti-deterministic*, *active*, *educative*, and *empirical* approach to counseling that suggests that in a relatively short amount of time, people can effect changes in their lives.

Beck posits a *diathesis–stress model* of mental disorders that suggests that a combination of genetics, biological factors, and experiences combine to produce specific *core beliefs*, some of which may lie dormant and then suddenly appear as the result of stress and other conditions impinging on the person. Core beliefs are embedded, underlying beliefs that provide direction toward the manner in which one lives in the world (Beck, A., 1967, 1991), with negative core beliefs leading to negative feelings and dysfunctional behaviors, and positive core beliefs leading to healthy ways of living. Three broad categories of negative core beliefs are listed in Box 4.11.
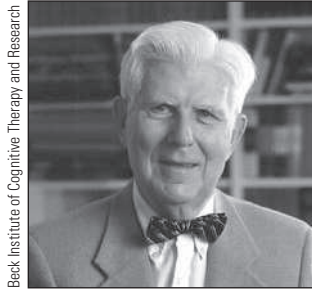
Aaron Beck

BOX 4.11

Negative Core Beliefs

Helpless Core Beliefs
"I am inadequate, ineffective, incompetent; I can't cope."
"I am powerless, out of control; I can't change; I'm stuck, trapped, a victim."
"I am vulnerable, weak, needy, likely to be hurt."
"I am inferior, a failure, a loser, not good enough; I don't measure up to others."

Unlovable Core Beliefs
"I am unlikable, undesirable, ugly, boring; I have nothing to offer."
"I am unloved, unwanted, neglected."

"I will always be rejected, abandoned; I will always be alone."
"I am different, defective, not good enough to be loved."

Worthless Core Beliefs
"I am worthless, unacceptable, bad, crazy, broken, nothing, a waste."
"I am hurtful, dangerous, toxic, evil."
"I don't deserve to live."

Source: Beck, J. (2005). *Cognitive therapy for challenging problems*. New York: Guilford Press, p. 22.
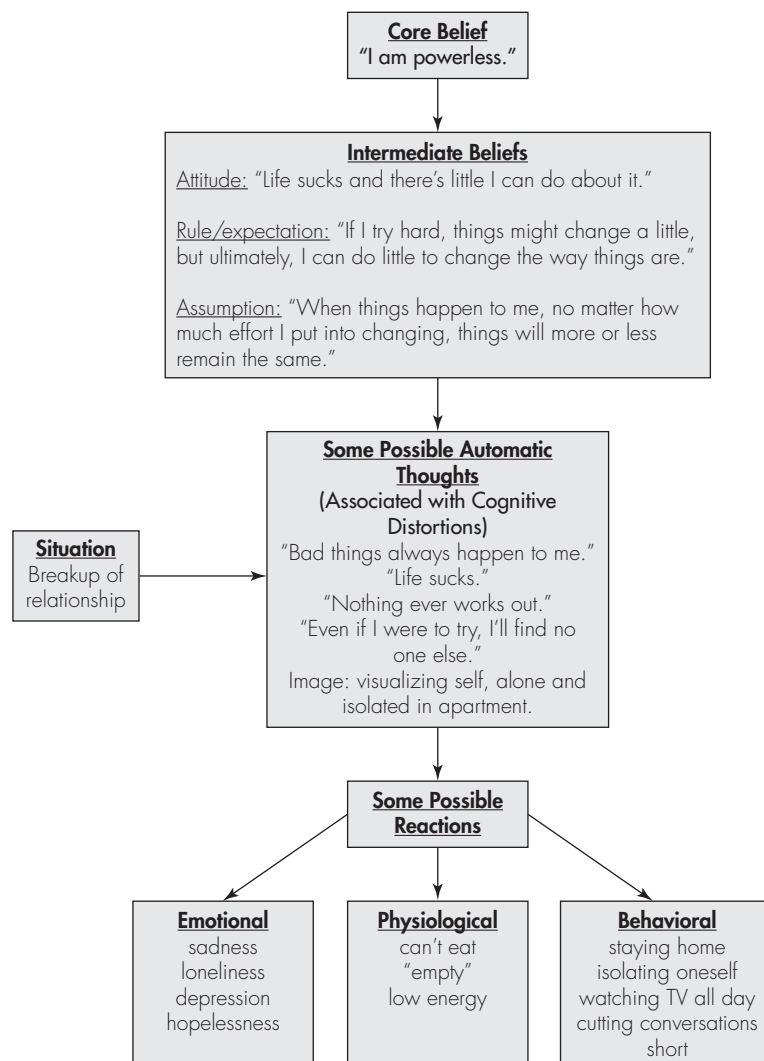
Beck believes that most individuals are not aware of their core beliefs. Instead, such beliefs become the underlying mechanism for the creation of *intermediate beliefs*, which set the *attitudes*, *rules* and *expectations*, and *assumptions* we live by. These attitudes, rules and expectations, and assumptions can be understood by looking at how situations lead to what are called *automatic thoughts*, which result in a set of behaviors, feelings, and physiological responses that end up reinforcing core beliefs. Beck found that automatic thoughts are often related to one of a number of *cognitive distortions*, which are similar to Ellis's three core irrational beliefs as well as his original 11 irrational beliefs (see Table 4.1). Beck also found that certain diagnoses are related to specific core beliefs. Thus, when a client comes in presenting with certain symptoms, if an accurate diagnosis is made, the counselor can make a fairly good guess at the core belief that fuels the clients intermediate beliefs, automatic thoughts, and cognitive distortions.

T A B L E 4.1

Cognitive Distortions
1. *All-or-nothing thinking:* Seeing the world categorically, rather than in a more complex fashion. *Example:* "I am never good at my job." Or, "You are always happy."
2. *Catastrophisizing:* Assuming something will go wrong rather than looking at situations more realistically. *Example:* "I shouldn't have said that to my boss, I know I'll get fired." Or, "If I fly, the plane will crash."
3. *Disqualifying or discounting the positive:* Even when a positive event occurs, assuming it means little. *Example:* "That award I won at work is meaningless, everybody wins awards."
4. *Emotional reasoning:* Assuming feelings are always correct, even when there is evidence to the contrary. *Example:* "My wife and kids may tell me they love me, but I know no one can love me."
5. *Labeling:* Defining oneself in terms of a "label" or "type" instead of more nuanced ways. *Example:* "I'm just a negative person." Or, "I'm always introverted."
6. *Magnification/minimization:* Magnifying the negative or minimizing the positive. *Example:* "I might have done well on that one test, but I know I'm not good in that subject."
7. *Mental filter:* Focusing on one negative aspect of oneself, of another, or of a situation. *Example:* "I know why people stay away from me: They always see my disability."
8. *Mind-reading:* Making assumptions about what other people are thinking and discounting other possibilities. *Example:* "She thinks I'm ugly."
9. *Overgeneralization:* Making large generalizations from a small event. *Example:* "That dinner for my kids was horrible; I'll never be a good parent."
10. *Personalization:* Assuming you are the cause for other person's negative behavior. *Example:* "My colleague, James, was in a bad mood today because I didn't get that project to him in time."
11. *"Should" and "must" statements:* Believing if one does not act in a specific manner, it is horrible. *Example:* "My grandmother never should have acted so boldly in front of the company."
12. *Tunnel vision:* Only seeing the downside or negative aspect of a situation. *Example:* "Her expressing her opinion is uncalled-for. We'll never get friends that way."
Adapted from: Beck, J. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Cognitive therapists initially focus on the client's automatic thoughts, as they are easily "caught" and are a more natural starting point (e.g., a core belief of "I am inadequate" is much more difficult for a client to initially grasp than an automatic thought of "I never will get this report done right"). Slowly and methodically, the therapist, in collaboration with the client, works his way up toward the client's core beliefs. As the client increasingly understands the relationships between symptoms, automatic thoughts, cognitive distortions, intermediate beliefs, and core beliefs, he or she can begin to change. Figure 4.2 shows a graphic representation of this for a client who comes in after a breakup of a relationship and initially presents with a variety of emotional, behavioral, and physiological responses. Fairly quickly, the client can begin to "catch" his or her automatic thoughts and over time can see the relationship between those thoughts and the more embedded cognitive distortions, intermediate beliefs, and lastly, core beliefs.

FIGURE 4.2
Example of the Relationships among Core Beliefs, Intermediate Beliefs, and Automatic Thoughts

Core Belief
"I am powerless."

Intermediate Beliefs
Attitude: "Life sucks and there's little I can do about it."

Rule/expectation: "If I try hard, things might change a little, but ultimately, I can do little to change the way things are."

Assumption: "When things happen to me, no matter how much effort I put into changing, things will more or less remain the same."

Situation
Breakup of relationship

Some Possible Automatic Thoughts
(Associated with Cognitive Distortions)
"Bad things always happen to me."
"Life sucks."
"Nothing ever works out."
"Even if I were to try, I'll find no one else."
Image: visualizing self, alone and isolated in apartment.

Some Possible Reactions

Emotional
sadness
loneliness
depression
hopelessness

Physiological
can't eat
"empty"
low energy

Behavioral
staying home
isolating oneself
watching TV all day
cutting conversations short

In working with clients, counselors initially build a strong therapeutic alliance by being *collaborative*, demonstrating *empathy*, being *caring*, and being *optimistic*. Fairly quickly, the counselor uses *Socratic questioning* to help the client understand his thought processes while at the same time educating the client about the cognitive model. Soon clients are able to identify and challenge automatic thoughts and later can identify and challenge cognitive distortions, intermediate beliefs, and core beliefs. In the change process, a number of techniques are used, with some of the more common ones being: *identifying and challenging* automatic thoughts, cognitive distortions, intermediate beliefs, and core beliefs; *homework assignments* to work on changing beliefs and behaviors; *thought-stopping*; *imagery-changing*; *rational–emotional role-play*; and a wide range of *behavioral and emotive techniques*.

Reality Therapy and Choice Theory

William Glasser Institute

William Glasser

In 1960, William Glasser (1925–   ) wrote his first book, *Mental Health or Mental Illness,* and then, in 1965, he wrote *Reality Therapy*. These books criticized the psychiatric profession for propagating the belief that mental illness was the result of some inherently flawed biological brain functioning. Instead, he suggested that individuals labeled as mentally ill, as well as those having daily living problems, were exhibiting irresponsible behaviors because they had not formed relationships that had helped them learn how to effectively meet their needs.

Over the years, Glasser has greatly refined his theory. Today, reality therapy posits that we have *five genetically based needs*, the original of which is the *survival or self-preservation need* that helped us endure thousands of years ago in a difficult world. From the survival need spun off the needs for *love and belonging*, *power* (or *inner control*), *freedom* (or *independence*), and *fun* (or *enjoyment*), each of which has helped the human species thrive in distinct ways. Today, the strength of all five needs is said by Glasser to be "fixed at birth and does not change" (1998, p. 91). The manner in which each of us learns to meet our unique *need-strength profile* is said to be a reflection of our personality. Reality therapy today is based on *choice theory*, which suggests that only we can satisfy our needs and control our behaviors and that although the past affected who we are today, we can only learn how to meet our needs in the present.

Glasser (1998, 2001) suggests that from the moment we are born, we begin to create our *quality worlds*, which contain pictures in our minds of the people, things, and beliefs most important to us in meeting our unique need-strength profiles. Because these pictures are unique, they represent each person's take on reality (Brickell, 2007; Wubbolding, 2010; Wubbolding & Brickell, 1999). As some examples, these pictures might include the life partner we want, the car we want to buy, and a religious belief to which we want to adhere. If the individual is able to choose behaviors that match the pictures in his or her quality world, he or she will satisfy one or more of the five needs and feel content, at least for a short period of time. These pictures can change throughout one's lifetime; however, sometimes pictures that previously satisfied us can remain in our minds for long periods of time and can sometimes become a source of pain if we cannot satisfy them. For instance, it can take a long time to rid oneself of the image of a lover who has left.

Central to reality therapy is the idea that our *total behavior* is chosen and generated from within in an effort to match the pictures in our quality worlds. By total behavior, Glasser means our actions, our thinking process, our feelings, and our physiological responses. Glasser goes on to state that we can only *choose our actions and thoughts*, which are jointly called *doing*, and that our feelings and our physiology result from those choices.

Glasser suggests that language usage is reflective of how individuals make choices in their attempts to meet their needs (Glasser & Glasser, 1999). *Internal-control language* is accepting, respectful, and supportive of others, and reflects a person who is clear about the choices that will best meet his or her needs. On the other hand, *external control language* is blaming, critical, threatening of others, and reflects a person who sees his or her life controlled by others and by events. Along these lines, Glasser suggests that instead of saying: "My depression is making me sleep all the time," or "I have a mental illness that has stopped me from working," or "My anger makes my blood pressure go up," individuals say: "I am depressing myself and choosing to sleep much of the time," "I make myself mentally ill and choose not to work," and "I anger myself and make my blood pressure rise." Language such as this shows that the individual is in control of his or her state of being and differs with the mainstream psychiatric view that suggests mental disorders are the result of intrinsic, organically based problems (e.g., genetic differences in brain function) or that individuals are determined by such things as early childhood experiences.

As you can probably tell, Glasser's approach is *anti-deterministic*, because at any point in life, a person can evaluate his or her total behaviors and adopt internal control language and make new choices that better match one's need-strength profile and quality world. And, because Glasser believes that needs can only be satisfied in the here and now, the approach is focused mostly on the *present*. Even if an individual had been traumatized and learned maladaptive ways of behaving in an attempt to meet his or her needs, that person can learn new ways of choosing that can lead to more effective satisfaction of needs. Generally, people can learn these new ways through the development of relationships that are accepting, loving, and caring, like one might find in counseling. Such relationships teach internal-control language, how to make better choices, and how to best match one's quality world.
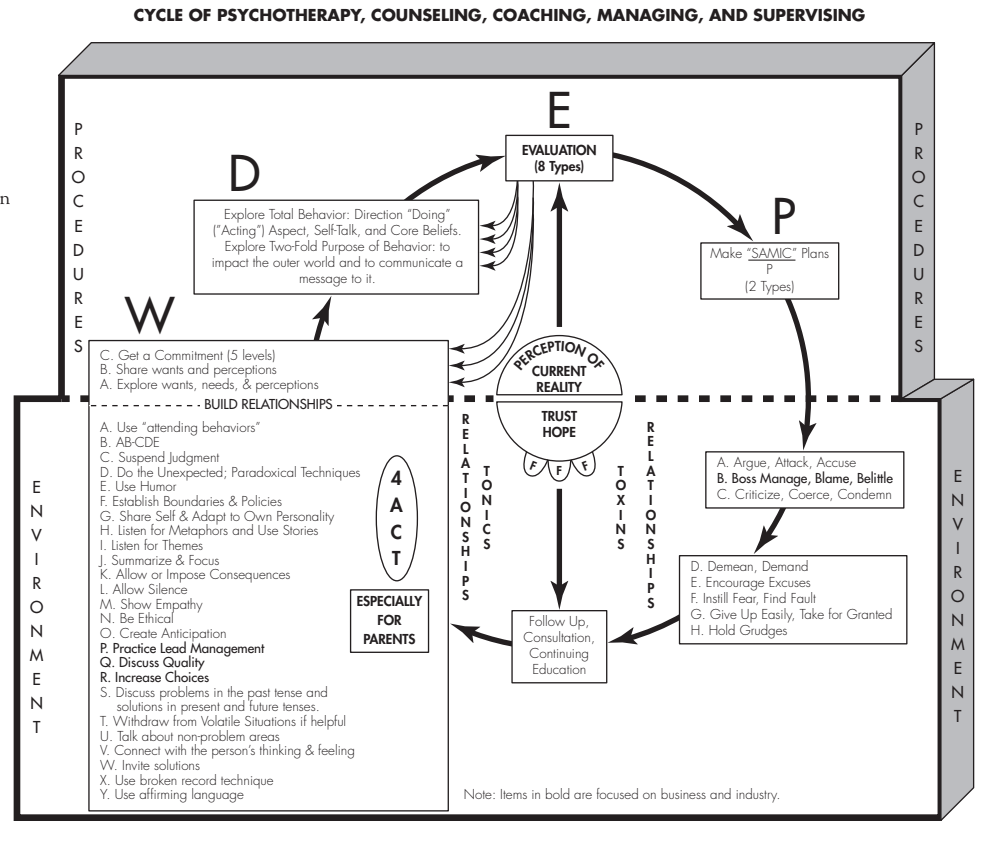
Today, a common method of training reality therapists is the *WDEP* system developed by Bob Wubbolding (Wubbolding, 2000; Wubbolding & Brickell, 1999). This system stands for **w**ants of the client, what the client is **d**oing in his or her life's direction, **e**valuating if what the client is doing is working, and developing a **p**lan of action that can be implemented. This system allows clients to look at what their needs are, what they are doing to get their needs met, examine if what they are doing is working for them, and decide on what they need to do differently to better get their needs met. Wubbolding suggests that for a client to effectively involve him- or herself in the WDEP cycle, there must be a strong therapeutic relationship based on trust and hope. This is accomplished by the counselor's demonstrating the techniques and embodying the attitudes of what Wubbolding calls the *environmental elements*, which include exhibiting the *tonics of creating the counseling relationship* and avoiding the *toxins of creating the counseling relationship* (see Figure 4.3).

Post-Modern Approaches

Narrative therapy and *solution-focused brief therapy*, the two approaches we will examine in this section, are recent additions to the therapeutic milieu and are based on the philosophies of *post-modernism*, *social constructionism*, and *post-structuralism*. Post-modernists question modernism and the many assumptions and beliefs that are taken for granted as a result of the use of empiricism and the scientific method. Post-modernism 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 approach to communication in understanding a person. Social constructionism has to do with how values are transmitted through language by the social milieu (e.g.,

FIGURE 4.3
Wubbolding's WDEP Model

Source: Developed by Robert E. Wubbolding, Ed.D from the works of William Glasser, MD. Copyright 1986 Robert E. Wubbolding, EdD. 17th Revision 2010.

CYCLE OF PSYCHOTHERAPY, COUNSELING, COACHING, MANAGING, AND SUPERVISING

E
EVALUATION (8 Types)

D
Explore Total Behavior: Direction "Doing" ("Acting") Aspect, Self-Talk, and Core Beliefs. Explore Two-Fold Purpose of Behavior: to impact the outer world and to communicate a message to it.

P
Make "SAMIC" Plans P (2 Types)

W
C. Get a Commitment (5 levels)
B. Share wants and perceptions
A. Explore wants, needs, & perceptions
- - - BUILD RELATIONSHIPS - - -
A. Use "attending behaviors"
B. AB-CDE
C. Suspend Judgment
D. Do the Unexpected; Paradoxical Techniques
E. Use Humor
F. Establish Boundaries & Policies
G. Share Self & Adapt to Own Personality
H. Listen for Metaphors and Use Stories
I. Listen for Themes
J. Summarize & Focus
K. Allow or Impose Consequences
L. Allow Silence
M. Show Empathy
N. Be Ethical
O. Create Anticipation
P. Practice Lead Management
Q. Discuss Quality
R. Increase Choices
S. Discuss problems in the past tense and solutions in present and future tenses.
T. Withdraw from Volatile Situations if helpful
U. Talk about non-problem areas
V. Connect with the person's thinking & feeling
W. Invite solutions
X. Use broken record technique
Y. Use affirming language

4 ACT
ESPECIALLY FOR PARENTS

PERCEPTION OF CURRENT REALITY
TRUST HOPE
F F F

PROCEDURES (left)
PROCEDURES (right)
ENVIRONMENT (left)
ENVIRONMENT (right)
RELATIONSHIPS TONICS
RELATIONSHIPS TOXINS

A. Argue, Attack, Accuse
B. Boss Manage, Blame, Belittle
C. Criticize, Coerce, Condemn

D. Demean, Demand
E. Encourage Excuses
F. Instill Fear, Find Fault
G. Give Up Easily, Take for Granted
H. Hold Grudges

Follow Up, Consultation, Continuing Education

Note: Items in bold are focused on business and industry.

family, culture, and society) and suggests that the person is constantly changing with the ebb and flow of the influences of significant others, culture, and society. Post-structuralism questions the inherent "truth" of such things as intrinsic psychological structures to which many psychological theorists point in explaining their view of human nature. Those with this philosophy doubt many of the basic assumptions of past popular therapies, which suggest that certain structures cause mental health problems (e.g., id, ego, superego, core beliefs, lack of internal locus of control, etc.). Rather than harp on past problems that tend to be embedded in oppressive belief systems, post-modern approaches suggest that clients can find exceptions to their problems and develop creative solutions. Post-modern therapies tend to be short-term, with solution-focused brief therapy being considered a particularly brief approach, sometimes lasting fewer than five sessions.

Narrative Therapy

One of the newest forms of therapy, narrative therapy was developed by Michael White (1948–2008) and David Epston (1948–   ), amongst others. Greatly affected by the philosophy of social constructionism and post-modernism, White and Epston began to develop a new means of working with clients based on such premises as: *realities*

are socially constructed, *realities are constituted through language*, *realities are organized and maintained through narrative*, and *there are no essential truths* (Freedman & Combs, 1996). The narrative therapist's belief in there being no essential truths is closely associated with issues of power and inequity in society, because "truths" from the dominant culture are often accepted and subtly forced upon us. And, say the narrative therapists, it is these same truths that tend to maintain the power structure in society that is responsible for the oppression of nondominant groups. For the narrative therapist, *dominant stories* from society are internalized by individuals, cause people to live out and believe stories that tend to oppress the underclass, and blind clients to other possible stories and opportunities (Freedman & Combs, 1996; White, 1993, 1995; White & Epston, 1990). Thus, stories about how certain individuals or groups of people are "lazy," "stupid," "rebellious," and so on are often subtly, and sometimes blatantly, passed down. These constructions become part of the dominant stories of those in power and are even sometimes internalized and "believed" by the very people whom the stories are about. For these reasons, narrative therapy is often referred to as an approach that has a very strong *social justice orientation*.

From the narrative point of view, individuals are constantly in discourse with others within their social milieu, and it is through such interactions that they develop their sense of self. Although people are deeply affected by the language used in their social spheres, narrative therapy is *anti-deterministic* because it assumes that people can understand the realities that have been created, *deconstruct* their foundations (take them apart), and develop or *re-author* new stories that are empowering. Because the major focus of narrative therapy is "where people want to go" rather than "where they have been" (Hoyt, 1994, p. 1), narrative therapy is more optimistic than many other approaches. In fact, narrative therapists are considered *anti-objectivists*, which means that they oppose those approaches that develop a theoretical model that explains reality and then uses that hypothetical model to define the experience of others (e.g., psychodynamic approaches, the DSM). This objectification of others, which almost always focuses on the client's past, often results in the disdain for or oppression of the client:

> *The objectivists and monumentalists, on the other hand, prefer to stand above the fray, where they can assume a position of omniscience, and work in the "clean" realm of detachment and ethical neutrality. To me, the attitudes embodied in their "standing above it all" range from mild condescension through active surveillance to brute domination. . . .* (Rosaldo, 1993, p. 221)

Narrative therapists suggest that we are all *multistoried* and that some stories are helpful, while others are unhelpful, such as the dominant, *problem-saturated stories* with which clients often present. They suggest that it is important to help clients deconstruct their problem-saturated story and begin to look at other stories (or narratives) that are also an aspect of an individual's life. In doing this, they suggest that clients will move from what they call *thin stories* toward *thick stories*, or more complex ways of seeing their lives, which is not based on the problem-saturated dominant story. Narrative therapists help clients find *exceptions* to their problem-saturated dominant stories and have them look at the multiple stories that are present in their lives. In this way, clients can begin to re-author their lives, or identify with new stories that are not problem-saturated (Figure 4.4)

Photo by Jill Freedman

Michael White

FIGURE 4.4
Identification of New, Alternative Stories

The line with the triangles is symbolic of times John remembers being verbally abused by his father for being sensitive—his dominant story. The line with the ovals represents times John remembers being a content, sensitive child or man. And the line with stars reflects times John remembers being a content "strong" child or man. John is now beginning to re-author or redefine who he is, and the problem-saturated story is beginning to become less meaningful.

Old, Problem-Saturated Dominant Story

New Emerging Stories

Birth   Current Age

Narrative therapists approach the client with *mystery, respectful curiosity,* and *awe.* They will often ask a lot of *questions* in an effort to have the client talk about their dominant problem-saturated story and help them look at other, less dominant but potentially empowering stories. They tend to be *collaborative* and *encouraging* to clients in their attempts to help clients look at the stories that sprinkle their lives. Oftentimes, the narrative therapist will have clients name and externalize the dominant problem so they will not see the problem as being something inherent. They will help clients see how the dominant, problem-saturated story has affected their lives and help them identify unique outcomes or exceptions to these stories. In this way, they can begin to examine new stories and re-author their lives. To reinforce these new stories, they will sometimes have clients *journal,* have outside *witnesses* listen to their new stories, and have clients *retell* their new stories to reinforce the new, more positive way of being. Sometimes *symbols* might be used to reinforce the new stories (e.g., handing a client who has lived a story that she is "dumb" a certificate of "brightness").

Narrative therapy can be viewed in four phases. *Phase 1, the joining phase,* occurs when the therapist meets the client, begins to build a relationship, and invites the client to share his or her problem-saturated story; *Phase 2, examining patterns,* is when the client is invited to examine stories that contradict, deny, or oppose the problem-saturated story; *Phase 3, re-authoring,* is when the client begins to build new, more positive stories; and *Phase 4, moving on,* is when the client has developed a new, more positive outlook on life and is ready to leave therapy. An exciting and relatively new type of therapy, narrative therapy is quickly becoming an approach

that challenges many of the existing therapy's understanding of client problems and of mental illness.

Solution-Focused Brief Therapy

> *Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?*
> (de Shazer, 1988, p. 5)

Insoo Kim Berg

Steve de Shazer

Developed by the husband and wife team of Steve de Shazer (1940–2005) and Insoo Kim Berg (1934–2007), *solution-focused brief therapy* (SFBT) was greatly influenced by John Weakland and others at the *Brief Family Therapy Center* of the *Mental Research Institute* (MRI) in Palo Alto, CA.

After taking part in training at MRI, de Shazer and Berg, as well as three other colleagues, decided to start the *Brief Family Therapy Center* (BFTC) of Milwaukee, which initially mirrored what was happening at MRI. As the team began to treat large numbers of clients, they noticed that solution-focused interventions, in contrast to problem-focused ones, seemed to have better and quicker results. In fact, the group realized that the average number of sessions clients spent in therapy was six, yet most therapists, with their insight-oriented approaches, expected clients to be in therapy for months, if not years (Gingerich, 2006). They also realized that most therapists saw clients as diseased and were continually hypothesizing about their clients as if the therapist knew something about them that they did not know about themselves (Cade, 2005).

Deciding that clients were their own best resources and confident that clients could be helped quickly, they decided to use videotapes and live observation to determine which techniques seemed to have the quickest and best results. In fact, this is how de Shazer (1988) came up with his famous *miracle question* that is quoted at the beginning of this section. Confident they could quickly and effectively work with clients, the team decided to contract with one health insurance company for a flat fee of $500 per client, regardless of how long treatment took (Riding the. . . , 2006). Using informal follow-up studies of their clients, de Shazer was able to show that his new approach to counseling was effective in a short amount of time (Gingerich, 2006).

Today, SFBT is a *pragmatic*, *optimistic*, *anti-deterministic*, and *future-oriented* approach that believes in the ability of the client to change. SFBT rejects the notion that individuals have an inherent tendency toward mental health problems or illnesses and focuses almost exclusively on solutions and on client strengths, not on client deficits or problems (Fernando, 2007). Trusting that change can occur quickly, this approach asserts that individuals can find *exceptions* to their problems and build on those exceptions to find new ways of living in the world (O'Hanlon & Weiner-Davis, 2003).

Although de Shazer and Dolan (2007) have suggested that SFBT is "not theory-based" (p. 1), most modern-day solution-focused therapists would likely identify themselves as *social constructionists* and *post-modernists*, and it is clear that this
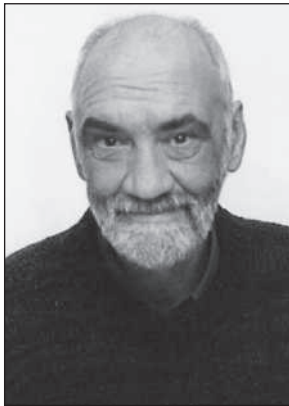
is where solution-focused therapy has its philosophical home (Bidwell, 2007; Guterman, 2006). The post-modern, social-constructionist position asserts that pathology, for all practical purposes, does not exist, because one cannot prove that it is inherently found within the person. Thus, this perspective assumes that problems can be viewed as challenges that are inherent in a language-based system. Seen from this viewpoint, how the counselor brings him- or herself into the relationship is critical to helping the individual overcome his or her problems. If the counselor believes that pathology exists within the person, he or she will find this pathology; if the counselor believes that the problems are system-based (e.g., residing within the family), he or she will find this to be the case; but if the counselor assumes that problems are a function of the language used by the client within his or her social sphere (including the counselor's office!), opportunities for change through the use of new language are plentiful. With this in mind, "SFBT eschews the 'medical model' perspective and takes a nonpathological approach" (Watts & Pietrzak, 2000, p. 443).

Given the pragmatic and future-oriented focus, as well as the philosophical assumptions inherent in social constructionism and post-modernism, solution-focused therapists believe that clients can change quickly; are the experts; have strengths that can be expanded upon; should focus on solutions, not problems; should focus on the future; and in dialogue with the counselor, can create problem-free language as they move toward a new reality (O'Hanlon & Weiner-Davis, 2003). To work quickly and effectively with clients, SFBT uses a variety of techniques that can be seen through the following six stages:

STAGE 0: PRE-SESSION CHANGE   Knowing that clients are generally ready to change when they seek counseling, prior to the first session the therapist and client decide on an appointment time and the therapist asks the client to become cognizant of any changes that are made prior to their first meeting.

STAGE 1: FORMING A COLLABORATIVE RELATIONSHIP   Instead of presenting oneself as an expert at knowing a particular theory that posits why the client might respond in a certain manner, the solution-focused therapist focuses on downplaying power differentials and helping the client identify his or her own strengths and resources. Thus, the counselor builds a *trusting, collaborative,* and *equal relationship* by being an *ambassador* (showing *curiosity, respect,* and *acceptance*), being a good *listener,* using *empathy,* and being *tentative.*

STAGE 2: DESCRIBING THE PROBLEM   Although the focus of therapy is almost exclusively on solutions, it is important that when clients first enter counseling they feel heard, so many of the same skills that are used to form the collaborative relationship are initially used to listen to clients' problems. However, De Jong and Berg (2002) suggest that problems only need to be listened to for about 15 minutes before the therapist begins to use other techniques that will move clients toward focusing on preferred goals.

STAGE 3: ESTABLISHING PREFERRED GOALS   One of the first steps toward helping clients focus on *preferred goals* is to have them begin to respond to questions about what they would like to see in the future. Letting go of the problem-saturated way of viewing the world is critical for clients if they are to make progress quickly. O'Connell (2003) suggests asking the following types of questions to facilitate this movement toward preferred goals:

- How will you know that coming here has been worthwhile for you?
- What are your best hopes for this session?
- What will be the first sign for you?
- How will you know when things are getting better?
- How long do you think it will take before things get better?
- How will you know when things are getting better? (p. 7)

STAGE 4: PROBLEM-TO-SOLUTION FOCUS   To help clients increasingly focus on solutions instead of problems, a number of different types of questions are employed, including:

- *evaluative questions*, which help clients distinguish behaviors that have led to preferred goals from those that have not,
- *coping questions*, which help clients focus on past behaviors that have been successful in dealing with problems,
- *exception-seeking questions*, which help clients examine when they haven't had the problem in their lives to explore how they previously lived a problem-free life, and
- *solution-focused questions*, which are future-oriented and offer clients the opportunity to develop new, positive ways of reaching their preferred goals.

Therapists support clients' solution focus in a number of ways, including: *amplification*, which encourages clients to detail how they have used their strengths and resources so that they can increasingly employ these strategies as they work toward their preferred goals; *reframing*, which provides a different take on past behaviors in an effort to normalize and de-pathologize how clients view themselves (e.g., a client who sees him- or herself as a procrastinator, may be reframed as a person who reflects deeply before making decisions); and *complimenting*, in an effort to reinforce clients' efforts toward reaching their preferred goals.

STAGE 5: REACHING PREFERRED GOALS   By the end of the first session, clients have shifted from focusing on problems to focusing on solutions. Between their first and subsequent sessions, they work on implementing and reaching their preferred goals. Therapists help clients evaluate the effectiveness of their new solution focus by using *scaling*, which involves a rating scale to measure progress, and can tweak goals in future sessions, with the focus being on working quickly. Therapists reinforce clients by being good listeners, showing empathy, and by complimenting them on their efforts.

STAGE 6: ENDING THERAPY

> *. . . [B]rief therapy means, among other things, "as few sessions as possible and not one more than necessary."* (de Shazer as cited in Hoyt, 1996, p. 61)

Because therapy is brief, as soon as the preferred goals are reached, therapy is finished. Follow-up can be conducted to ensure that clients are continuing their solution-focused orientation. As in Stage 5, the chief techniques include listening and empathy, complimenting, and scaling.

Solution-focused brief therapy is one of the newest and most popular forms of counseling and seems to fit in well with our fast-paced world and the demands by some insurance companies to help clients quickly. Its solution-focused, constructionist and post-modern bent is in stark contrast to many of the more traditional approaches we have examined in this chapter.

Extensions, Adaptations, and Spinoffs of the Major Theories

With hundreds of approaches to counseling and psychotherapy out there (Gabbard, 1995; O'Leary, 2006; "List of psychotherapies," 2009), even if we spent the rest of our lives in therapy, we could only participate in a small number of them. But, why is it that some theories become the standard bearers while others do not? A combination of factors is probably at play. First, the standard bearers usually have some history to them—they've been used and people believe they are helpful. Second, these approaches usually have some research, or significant clinical experience, to back them up. Third, the theorists who created these theories have generally written a great deal, thus publicizing their theories. Fourth, many of the theorists were entrepreneurs in the sense that they wrote, developed institutes, initiated journals, and were out on the road giving workshops about their theories. And finally, the public seems to have a thirst for certain theories at specific times in history. For some theories, it's just the right time.

In this section of the chapter, we will look at a number of extensions, adaptations, and spinoffs of the theories already discussed. Some of these theories have had staying power and appear to have much to offer. Others are very new and riding a wave of popularity, and some are just interesting and are the newest "breakthrough" theories. The following offers only a "taste" of these approaches. As you read through them, you may find that you are drawn to one or more. If so, read about it, study it, and maybe embrace that theory as one of your main approaches to counseling and therapy. However, try to stay open to many approaches as you may find other ways of working with clients helpful in your therapeutic journey.

Let's take a look at Erikson's psychosocial theory, object–relations theory, relational and subjectivity therapy, dialectical behavior therapy, acceptance and commitment therapy, constructivist therapy, eye movement desensitization therapy, motivational interviewing, gender-aware therapy, positive psychology and wellness therapy, and complementary,

alternative, and integrative approaches (see Neukrug, 2011 for a broader description of these theories).

Erikson's Psychosocial Theory

Erikson suggested that individuals pass through *eight stages of psychosocial development* and that social forces play a bigger role in development than Freud or earlier psychoanalysts had suggested. He believed that the influence of instincts and the unconscious were not as great as many had suggested and that as individuals pass through the stages they are faced with a task that could be seen as representing opposing forces (e.g., trust vs. mistrust; autonomy vs. shame and doubt). He also believed that the development of a healthy ego is contingent on the individual's ability to master the stages and is highlighted by a particular *virtue* or *strength* that is associated with successful passage through each stage. For more on this theory, see Chapter 9.

Object–Relations Theory

The purpose of *object–relations therapy* is to resolve early traumatic experiences so the individual can build a new self-structure. In contrast to the instincts of sex and aggression driving behavior, object–relations theory stresses the importance of relationships in motivating people. Object–relation theorists talk about *good-enough mothering* and providing positive holding environments for children in the development of the self through a series of stages that tend to move from *symbiosis* to *separation of self*. These theorists also suggest that *splitting* of others (e.g., into a good and bad "other") plays an important role in the development of the self and needs to be overcome for the successful development of the ego. In object–relations therapy clients are re-parented by taking in new *objects* (the therapist), which then serve as a new blueprint for the self. Some of the better-known object–relations theorists include Melanie Klein, Margaret Mahler, and Harry Stack Sullivan.

Relational and Subjectivity Therapy

One of the more recent additions to the psychodynamic approach, *relational and subjectivity therapy* speaks to the importance of an ongoing dialogue between the client and the therapist. These therapists suggest that we have internalized images of significant, early relationships (e.g., parents), and those images impact how individuals relate. However, they also argue that personality and the patterns of understanding and relating do not develop in isolation from others but rather within the mutually influencing subjectivities of people in relationships. They highlight the *myth of the independent mind*, suggesting that it is through interactions that the "self" is formed. Those who practice this perspective develop a deep, intimate, self-disclosing relationship with their clients and give attention to transference and to carefully timed self-disclosures of the therapist's countertransference as well. Mutual sharing is geared to elicit experiencing, which can then be understood in terms of past patterns in relationships and how it affects current relationships. Some of the more well known theorists include Robert Stolorow and Daniel Stern.

Dialectical Behavior Therapy (DBT)

Developed by Marsha Linehan, DBT was designed to treat borderline personality disorders, but is now used for other disorders. Based on a *biosocial theory of personality development*, DBT assumes that some people are born with heightened emotional sensitivity. These individuals need particular acceptance, but also need to be encouraged to change. DBT therapists are accepting by demonstrating empathy, genuineness, caring, warmth, understanding, and by teaching *mindfulness*. They show commitment and realness to clients by being willing to do some self-disclosure and by being open to such things as receiving telephone contacts between sessions. Such therapist behaviors discourage self-destructive patterns and encourage new, healthier behaviors.

Acceptance and Commitment Therapy (ACT)

ACT is based on *relational frame theory*, which explains behaviors and cognitions as a complex web of relational associations. Developed by Steven Hayes and others in the late 1980s, ACT uses a mixture of cognitive techniques, behavioral techniques, and Eastern philosophy, and applies it in novel ways. The goal of ACT is to help create a rich and meaningful life while accepting the pain that inevitably goes with it, and is reached by applying six core principles of psychological flexibility: *defusion, acceptance, contact with the present moment, self as context, values,* and *committed action.* ACT can be viewed through three stages: *accepting thoughts and feelings, choosing direction,* and *taking action.*

Constructivist Therapy

Developed by Michael Mahoney, *constructivist therapy* suggests that people are continually creating and recreating their understanding of reality. Constructive therapists believe that deep underlying schemata are more difficult to change than surface structures. They suggest there is a complex and inseparable interaction between one's thoughts, feelings, and actions; we do not simply have thoughts and interpretations of the world; we are our thoughts and interpretations. Such thoughts and interpretations are constantly undergoing reconstruction as we interact with others. Using a *dialectical process* to examine the client's meaning-making system, the goal of therapy is to assist the client in understanding how he or she makes sense out of the world and to help the client create new constructions that may work better for him or her.

Eye Movement Desensitization Therapy (EMDR)

Developed by Francine Shapiro in the late 1980s, EMDR has clients focus on *rapid eye movements*, or some other *rhythmic stimulation* (e.g., tapping), while imagining a traumatic or troubling event. In addition, new, positive core beliefs are substituted for older, negative ones, and new behaviors are encouraged. EMDR suggests that past traumas become

embedded in our psyche; core beliefs maintain negative experiences; new cognitions and behaviors can help a person adopt new ways of being in the world; and there are neural pathways that store traumatic memories that can become *depotentiated* or blocked during treatment. Using these core ideas, EMDR treatment involves eight phases that sometimes can be completed within a few sessions.

Motivational Interviewing

Originally used with substance abuse, gambling, anxiety disorders, eating disorders, chronic disease management, and health-related disorders, in recent years motivational interviewing has been applied to a vast array of client issues. Motivational interviewing assumes that motivation is a key to change, is multidimensional, is dynamic and fluctuating, is influenced by social interactions, can be modified, and is influenced by the clinician's style. The main task of clinicians is to be *collaborative*, *evocative*, and *honoring of their clients*. At the same time, clinicians try to elicit and enhance motivation by adhering to four basic principles (Miller & Rollnick, 2002): (1) *expressing empathy* in an effort to build a relationship and hear the client, (2) *developing discrepancies*, to help clients hear how their behaviors and values may not always be in sync (a gambling-addicted father who values saving money for his child to go to college), (3) *rolling with resistance*, in an effort to understand the importance of the client's resistance and what purpose it serves (the gambler gets a "rush" because he or she has no meaning in life), and (4) *supporting self-efficacy* or believing and supporting that the client has the necessary skills to make change and is the final decider in the change process.

Gender-Aware Therapy

Encompassing feminist therapy and counseling men, gender-aware therapy includes the following common elements: gender is central to counseling, problems are viewed within a societal context, counselors actively address gender injustices, collaborative and equal relationships are developed, and clients choose their gender roles regardless of their political correctness. Feminist therapy has its origins in the feminist movement and recognizes the impact of gender, the oppression of women, and the influence of politics. The goal of feminist therapy is empowerment of female clients through the use of a wellness model. To help understand how to work with women, the American Psychological Association's *Guidelines for Psychological Practice with Girls and Women* (American Psychological Association, 2007) are often used. Men too have unique issues that impinge on them and affect their way of viewing the world. When working with men it is important to be accepting of the feelings men tend to be comfortable with (e.g., anger, competitiveness) and not to push men too quickly to focus on what have been called "traditionally female feelings." In addition, counselors need to know common issues related to the male experience and should have empathy for the male perspective. (See Chapter 15 for a more in-depth look at gender-aware therapy.)

Positive Psychology and Well-Being Therapy

A recent addition to the field of therapies, officially launched in 1998 by then-president of the APA Martin Seligman, positive psychology can be traced to the humanistic therapies. However, in contrast to humanistic therapies' tendency to believe in an inherent

BOX 4.12

Your Positivity Ratio

Want to determine your positivity ratio? Go to http://www.positivityratio.com/single.php and take the test.

---

good self, positive psychology suggests that humans are capable of good and bad but helps clients focus on the positive aspects of self. Recent research by Fredrickson supports this approach, as she has shown that positive emotions increase happiness and psychological growth, result in longer life, increase intuition and creativity, increase resilience to adversity, and a decrease in health problems. She suggests a positivity ratio of three-to-one of positive to negative feelings (see Box 4.12).

One positive psychology therapeutic model recently developed by Giovanni Fava, *well-being therapy*, suggests that clients be viewed through three phases along *Ryff's six dimensions of well-being*: *autonomy, personal growth, environmental mastery, purpose in life, positive relations*, and *self-acceptance*. This approach attempts to replace negative thoughts and behaviors with positive ones by identifying the problematic areas of the six dimensions and then helping the client develop positive aspects in his or her life in those areas.

Complementary, Alternative, and Integrative Approaches

Although recently gaining in popularity, the many different types of complementary, alternative, and integrative approaches are based on some of the oldest forms of healing. *Complementary medicine or therapy* includes products, systems, or practices used in conjunction with conventional methods to treat biological and mental health problems. *Alternative therapy* is when alternative approaches are used instead of conventional methods. An *integrative approach* suggests that traditional healing methods are integrated with complementary or alternative approaches. In 1998, the National Center for Complementary and Alternative Medicine (NCCAM, 2009) categorized these approaches into five main domains: *biologically based systems, manipulative and body-based approaches, mind–body medicine, alternative medical systems*, and *energy therapies*. The overall emphasis of these approaches is to focus on a client's overall wellness, such as what Myers and Sweeney (2004, 2005) describe as one's *creative self, coping self, social self, essential self*, and *physical self*.

Integrative Counseling and Psychotherapy (Eclecticism)

The idea that a helper might be able to combine varying theoretical approaches into his or her own way of working with clients is not new (Gold & Stricker, 2006; O'Leary, 2006). In fact, today, about one-fourth of mental health professionals identify themselves as using a purely *integrative approach* (Norcross, Bike, & Evans, 2009). In many ways, as most of us mature as professionals, we take on a more integrative approach as our adherence to one theoretical orientation becomes less rigid and we incorporate other ideas into our way of doing counseling and psychotherapy.

Formerly called *eclecticism*, an integrative approach is when the helper develops a core theory by integrating elements from different theories into his or her approach. Unfortunately, some counselors who think they are using an integrative approach are actually practicing a mishmash of techniques that have little or no underlying theoretical basis. This type of a theoretical eclecticism is counterintuitive and is considered by many to be "shooting-from-the-hip" therapy. Integration of this kind is not based on systematic research and is detrimental to the goals of our profession and, more important, to the successful treatment of clients. Effective helpers, on the other hand, know that an integrative approach involves a deliberate effort to integrate techniques into the helper's repertoire. Although different models attempt to explain this process (cf. Brooks-Harris, 2008; O'Leary & Murphy, 2006; Stricker & Gold, 2006; O'Leary, 2006), most of these models address some common elements that lead me to view an integrative approach as a developmental process that moves from *chaos*, to *coalescence*, to *multiplicity*, and ends with a *commitment to a metatheory*.

Stage 1: Chaos. This initial stage of developing an eclectic approach is based on a limited knowledge of theory and involves moment-to-moment subjective judgments of the helper. Often practiced while students are still in training programs, this approach is the helper's first attempt to pull together different theoretical orientations, and if used with clients, is likely to be of limited help.

Stage 2: Coalescence. As theory is learned, most helpers begin to drift toward adherence to one approach. Although they mostly ascribe to one theory, they are beginning to use some techniques from other approaches when they believe it would be helpful to clients.

Stage 3: Multiplicity. During this stage, helpers have thoroughly learned one theory and are beginning to gain a solid knowledge of one or more other theories. They are also now beginning to realize that any of the theories may be equally effective for many clients. This knowledge presents a dilemma for the counselor (Spruill & Benshoff, 2000): "What theoretical perspective should I adhere to, and how might I combine, or use at different times, two or more theoretical perspectives so that I could offer the most effective treatment?" Ultimately, this helper is able to feel facile with different approaches and is sometimes willing to integrate other approaches into his or her main approach.

Stage 4: Metatheory. At this point, the helper has become a master therapist and has settled into a theoretical orientation based on his or her work with clients and the gathering of knowledge about theories over the years. This master therapist has a *metatheory* that drives what he or she does. This metatheory is a thought-through approach that defines the theoretical nature of the therapist's work (e.g., psychodynamic, humanistic, cognitive–behavioral, post-modern, systems, etc.), and usually incorporates a number of different elements from many theories into the helper's way of doing counseling and therapy. However, the elements chosen from other approaches have a "flavor" that reflects the helper's unique style of helping. For instance, the "humanist" will use behavioral techniques but use them from the framework of the humanistic perspective.

The ability to assimilate techniques from varying theoretical perspectives takes knowledge, time, and finesse. If you are just beginning your journey as a counselor, you should expect eventually to pass through these four stages as you begin to sort through the various theoretical approaches and develop your own unique style of counseling.

▨ *Multicultural/Social Justice Focus: Bias in Counseling Approaches*

Almost every predominant theory of counseling and psychotherapy has been developed by White men. Now, not every White male is prejudiced, but they do tend to carry with them values based on their heritage. And with their heritages being, for the most part, from a Western European framework, it is not surprising that many of the approaches stress Western values. Some of the values that are embraced by many of these approaches include the following (Hansen, 2008; Ivey, D'Andrea, Ivey, & Simek-Morgan, 2002; Kim, 2004; Sue & Sue, 2003).

1. The importance of individualism and being able to work things out on one's own.
2. It is healthier to express feelings than not express them.
3. One must search within "self" to discover the truth of one's existence.
4. If one works hard enough, he or she will meet with success when working on problems.
5. Mind–body dualism, or the sense that there is a separation of our thinking selves and our physical selves.
6. Truth can be found, or uncovered, through scientific inquiry.
7. Facts can be found, values are opinions.
8. External factors are of little impact on internal psychological states.

For some clients, the above values work. These clients want to search within self, get in touch with their feelings, uncover the "truth," and work hard, on their own, to feel better. Other clients do not hold the above values and may be labeled by some therapists as resistant, defensive, or lacking in insight. These are the clients who view expression of feelings as a weakness. And, they are the clients who defer to family or community for answers to life's questions. These are the clients who find it strange to think of the mind and body as separate. And, these are the clients who feel comfortable in the mystical, nonscientific world, believing that answers don't always come from empirical evidence. These are the clients who believe fate is in God's hands, and these are the clients who believe that prejudice and racism are the reasons for their hardships. Who are these clients? Mostly, they are minority clients, the immigrant, and the American with roots outside the dominant culture, for they have not historically experienced life in the United States in the same way as those in the dominant culture, they might not share the same values as the majority culture, and they have not, for the most part, had the same privileges as most White Americans.

So, imagine a world where symbols often reflect male phalluses, and if you don't see them, you're hiding from your feelings of inadequacy (e.g., psychoanalysis). Or, imagine a world where you're told you're your defensiveness is your conscious and unconscious minds struggling with one another (psychodynamic theories). Imagine a world where you were marginalized for not crying after the death of a loved one (Gestalt therapy and some other humanistic approaches), or a world where you were made to feel as if you were acting irrationally because you spoke out loud to God to find the answers to your life's questions (REBT). Imagine a world where you were told that you alone control your own fate (existential therapy). Or, imagine a world where you were given the message that every negative feeling you have you *chose* and that only you can choose to act and feel

differently (reality therapy). And, imagine a world where you were told that you're thinking irrationally or distorting reality and you can adopt a more rational or sane way of living (REBT and cognitive therapy). Well, many clients have been subtly, and sometimes not so subtly, given these messages. If you're a client from a nondominant group, you're more likely to feel at odds with many of the above assumptions. This means you are more likely to be labeled as defensive, be misdiagnosed, drop out of therapy, and find counseling less helpful than clients from the dominant culture. These are the clients that don't follow the Western values that many hold as "truth."

Finally, we must acknowledge that these days, every approach to counseling and psychotherapy has heard the call of bias. Let's at least give them credit for trying to respond to the bias that is inherent in many of their approaches.

Ethical, Professional, and Legal Issues

Regardless of your theoretical orientation, a number of ethical issues arise in reference to the counseling relationship. Although we cannot touch on all of these issues, we will highlight a few of the more common ones that are addressed in Section A: The Counseling Relationship, and Section B: Confidentiality, Privileged Communication, and Privacy, of ACA's ethical code (2005). However, it cannot be stressed enough that the following is only a synopsis of aspects of Sections A and B and judgments concerning client situations should only be made after fully reading the code (see http://www.counseling.org/Resources/; then click "Ethics").

Section A.1: Welfare of Those Served by Counselors

One of the primary elements of the counseling relationship is respecting the dignity and promoting the welfare of the client. This is done in many ways but includes maintaining accurate and professional records, developing counseling plans that are likely to succeed and are reviewed regularly by clients, incorporating client support networks (e.g., family, community members) when helpful, and assisting in employment and career development needs.

Section A.2: Informed Consent in the Counseling Relationship

Clients choose whether they wish to be in or remain in a counseling relationship and should be informed verbally and in writing about all procedures throughout the relationship, including: "the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information" (ACA, 2005, Section a.2.b). Clients should also know about the impact of diagnosis, testing, reports, and fees, and the limits of confidentiality, and should be sensitive to possible cross-cultural misunderstanding when discussing informed consent and confidentiality. Clients who do not have the legal or mental capacity to give informed consent should be included, whenever reasonable and possible, in the informed consent process.

Section A3: When Clients Are Served by Others

Clients should be asked if they would allow the counselor to contact other mental health professionals that the client is seeing when such contact will foster a healthy and collaborative relationship.

Section A4: Avoiding Harm and Imposing Values

Counselors act in a manner that will not harm their clients, are aware of how their cultural biases, beliefs, attitudes, and behaviors affect clients, and try not to impose their values on clients.

Section A5: Roles and Relationships with Clients (including sexual relationships)

Sexual or romantic relationships with clients, the romantic partners of clients, or family members of clients are prohibited for five years following a professional relationship with a client. After five years, the counselor must consider how such a relationship could still be harmful or exploitive and document such a potential relationship and its potential harm in writing. Counselors should avoid non-professional relationships with clients and friends and family members of clients except when such a contact could be beneficial (e.g., attending a graduation of a high school student who is your client). When counselors change roles with clients, clients have a right to deny services based on that change (e.g., from individual to family counseling; from assessment to individual counseling).

Section A6: Roles and Relationships at Individual, Group, Institutional, and Societal Levels

If a client gives the counselor consent, the counselor can advocate for removing barriers and obstacles to client growth with other individuals, with groups, with institutions, and at the societal level.

Section A7: Multiple Clients

Counselors will sometimes work with more than one individual at a time (e.g., conflict between a couple) and it is important to clarify the nature of the relationship, who is obtaining counseling services, and to adjust for changes in the counseling relationship (individual counseling yields to one session that includes a partner, yields to couples counseling).

Section A9: End-of-Life Care for Terminally Ill Clients

Counselors can choose to work (or not work) with clients facing end-of-life decisions. If clients choose to hasten their death, counselors must consider the laws and circumstances and seek supervision before deciding whether or not to break confidentiality.

Section B1: Respecting Client Rights (including foreseeable harm and life-threatening diseases)

Counselors should understand confidentiality and privacy within the cultural context of the client. They should always respect the client's right to privacy and

BOX 4.13

The Tarasoff Case and Foreseeable Harm (Duty to Warn)

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 Mr. Poddar further, the campus police released him. Two months later, he killed his girlfriend, Tatiana Tarasoff. Ms. 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.

confidentiality. When initiating counseling, counselors should inform clients of any times when confidentiality would have to be breached (see Box 4.13). In general, counselors do not break confidentiality unless there is foreseeable harm to the client or to others or when there are legal requirements to do so (e.g., mandated child abuse reporters). Counselors and clients should be aware that in cases of contagious, life-threatening diseases, counselors may be required and justified in breaking confidentiality.

The Counselor in Process: Embracing a Theory but Open to Change

For a few years after obtaining my master's degree, I remember dogmatically adhering to an existential–humanistic approach in my counseling style. I staunchly argued against a psychodynamic approach, even though I had minimal knowledge about this orientation. Although I was barely aware of it at that time, the views I had were at least partly based on some of my own unfinished issues.

As I have grown older, I have acquired a deep appreciation for all counseling approaches. I believe each of them offers us something. No doubt, as you have read through the various theories, you have identified more with some than others. Probably this is due to some personal style and perhaps some unfinished business of your own. Although I encourage you to practice and learn more about the theory or theories with which you feel an affinity, I also strongly suggest that you not stubbornly adhere to only one approach; I hope that you gain some knowledge from all theories. As your professional life as a counselor proceeds, and as you read new research about differing theories, I hope that you remain open to changing your theoretical views and adapting your theory accordingly (see Spruill & Benshoff, 2000). Those who are closed to this ongoing process are stuck in one view of the helping relationship, and this rigidity is likely to hinder client growth.

Perhaps we can learn something from Hoyt (1994), who suggests that counselors, like clients undergoing solution-focused therapy, might want to answer the following "miracle" question:

> *Suppose tonight, while you're sleeping, a miracle occurs . . . and when you awaken you find you are helping clients in a more positive and effective way than before! How will you notice your practice has changed? What new skills will you be using?* (p. 8)

◼ *Summary*

This chapter focused on a number of major theories of counseling and psychotherapy. We began by explaining the concept of paradigm shifts and we reviewed how familiarity with past knowledge is crucial for an understanding of current knowledge. Relating this concept to counseling theories, we realized that such theories are our best current conception of what is effective in the counseling and psychotherapy process. We noted that by their very nature, theories are heuristic, or researchable and testable, and can be modified over time. We also discussed the intimate relationship between one's view of human nature and the theory to which it adheres. We encouraged you to examine your view of human nature.

As the chapter continued, we offered a quick overview of twelve theories that encompassed four conceptual orientations. In the psychodynamic arena, we examined psychoanalysis, analytical therapy, and individual therapy. From the existential–humanistic perspective we explored existential therapy, gestalt therapy, and person-centered counseling. The cognitive–behavioral focus had us review behavior therapy, rational emotive behavior therapy, cognitive therapy, and reality therapy, and the post-modern perspective highlighted narrative therapy and solution-focused brief therapy. We then offered a very brief look at a number of extensions, adaptations, and spinoffs of these approaches including Erikson's psychosocial theory, object–relations theory, relational and subjectivity therapy, dialectical behavior therapy, acceptance and commitment therapy, constructivist therapy, eye movement desensitization therapy, motivational interviewing, gender-aware therapy, positive psychology and wellness therapy, and complementary, alternative, and integrative approaches.

The chapter next explored a recent trend in counseling and psychotherapy: the adaptation by many counselors of an integrative approach to therapy (eclecticism). We noted that an integrative approach tends to progress in complexity from chaos to coalescence to multiplicity and to metatheory as counselors learn more about different theories and become more willing to integrate other ideas into their existing ways of practicing counseling.

We examined in this chapter how most of the counseling theories used today have been developed from a European perspective that stresses a number of Western values such as individualism, expression of feeling, searching for "self" within, hard work will meet with success, mind–body dualism, truth through scientific inquiry, facts are findable whereas values are opinions, and the notion that external factors have little impact on internal psychological states. We pointed out that the counseling theories examined in this chapter were developed largely by White men from Western heritages and suggested that counselors may need to be particularly vigilant in assuring that they can adapt their

approaches to nondominant clients. We noted that many of the approaches have tried to make some adaptations as a result of these value differences.

The chapter neared its conclusion by reviewing a number of ethical issues related to the counseling relationship from parts of Standards A and B of the ACA ethics code. These included: Section A.1: Welfare of Those Served by Counselors, Section A3: When Clients Are Served by Others, Section A4: Avoiding Harm and Imposing Values, Section A5: Roles and Relationships with Clients (including sexual relationships), Section A6: Roles and Relationships at Individual, Group, Institutional, and Societal Levels, Section A7: Multiple Clients, Section A9: End-of-Life Care for Terminally Ill Clients, and Section B1: Respecting Client Rights (including foreseeable harm and life-threatening diseases). We highlighted the Tarasoff case as an important legal decision regarding foreseeable harm. Finally, the chapter discussed the importance of being open to different theoretical approaches throughout one's career.

References

Alberto, P. & Troutman, A. C. (2006). *Applied behavior analysis for teachers* (7th ed.). Upper Saddle River, NJ: Merrill Prentice Hall.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://wwwcounselingorg/Resources/CodeOfEthics/TP/Home/CT2aspx

American Psychological Association. (2007). *Guidelines for psychological practice with girls and women*. Washington, D.C.: Author.

Ansbacher, H. L. (1964). The increasing recognition of Adler. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 3–19). Evanston, IL: Northwestern University Press.

Ansbacher, H. L., & Ansbacher, R. R. (Eds.). (1956). *The individual psychology of Alfred Adler: A systematic presentation in selections from his writings*. New York: Basic Books.

Aviv, R. (2005, August 19). The interpretation of reams: Talking with Albert Ellis, world-renowned anti-Freud therapist. *The Village Voice*. Retrieved from http://www.villagevoice.com/people/0534,interview,67068,24.html

Bandura, A. T. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. T., Ross, D., & Ross, S. A. (1963). Imitation of film-mediated aggressive models. *Journal of Abnormal and Social Psychology, 67*, 3–11. doi:10.1037/h0048687

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper and Row. Republished as Depression: Causes and treatment, Philadelphia: University of Pennsylvania Press, 1972.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A. T. (1991). Cognitive therapy: A 30-year retrospective. *American Psychologist, 46*(4), 368–375. doi:10.1037/0003-066X.46.4.368

Beck, A. T. (1999). *Prisoners of hate: The cognitive basis of anger, hostility, and violence*. New York: HarperCollins.

Beck, A. T. (2005). The current state of cognitive therapy: A 40-year retrospective. *Archives of General Psychiatry, 62*, 953–959. doi:10.1001/archpsyc.62.9.953

Beck, J. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Beck, J. (2005). *Cognitive therapy for challenging problems*. New York: Guilford Press.

Bidwell, D. R. (2007). Miraculous knowing: Epistemology and solution-focused therapy. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 65–87). New York: The Haworth Press.

Brickell, J. (2007, February). Reality therapy: Helping people take more effective control of their lives. *Counseling at Work*, 6–9.

Brooks-Harris, J. E. (2008). *Integrative multitheoretical psychotherapy*. Boston: Houghton Mifflin.

Bugental, J. F. T. (1976). *The search for existential identity: Patient–therapist dialogues in humanistic psychotherapy*. San Francisco: Jossey-Bass.

Cade, B. (2005). *Obituary: Steve de Shazer: 1940–2005*. Retrieved from http://www.ebta.nu/page28/page32/page32.html

Cain, D. J. (2002). Defining characteristics, history, and evolution of humanistic psychotherapies. In D. J. Cain (Ed.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 3–54). Washington, DC: American Psychological Association.

Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice*. Washington, D.C.: American Psychological Association.

De Jong, P. & Berg, I. K. (2002). *Interviewing for solutions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: W. W. Norton & Company.

de Shazer, S., & Dolan, Y. V. (2007). *More than miracles: The state of the art of solution-focused therapy*. Binghamton, NY: Haworth Press.

Dinkmeyer, D., & Dreikurs, R. (1963). *Encouraging children to learn: The encouragement process*. Englewood Cliffs, NJ: Prentice Hall.

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.

Ellis, A., & Maclaren, C. (2005). *Rational emotive behavior therapy: A therapist's guide* (2nd ed.). Atascadero, CA: Impact publishers.

Frankl, V. E. (1968). *Psychotherapy and existentialism*. New York: Simon & Schuster.

Frankl, V. E. (2004). *The doctor and the soul: From psychotherapy to logotherapy*. London: Souvenir. (Original work published 1946)

Frankl, V.E. (2006). *Man's search for meaning*. Boston: Beacon Press. (Original work published 1946)

Freud, A. (1966). *The ego and the mechanisms of defense*. New York: International Universities Press. (Original work published 1936)

Freud, S. (1961). *Beyond the pleasure principle*. (J. Strachey, Trans.). New York: W. W. Norton. (Original work published 1920)

Freud, S. (1976a). *The interpretation of dreams*. (J. Strachey, Trans.). New York: Penguin Books. (Original work published 1899)

Freud, S. (1976b). *Jokes and their relation to the unconscious*. (J. Strachey, Trans.). New York: Penguin Books. (Original work published 1905)

Freud, S., & Breuer, J. (1974). *Sudies in hysteria*. (J. Strachey, Trans.). New York: Penguin Books. (Original work published 1895)

Fernando, D. M. (2007). Existential theory and solution-focused strategies: Integration and application. *Journal of Mental Health Counseling, 29*(3), 226–241.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W. W. Norton and Company.

Gabbard, G. O. (1995). Are all psychotherapies equally effective? *The Menninger Letter, 3*(1), 1–2.

Gingerich. W. (2006). Obituary: Steve de Shazer. *Research on Social Work Practice, 16,* 549–550. doi:10.1177/1049731506289129

Glasser, W. (1960). *Mental health or mental illness: Psychiatry for practical action*. New York: Harper & Row.

Glasser, W. (1965). *Reality Therapy: A new approach to psychiatry*. New York: Harper & Row.

Glasser, W. (1998). *Choice theory: A new psychology of personal freedom*. New York: HarperCollins.

Glasser, W. (2001). *Counseling with choice theory: The new reality therapy*. New York: HarperCollins.

Glasser, W., & Glasser, C. (1999). *The language of choice theory*. New York: HarperCollins.

Gold, J., & Stricker, G. (2006). Introduction: An overview of psychotherapy integration. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 3–16). Washington, D.C.: American Psychological Association.

Guterman, J. T. (2006). *Solution-focused counseling*. Alexandria, VA: American Counseling Association.

Hansen, J. T. (2008). Neopragmatic thought and counseling values: Reconsidering the role of values in counseling from an alternative epistemological foundation. *Counseling and Values, 53(2)*, 100–112.

Hart, J., Corriere, R., & Binder, J. (1975). *Going sane: An introduction to feeling therapy*. New York: Jason Aronson.

Hoffman, E. (1994). *The drive for self: Alfred Adler and the founding of individual psychology*. New York: Addison-Wesley.

Hoyt, M. F. (1994). *Introduction: Competency-based future-oriented therapy*. In M. F. Hoyt (Ed.). *Constructive therapies* (pp. 1–11). New York: Guilford Press.

Hoyt, M. F. (1996) Solution building and language games: A conversation with Steve de Shazer. In M. F. Hoyt (Ed.), *Constructive therapies* (Vol. 2, pp. 60–86). New York: Guilford Press.

Ivey, A. E., D'Andrea, M. D., Ivey, M. B., & Simek-Morgan, L. (2002). *Counseling and psychotherapy: A multicultural perspective* (5th ed.). Boston: Allyn & Bacon.

Jones, J., & Wilson, W. (2006). An incomplete education (3rd ed.). New York: Ballantine Books.

Jung, C. G. (1968). *Analytical psychology, Its theory and practice: The Tavistock lectures*. New York: Pantheon Books. (Original work published 1935)

Jung, C. G. (1975). *Critique of psychoanalysis* (R. F. C. Hull, Trans.) Princeton, NJ: Princeton University Press. (Original work published 1929)

Kemeny, J. (1970, producer). *The hidden nature of man*. Columbus, OH: Learning Corporation of America.

Kim, B. S. K. (2004). Treatment issues with Asian American clients. In D. R. Atkinson, *Counseling American minorities* (6th ed., pp. 258–278). New York: McGraw-Hill.

Kirschenbaum, H. (2009). *The life and work of Carl Rogers*. Alexandria, VA: American Counseling Association.

Kirschenbaum, H., & Henderson, V. L. (Eds.). (1989). *The Carl Rogers reader*. Boston: Houghton Mifflin.

Leahy, R. L. (2003). *Cognitive therapy techniques: A practitioner's guide*. New York: Guilford Publications.

List of psychotherapies. (2010). *The Wikipedia free encyclopedia*. Retrieved from http://en.wikipedia.org/wiki/List_of_psychotherapies

Maslow, A. H. (1968). *Toward a psychology of being*. Princeton, NJ: D. Van Nostrand.

Maslow, A. (1970). *Motivation and personality* (rev. ed.). New York: Harper & Row.

May, R., Angel, E., & Ellenberg, H. F. (Eds.). (1958). *Existence: A new dimension in psychiatry and psychology*. New York: Basic Books.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Mosak, H. H., & Maniacci, M. P. (1999). *A primer of Adlerian psychology: The analyticbehavioral–cognitive psychology of Alfred Adler*. Philadelphia: Brunner/Mazel.

Myers, J. E., & Sweeney, T. J. (2004). *Counselors for wellness: Theory, research, and practice*. Alexandria, VA: American Counseling Association.

Myers, J. E., & Sweeney, T. J. (2005). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 61*(3), 269–278.

National Center for Complementary and Alternative Medicine (2009). *About NCCAM*. Retrieved from http://nccam.nih.gov/about/

Neukrug, E. (2011). *Counseling theory and practice*. Belmont, CA: Brooks/Cole.

Neukrug, E., & Fawcett, R. (2010). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Neukrug, E., & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional counseling.* Pacific Grove, CA: Brooks/Cole.

Nicholi, A. M. (2002). *The question of God: C.S. Lewis and Sigmund Freud debate God, love, sex, and the meaning of life.* New York: Free Press.

Norcross, J. C., Bike, H., & Evans, K. L. (2009). The therapist's therapist: A replication and extension 20 years later. *Psychotherapy Theory, Research, Practice, Training, 46*(1), 32–41.

Nye, R. D. (1992). *The legacy of B. F. Skinner: Concepts and perspectives, controversies and misunderstandings.* Pacific Grove, CA: Brooks/Cole.

Nye, R. D. (2000). *Three psychologies: Perspectives from Freud, Skinner, and Rogers* (6th ed.). Belmont, CA: Brooks/Cole.

Oberst, U. E., & Stewart, A. E. (2003). *Adlerian psychotherapy: An advanced approach to individual psychology.* New York: Brunner-Routledge.

O'Connell, B. (2003). Introduction to the solution-focused approach. In B. O'Connell, & S. Palmer (Eds.), *Handbook of solution-focused therapy* (pp. 1–11). Thousand Oaks, CA: Sage.

O'Hanlon, B., & Weiner-Davis, M. (2003). *In search of solutions: A new direction in psychotherapy* (rev. ed.). New York: Norton.

O'Leary, E. (2006). The need for integration. In E. O'Leary & M. Murphy (Eds.), *New approaches to integration in psychotherapy* (pp. 3–12). New York: Routledge.

O'Leary, E., & Murphy, M. (2006). *New approaches to integration in psychotherapy.* New York: Routledge.

Perls, F. (1970). Four lectures. In J. Fagan & I. L. Shepherd (Eds.), *Gestalt therapy now* (pp. 14–46). New York: Harper & Row.

Perls, F. (1973). *The gestalt approach and eyewitness to therapy.* Palo Alto: Science and Behavior Books.

Perls, F. (1978). Finding self through Gestalt therapy. *Gestalt Journal, 1*(1), 54–73.

Perls, F, Hefferline, R., & Goodman, P. (1951). *Gestalt therapy: Excitement and growth in human personality.* New York: Julian Press.

Polster, E., & Polster, M. (1973). *Gestalt therapy integrated: Contours of theory and practice.* New York: Brunner/Mazel.

Riding the . . . (2006). Riding the underground railroad: Insoo Kim Berg talks about the origins and future of the solution focused approach. *Solution News, 2*(3), 3 – 6. Retrieved from http://www.solution-news.co.uk/issues/solutionnews2(3).pdf

Rogers, C. R. (1942). *Counseling and psychotherapy: New concepts in practice.* Boston: Houghton Mifflin.

Rogers, C.R. (1951). *Client-centered therapy: Its current practice, implications and theory.* Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103. doi:10.1037/h0045357

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science, Vol. 3, Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.

Rogers, C. R. (1980). *A way of being.* Boston: Houghton Mifflin.

Rosaldo, R. (1993). *Culture and truth: The remaking of social analysis.* Boston: Beacon Press.

Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis.* New York: Appleton-Century.

Skinner, B. F. (1971). *Beyond freedom and dignity.* New York, Knopf.

Spruill, D. A., & Benshoff, J. M. (2000). Developing a personal theory of counseling: A theory building model for counselor trainees. *Counselor Education and Supervision, 40*, 70–80.

Stein, H. T. (2007). *Adler's legacy: Past, present, and future.* Retrieved from http://home.att.net/~Adlerian/adlers-legacy.htm

Stricker, G., & Gold, J. (2006). *A casebook of psychotherapy integration*. Washington, D.C.: American Psychological Association.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally different: Theory and practice* (4th ed.). New York: Wiley.

Sweeney, T. (1998). *Adlerian counseling: A practitioner's approach* (4th ed.). Philadelphia: Accelerated Development.

The top 10: The most influential therapists of the past quarter-century (2007, March/April). *Psychotherapy Networker*. Retrieved from http://www.psychotherapynetworker.org/component/content/article/81-2007-marchapril/219-the-top-10?q=influential

Wampold, B. E. (2010a). *The basics of psychotherapy: An introduction to theory and practice*. Washington, DC: American Psychological Association.

Wampold, B. E. (2010b). *The great psychotherapy debate: Models, methods, and findings* (2nd ed.). Florence, KY: Taylor & Francis.

Watson, J. B. (1925). *Behaviorism*. Chicago: University of Chicago Press.

Watson, J. B., & Raynor, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology, 3*, 1–14. doi:10.1037/h0069608

Watts, R. E., & Holden, J. M. (1994). Why continue to use "fictional finalism?" *Individual Psychology, 50*, 161–163.

Watts, R. E., & Pietrzak, D. (2000). Adlerian "encouragement" and the therapeutic process of solution-focused brief therapy. *Journal of Counseling and Development, 78*, 442–447.

Weishaar, M. E. (1993). *Aaron T. Beck*. Thousand Oaks, CA: Sage Publications.

Wolfgang, C. H. (2001). *Solving discipline and classroom management problems: Methods and models for today's teachers* (5th ed.). New York: John Wiley & Sons.

White, M. (1993). *Narrative therapy using a reflective team* [video]. Alexandria, VA: American Counseling Association.

White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wolfgang, C. H. (2001). *Solving discipline and classroom management problems: Methods and models for today's teachers* (5th ed.). New York: John Wiley & Sons.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

Wolpe, J., & Lazarus, A. A. (1966). *Behavior therapy techniques: A guide to the treatment of neuroses*. New York: Pergamon Press.

Wubbolding, R. (2000). *Reality therapy for the 21st century*. Philadelphia, Pa: Brunner-Routledge.

Wubbolding, R. (2010). *Reality therapy: Monograph psychotherapy series*. Washington, DC: American Psychological Association. (In Press).

Wubbolding, R., & Brickell, J. (1999). *Counseling with reality therapy*. Oxon, United Kingdom.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Yonteff, G. M. (1976). Theory of Gestalt therapy. In C. Hatcher & P. Himelstein (Eds.). *The handbook of Gestalt therapy* (pp. 213–221). New York: Jason Aronson.

Counseling Skills

*T*he first time I counseled was at a drug crisis clinic in college. I had no training, but somehow I instinctively knew that it was probably best to listen and have a caring attitude. I had never had a course in counseling theories or counseling methods. I knew little about the correct way to respond to a drop-in at the center. Looking back, I hope that I did more good than harm as I tried to help students who had overdosed or were "bumming."

In graduate school, I learned the way to counsel. I became an ardent existential–humanist and believed that it was best to help people express their feelings. After obtaining a job at a crisis center, I began to practice my skills on my unsuspecting clients. Although my counseling approach had become somewhat focused, my old untrained self, which sometimes would get very advice oriented, periodically raised its ugly head.

Over the years, I have had numerous jobs, obtained my doctorate, attended continuing education workshops, and read the professional journals. Experience, education, and reading have all helped me fine-tune my skills. Although there are some whom I believe to be natural counselors, I have come to suspect that one is not born with an ability to counsel, but must learn, as I have, how to apply counseling skills. In fact, even those with natural ability need training to become masters at what they do. Much like riding a bicycle or learning how to use a skateboard for the first time, learning counseling skills at first feels awkward. However, you will find that the more you practice, the more natural and at ease you will feel. In my own life, I now approach the learning and refinement of my skills as a never-ending process.

To help you move from being a natural but untrained helper to becoming a professional counselor, this chapter will examine the importance of the counseling environment and some of the techniques that have been shown to be effective in working with clients. We will also explore one model of client case conceptualization, which is a method of organizing one's thinking around working on client problems. In addition, we will identify six stages of counseling and review how the case conceptualization process can be understood in relationship to these stages. The chapter will also present important issues related to record keeping and the writing of case notes.

The Counseling Environment

> *. . . alliance formation, as understood by clients, actually begins before the counselor fully engages the client, as clients may develop predispositions or impressions on the basis of the counselor's attire, the counselor's nonverbal gestures, the counselor's greeting the office environment, and the reception staff . . .* (Bedi, 2006, p. 33)

A client who walks into a counselor's office immediately encounters the world of the counselor as reflected in his or her work environment. Soon, this client will be asked to look at his or her inner world. Although we have no control over the defensiveness the client brings to the session, through a careful assessment of the *counseling environment* we can reduce or eliminate any external irritation that could potentially increase defensiveness. Thus, that first experience of the counselor's environment is crucial to building an effective counseling relationship.

What creates the counseling environment? Three components are particularly important: the office itself, the use of nonverbal behaviors, and how the counselor presents him- or herself to the client. Let's take a look at how each of these factors plays an important role in the success or failure of the counseling relationship.

The Office

Whether in an agency, business, or school, the practice of counseling requires that one has a place to go to establish a relationship. Almost always, this will be one's office. The counseling relationship requires the quiet, comfort, safety, and confidentiality that *the office* provides. Although counselors sometimes have to build the helping relationship outside of the office (e.g., school counselors; counselors who work with clients uncomfortable in a traditional office), an office can be key to deepening the relationship. This is partly because a successful counseling relationship requires the quiet, comfort, safety, and confidentiality that the office provides.

The arrangement of one's office can be crucial to eliciting positive attitudes from people and to building the therapeutic alliance (Bedi, 2006; Pressly & Heesacker, 2001). How should the office be arranged? There is little question that it should be soundproofed, have soft lighting, be relatively uncluttered, have client records stored appropriately, be free from distractions such as the phone ringing or people knocking on the door, and have comfortable seating. As we create our offices, each of us will try to find a balance between having it reflect our taste and making sure that it is appealing to the vast majority of our clients (see Box 5.1).

No matter how you arrange your office, there will be some people who are offended by something. Thus, it is probably best if one tries to arrange one's office in a manner that is likely to offend the fewest people. Of course, it may be that you will want to attract a certain clientele who would feel comfortable with a particular ambiance. For instance, a Christian counselor might include articles of a religious nature in his or her office, while a person dealing with mostly gay, lesbian, and bisexual issues might include related literature in his or her office.

How one dresses and the language one uses with clients are two additional components of the office environment. Should you wear jeans at work? What about an expensive suit? Are your clothes revealing? What does your jewelry or hairstyle say about you? Do you call your client by his or her first name? Should you change the way you talk for the client, such as using less complex language for a client who is less educated?

BOX 5.1

What Should Your Office Look Like?

Review the items below and reflect on whether or not you think any of them would be offensive to you if you walked into a counseling office. Then think about the most liberal and the most conservative person you know and imagine how he or she might feel about each of the following:

- Feminist literature
- A bear rug
- Gay literature
- A cluttered desk

- Information on abortion
- A leather chair
- Fundamentalist religious literature
- A compulsively clean desk
- An AIDS pin
- A desk between you and your client
- Information on female and male sexuality
- A brochure supporting a politician

Ultimately, each counselor must determine the importance of these factors and how he or she will be addressed.

Nonverbal Behavior

Many studies of interaction document that nonverbal gestures—body positioning, body countenance, facial expressions, hand movements, and the like—are as important to effective cooperation as spoken words. . . . (Turner, 1997, p. 211)

The importance of our nonverbal interactions with clients is vastly underrated. In fact, *nonverbal behavior* is involved in an ongoing, elaborate interaction with verbal behavior that leads people to send and interpret "complex emotional messages" (Planalp & Knie, 2002, p. 63). With conservative estimates indicating that more than twice the amount of communication occurs nonverbally than verbally (Guerrero & Floyd, 2006), the implications for counselors are great, as they must be able to accurately read messages from clients and be clear about the messages they are sending.

A number of nonverbal behaviors can affect our relationship with our clients. For instance, *posture*, *eye contact*, or *tone of voice* that communicates, "Don't open up to me," will obviously affect clients differently from the counselor who is nonverbally communicating, "I'm open to hearing what you have to say."

Personal space is an additional nonverbal factor that affects the counseling relationship (Guerrero & Floyd, 2006; Zur, 2007). Mediated at least somewhat by culture, age, and gender, individuals vary greatly in their degree of comfort with personal space. Therefore, the counselor must allow for enough personal space so that the client feels comfortable, yet not so much that the client feels distant from the counselor. When necessary, the counselor should take the lead in respecting the client's need for personal space.

Touch is a final aspect of nonverbal behavior important to the counseling relationship (Ferch, 2000; Zur, 2007). Touching at important moments is quite natural. For instance, when someone is expressing deep pain, it is not unusual for us to hold a hand or embrace a person while he or she sobs. Or, when a person is coming to or leaving a

session, one might find it natural to place a hand on a shoulder or give a hug. However, in today's litigious society, touch has become a particularly delicate subject, and it is important for each of us to be sensitive to our clients' boundaries, our own boundaries, and limits as suggested by our professional ethics.

Some have become so touchy over this issue that a therapist in Massachusetts, branded "the hugging therapist," was fired from his job at a mental health agency because he hugged his clients too much. Brammer and MacDonald (2003) suggest that whether or not one has physical contact with a client should be based on (1) the helper's assessment of the needs of the helpee, (2) the helper's awareness of his or her own needs, (3) what is most likely to be helpful within the counseling relationship, and (4) risks that may be involved as a function of agency policy, customs, personal ethics, and the law.

Traditionally, counselors have been taught to lean forward, have good eye contact, speak in a voice that meets the client's affect, and rarely touch the client. However, even though many nonverbal behaviors appear to be universal, culture can mediate the expression of nonverbal behaviors (Matsumoto, 2006; Pease & Pease, 2006). Therefore, it is now suggested that counselors be acutely sensitive to client responses to nonverbal behaviors. Counselors must understand that some clients will expect to be looked at, while others will be offended by eye contact; that some clients will expect you to lean forward, while others will experience this as an intrusion; and that some clients will expect you to touch them, while others will see this as offensive. With respect to nonverbal behavior, effective counselors keep in mind what works for the many while remaining sensitive to what works for the few.

Counselor Qualities to Embrace/Counselor Qualities to Avoid

How we bring ourselves into the counseling relationship can have a positive or negative effect on the outcome of counseling, and the qualities highlighted in Chapter 1 are crucial to the establishment of an effective counseling relationship. As a quick reminder, they include the six factors related to building an effective working alliance (empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence, the "it" factor) and the three factors related to effectively delivering your theoretical approach (ability with and belief in your theory, competence, and cognitive complexity). The counselor who continually makes empathic failures is not hearing the client. The counselor who seems false, judgmental, and closed-minded will create an atmosphere of defensiveness during the session. The counselor who struggles with his or her own issues will attend poorly to the client, and the counselor who cannot understand cultural differences will have difficulty relating to his or her client. The counselor who is not cognitively complex will view the client's situation in a limited way, and the counselor who lacks the knowledge of and commitment to a theory will proceed awkwardly with his or her clients.

Not only must the counselor be able to demonstrate the personal characteristics that will nurture a healthy counseling relationship, but also he or she must avoid attitudes and behaviors that will foster a destructive relationship. The many common attitudes that would be detrimental to a counseling relationship and need little explanation include such attitudes as being critical, disapproving, disbelieving, scolding, threatening, discounting, ridiculing, punishing, and rejecting of one's client (Benjamin, 2001; Glasser & Glasser, 2007; Van Nuys, 2007). Clearly these attitudes and behaviors, as well as others of a similar nature, are to be avoided. Let's now take a look at some of the specific skills that will foster a productive counseling relationship.

■ *Counseling Skills*

Ask a room filled with therapists to agree on the time of day and you're most likely to have a room filled with therapists arguing that it would be dependent on one's time zone and discussing the subjective nature of time. In the same way, arriving at any consensus regarding what may be considered the most important skills to use within the counseling relationship would, to say the least, be difficult. However, I have attempted to categorize skills into four broad categories with which many therapists might agree. These include foundational skills, commonly used skills, commonly used advanced skills, and advanced and specialized skills. Certainly, regardless of what skills are used, the misuse or abuse of counseling skills can quickly have a deleterious effect on the outcome of counseling.

Foundational Skills

Regardless of the theoretical orientation to which you adhere, some skills are essential to establishing the relationship, building rapport and trust, setting a tone with the client, and beginning the client's process of self-examination. Although these skills remain important throughout the counseling relationship, they are generally most crucial as counseling begins and should be continually revisited, especially when an impasse is reached. They include the ability to listen, show empathy, and use silence effectively.

Listening Skills

> . . . *First there is the hearing with the ear, which we all know; and the hearing with the non-ear, which is a state like that of a tranquil pond, a lake that is completely quiet and when you drop a stone into it, it makes little waves that disappear. I think that [insight] is the hearing with the non-ear, a state where there is absolute quietness of the mind; and when the question is put into the mind, the response is the wave, the little wave*. (Krishnamurti, cited in Jayakar, 1996/1986, p. 328)

We have all been in the situation when someone close to us has said, "You're not listening to me," or "You're not hearing me," and, we have also probably been in the situation when we have accused others of the same. Although we all have a general sense of what *listening* is, this skill is particularly difficult to implement, as Americans are rarely taught how to hear another person. In fact, ask an untrained adult to listen to another, and usually he or she ends up interrupting and giving advice. Listening helps to build trust, convinces the client you understand him or her, encourages the client to reflect on what he or she has just said, ensures that you are on track with your understanding of the client, and is an effective way of collecting information from a client without the potentially negative side effects of using questions (Neukrug & Schwitzer, 2006) (see Box 5.2). You can see why good listening is intimately related to positive client outcomes.

A good listener:

1. talks minimally,
2. concentrates on what is being said,
3. does not interrupt,
4. does not give advice,

BOX 5.2

Listen to Me

When I ask you to listen to me and you start giving me advice, you have not done what I asked.

When I ask you to listen to me and you begin to tell me why I shouldn't feel that way, you are trampling on my feelings.

When I ask you to listen to me and you feel you have to do something to solve my problem, you have failed me, strange as that may seem.

Listen: All that I ask is that you listen, not talk or do— just hear me.

When you do something for me that I can and need to do for myself, you contribute to my fear and inadequacy.

But when you accept as a simple fact that I do feel what I feel, no matter how irrational, then I can quit trying to convince you and get about this business of understanding what's behind these feelings.

So, please listen and just hear me.

And, if you want to talk, wait a minute for your turn— and I'll listen to you.

(Author Unknown)

5. gives and does not expect to get,
6. accurately hears the content of what the helpee is saying,
7. accurately hears the feelings of what the helpee is saying,
8. is able to communicate to the helpee that he or she has been heard (through head nods, "uh-huhs," or reflecting back to the client what the helper heard),
9. asks clarifying questions such as "I didn't hear all of that. Can you explain that in another way so I'm sure I understand you?" and
10. does not ask other kinds of questions.

HINDRANCES TO LISTENING.   A number of factors can impede the counselor's ability to listen effectively. Some of these include: (1) having preconceived notions about the client that interfere with the counselor's ability to hear the client, (2) anticipating what the client is about to say and not actually hearing the client, (3) thinking about what you are going to say and therefore blocking what the client is saying, (4) having personal issues that interfere with your ability to listen, (5) having a strong emotional reaction to your client's content and therefore not being able to hear the client accurately, and (6) being distracted by such things as noises, temperature of the office, or hunger pains (Neukrug & Schwitzer, 2006).

PREPARING TO LISTEN.   When you are ready to listen, the following practical suggestions should assist you in your ability to hear a client effectively (Egan, 2010; Ivey, Ivey, & Zalaquett, 2010).

1. Prior to meeting your client, calm yourself down: meditate, pray, jog, or blow out air to calm your inner self.
2. Maintain appropriate eye contact with the client (be sensitive to cultural differences).
3. Have an open body posture that invites the client to talk (be sensitive to cultural differences).
4. Be sensitive to the personal space between you and the client.

5. Clear your mind of extraneous thoughts that are not relevant to hearing the client (e.g., personal issues or interpretations of client behavior).
6. Concentrate on the client and be prepared to focus on the meaning and feeling of what the client is discussing.
7. Do not talk except to gently encourage the client to talk.
8. Listen.

Whereas basic listening is a crucial skill for counselors, empathic understanding, the next essential skill, takes listening to new depths.

Empathy and Deep Understanding: A Special Kind of Listening

Highlighted as one of the nine personal qualities to embrace in Chapter 1, *empathy* is also one of most important counseling skills to develop. The importance of listening to a person from a deep inner perspective was extolled by many early Greek philosophers and recognized for centuries for its healing qualities (Gompertz, 1960). At the turn of the twentieth century, Theodor Lipps (1960/1903) coined the word *empathy* from the German word *Einfuhlung*, "to feel within," but probably the person who has had the greatest impact on our modern-day understanding and use of empathy is Carl Rogers.

> *The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition.* (Rogers, 1959, pp. 210–211)

The popularity of Rogers in the 1950s and 1960s naturally led to a number of operational definitions of empathy. For instance, Truax and Mitchell (1961) developed a nine-point rating scale to measure empathy, which was later revised by Carkhuff (1969) into a five-point scale. A scale to measure empathy had important implications. For the first time, researchers could measure the empathic ability of counselors and determine whether there was a relationship between good empathic responses and client outcomes in therapy. Indeed, numerous research studies indicated that good empathic ability was related to progress in therapy (Carkhuff, 2009; Carkhuff & Berenson, 1977; Elliott, Greenberg, & Lietaer, 2004; Wampold, 2010a, 2010b).

The *Carkhuff scale* became a mainstay of counselor training during the 1970s and 1980s, and although it is no longer used as extensively, the scale set the stage for similar microcounseling skills training methods in counselor education (Baumgarten & Roffers, 2003; Egan, 2010; Gazda et al., 2006; Schaefle, Smaby, Packman, & Maddux, 2007). The scale ranged from a low of 1.0 to a high of 5.0 with .5 increments. Any responses below a 3.0 were considered subtractive or nonempathic, while responses of 3.0 or higher were considered empathic, with responses over 3.0 called "additive" responses (see Figure 5.1).

FIGURE 5.1
The Carkhuff Scale

1———— 2———— 3———— 4———— 5
  1.5   2.5   3.5   4.5
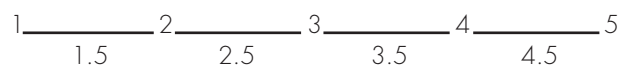
TABLE 5.1

Carkhuff's Accurate Empathy Scale
Level 1   The verbal and behavioral expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.
Level 2   While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he subtracts noticeable affect from the communications of the second person.
Level 3   The expressions of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.
Level 4   The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.
Level 5   The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (1) accurately express feelings below what the person himself was able to express or (2) in the event of ongoing, deep self-exploration on the second person's part, to be fully with him in his deepest moments.
Source: Carkhuff, 1969, p. 121.

The original Carkhuff scale is reproduced in Table 5.1. Dramatically changing the manner by which empathic responding was being taught, this scale allowed professors, students, and counselors to assess one another's ability to make an empathic response. As reflected in Table 5.1, a Level 1 or Level 2 response in some ways detracts from what the person is saying (e.g., giving advice, not accurately reflecting feeling, not including content) with a Level 1 response being way off the mark and a Level 2 only slightly off. For instance, suppose a client said, "I've had it with my dad; he never does anything with me. He's always working, drinking, or playing with my little sister." A Level 1 response might be, "Well, why don't you do something to change the situation, like tell him what an idiot he is?" (advice giving and being judgmental). A Level 2 response might be, "You seem to think your dad spends too much time with your sister" (does not reflect feeling and misses content). On the other hand, a Level 3 response, such as "Well, it sounds as though you're pretty upset at your dad for not spending time with you," accurately reflects the affect and meaning of the client.

Level 4 and Level 5 responses reflect feelings and meaning beyond what the person is outwardly saying and add to the meaning of the person's outward expression. For instance, in the above example a Level 4 response might be, "It sounds as though you're pretty angry at your dad because he doesn't pay any attention to you" (expresses a new feeling, anger, which the client didn't outwardly state). Level 5 responses are usually made in long-term therapeutic relationships by expert counselors. They express to the helpee a deep understanding of the pain he or she feels as well as recognition of the complexity of the situation.

Usually, in the training of helpers it is recommended that they attempt to make Level 3 responses, as a large body of evidence suggests that such responses can be learned in a relatively short amount of time and are beneficial to clients (Carkhuff, 2009; Neukrug, 1980, 1987; Schaefle, Smaby, Maddux, & Cates, 2005). Effective empathic responses not only accurately reflect content and feelings but do so at a moment when the client can hear this reflection. For instance, you might sense a deep sadness or anger in a client and reflect this back to him or her. However, if the client is not ready to accept these feelings, then the timing is off and the response is considered subtractive.

Often, when first practicing empathic responding, it is suggested that beginning counselors make a formula response, which generally starts with reflection of feeling followed by paraphrasing of content. Look at the example below:

Client: I'm at my wit's end. I'm as depressed as ever. I keep trying to change my life and nothing works. I try communicating better, I change my job, I change my looks. I even take antidepressants, but nothing helps.

Counselor: You feel frustrated because you try making all of these changes and things are not any better.

As counselors become more comfortable with formula responses, they can begin to use more natural conversational tones when making empathic responses. For instance, to the client above, a counselor might say:

Counselor: Your frustration really shows—you've tried so many different things yet nothing seems to work. I can see your frustration and sadness in your eyes.

Master therapists become very creative with empathic responding and will use metaphors, analogies, and self-disclosure in an attempt to tell the client he or she has been heard accurately (Neukrug, 1998):

Counselor: It's kind of like you're rearranging deck chairs on the *Titanic.*

or

Counselor: When you just told me what you're going through, I felt my stomach twist and turn. I imagine this is how you must be feeling.

As noted in Chapter 4, over the years, empathic responses sometimes have been confused with "active listening" or "reflection of feeling." Although Carl Rogers was instrumental in encouraging the use of empathy, he warned against the mechanistic, stilted, and wooden response to clients that is sometimes found when helpers practice reflection of feeling. Usually with practice, however, a helper's response to clients becomes more naturally empathic, as in some of the more advanced examples given above.

Silence

> *That I do not say something does not mean that nothing has been said. That I do not hear something does not mean that there is nothing to hear. I listen to silence and it speaks. I cannot, ever, say nothing at all.* (Linnell, Bansel, Ellwood, & Gannon, 2008, p. 305)

When   is   empty   space   facilitative   and   when   does   it   become   a   bit   much? *Silence* is a powerful tool that can be used advantageously by the counselor for the growth of the client (Linda, Miller, & Johnson, 2000; Sommers-Flanagan & Sommers-Flanagan, 2009). It allows the client to reflect on what has been said and gives the counselor time to process the session and to formulate the next response. It shows the client that communication does not always have to be filled with words and that words can sometimes be used as a diversion from feelings. Silence is powerful. It will sometimes raise anxiety within the client, anxiety that on the one hand could push the client to talk further about a particular topic and on the other hand could cause a client to drop out of treatment.

A former professor of mine suggested waiting 30 seconds before making a response. During a counseling session, 30 seconds is a veeeeeeeeeeery looooonng tiiiiiiiiiiiiiiiiiime. There have been times when I've had a student role-play a client, and I've waited 30 seconds before responding. Trust me, this is a very long time. I would have difficulty waiting this much time during a counseling session. However, others may feel comfortable with this amount of silence. For instance, during these 30 seconds you could see my former professor thinking about the client's last statement, moving in his chair, and thinking about what he was to say next. This worked for him. Silence is powerful.

Finally, the use of silence may be somewhat culturally determined. For instance, some research has found that the *pause time* for different cultures varies. Therefore, one's natural inclination to talk—to respond to another—will vary as a function of culture (Tafoya, 1996; Zur, 2007). As a counselor, you may want to consider your pause time to discover your comfort level with silence, and when working with clients you might consider a client's pause time. In fact, Tafoya notes that Native Americans have at times been labeled reticent and resistant to treatment when in fact they merely have long pause times. Treated by Native American therapists, they most likely would not have been labeled in this fashion.

Commonly Used Skills

Although foundational skills are the bedrock of the counseling relationship, a number of additional skills are employed that counselors should understand. Some of these *commonly used skills* should be used judiciously and cautiously, as their overuse or misuse can lead to client defensiveness or create client dependency issues. These skills include the use of questions; self-disclosure; modeling; affirmation giving and encouragement; and offering alternatives, providing information, and advice giving.

Questions

What purposes do questions serve? Can you tell me more about the use of questions? Is a question really a question or a hidden statement about self? When should questions be questioned? Would you prefer the use of short or long questions? Why do you question questions? A question can come in many different forms, can't it? Would you prefer a question that gives you two options from which to choose, or one that offers an open-ended response?

Questions can serve a multitude of purposes, including finding historical patterns, revealing underlying issues, gently challenging the client to change, encouraging the client to deepen his or her self-exploration, and helping clients move toward preferred goals. Although many different kinds of questions exist, some of the more important ones to the counseling relationship include open and closed questions, tentative questions, solution-focused questions, and "why" questions.

OPEN VERSUS CLOSED QUESTIONS.   *Open questions* allow clients to respond in a myriad of ways, whereas *closed questions* focus on a particular topic or point of view and force clients to pick between the choices given (Neukrug & Schwitzer, 2006). Open questions offer a client greater options in the kinds of responses he or she can make and are

generally considered more facilitative than closed questions, which limit client response (Langewitz, Nübling, & Weber, 2003; Sommers-Flanagan & Sommers-Flanagan, 2009). For instance, one could ask the closed question, "Do you feel you had a good or bad childhood?" An even more limiting question would be, "What made your childhood so bad?" Instead, one could ask the open question, "What was your childhood like?" which allows for unlimited response. Although open questions are generally considered more expansive than closed ones, there are times, such as when you need to gather information quickly, when you want to zero in on a couple of responses rather than leaving the question wide open.

TENTATIVE QUESTIONS.   Benjamin (2001) notes that a question can be made even more open if it is asked indirectly or tentatively. For instance, I could ask an open question directly: "What feelings did you have concerning your wife leaving you?" However, to make the question even more palatable, I might ask it in the following manner: "I would guess you must have had many feelings concerning your wife leaving?" In fact, this *tentative question* is more akin to making an empathic response. Open questions that are tentative tend to sit well with clients. They're easier for clients to hear, help the session flow, help to create a nonjudgmental and open atmosphere, are expansive rather than delimiting, and are easily responded to by clients. However, if you need to get some information quickly, you may want to stay away from these kinds of questions.

SOLUTION-FOCUSED QUESTIONS.   In contrast to the more traditional ways of conducting counseling in which open, closed, and tentative questions might be used, with the advent of brief treatment, questions have played an increasingly important role. If you find yourself in a setting where brief treatment is being used, you might want to consider the kinds of questions that follow. Borrowing from solution-focused counseling as noted in Chapter 4, we find the following:

Preferred goals questions: These are questions which are generally asked near the very beginning of counseling to assess what the goals or hope of counseling would be. For instance, one might ask, "How will you know that coming to counseling has been worthwhile for you?"

Evaluative questions: These questions help clients distinguish behaviors that have led to preferred goals from those that have not. (e.g., Has that new behavior worked for you?)

Coping questions: Coping questions focus on past behaviors that have been successful in dealing with problems (e.g., So, you've had this problem in the past, how did you tend to cope with it then?)

Exception-seeking questions: These questions help clients examine when they haven't had the problem in their lives, so that they can explore how they previously lived a problem-free life. (e.g., So what was going on in your life when you were not feeling this way?)

Solution-focused questions: Future oriented, these questions offer clients the opportunity to develop new, positive ways of reaching their preferred goals (e.g., What kinds of things do you think you can do to help reach your preferred goals?)

THE USE OF "WHY" QUESTIONS.   "Why do you feel that way?" Ever been asked that question? Did it make you feel defensive? In actuality, if one could honestly answer "why," the

why question would be one of the most powerful questions used in counseling. However, clients are in counseling to find the answer to "why"; if they knew, they wouldn't be in your office. Because "why" questions tend to make a person feel defensive, it is generally recommended that counselors use other kinds of questions or empathic responses. I have found that after I've formed an alliance with a client, I might periodically slip in a soft "why" question and say something like, "Why do you think that is?" However, if I use this type of question at all during a session, I use it sparingly.

WHEN TO USE QUESTIONS.   Questions can be helpful in uncovering patterns, gathering information quickly, inducing self-exploration, challenging the client to change, and moving a client along quickly to preferred goals. However, their overuse can create an authoritarian atmosphere in which the client feels humiliated and dependent as he or she expects the counselor to come up with a solution for him or her (Benjamin, 2001; Sommers-Flanagan & Sommers-Flanagan, 2009). In addition, a question is generally not as facilitative as an empathic response that empowers the client to discover answers on his or her own (Neukrug, 2002; Neukrug & Schwitzer, 2006; Rogers, 1942). In fact, often an empathic response can be made in place of asking a question. For instance, suppose the client said the following:

Client: You know, I can't stand talking about my parents' destructive attitude toward me and my siblings any longer.

A counselor could respond with an open question, such as:

Counselor: What is it about discussing your parents' destructive attitude that is so disturbing to you?

However, probably a more effective response would be:

Counselor: I hear how upset you get when you begin to talk about your parents' destructive attitude toward you and your siblings.

In short, those counselors who view themselves as less directive, less authoritarian, and more client-centered would tend to avoid questions. Those who are more directive, involved in brief treatment, and see themselves as more counselor-centered, may be at ease with the use of some questions. Keeping this in mind, and adapting what Benjamin (2001) suggests, one might want to consider the following prior to the use of questions:

- Are you cognizant of when you are using a question?
- Are you aware of why you have decided to use a question?
- Do you have limited time with the client, and thus are deciding that questions might be useful?
- Are you aware of the impact a question has on the counseling relationship?
- Are there better alternatives to the use of questions?

Self-Disclosure

A former student of mine was in therapy with a psychiatrist, who, over time, increasingly began to disclose *his* problems to *her*. One day she heard that he had committed suicide. Following his death, she revealed to me that she felt intense guilt that she hadn't saved his life. What a legacy to leave this student! Clearly, the psychiatrist's *self-disclosure* was unhealthy and unethical. However, under some circumstances, certain amounts of

self-disclosure may facilitate a client's ability to open up and may also serve as a model of positive behaviors.

Self-disclosure has been broadly defined as "anything that is revealed about a therapist verbally, nonverbally, on purpose, by accident, wittingly, or unwittingly…" (Bloomgarden & Mennuit, 2009, p. 8). Although self-disclosure can be an important tool for clients, as a counseling skill it is a mixed bag and is best conducted intentionally and judiciously (Bloomgarden & Mennuit, 2009; Farber, 2006; Maroda, 2009). Kleinke (1994) identifies two types of self disclosure, content self-disclosure, when one reveals information about him- or herself; and process self-disclosure, when one reveals information about how the counselor is feeling toward the client in the moment.

CONTENT SELF-DISCLOSURE. This kind of disclosure could have a number of positive results, including showing your client that you are "real" and thus creating a stronger alliance; developing deeper intimacy in the helping relationship, which ultimately could foster deeper client self-disclosure; and offering behavior your client can model. Sometimes client actions may necessitate *content self-disclosure* (see Box 5.3).

PROCESS SELF-DISCLOSURE. Sometimes called *immediacy, process disclosure* involves the counselor sharing his or her moment-to-moment experience of self in relation to the client (George & Cristiani, 1995; Farber 2006). Such process comments could help a client see the impact he or she has on the therapist and, ultimately, on others in his or her life; help a client see how moment-to-moment communication can enhance relationships; and act as a model for a new kind of communication that can be generalized to important relationships in the client's life. Similar to the Rogerian concept of genuineness, process self-disclosure suggests that the counselor be real with his or her feelings toward the client.

> *. . . Certainly the aim is not for the therapist to express or talk out his own feelings, but primarily that he should not be deceiving the client as to himself. At times he may need to talk out some of his own feelings (either to the client, or to a colleague or supervisor). . . .* (Rogers, 1957, p. 98)

BOX 5.3

Awkward Self-Disclosure with a Client

A former client of mine who was in a dysfunctional relationship with her boyfriend was struggling with feelings of attraction toward me. We had discussed these feelings and noted that perhaps they were being exaggerated as she contrasted her feelings toward an "idealized" me with her feelings toward her verbally abusive boyfriend. She was a runner, as I was, and during one session, she informed me that she was interested in going to the Bahamas to run in an international race. I had already planned on running in this same race and was planning on going to the island with the woman I was dating. I suddenly was faced with a number of dilemmas. Do I disclose my plans and reveal an intimate aspect of my life, or do I wait, and almost assuredly run into my client on the island? Or I could decide to not go. I quickly assessed the situation, and it seemed obvious to me that I needed to reveal my plans to her. I believe it would have been a mistake for me to change my plans, yet I didn't want to create an awkward situation for my client when on the island. Revealing as little information as possible about my life, I said to my client that I was planning on going to the race with a woman friend. Having this information, my client eventually decided not to go.

Warning counselors not to share transient feelings toward clients, Rogers (1957) pointed out that clients were rapidly changing as they shared deeper parts of themselves; and, as they changed, the counselor's feelings toward them would likely change. Instead of sharing moment-to-moment feelings, he suggested sharing persistent feelings, as these are more meaningful to the relationship (Rogers, 1970).

Self-disclosure needs to be done sparingly, at the right time, and as a means for promoting client growth rather than satisfying the counselor's needs (Zur, 2009). A general rule of thumb is: If it feels good to self-disclose, don't. If it feels good, you're probably meeting more of your needs than the needs of your client. Hill & Knox (2002) suggest a number of guidelines for counselor self-disclosure:

1. Therapists should generally disclose infrequently.
2. The most appropriate disclosure is about professional issues, and the least appropriate is about sexual issues.
3. Disclosure is best used to normalize situations, validate reality, build the relationship, or offer alternatives.
4. Avoid disclosures for own needs or disclosures that are intrusive, blur boundaries, interfere with the flow, or confuse the client.
5. The best disclosures are probably ones that match the client's disclosure.
6. Some clients respond better to disclosures than others, so it is important to see how the client reacts to disclosures and back off of them when necessary.

Finally, I agree with Kahn (2001), who states that

I try not to make a fetish out of not talking about myself. If a client, on the way out the door, asks in a friendly and casual way, "Where are you going on your vacation?" I tell where I'm going. If the client were then to probe, however ("Who are you going with? Are you married?") I would be likely to respond, "Ah . . . maybe we'd better talk about that next time." (p. 150)

Modeling

Clients can learn a wide variety of new behaviors by observing desired behaviors in others and later *modeling* these behaviors by practicing them on their own. Sometimes called *social learning, imitation,* or *behavioral rehearsal*, modeling can be a significant part of the change process as one imitates the behaviors of others and rehearses those behaviors he or she intends on integrating (Cooper, Heron, & Heward, 2007; Naugle & Maher, 2003).

Modeling can occur in a number of ways, such as (1) when a therapist decides to highlight certain clinical skills with hopes that the client will learn from example (e.g., expressing empathy, being nonjudgmental, being assertive), (2) through the use of role-playing during the session (e.g., the counselor might role-play job interviewing techniques for the client), and (3) by teaching the client about modeling and encouraging him or her to find models outside the session to emulate (e.g., a person who has a fear of speaking to a large group might choose a speaker he or she admires and view the specifics of how that person makes a speech).

With modeling, targeted behaviors that the client wishes to acquire need to have a high probability for success (Bandura, 1977). Thus, it is important to accurately identify desired behaviors that want to be changed, pick appropriate models from which one can emulate the identified behavior, ensure that the client can remember the model and has

the ability to repeat what was observed, and be motivated to practice the new behaviors within and outside of the session. For instance, an individual who has a fear of making speeches would first need to find a model to emulate. After observing this model, a hierarchy could be devised whereby the client would make a speech—first to the counselor, then to some trusting friends, then to a small group, and so forth, perhaps asking for feedback along the way in order to sharpen his or her performance.

Modeling has been used to help clients develop a wide range of new behaviors. Imagine how one might use modeling to help clients become more assertive, communicate more effectively, eat more slowly, or relax more easily. Finally, modeling occurs all of the time, even when one does not purposefully seek to model another person's behaviors. And, the more perceived power the model holds, the more likely modeling will occur. As you might expect, counselors who are often looked up to and sometimes even idealized by their clients can be very powerful models, even unintentionally (Brammer & MacDonald, 2003). Thus, regardless of the theoretical approach of the counselor, he or she should consider that the very skills being demonstrated during a session will likely be modeled to some degree by the client.

Affirmation Giving and Encouragement

> The need for supporting core self-esteem doesn't end in childhood. Adults still need "unconditional" love from family, friends, life partners, animals, perhaps even an all-forgiving deity. Love that says: "no matter how the world may judge you, I love you for yourself." (Steinem, 1992, p. 66)

Although *affirmation giving* and *encouragement* are not generally considered techniques, it is the rare counselor who does not affirm and encourage clients. Fleeting statements such as "good job," "I'm happy for you," "I know you can do it," or strong handshakes, warm hugs, and approving smiles are just a few of the ways in which counselors affirm and encourage their clients. Whereas affirmations are seen as a genuine positive response to a client's behaviors, encouragement is focused more on helping a client achieve a specific goal. Whether called reinforcement or a genuine response to our client's hard work, such responses may greatly affect our clients and perhaps not always in positive ways (Orlinsky, Ronnestad, & Willutzki, 2004). In fact, some believe that the use of such responses may lead to the formation of a therapeutic relationship based on external validation (Benjamin, 2001). Therapists must reflect upon whether or not affirmations and subtle encouragement of client progress are assisting in the formation of a higher degree of self-worth or if they may actually be fostering dependency and the continuation of a higher degree of externality. In my practice, I aim to genuinely affirm the client while taking care not to inadvertently foster a dependent relationship.

Offering Alternatives, Providing Information, and Giving Advice

Like affirmations and encouragement, *offering alternatives*, *providing information*, and *giving advice* are not typical counselor responses because they tend to place the counselor in the role of expert and can result in leading the client toward certain behaviors (often based on the counselor's values). As with affirmation giving and encouragement, these types of responses can encourage externality and foster dependency (Benjamin, 2001; Sommers-Flanagan & Sommers-Flanagan, 2009). It is therefore not surprising that some research

FIGURE 5.2
Comparison of Damaging Effects of Problem-Focused Strategies

Offering alternatives   Information giving   Advice giving

Safer   Potentially destructive

Non-judgmental   Judgmental
Client-centered   Helper-centered
Fosters self-sufficiency   Fosters dependency
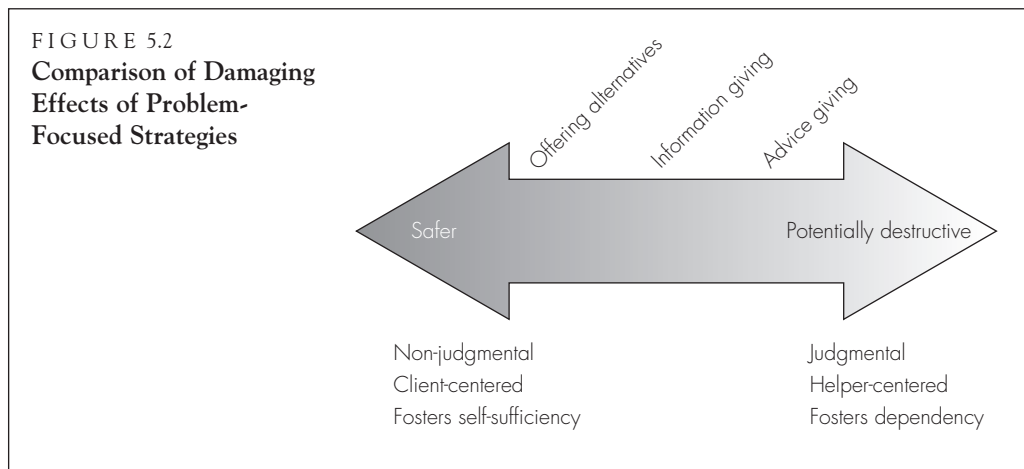
has shown that these types of responses are not particularly effective (Orlinsky et al., 2004). Nevertheless, there may be times when these responses are helpful, such as when a client and counselor have agreed upon a specific course of action and the client wants suggestions on how to move in that direction (e.g., a client who is committed to working on her social skills is advised by the counselor to join a local community group), or when it appears obvious that the actions of a client will be harmful to the client or others.

Although offering alternatives, providing information, and giving advice are similar in the sense that they are all "counselor-centered" and not "client-centered," each has a different potential for being destructive to the counseling relationship. Clearly, of the three possible leading responses, offering alternatives would be least likely to have destructive influences in the counseling relationship (see Figure 5.2). As we move toward advice giving, the counselor's responses become more value laden and more counselor-centered (Doyle, 1998). Whether any of these responses are used should be based on a careful understanding of your client's needs and whether an alternative response could be more effective for the client. Finally, as Meichenbaum notes (as cited in Kleinke, 1994), when counseling is optimal, the timing of this kind of response should be such that the client is a step ahead of the advice that would have been offered. Thus, the client in essence is gaining so much from counseling that he or she is coming up with solutions prior to the counselor suggesting them.

Commonly Used Advanced Skills

In addition to the commonly used skills we just discussed, other skills that involve a little more sophistication on the part of the counselor are often employed at different points of the counseling relationship. These include confrontation, interpretation, and collaboration.

Confrontation: Support, then Challenge

People generally define *confrontation* as some type of hostile challenge when attempting to overcome an obstacle. However, within the context of the counseling relationship, confrontation is usually thought of as a much softer challenge to the client's understanding

of the world, which invites the client to gain an alternative understanding of his or her current situation (Toth & Erwin, 1998). To be effective, this gentle challenge needs to be preceded by the building of a trusting and caring relationship, thus lessening the likelihood that any harm to the client will occur (Egan, 2010; Neukrug & Schwitzer, 2006; Polcin, 2006). The use of good listening skills and empathy is generally considered to be the most effective way to develop a relationship that can successfully process a challenge and potentially change the client's perception of reality. In short, confrontation requires accurate timing, tact, and gentleness on the part of the counselor (see Box 5.4).

Some have suggested that confrontation assists the client to see discrepancies among words, feelings, and/or behaviors (Hackney & Cormier, 2009; Hill, 2004). For instance, discrepancies can exist between a client's (1) values and behavior (e.g., a client says she believes in honesty in relationships, yet won't express her anger toward her lover because she is afraid he will leave her); (2) feelings and behavior (e.g., a man who says he loves his wife deeply and then tells the counselor about the affair he is having); and (3) self-descriptions and other verbal statements (e.g., a client who states she wants to communicate more effectively but finds excuses for not doing so: "If only I had more time to work on my communication problems"), and (4) verbal expression of feelings and the underlying feelings to which a client won't admit or of which he or she is not currently aware (e.g., a person who states she feels fine about her marriage and yet seems to be holding back tears; you note this, and she begins to sob). Following the building of a trusting and caring relationship, there are a number of ways a discrepancy can be confronted:

1. *You/But Statements*. Such statements point out client incongruities by reflecting them back in a "you/but" framework (Hackney & Cormier, 2009). For instance, to a client who states he believes in honesty but is having an affair, the counselor might say:

   Counselor: On the one hand, you say that you believe in honesty, but you seem to be hiding a serious matter from your wife.

BOX 5.4

Confronting Sally

Sally made close to $60,000 a year and was in a verbally abusive relationship. Even though she had no major bills to pay, she insisted that she could not leave the relationship and live on a "meager" $60,000 a year. Clearly, her verbal statement that she could not leave the relationship did not match the reality that one could live on this amount (certainly, most of us would be happy to live on this amount). After building a relationship using empathy, I gently challenged this perception. I did this by using many of the techniques described above. Using "you/but" statements, I pointed out the obvious discrepancy between her salary and her perceived inability to live on her own. Also, I gently asked her to justify to me how she could feel this way. This assisted her to see that her logic did not hold up. Using higher-level empathy, I reflected back a deeper issue that I experienced her saying—that she felt as if she was a failure in the relationship and was scared to be alone (she was a recovering alcoholic and was concerned she would start drinking again if alone). I encouraged her to work on communication issues with her lover. At the same time, I assisted her in reframing her situation so that she could believe that she could live on her own—if she chose eventually to do this. I did not use irony with her, as I felt it would be too disturbing for her. The result for this client was that she became a more assertive woman who improved her communication with her lover and could realistically see her choices about staying in the relationship or finding a place on her own.

2. *Asking the Client to Justify the Discrepancy.* This kind of response has the counselor gently asking the client to explain how he or she justifies the discrepancy. For example, in the above example the counselor might say:

> *Counselor:*   Based on your knowledge of who you are, tell me how you make sense of the fact that you say you are honest, and yet you are hiding an affair from your wife?

3. *Reframing.* This way of highlighting the discrepancy challenges the client to view his or her/situation differently by offering an alternative reality.

> *Counselor:*   What you're telling me is that in some cases honesty is not always the best way to go.

4. *Using Irony or Satire.* Using irony or satire highlights the absurdity of the discrepancy and is more confrontational than the other techniques. This technique should be used carefully. For instance, in the above example, you might say:

> *Counselor:*   Well, I guess it's okay in this instance to be dishonest; after all, you are saving your wife from those painful feelings, aren't you?

5. *Higher-Level Empathy.* Higher-level empathy, the final way of challenging a client's discrepancy, reflects to the client underlying, out-of-awareness feelings and conflicts, and challenges the client to expose deeper parts of self. For instance, in the above example:

> *Counselor:*   You must be feeling quite conflicted. On the one hand, you say you believe in honesty; on the other hand, you are hiding an affair. I guess I sense there is more to this story for you.

Interpretation

A client offers details to you, his counselor, about his current lover. Later he shares details about his relationship with his parents. You hear similar themes and feelings running through these relationships and reveal your analysis to the client. The client nods his head in agreement. Is this *interpretation* or is this empathy? Although some may consider this, I consider this a high-level empathic response (above Level 3.0 on the Carkhuff scale) for a number of reasons. First, it is a result of deep listening and concentration on the part of the counselor. Second, it is based on a deep understanding of the client's framework of reality. Third, you have reflected back your understanding of the client's predicament without adding material from an external source, such as a counseling theory, that might suggest certain conclusions about your client. And finally, the client agrees with your assessment. You are on target with your response. This definition of empathy is a profound response to the client that reaches deep inside the client's soul and speaks to the imaginary line between facilitating and leading a client (Benjamin, 2001).

On the other hand, true interpretation is the analysis of a client's behaviors and meaning-making system from the perspective of the counselor, usually with a preset model of counseling and psychotherapy in mind that makes assumptions about how a person would react under certain circumstances. Psychoanalysis uses interpretation as a major therapeutic intervention. For instance, many psychodynamic therapists believe that our dreams hold symbols to unresolved conflicts from our psychosexual development and can provide the client with understanding of his or her development

(Brill, 1921/2010). In this vein, a dream about a goat being your pet in an immaculately clean apartment could represent an underlying need to rebel against a repressive upbringing, the goat representing the archetypal oppositional animal. Similarly, interpretations about the transference relationship are used in many psychodynamic therapies to explain how a person's current relationships are reflections of past relationships. Some cognitive therapists also use interpretation when they assume that individuals with specific diagnoses would be expected to have certain kinds of underlying cognitive structures, which can be explained (interpreted) to the client (Beck, 2005). For example, it would be assumed that a person with an anxiety disorder has underlying cognitive beliefs that the world is a fearful and dangerous place. Whether we are psychodynamically oriented, cognitively oriented, or relying on some other theoretical approach, the timing of the interpretation is crucial, with the desired result being a deeper understanding of why the client responds the way he or she does—an understanding that may lead to client change.

When on target, interpretations can assist a client in making giant leaps in counseling. However, there are risks involved in using this technique. For instance, interpretation sets the counselor up as the "expert" and lessens the realness of the relationship (Kleinke, 1994). In addition, it detracts from the here-and-now quality of the therapeutic relationship while increasing the amount of intellectualizing that occurs as both the counselor and client discuss the interpretive material (Safran & Segal, 1996). Finally, research done on the use of interpretation seems, at best, mixed relative to successful client outcomes (Høglend et al., 2008; Orlinksy & Howard, 1986: Orlinsky, Ronnestad, & Willutzki, 2004).

For these reasons Carl Rogers and others (e.g., Benjamin, 2001; Kahn, 2001) warn that the use of interpretation can be detrimental to the counseling relationship.

> *. . . To me, an interpretation as to the cause of individual behavior can never be anything but a high-level guess. The only way it can carry weight is when an authority puts his experience behind it. But I do not want to get involved in this kind of authoritativeness. "I think it's because you feel inadequate as a man that you engage in this blustering behavior," is not the kind of statement I would ever make.* (Rogers, 1970, pp. 57–58)

Collaboration

Collaboration in the counseling relationship involves communicating to your client that you value his or her feedback and that you want to come to a mutually agreed upon decision about the next phase in treatment (Sommers-Flanagan & Sommers-Flanagan, 2009). Here, the counselor is asking for feedback from the client as to his or her assessment of the counseling relationship and uses techniques that lead to a mutual decision about the future of treatment. Effective collaboration implies that one has built a strong therapeutic alliance and is increasingly used in a wide variety of counseling approaches (see Neukrug, 2011). Generally, collaboration includes the following:

1. The use of one's foundational skills to offer a summary of what has been discussed thus far.
2. Asking the client, through the use of questions, how he or she feels about the course of treatment thus far.

3. Asking the client, through the use of questions, about the direction he or she would like to take in treatment.
4. Sharing with the client one's own thoughts about which areas might be important to focus upon.
5. Having an honest discussion concerning any discrepancies between numbers 3 and 4, which leads to a mutual decision about the course of treatment.

Collaboration can and often does occur throughout the helping relationship and is often most useful at transitional points, such as (1) after rapport building and prior to problem identification, (2) after problem identification and prior to the development of treatment goals, (3) after the development of treatment goals and prior to treatment planning, and (4) during the closure stage prior to ending counseling. These stages of the relationship will be discussed later in this chapter.

Advanced and Specialized Counseling Skills

We have examined in this chapter a number of common skills used by most counselors, whether they are beginning students or advanced master therapists. Although not within the purview of this text, there are literally dozens of other skills that can be attained through additional training by an interested and astute counselor. Many of these skills are unique to specific counseling approaches. Mentioning just a few, they include such things as the use of metaphor, hypnosis, strategic skills, cognitive restructuring methods, narratives and storytelling, therapeutic touch, paradoxical intention, role-playing, visualization techniques, and on and on (Neukrug, 2011; Rosenthal, 1998, 2001). Suffice it to say that use of these skills may often take training beyond the master's degree. Today, there are many institutes nationally and internationally that offer such advanced training. Such training can also be obtained through the attainment of an advanced degree, participation in workshops at conferences, and good supervision.

Conceptualizing Client Problems: Case Conceptualization

Case conceptualization is a method that allows the counselor to understand a client's presenting problems and subsequently apply appropriate counseling skills and treatment strategies based on the counselor's theoretical orientation. Whereas experienced counselors develop their own systematic method of conceptualizing client problems, beginning counselors, who are often still struggling with their theoretical orientation, have a more difficult time conceptualizing client problems (Neukrug & Schwitzer, 2006; Schwitzer, MacDonald, & Dickinson, 2008). One model of case conceptualization is Schwitzer's (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997) *inverted pyramid heuristic* (IPH).

IPH is a step-by-step method that can be used to identify and understand client concerns while offering a visual guide for counselors in how to organize client information; see connections among client concerns, symptoms, and behaviors; and consider different areas to focus on in counseling. The inverted pyramid method includes four steps in clinical problem formulation (see Figure 5.3):

1. Broadly identifying symptomatic behavior.
2. Organizing client difficulties into logical groupings or constellations.

**Step 1. Problem identification:
Identify and list client concerns**

e.g.: depression; obsessive worry; afraid of anger, confrontation; low energy, amotivation; rumination about family and other concerns; poor concentration; roommate conflicts; anxiety about independence; dependence on boyfriend; dependent on mother's approval; isolation; unclear goals; accepts boyfriend's abuse; conflict with family/hurt; powerless with roommate; sleep difficulty; career indecision

**Step 2. Thematic groupings:
Organize concerns into logical constellations**

e.g.: moderate depression; relationship/dependency issues; generalized anxiety (perceives world as threat); identity confusion

**Step 3. Theoretical inferences:
Attach thematic groupings to inferred areas of difficulty**

e.g.: fragile self-esteem (humanistic perspective); or autonomy conflicts (psychodynamic); or catastrophizing and learned avoidance (cognitive behavioral)

**Step 4. Narrow inferences:
Suicidality and deeper difficulties**

e.g.: undeveloped self-worth/"fatal flaw" (humanistic); or abandonment/disintegration (psychodynamic)

3. Tying symptom groups to deeper theoretical, interpretive, or causal references.
4. Narrowing these symptom groups to the client's most basic difficulties in development or adjustment based on one's theoretical orientation.

Using this method, a beginning counselor would start at the top of the inverted pyramid and attempt to identify problem behaviors. Going down the inverted pyramid, the counselor would, in Step 2, attempt to organize the information obtained in Step 1 into a few groups called "thematic groupings" (Schwitzer, 1996, p. 260). During Step 3, the groupings developed in the two previous steps are related to the counselor's theoretical perspective. In Step 4, inferences from Step 3 are further distilled into deeper difficulties in functioning or deeper personality traits, when present.

The pyramid offers a visual and cognitive map that assists us to consider horizontal choices (for example, addressing depressed mood versus a relationship problem in the topmost section of the diagram) and vertical decisions (for example, addressing career indecision, topmost section, versus underlying identity confusion or struggle for independence, third section down) in making treatment decisions. It is clear that decisions concerning treatment approaches can be greatly aided through the use of the case conceptualization process.

Stages of the Counseling Relationship

The application of counseling skills can vary considerably as a function of the counselor's job role, setting, and theoretical orientation. Despite these differences, there are many commonalities within the counseling relationship. For instance, all counselors have to address technical issues unique to the first session (e.g., meeting times, length of session, billing issues, and frequency of sessions). All counselors will face issues of trust. All counselors will need to identify client concerns, develop goals, and assist the client in working on the identified goals. And all counselors will have to deal with termination. These commonalities tend to be displayed in a series of stages of the counseling relationships through which clients pass (Neukrug & Schwitzer, 2006). Let's examine these stages and see how our conceptual model may be applied within them. Refer back to Figure 5.3 as you consider this material.

Stage 1: Rapport and Trust Building

When clients initially see a counselor, they are wondering whether they can trust their counselor enough to discuss the concerns they have. The counselor, on the other hand, is dealing with a number of issues that are crucial to the development of an effective working relationship. For instance, the counselor is concerned about using basic skills to build trust in the relationship, ensuring that the physical environment feels safe, and informing the client of the basic framework and concerns of the counseling relationship:

> Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services;

the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. (American Counseling Association [ACA], 2005, Section A.2.b)

Oftentimes, these *professional disclosure statements* are provided in written form for both the client and counselor to sign and are considered legal documents to which the counselor should adhere (Remley & Herlihy, 2010).

During the *rapport and trust building stage*, the development of a comfortable, trusting, and facilitative relationship can be accomplished through the use of listening skills, empathic understanding, cultural sensitivity, and a fair amount of good social skills (Hackney & Cormier, 2009). During these beginning sessions, it is usual to discuss superficial items with clients or common interests in an effort to establish camaraderie. However, always keep in mind that the one major purpose of counseling is to assist the client toward disclosure of self-identified problems. Therefore, it is probably wise to not make the session too chatty.

As this stage continues, the counselor will begin to mentally identify and eventually delineate the issues presented by the client. This is the first step of our case conceptualization model. The counselor should review and evaluate the accuracy of this list with the client by reflecting back to the client those problems thought to be highlighted during this stage or by asking the client directly if the list is accurate.

Stage 2: Problem Identification

The building of a trusting relationship and the ability to do an assessment of client problems are signs that you are moving into the second stage where you and your client will validate your initial identification of the problem(s). It may be that what the client initially came to counseling for was masking other issues. Or additional issues may arise as you explore the client's situation—perhaps even issues of which the client was not fully aware. In either case, during these sessions you validate your original assessment and make appropriate changes as necessary. Validation of original concerns or reassessment and identification of new issues in the *problem identification stage* allow you to move into Step 2 of your conceptual model, the grouping of identified problems into broad themes.

Stage 3: Deepening Understanding and Goal Setting

Although your basic counseling skills are still important, because trust has been built in the earlier stages, other skills can now be added—skills that will allow you to understand your client in deeper ways. For instance, in the *deepening understanding and goal setting stage* the client will now allow you to confront him or her, ask probing questions, and give advanced empathic responses. You can increasingly push the envelope and move into the inner world of the client. However, it is always crucial to maintain sensitivity to your client's needs and to maintain a supportive and nurturing base. Move too fast, and the client will rebuff your attempts to expose his or her inner world. Move at the right pace for the client, and the counseling relationship will deepen, and advanced skills based on your particular theoretical orientation can be used.

As you begin to understand your client in deeper and broader ways, you move into Step 3 of your conceptual model, where you begin to make inferences based on your

theoretical orientation about underlying themes. These may be shared with your client, and at this point clients are likely to begin to work on some of these identified themes. If given enough time, with some clients you will move into Step 4 of your conceptual model. In this step, based on your theoretical orientation, you can now identify specific underlying themes that permeate the client's life and affect many aspects of his or her functioning.

Now that themes have been identified from Step 3 or Step 4 of your conceptual model, goals can be established based on these themes. The counselor, in collaboration with the client, can determine how the client would like to reach these goals. This will be based partly on the practicality of the relationship (e.g., the number of sessions available for counseling), the desires of the client (e.g., the client may want short-term counseling), and the theoretical orientation of the counselor. The result of this collaboration should be anything from an informal verbal agreement concerning goals to a written contract that is signed by both the client and counselor.

Stage 4: Work

During the fourth stage, the client is beginning to work on the issues that were identified in stage 3 and agreed upon between the counselor and client. The counselor will use his or her counseling skills to facilitate progress, and, if necessary, the counselor and client may want to revisit and reevaluate some of the goals set.

In the *work stage* the client increasingly takes responsibility for and actively works on his or her identified issues and themes. For instance, if the counselor is humanistically oriented, the client is pushing him- or herself to work on identified existential–humanistic themes (e.g., issues related to self-esteem). If the counselor is cognitive/behavioral, the client will be actively working on changing cognitions and behaviors (e.g., self-statements like "I am worthless" are worked upon, and self-affirming behaviors are practiced). If the counselor is psychodynamic, the client will be exploring identified analytical themes in the session (e.g., what impact past overdependency on his or her mother has on current relationships). Advanced skills based on the counselor's theoretical orientation are used in this stage. As clients work through their issues, they move closer to termination of counseling.

Stage 5: Closure

The main issues of the *closure stage* are termination and the loss associated with it. As the client has successfully worked through some of his or her issues, it becomes increasingly clear that there is little reason for counseling to continue. Counseling is one of the few intimate relationships that is time-limited, which consequently means that clients (and counselors) will have to work through their feelings of loss (Murdin, 2000).

When is a client ready to terminate a counseling relationship? Kleinke (1994) has found a number of reasons to consider *termination*, including (1) the reduction or elimination of symptoms; (2) the gaining of enough insight to deal with future recurring symptoms; (3) the resolution of transference issues; (4) the ability to work effectively, enjoy

life, and play; and (5) having reached the point of diminishing returns in therapy (remaining issues may not be worth the effort and time).

Termination should be a gradual process in which the client and counselor have time to deal with the loss involved and discuss whether or not stated goals have been met. As with many issues that carry a heavy emotional burden, many clients will attempt to defend against or resist the termination process (Sommers-Flanagan & Sommers-Flanagan, 2009; Murdin, 2000). This can happen in a number of ways:

1. The client may insist that he or she needs more time to work on the problem(s).
2. New issues may suddenly arise.
3. The client may miss sessions in an effort to avoid discussion of termination.
4. The client may suddenly become angry with the therapist in an effort to distance him- or herself.
5. The client may prematurely end therapy in an effort to avoid discussion of termination.

Because counselors also may find themselves resisting termination (Sommers-Flanagan & Sommers-Flanagan, 2009), it is important that they be vigilant about working through their own loss issues while, at the same time, being sensitive to the loss issues of their clients. Of course, consultation with colleagues and supervisors can be invaluable at this point in the therapeutic relationship.

Finally, successful termination is more likely if (1) clients discuss termination early, (2) goals are clear so clients know when counseling is near completion, (3) the counselor respects the client's desire to terminate yet feels free to discuss feelings that termination may be too soon, (4) the relationship remains professional (e.g., does not move into a friendship), (5) clients know they can return, (6) clients are able to review the success they had in counseling, and (7) clients can discuss feelings of loss around termination (Kleinke, 1994).

Stage 6: Post-Interview Stage

> We believe that patients can and should return as needed. (Budman & Gurman, 1988, p. 20)

The end of counseling may not be the end. Clients may return with new issues, may want to revisit old ones, or may desire to delve deeper into themselves. In fact, it is not unusual for clients to return to the same counselor or seek out another counselor at some other date.

The *post-interview stage* involves ensuring that you have completed your case management tasks such as paperwork, billing tasks, and eventual follow-up with clients. Follow-up with clients can function as a check to see if clients would like to return for counseling or would like a referral to a different counselor. Follow-up also allows the counselor to assess if change has been maintained. Follow-up, usually done a few weeks to six months after counseling has been completed, enables the counselor to look at which techniques have been most successful, gives him or her the opportunity to reinforce past change, and is one way in which the counselor can evaluate services provided (Neukrug, 2002; Neukrug & Schwitzer, 2006). Some counselors follow up by making a phone call, others send a letter, and still others do a more elaborate survey of clients.

Theory, Skills, Stages, and Case Conceptualization: A Reciprocal Relationship

The application of our counseling skills deepens our relationship with our client and moves the client into the next counseling stage (see Figure 5.4). Movement into the next stage necessitates the use of new skills and brings forth a deeper understanding of our client from our unique theoretical orientation. Concurrently, as we apply our case conceptualization model we gain a deeper understanding of our client from our particular theoretical perspective. In other words, our case conceptualization model informs our theoretical model. As we understand our client in new and deeper ways, we move into later stages of the counseling relationship that necessitate the use of new counseling skills. After the counseling relationship has ended, counselors should follow up, at which point they may find that the client wants to recycle through the stages of the relationship or be referred to a new counselor. Thus, we see a deepening reciprocal relationship among the skills that we use, our case conceptualization model, our theoretical orientation, and the stages of the counseling relationship.

FIGURE 5.4
Relationship among Case Conceptualization, Theory, Stages, and Skills
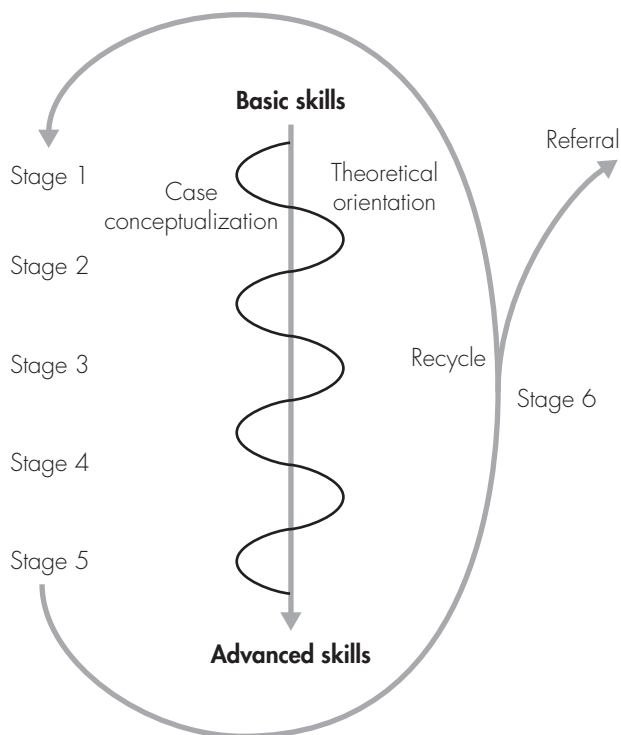
■ *Case Notes*

With the increasing number of people reading and writing *case notes*, note taking has become particularly important in the life of the counselor. Regardless of the setting in which you work, there are numerous reasons why the writing of careful case notes has become so critical (Neukrug, 2002, 2004; Neukrug & Schwitzer, 2006; Prieto & Scheel, 2002):

- They are important in the case conceptualization process.
- They can help us pull together our thoughts when making a diagnosis.
- They are a measure of our standard of care and subsequently can be used in court, if necessary, to show adequate client care.
- They assist in our understanding of whether or not our clients have made progress.
- They can be useful when we obtain supervision.
- They can help us remember what our client said.
- They are needed by insurance companies, agencies, and schools to support the treatment we are providing to our clients.

Today, there are many kinds of case report writing, including daily case (progress) notes, intake summaries, quarterly summaries, summaries for insurance companies, summaries for students' individual education plans, summaries for vocational rehabilitation planning, summaries for referrals to other clinicians, and termination summaries. Although many settings require the counselor to write notes during or directly following a session, the frequency of writing more involved case summaries, such as quarterly or semiannual summaries, varies dramatically from setting to setting.

Although most agencies and educational settings require case notes, how they are recorded may vary. More than likely, however, you will be using a computer for your case notes or employing the tried-and-true fashion of writing them out. Although laborious, writing case notes can help a counselor organize his or her thoughts about a client and can help in the case conceptualization process (Cameron & turtle-song, 2002; Prieto & Scheel, 2002). One approach to writing case notes that has gained popularity over the years is called the *S.O.A.P. format*, which stands for Subjective, Objective, Assessment, and Plan. Table 5.2 shows how such notes are used.

Because taking notes during a session can be distracting and, for some counselors, make it difficult to listen, many suggest waiting until after the session is finished to write notes. On the other hand, some counselors find that case note taking during the session helps them focus and strengthens their ability to conceptualize client problems. Regardless of when you take notes, it is important to be objective and not to include speculation that has little basis in fact. Although the requirements for case note writing can vary dramatically, daily notes are generally less than a page long, whereas quarterly summaries are a few pages long.

For more involved summaries, some of the more typical headings that are used include: demographic information (e.g., DOB, address, phone, e-mail address, date of interview), reason for report, family background, other pertinent background information (e.g., health information, vocational history, history of adjustment issues/emotional problems/mental illness), mental status, assessment results, diagnosis, summary, conclusions, and recommendations.

TABLE 5.2

S.O.A.P. Case Notes		
	SUBJECTIVE-DESCRIPTION	SUBJECTIVE-EXAMPLES	SUBJECTIVE-POINTERS
S	• What the client tells you (feelings, concerns, plans, goals, thoughts) • How the client experiences the world • Client's orientation to time, place, and person	• Client reports… • Client shares… • Client describes… • Client indicates…	• Avoid quotations • Full names of others are generally not needed. • Be concise • Limit adjectives
	OBJECTIVE-DESCRIPTION	OBJECTIVE-EXAMPLES	OBJECTIVE-POINTERS
O	• Factual: what the helper personally observes and/or witnesses • Quantifiable: What was seen, heard, smelled, counted, or measured (may include outside written materials)	• Appeared _____ as evidenced by… • Test results indicate… • Client's hair uncombed; clothes unkempt	• Avoid words like client "appeared" or "seemed" when not supported by objective examples • Avoid labels, personal judgments, or opinionated statements
	ASSESSMENT-DESCRIPTION	ASSESSMENT-EXAMPLES	ASSESSMENT-POINTERS
A	• Summarizes the helper's clinical thinking • Includes diagnoses or clinical impressions and reasons for behavior	• Behavior/attitude consistent with individuals who… • DSM-IV-TR diagnosis • Rule out…	• May note themes, or recurring issues • Remain professional • Remember that others may view assessment.
	PLAN-DESCRIPTION	PLAN-EXAMPLES	PLAN-POINTERS
P	• Describes parameters of treatment • Includes action plan; interventions; progress; prognosis; treatment direction for next session	• Counselor established rapport, challenged, etc. • Client progress is indicated by… • Next session, counselor will… • Client and counselor will continue to…	• Give supporting reasons for progress • "Progress is fair due to client's inconsistent attendance at sessions"

Adapted from: Cameron, S., & turtle-song, i. (2002). Learning to write case notes using the SOAP format. *Journal of Counseling & Development, 80,* 286–92.

Finally, a wide range of ethical, professional, and legal issues accompanies the case note process and is illuminated by ACAs ethical code. Some of these more common concerns will be addressed shortly in the section of this chapter on Ethical, Professional, and Legal issues.

■ *Multicultural/Social Justice Focus: Applying Skills Cross-Culturally*

It must be stressed that while the application of specific counseling skills discussed in this chapter may be beneficial to some clients, they may not be helpful and even may be harmful to the counseling relationship when used in a cross-cultural counseling relationship

(McAuliffe, 2008). For instance, a Native American client may feel uncomfortable with prolonged eye contact; many Latin-American clients are comfortable with less personal space than other clients and may interpret counselor distance as aloofness; a Muslim may consider being touched by the left hand of a counselor as obscene, because the left hand is seen as unclean and used as an aid in the process of elimination, while the right hand is seen as clean and used for eating; and an African-American client may be put off by a white counselor who is non-directive and aloof.

In a similar vein, some clients may feel defensive with the use of questions, while other clients may feel uncomfortable because the counselor uses an abundance of empathy. Some clients may feel as though they are being pushed to self-disclose—a quality viewed as weak in their culture—while other clients may feel offended that the counselor has not allowed them to talk more, as their culture tends to feel comfortable with the expression of feeling. And members of some cultures may be embarrassed by counselor self-disclosure, while for others, such disclosure may bring a counselor and client who are from two different cultures closer together.

Clearly, counselors need to have knowledge of the cultural background of the client and how a specific client's values, beliefs, and customs will play a part in the counseling relationship. At the same time, it must be remembered that each client is unique. For instance, although many Latin-American clients may be turned off by too much counselor–client personal space, some will feel uncomfortable with little space. Or an African-American client may be offended by the intentional lack of eye contact from his or her white counselor as a result of the counselor's belief that African Americans prefer less eye contact from White counselors.

Ethical, Professional, and Legal Issues

Ethical and Legal Issues Relative to Case Notes and Records

> *Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services provided. If errors are made in client records, counselors take steps to properly note the correction of such errors according to agency or institutional policies.*
> (ACA, 2005, Section A.1.b)

Listed as one of the most important issues relative to the client's welfare, maintenance of client records encompasses a broad range of issues such as confidentiality of records, client right to access records, permission to record or observe the client, proper storage and disposal of records, and security of records. The following addresses some of the more salient issues that have arisen over the years: *confidentiality of records* and *privileged communication*, *client's rights to records*, and *security of records*.

Confidentiality of Records and Privileged Communication

As noted in ACAs (2005) ethical code, client records should be kept confidential except when legal concerns supersede confidentiality (see next section on client rights to records). For instance, in cases where there is danger to a person or society, when a court has the legal right to obtain records, or when clients want access to their records, counselors would likely need to yield their records.

A 1996 Supreme Court ruling, involving the case records of a social worker, upheld the right for licensed professionals to maintain the confidentiality of their records. Describing the social worker as a "therapist" and "psychotherapist," the ruling suggested that all licensed therapists who hold *privileged communication* have a right to withhold information about their clients (Remley, Herlihy, & Herlihy, 1997) (see Box 5.5). Privileged communication is the right of the client to expect that communication with the counselor is confidential as defined by state or federal statute.

Despite this ruling, licensed counselors should continue to act cautiously, as the definition of privileged communication varies dramatically as a function of the state in which one is licensed and there are many exceptions to privilege (Glosoff, Herlihy, & Spence, 2000). For instance, look below at how limiting the privileged communication statute is in Virginia. It starts out by asserting privileged communication and ends by stating that the court, for almost any reason, can nullify such privilege:

> . . . *no duly licensed practitioner of any branch of the healing arts shall be required to testify in any civil action, . . . [except] when a court, in the exercise of sound discretion, deems such disclosure necessary to the proper administration of justice. . . .* (Virginia Code, 2005, para.1, 2)

BOX 5.5

Jaffee v. Redmond

Mary Lu Redmond, a police officer in a village near Chicago, responded to a "fight in progress" call at an apartment complex on June 27, 1991. At the scene, she shot and killed a man she believed was about to stab another man he was chasing. The family of the man she had killed sued Redmond, the police department, and the village, alleging that Officer Redmond had used excessive force in violation of the deceased's civil rights. When the plaintiff's lawyers learned that Redmond had sought and received counseling from a licensed social worker employed by the village, they sought to compel the social worker to turn over her case notes and records and testify at the trial.

Redmond and the social worker claimed that their communications were privileged under an Illinois statute. They both refused to reveal the substance of their counseling sessions even though the trial judge rejected their argument that the communications were privileged. The judge then instructed jurors that they could assume that the information withheld would have been unfavorable to the policewoman, and the jury awarded the plaintiffs $545,000 (Remley et al., 1997, p. 214).

After a series of appeals, the case was heard by the Supreme Court on February 26, 1996. The Court decided that the licensed therapist did indeed hold privilege and that the judge's instruction to the jury was therefore unwarranted.

The Clients' Rights to Records

Clients generally have a legal right to view their records, and increasingly they have been exercising these rights in schools and agencies (Corey, Corey, & Callanan, 2011; Remley & Herlihy, 2010). Along these same lines, it has generally been assumed that parents have the right to view records of their children (Attorney C. Borstein, personal communication, March 20, 2010). ACA's ethical standards support these assumptions by stating that clients should generally be provided access to their records:

> *Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client.* (ACA, 2005b, Standard B.6.d.)

In terms of federal law, the *Freedom of Information Act of 1974* allows individuals access to any records maintained by a federal agency that contain personal information about the individual, and every state has followed along with similar laws governing state agencies (U.S. Department of Justice, 2004). Similarly, the *Family Education Rights and Privacy Act* (FERPA), ensures parents the right to access their children's educational records (Committee on Government Operations, 1991), although FERPA generally excludes counseling notes from the category of educational records (Glosoff & Pate, 2003; Remley, Hermann, & Huey, 2003). Finally, the *Health Insurance Portability and Accountability Act* (HIPAA) ensures the privacy of client records and limits sharing of such information (Zuckerman, 2008). In general, HIPAA restricts the amount of information that can be shared without client consent and allows for clients to have access to their records, except for process notes used in counseling (U.S. Department of Health and Human Services, n.d.).

In a more practical vein, clients generally do not ask to view their records. However, if a client did make such a request, I would first explore with the client why he or she wants to see the records. Next, I would want to talk with the client about what is written in the records. If this was not satisfactory to the client, I would suggest that I might write a summary of the records. However, if a client steadfastly states a desire to view his or her records, generally, this is his or her right.

Security of Record Keeping

The security of your records is vital, as clients have the ethical and often legal right to have information they share with others kept confidential (Remley & Herlihy, 2010). Therefore, it is critical that information obtained both verbally and in writing be kept confidential, secured, and not shared with others without client permission. This rule may not apply in certain instances, such as when you share client information with your supervisor, if the court subpoenas your records, and in some cases, if parents request information regarding their children. If you are going to share information with other agencies who might also be working with your client, it is essential that you obtain permission in writing from your client or your client's parent(s). This ensures your client's right to privacy and affords you legal protection.

Written client records need to be kept in secured places such as locked file cabinets (see Box 5.6). If records are kept on computers, then access to those files needs to be

BOX 5.6

How Secure Are Records?

When I worked as an outpatient therapist at a mental health center, a client of another therapist had apparently obtained his records, which had been left "lying around." As his records tended to be written in psychological jargon, he was understandably quite upset by what he found. He therefore would periodically call the emergency services at night and read his records over the phone to the emergency worker while making fun of the language used in the records.

Another time, while taking a class in my doctoral program, we reviewed an assessment of an adolescent that had been done a number of years prior. Suddenly, one of the students in the class yelled out, "That's me!" Apparently, although there was no identifying name on the report, he recognized it as himself (he had been given a copy of the report previously).

limited to you and possibly your supervisor. Clerical help should have explained to them the importance of confidentiality when working with records. In fact, today's agencies sometimes will have nonclinical staff who have access to client information sign statements acknowledging that they understand the importance of confidentiality and that they will not discuss client issues outside the office. Obviously, the importance of hiring nonclinical staff whom you can trust with client information is paramount.

Professional Issue: Crisis, Disaster, and Trauma Counseling

Crisis, disaster, and trauma counseling is a specialized form of counseling in which a quick and immediate response is needed to minimize the long-term effects of trauma as a result of a crisis or a disaster. As noted in Chapter 2, the most recent 2009 CACREP standards now require training in crisis, disaster, and trauma counseling. Many of the basic counseling techniques discussed in this chapter are applied when first meeting a client who has just experienced a crisis or disaster. Whereas past training programs often neglected this important area, programs can no longer be accredited without students gaining knowledge in this area. The National Child Traumatic Stress Network and National Center for Post Traumatic Stress Disorder (PTSD) (Brymer et al., 2009) delineate eight steps in this process, which include:

1. *Contact and Engagement*
    <u>Goal</u>:   To respond to contacts initiated by survivors or to initiate contacts in a non-intrusive, compassionate, and helpful manner.
2. *Safety and Comfort*
    <u>Goal</u>:   To enhance immediate and ongoing safety and provide physical and emotional comfort.
3. *Stabilization (if needed)*
    <u>Goal</u>:   To calm and orient emotionally overwhelmed or disoriented survivors.
4. *Information Gathering: Current Needs and Concerns*
    <u>Goal</u>:   To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.
5. *Practical Assistance*
    <u>Goal</u>:   To offer practical help to survivors in addressing immediate needs and concerns.

6. *Connection with Social Supports*
   <u>Goal</u>:   To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources.
7. *Information on Coping*
   <u>Goal</u>:   To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.
8. *Linkage with Collaborative Services*
   <u>Goal</u>:   To link survivors with available services needed at the time or in the future. (p. 19)

The Counselor in Process: The Developmental Nature of Counseling Skills

When you first learn specific counseling skills, you may want to adhere rigidly to the techniques you are taught. I believe this is good, because the counselor who practices the skills repeatedly will learn them well. However, giving responses in a mechanistic manner can lead to stiltedness in the helping relationship. Thus, one needs to try to find a balance between offering the "right" responses and being genuinely oneself in the relationship. Finding this balance is often not easy; yet, once you do, you will begin to feel more comfortable within the relationship, and you are likely to find your voice as a counselor.

As you continue through your career, you will refine your skills, learn new skills, become more proficient at case conceptualization, and adjust and maybe even change your theoretical orientation. Slowly, you will become more grounded in your approach. It's as though you're continually finding yourself—rediscovering your voice and making it a little clearer. Carl Rogers used to say that as an individual goes through his or her self-discovery process, choices become clearer—almost as if one does not have a choice because his or her path in life becomes obvious (Rogers, 1989c). I believe a similar process occurs as we develop ourselves as counselors. Our skills, abilities, and who we are within the relationship become increasingly more refined and more focused. It's as if we have little choice in how we should act within the relationship—we become the master counselor.

Summary

This chapter examined the basic skills necessary for a successful counseling relationship and began with an overview of the importance of having an environment that can optimize the use of these basic skills. First, we examined the counseling environment, including having a comfortable office that ensures confidentiality, understanding nonverbal behaviors, and embracing counselor qualities that will lead to effective client outcomes, such as the nine personal qualities highlighted in Chapter 1.

The chapter next examined counseling skills, starting with foundational skills. Thus, we looked at how to listen effectively and how to make an effective empathic response and we particularly emphasized the Carkhuff scale. We concluded this section with a short discussion concerning the importance of silence and pause time. We next examined a number of commonly used skills that are employed throughout the counseling relationship, including the use of questions, such as open and closed questions, tentative

questions, solution-focused questions, and why questions; self-disclosure, including content self-disclosure and process self-disclosure; modeling; affirmation giving and encouragement; and offering alternatives, providing information, and giving advice. We then went on to review some commonly used, albeit more complex skills, such as confrontation (support and challenge) that assist clients in seeing discrepancies; interpretation; and collaboration. We pointed out the pitfalls of many of these counselor responses, including the creation of defensiveness or dependency needs on the part of the client. We concluded this section by noting that, with advanced training, there are many advanced and specialized skills that a counselor can adopt.

Counseling skills are important to a successful counseling relationship; however, they become even more powerful when placed within the context of case conceptualization. Looking at the inverted heuristic pyramid model of case conceptualization, we discussed how this process can assist the counselor in understanding symptomatic behaviors, feelings, and thoughts of the client and how it can help the counselor decide treatment planning and intervention strategies. We then identified six stages of the counseling relationship, including the rapport and trust-building stage, the problem identification stage, the deepening-understanding and goal-setting stage, the work stage, the closure stage, and the post-interview stage. We also showed how case conceptualization, counseling skills, and one's theoretical orientation can be applied across the stages of the counseling relationship.

In the chapter, we next highlighted the importance of case notes, talked about the many different kinds of case notes and case records, and highlighted one frequently used system of case note taking called S.O.A.P.

As the chapter continued, we examined the importance of knowing the values, beliefs, and customs of clients from diverse backgrounds in the application of counseling skills. We highlighted the fact that in the cross-cultural counseling relationship some clients from diverse backgrounds may be turned off by what the counselor might consider to be common counseling skills. At the same time, we encouraged counselors not to jump to conclusions and assume that because a client is from certain culture he or she will respond in a prescribed manner.

We next highlighted some of the ethical and legal issues related to case notes and records. We pointed out some aspects of ACAs ethical code relative to case notes, and noted that case notes and records are critically important issues related to the client's welfare. We also noted a broad range of ethical issues related to case notes and records such as confidentiality of records, client right to access records, permission to record or observe the client, proper storage and disposal of records, and security of records. We next pointed out that in the *Jaffee v. Redmond* Supreme Court decision, it was ruled that licensed therapists do have privileged communication. We noted the impact this decision has had on the right of all licensed therapists who have privileged communication. We warned, however, that full privilege is not offered currently in many states. We also noted that ethical guidelines and laws generally protect clients' rights to view their records. Such laws as the *Freedom of Information Act*, the *Family Education Rights and Privacy Act* (FERPA), and the *Health Insurance Portability and Accountability Act* (HIPAA), as well as ethical codes, such as ACAs, generally ensure this right. We also highlighted the importance of case note security.

The chapter highlighted a new professional issue in the counseling field—the importance of obtaining training in crisis, trauma, and disaster counseling. We presented the National Child Traumatic Stress Network and National Center for Post Traumatic Stress Disorder (PTSD) model of crisis counseling, which delineates eight steps in this process.

Finally, this chapter ended with a discussion of the importance of continually developing one's counseling skills and ability at case conceptualization. These evolving skills and formulations allow the counselor to feel more capable about his or her ability and move the counselor toward ever-increasing self-assurance and effectiveness.

■ *References*

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

Bandura, A. T. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Baumgarten, E., & Roffers, T. (2003). Implementing and expanding on Carkhuff's training technology. *Journal of Counseling and Development, 81,* 285–291.

Beck, J. (2005). *Cognitive therapy for challenging problems*. New York: Guilford Press.

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology, 53*(1), 26–35.

Benjamin, A. (2001). *The helping interview, with case illustrations*. Boston: Houghton Mifflin.

Bloomgarden, A., & Mennuti, R. B. (2009). Therapist self-disclosure: Beyond the taboo. In A. Bloomgarden, & R. B. Mennuit (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 3–16). New York: Taylor and Francis Group.

Brammer, L. M., & MacDonald, G. (2003). *The helping relationship: Process and skills* (8th ed.). Boston: Allyn & Bacon.

Brill, A. (2010). *Basic principles of psychoanalysis*. London: Kessinger Publishing. (Original work published 1921)

Brymer M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., … & Watson, P. (2009). *Psychological first aid: Field operations guide* (2nd ed.). Durham, N.C.: National Child Traumatic Stress Network and National Center for PTSD.

Budman, S. H., & Gurman, A. S. (1988). *Theory and practice of brief therapy*. New York: Guilford Press.

Cameron, S., & turtle-song, i. (2002). Learning to write case notes using the SOAP format. *Journal of Counseling and Development, 80,* 286–92.

Carkhuff, R. (1969). *Helping and human relations* (Vol. 2). New York: Holt, Rinehart & Winston.

Carkhuff, R. (2009). *The art of helping in the twenty-first century* (9th ed.). Amherst, MA: Human Resource Development Press.

Carkhuff, R. R., & Berenson, B. G. (1977). *Beyond counseling and therapy* (8th ed.). New York: Holt, Rinehart & Winston.

Committee on Government Operations (Fourth Report). (1991). *A citizen's guide on using the freedom of information act and the privacy act of 1974 to request government records* (House Report 102–146). Washington, DC: U.S. Government Printing Office.

Cooper, J.O., Heron, T.E., & Heward, W.L. (2007). *Applied behavior analysis* (2nd ed.). Columbus, Ohio: Merrill.

Corey, G., Corey, M. S., & Callanan, P. (2011). Issues and ethics in the helping professions (8th ed.). Belmont, CA: Brooks/Cole.

Doyle, R. E. (1998). *Essential skills and strategies in the helping process* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Egan, G. (2010). *The skilled helper: A problem management and opportunity-development approach to helping* (9th ed.). Belmont, CA: Brooks/Cole.

Elliott, R., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 493–539). New York: Wiley.

Farber, B. A. (2006). *Self-disclosure in psychotherapy.* New York: The Guilford Press.

Ferch, S. R. (2000). Meanings of touch and forgiveness: A hermeneutic phenomenological inquiry. *Counseling and Values, 44*(3), 155–173.

Gazda, G. M., Balzer, F. J., Childers, W. C., Nealy, A., Phelps, R., & Walters, R. P. (2006). *Human relations development: A manual for educators* (7th ed.). Boston: Allyn & Bacon.

George, R. L., & Cristiani, R. S. (1995*). Counseling theory and practice* (4th ed.). Boston: Allyn & Bacon.

Glasser, W., & Glasser, C. (2007). *Eights lessons for a happier marriage.* New York: HarperCollins.

Glosoff, H. L., & Pate, R. H. (2003). Privacy and confidentiality in school counseling. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.). *Ethical and legal issues in school counseling* (2nd ed., pp. 164–178). Alexandria, VA: American School Counselor Association.

Glosoff, H. L., Herlihy, B., & Spence, B. E. (2000). Privileged communication in the counselor–client relationship. *Journal of Counseling and Development, 78,* 454–462.

Gompertz, K. (1960). The relation of empathy to effective communication. *Journalism Quarterly, 37,* 535–546.

Guerrero, L. K., & Floyd, K. (2006). *Nonverbal communication in close relationships.* Mahwah, NJ: Lawrence Erlbaum Associates.

Hackney, H., & Cormier, L. S. (2009). *The professional counselor: A process guide to helping* (6th ed.). Upper Saddle River, NJ: Pearson..

Hill, C. E., & Knox, S. (2002). Self-disclosure. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 255–266). New York: Oxford University Press.

Høglend, P., Bøgwald, K., Amlo, S., Marble, A., Ulberg, R., Sjaastad, M., & Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *The American Journal of Psychiatry, 165*(6), 763–771. doi:10.1176/appi.ajp.2008.07061028

Hill, C. E. (2004). Challenge. In C. E. Hill (Ed.), *Helping skills: Facilitating exploration, insight, and action* (2nd ed., pp. 227–243). Washington, DC: APA.

Ivey, A., E., Ivey, M., & Zalaquett, C. P. (2010). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (7th ed.). Belmont, CA: Brooks/Cole.

Jayakar, P. (1996). *J. Krishnamurti: A biography.* New York: Penguin Books. (Original work published 1986)

Kahn, M. (2001). *Between therapist and client: The new relationship* (rev. ed.). New York: W. H. Freeman/Owl.

Kleinke, C. L. (1994). *Common principles of psychotherapy.* Pacific Grove, CA: Brooks/Cole.

Langewitz, W., Nübling, M., & Weber, H. (2003). A theory-based approach to analysing conversation sequences. *Epidemiologia e Psichiatria Sociale, 12*(2), 103–108.

Linda, S., & Miller, G., & Johnson, P. (2000). *Counseling and spirituality: The use of emptiness and the importance of timing.* Paper presented at the Annual Conference of the American Counseling Association, Washington, DC. Retrieved from ERIC database (ED 442021).

Linnell, S., Bansel, P., Ellwood, C., & Gannon, S. (2008). Precarious listening. *Qualitative Inquiry, 14*(2), 285–306.

Lipps, T. (1960). Empathy, inner-imitation, and sense feelings. In M. M. Rader (Ed.), *A modern book of esthetics: An anthology* (3rd ed., pp. 374–381). New York: Holt, Rinehart, and Winston. (Original work published 1903)

Maroda, K. J. (2009). Less is more: An argument for the judicious use of self-disclosure. In A. Bloomgarden, & R. B. Mennuit (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 17–29). New York: Taylor and Francis Group.

Matsumoto, D. (2006). Culture and nonverbal behavior. In V. Manusov & M. L. Patterson (Eds.), *The Sage handbook of nonverbal communication* (pp. 219–236). Thousand Oaks, CA: Sage Publishing.

McAuliffe, G. (2008). *Culturally alert counseling: A comprehensive introduction.* Thousand Oaks, CA: Sage Publishing.

Murdin, L. (2000). *How much is enough? Endings in psychotherapy and counseling.* New York: Routledge.

Naugle, A. E., & Maher, S. (2003). Modeling and behavioral rehearsal. In W. O'Donohue, U. J. Fisher, & S. C. Hayes (Eds.), *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (pp. 238–246). Hoboken, NJ: John Wiley & Sons.

Neukrug, E. (1980). The effects of supervisory style and type of praise upon counselor trainees' level of empathy and perception of supervisor. (Doctoral dissertation, University of Cincinnati, 1980). *Dissertation Abstracts International, 41*(04A), 1496.

Neukrug, E. (1987). The brief training of paraprofessional counselors in empathic responding. *New Hampshire Journal for Counseling and Development, 15*(1), 15–19.

Neukrug, E. (1998). Support and challenge: Use of metaphor as a higher-level empathic response. In H. Rosenthal (Ed.), *Favorite counseling and therapy techniques* (pp. 139–141). Bristol, PA: Accelerated Development.

Neukrug, E. (2002). *Skills and techniques for human service professionals: Counseling environment, helping skills, treatment issues.* Pacific Grove, CA: Brooks/Cole.

Neukrug, E. (2011). *Counseling theory and practice.* Belmont, CA: Brooks/Cole.

Neukrug, E. & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional counseling.* Pacific Grove, CA: Brooks/Cole.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311–381). New York: Wiley.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., 307–389). New York: Wiley.

Pease, A., & Pease, B. (2006). *The definitive book of body language.* New York: Bantam Books.

Planalp, S., & Knie, K. (2002). How to do emotions with words: Emotionality in conversations. In S. R. Fussell (Ed.), *The verbal communication of emotions: Interdisciplinary perspectives* (pp. 55–77). Mahwah, NJ: Erlbaum.

Polcin, D. L. (2006). Reexamining confrontation and motivational interviewing. *Addictive Disorders and Their Treatment, 54*(4), 201–209.

Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. *Journal of Counseling and Development, 79*, 148–160.

Prieto, L. R., & Scheel, K. R. (2002). Using case documentation to strengthen counselor trainees' case conceptualization skills. *Journal of Counseling and Development, 81*, 11–21.

Remley, T. P., Herlihy, B., & Herlihy, S. B. (1997). The U.S. Supreme Court decision in *Jaffe v. Redmond:* Implications for counselors. *Journal of Counseling and Development, 75*, 213–218.

Remley, T. P., & Herlihy, B. (2010). *Ethical and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.

Remley, T. P., Hermann, W. C., & Huey, W. C. (2003). Chapter 5: Records. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 223–225). Alexandria, VA: American School Counselor Association.

Rogers, C. R. (1942). *Counseling and psychotherapy: New concepts in practice.* Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science, Vol. 3, Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.

Rogers, C. R. (1970). *Carl Rogers on encounter groups.* New York: Harper & Row.

Rogers, C. R. (1989c). A therapist's view of the good life: The fully functioning person. In H. Kirschenbaum & V. Henderson (Eds.), *The Carl Rogers reader* (pp. 127–134). Boston: Houghton Mifflin. (Original work published 1961)

Rosenthal, H. (Ed.). (1998). *Favorite counseling and therapy techniques*. Bristol, PA: Accelerated Development.

Rosenthal, H. (Ed.). (2001). *Favorite counseling and therapy homework assignments: Leading therapists share their most creative strategies*. Philadelphia: Brunner-Routledge.

Safran, J. D., & Segal, Z. V. (1996). *Interpersonal process in cognitive therapy*. Northvale, NJ: Aronson.

Schaefle, S., Smaby, M., Maddux, C., & Cates, J. (2005). Counseling skills attainment, retention, and transfer as measured by the skilled counseling scale. *Counselor Education and Supervision*, *44*(4), 280–292.

Schaefle, S., Smaby, M., Packman, J., & Maddux, C. (2007). Performance assessment of counseling skills based on specific theories: acquisition, retention and transfer to actual counseling sessions. *Education*, *128*(2), 262–273.

Schwitzer, A. M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education and Supervision, 35*, 258–267.

Schwitzer, A. M. (1997). The inverted pyramid framework: Applying self-psychology constructs to conceptualizing college student psychotherapy. *Journal of College Student Psychotherapy 11*, 29–48.

Schwitzer, A., MacDonald, K. E., & Dickinson, P. (2008). Using pop culture characters in clinical training and supervision. In L C. Rubin (Ed.), *Popular culture in counseling, psychotherapy, and play-based interventions* (pp. 315–342). New York: Spring Publishing.

Sommers-Flanagan, J., & Sommers-Flangan, R. (2009). *Clinical interviewing* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Steinem, G. (1992). *Revolution from within: A book on self-esteem*. Boston: Little, Brown.

Tafoya, T. (1996). *New heights in human services: Multiculturalism*. Keynote address at National Organization of Human Services Annual Conference, St. Louis, MO.

Toth, P. L., & Erwin, W. J. (1998). Applying skill-based curriculum to teach feedback in groups: An evaluation study. *Journal of Counseling and Development, 76*, 294–301.

Truax, C. B., & Mitchell, K. M. (1961). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (3rd ed.). New York: Wiley.

Turner, J. H. (1997). The evolution of emotions: The nonverbal basis of human social organization. In U. C. Olofsdotter Segerstråle & P. Molnár (Eds.), *Nonverbal communication: Where nature meets culture* (pp. 211–223). Mahwah, NJ: Erlbaum.

U. S. Department of Health and Human Services (n.d.). *Understanding health information privacy*. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

U. S. Department of Justice. (2004). *Freedom of information act guide*. Retrieved from http://www.usdoj.gov/oip/introduc.htm

Van Nuys, D. (2007). *An interview with William Glasser, MD and Carleen Glasser on happier marriages*. Retrieved from http://www.mentalhelp.net/poc/view_doc.php?type=weblog&id=283&wlid=9&cn=289

Virginia Code. (2005). *Communications between physicians and patients*. Retrieved from http://law.justia.com/virginia/codes/toc0800100/8.01-399.html

Wampold, B. E. (2010a). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.

Wampold, B. E. (2010b). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 49–82). Washington, DC: American Psychological Association.

Zuckerman, E. L. (2008). *The paper office: Forms, guidelines, and resources to make your practice work ethically, legally, and profitably* (4th ed.). New York: Guilford.

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. Washington, DC: American Psychological Association.

Zur, O. (2009). Therapist self-disclosure: Standard of care, ethical considerations, and therapeutic context. In A. Bloomgarden, & R. B. Mennuit (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 31–51). New York: Taylor and Francis Group.

The Helping Relationship II: The Counselor Working in Systems

Overview

*T*he three chapters of Section III examine how knowledge of the complex interactions of systems is crucial to working effectively with families, groups, and when consulting or supervising.

Chapter 6 starts with a brief history of couples and family counseling. This is followed by a discussion concerning the views of human nature held by most marriage and family counselors. The remainder of the chapter will examine key concepts of marriage and family counseling followed by an examination of different models of couples and family work. In Chapter 7, I remind the reader that groups, like families, are systemic and follow many of the same system rules as families. I examine some advantages and disadvantages of group work compared to other forms of counseling, present a brief history of group counseling, and discuss the kinds of groups that are conducted by counselors. Chapter 8 will examine two important aspects of the helping relationship: consultation and supervision. I will note that knowledge of systems is important for both the consultant and the supervisor and define and offer different models of consultation and supervision.

As you read through these chapters, consider how a contextual (systems) approach to the work of the counselor offers a different way of conceptualizing client issues and adds a new dimension to the counseling relationship.

Couples and Family Counseling

When I was in private practice, I received a call from a woman who wanted me to see her 12-year-old son; his grades in school had dropped precipitously and he was having behavioral problems. Having had training in family counseling, I asked the whole family to come to the first session, rather than just seeing the boy alone. During the first session I obtained basic information about the family. The boy was the older of two children; a sister was one year younger. The family was middle class, and there was no significant family history that could explain any problems. Both mom and dad had some difficulties in childhood, but nothing out of the ordinary.

I decided to see the parents and the boy in family sessions. Although some family counselors would insist on seeing the whole family, I did not work like that. The parents saw no reason to have the daughter in the sessions, and I didn't want to resist their resistance. My style is to go with the family's wishes in order to build rapport. At a later date, if I felt the daughter should come in, I would request that of the family.

I saw the family, without the daughter, for approximately two months. Other than the school problems, there seemed to be no significant issues, at least any that I could get a handle on. I did, however, notice that most of the sessions were centered around the boy. Suddenly, during one session, the father blurted out, "I'm really depressed." Next thing I knew, he was talking about wanting to kill himself. Then the mother started saying she was bulimic, throwing up a few times a day; then she started alluding to having an affair.

As the parents continued to talk about their problems, I looked at the boy and saw that, for the first time, he was relaxed. It was becoming clear: The parents were using the boy to divert the pain of their own problems. I asked them to begin to look at their issues and lay off their son a little. Within a week, the boy's grades started to improve and his acting out ceased. Now the real work was to begin—helping the couple deal with their issues! This is family counseling.

This chapter will start with a brief history of couples and family counseling and then describe some common elements of the view of human nature to which most couples and family counselors adhere. Next, we will describe key concepts to couples and family counseling followed by an examination of some of the more prominent models of

couples and family work including the human validation process model, structural family therapy, strategic family therapy, multigenerational approaches, experiential family therapy, psychodynamic family therapy, cognitive–behavioral family counseling, narrative family counseling, and solution-focused family therapy. The chapter will then focus on multicultural and social justice concerns and then examine some ethical, professional, and legal issues related to family counseling. As usual, we will conclude with a statement about "the counselor in process" relative to couples and family counseling.

■ *Couples and Family Counseling: A Brief History*

Although the emergence of couples and family counseling as a profession began around the middle part of the twentieth century, there were a number of events that led up to its birth. For instance, during the 1800s, two approaches to working with families and communities evolved (Burger, 2011). *Charity Organization Societies* had volunteers visiting the poor to assist in alleviating conditions of poverty. These *friendly visitors* would often spend years assisting one family by helping to educate the children, giving advice and moral support, and providing necessities. At about the same time, the settlement movement, which had staff who lived in the poorer communities, began to develop (Leiby, 1978). These idealistic staff believed in community action and tried to persuade politicians to provide better services for the poor. One of the best-known settlement houses was Hull House, established by social activist Jane Addams (1860–1935) in 1889 in Chicago (Addams, 1910). Out of involvement with the underprivileged, articles and books appeared concerned with finding methods of meeting the needs of the poor and how to work with destitute families within the larger social system. Here, we see the beginnings of *social casework* and the first time that the "system" is acknowledged as an important component to consider when helping individuals and families overcome their difficulties.

Paralleling the work of early social workers was the psychotherapeutic approach of Alfred Adler who believed that external forces greatly affected personality development and that through education, one could help to alleviate problems. In fact, Adler's approach to working with children is often cited as an early precursor to family therapy models (Goldenberg & Goldenberg, 2008; Sherman, 1999). At Adler's child guidance clinics, parents would often meet with therapists to discuss problems with their children, although generally the parents and children were not all in the same room together (Bottome, 1957). For the first time, counselors were suggesting that problems with one family member had a significant effect on the whole family.

Despite these early efforts at working with families, because psychoanalysis and other individual-oriented approaches were firmly embedded as the treatments of choice for counselors and psychotherapists, there was little room for novel therapeutic approaches to take hold (Guerin, 1976). Thus, until the late 1940s and early 1950s, counselors who saw value in working with the whole family often felt pressure to see the "patient" separately from the family. Soon, however, this new approach to psychotherapy began to take shape.

[At first, s]ome hospitals had a therapist to deal with the carefully protected intra-psychic process, another psychiatrist to handle the reality matters and administrative

procedures, and a social worker to talk to relatives. In those years this principle was a cornerstone of good psychotherapy. Finally, it became acceptable to see families together in the context of research. (Bowen as cited in Guerin, 1976, p. 3)

As increasing numbers of therapists believed it was useful to see the "whole" family together, a variety of approaches to family counseling developed during the 1950s (Guerin, 1976). Although some of these evolved independently, there was a core group of early therapists and family therapists who influenced one another and whose training often overlapped (see Bitter, 2009).

Although treating the whole family slowly became accepted, the continued popularity of psychoanalysis influenced many of the early pioneers of couples and family counseling and it was common for early family approaches to combine systems theory with basic psychoanalytic principles. Probably the most well known of these was developed by Nathan Ackerman (1958, 1966), a child psychiatrist. Another psychoanalytically trained therapist, Ivan Boszormenyi-Nagy (1973, 1987), stressed the importance of ethical relationships in families and highlighted the notion that one's sense of fairness and loyalties are unconsciously passed down through generations and create a specific view of the world that may, or may not, match the view of one's partner or spouse. Establishing the Eastern Pennsylvania Psychiatric Institute (EPPI), Boszormenyi-Nagy's *contextual family therapy* would sometimes include grandparents and other significant individuals when examining these cross-generational issues, with the goal of helping families develop healthier and more loving ways of communicating. At around the same time, Murray Bowen (1976, 1978) developed what some would later call *multigenerational family counseling*. Working initially at the Menninger Clinic in Kansas and later at the National Institute of Mental Health (NIMH) in Washington, D.C., Bowen was interested in understanding the communication of families in which one member was schizophrenic. Working with all members of a family, one member at a time, his experiences with these families, and later with families struggling with "normal" problems, resulted in new ideas about how family dysfunction is passed on through generations.

The group that was to have the most profound influence on the evolution of couples and family counseling was led by an anthropologist, Gregory Bateson, in Palo Alto, California (Guerin, 1976; Mental Research Institute, 2008). Fascinated by human communication, in the early 1950s Bateson hired Jay Haley, John Weakland, Don Jackson, and William Fry to look at how individuals communicate in systems, particularly families that had schizophrenic members. Their *double-bind theory* attempted to explain how schizophrenics are often caught in a web of mixed messages from family members who hold power. Applying principles of *general systems theory* and *cybernetics* to help understand family communication, their ideas fueled the manner in which a generation of couples and family counselors would work and continue to influence them today. Out of this project came the Mental Research Institute (MRI) at Palo Alto. Led by Don Jackson, and joined by Jay Haley, Virginia Satir, and later Cloé Madanes, this group focused on communication and family process. Satir's work at MRI, an earlier collaboration with Murray Bowen, and influences from humanistic psychology eventually led to the development of her *human validation process model*, which focused upon communication and self-esteem in couples and families (Satir, 1967, 1972a, 1972b). Meanwhile, Haley (1973, 1976, 2009) and Madanes (1981) would take a different route. Concentrating mostly on making strategic behavioral changes, their *strategic therapy* became one of the most popular and intriguing approaches to couples and family counseling.

At around the same time that the Palo Alto group was formulating their ideas, Carl Whitaker started to become popular. Influenced by individuals as varied as Gregory Bateson, Carl Jung, psychoanalyst Melanie Klein, and Buddhist philosopher Alan Watts, Whitaker was unconventional and willing to freely experiment with his responses during sessions. With the concurrent spread of humanistic psychology during the 1950s and 1960s, his *experiential approach* to couples and family work evolved at this time (Napier & Whitaker, 1972, 1978; Whitaker, 1976).

Influenced by his work with families in Israel, low-income and minority families in New York City, and the work of Bateson and others at Palo Alto, during the 1960s Salvador Minuchin (1974, 1981) developed one of the most widely respected approaches to couples and family counseling. An Argentine-born psychiatrist, Minuchin became known for his work with minorities and the poor at the Philadelphia Child Guidance Clinic where he applied his *structural family therapy* approach that demonstrated how family problems are related to problems in family structure. Eventually, Jay Haley joined Minuchin, and the two shared their ideas on working with families. It is also here that Jay Haley and Cloé Madanes met, and eventually married.

In 1966, within MRI, the Brief Family Therapy Center (BFTC) was established. Led by Paul Watzlawick, John Weakland, and Dick Fisch, BFTC focused solely on helping families solve their problems, as opposed to spending an inordinate amount of time on "underlying" issues, communication sequences, or systemic patterns (Cade, 2007; Goldenberg & Goldenberg, 2008). These individuals realized that the solutions families tried generally resulted in entrenching the problem more. Approaching couples and families with an attitude of experimentation, the therapists were highly active and they felt free to use any methods that were ethical and legal to solve problems or lessen presenting symptoms. Steve de Shazer (1982) and Insoo Kim Berg (1994), both of whom did postgraduate studies at BFTC, later became two leading figures in the development of *solution-focused family therapy*.

Intrigued by Gregory Bateson and inspired by the work of Jay Haley, the early 1970s saw an Italian group, known as the *Milan Group*, become popular (Palazzoli, Boscolo, Cecchin, & Prata, 1978). With Watzlawick from BFTC as their consultant, this group borrowed many ideas from Bateson's original work and were also influenced by the work of cognitive and constructivist therapists, who believed that language usage is critical to meaning-making and how one comes to make sense of one's family.

With the expansion of behavioral and cognitive approaches to individual therapy in the latter part of the twentieth century, we concomitantly saw these philosophies applied within couples and families. Finally, with what has come to be known as the *post-modern* movement, we see the recent rise of what is called *narrative family therapy*. Influenced by Michael White and David Epston (White, 1995; White & Epston, 1990), this approach attempts to understand a couple or family's narrative, or story, and helps them to *deconstruct* problem-saturated stories and then reconstruct how the couple or family comes to understand itself.

In recent years, the field of couples and family counseling has taken off, with 50 states having licensure for marriage and family counseling, according to the American Association of Marriage and Family Therapy (AAMFT, 2009). Today, AAMFT and the International Association for Marriage and Family Counselors (IAMFC), a division of the American Counseling Association (ACA), are the two main couples and family therapy associations in the country. These associations, along with their respective accreditation

bodies that include the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE) and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), lead the field in setting standards for accreditation, making recommendations to state licensing boards, defining best practices and ethical standards, and helping to set credentialing requirements in the field of couples and family therapy. Today, some training in couples and family counseling is commonplace in almost all programs that train helpers.

◼ *View of Human Nature*

Because couples and family counselors can have any of a number of theoretical orientations, their views of human nature can vary dramatically. For instance, a couples or family counselor can be psychodynamically oriented and believe that the unconscious plays an important role in one's life and also impacts the couple or family; behaviorally focused and view the individual as conditioned by his or her environment (including a partner and a family); existential–humanistically oriented and see the individual and the family as having a growth force that can be actualized; or have leanings toward social constructionism and believe that there is no one reality and that individuals construct their sense of meaning from language. Despite these differences, most (but not necessarily all!) couples and family counselors share a number of assumptions that are integrated into their theoretical orientations. These are summarized below (Barker, 2007; Turner & West, 2006).

1. The interactional forces between couples and in families are complex, and cannot be explained in a simple, causal fashion.
2. Couples and families have overt and covert rules that govern their functioning.
3. Understanding the complementary nature of couples and the hierarchy in a family (e.g., who's "in charge"; who makes the rules) can help one understand the makeup and communication sequences of couples and of families.
4. Comprehension of the boundaries and subsystems (e.g., spousal, sibling) of couples or families can help one understand the makeup and communication sequences of a couple and of a family.
5. Understanding whether boundaries are rigid or semi-permeable (e.g., how information flows in and out of couples and families) can help one make sense of how communication and change occur in couples and in families.
6. Understanding how couples and family members communicate can give insight into how couples and families maintain their way of functioning.
7. Each couple and family has its own unique homeostasis that describes how its members typically interact. This homeostasis is not "bad" or "good." It simply is.
8. Communication in couples and families is complex, and the language they use tells a message about who they are.
9. Change occurs by changing the homeostasis, or the usual patterns in the couple and in the family.
10. Issues passed down by language in families, in culture, and in society affect how couples and families come to define themselves.

11. Stress from the expected developmental milestones (marriage, birth of a child, etc.) can wreak havoc on the couple and family and counselors should be aware of the particular issues involved in such developmental crises.
12. In addition to being equipped to deal with stress from developmental milestones, couples and family counselors should have the tools to help couples and families deal with the unexpected stressors of life.

■ *Key Concepts*

The assumptions listed in the "View of Human Nature" section are an outgrowth of a number of ideas that have been generated over the years and will be expanded upon in this section. They include the following concepts: *general systems theory, cybernetics, boundaries and information flow, rules and hierarchy, communication theory, scapegoating and identified patients, stress, developmental issues*, and *social constructionism*.

General Systems Theory

> *The concept of system thus treats people and events in terms of their interactions rather than their intrinsic characteristics. The most basic principle underlying the systems viewpoint has been understood for some time. An ancient astronomer once said, "Heaven is more than the stars alone. It is the stars and their movements."*
> (Baruth & Huber, 1984, p. 19)

The amoeba. The family. The universe. What do these seemingly dissimilar entities have to do with couples and family counseling? Although knowledge of the amoeba and of the universe may seem like a far cry from helping us understand couples and families, in actuality, they all have something in common: They obey the rules of a system. The amoeba has a *semi-permeable boundary* that allows it to take in nutrition from the environment. This delicate animal could not survive if its boundaries were so rigid that they prevented it from ingesting food or so permeable that they would not allow it to maintain and digest the food. As long as the amoeba is in balance, it will maintain its existence.

The universe is an exceedingly predictable place, and it has a certain cadence to it. It maintains a persistent structure over a long period of time. However, remove a star, planet, moon, or asteroid, and the system is shaken, momentarily disequilibrated as it moves to reconfigure itself. As long as the universe is in balance, it will maintain its existence. Like the amoeba and the universe, what occurs in couples and families is predictable, because they too have boundaries and structure that maintain themselves over long periods of time. As long as the couple and family system is in balance, it will maintain its existence.

General systems theory (von Bertalanffy, 1934, 1968) was developed to explain the complex interactions of all types of systems, including living systems, family systems, community systems, and solar systems. Each system had a boundary that allows it to maintain its structure while the system interacts with other systems around it. As such, the action of the amoeba, one of the smallest of all living systems, affects and is affected by surrounding *suprasystems*, while the universe, the largest of all systems, is made up of *subsystems*

that have predictable relationships to one another. Similarly, the action of subsystems in families will affect other subsystems (e.g., the parental subsystem will affect the child subsystem); couples and family units will affect other couples and families; couples and families make up communities that affect society; and so on.

Cybernetics

The study of *cybernetics*, or control mechanisms in systems, has been used to explain the regulatory process of a system (Becvar & Becvar, 2009). The distinctive manner that each system has to maintain its stability is called its *homeostasis*. One type of cybernetic system of which we are all aware is the thermostat. As it becomes colder, the temperature drops, and the thermostat turns on the heating system; as the temperature goes up, the thermostat shuts down the heat. This type of cybernetic system is called a *negative feedback loop* because it keeps the irregularities within the system at a minimum. *Positive feedback loops* are when change in one component in a system leads to a change in another component within the same system, which leads to a change in the first component, and so on. On the relationship level, cybernetics explains how couples and families regulate themselves using their unique ways of communicating as they maintain their homeostasis. Although most couples and families are engaged in negative feedback loops, sometimes, such as in some cases of spousal abuse, you see a positive feedback loop when spouses egg each other on in a continual escalation of the fight (see Box 6.1).

Based on the example in Box 6.1, you might conclude that negative feedback loops are good and positive feedback loops are bad. Actually, this is not the case (Becvar & Becvar, 2009). Negative feedback loops are good if they result in healthy behaviors in couples and in families (good communication, good feelings, etc.). However, negative feedback loops will sometimes result in the maintenance of dysfunctional behaviors (lack of communication, negative feelings), and although positive feedback loops can lead to abuse, they also can be the impetus for shaking up the system and having it move toward healthier ways of communicating. In fact, couples and family counselors will often encourage the *disequilibration* of the "safe" yet unhealthy ways of relating that can be found in some negative feedback loops so that the couple or family can experiment with new ways of relating. Each couple and family has its unique way of interacting, which includes negative and sometimes positive feedback loop systems. If you examine communication sequences in any couple and family, you can begin to understand the unique boundaries, feedback loops, and homeostatic mechanisms involved.

Boundaries and Information Flow

A healthy system has *semi-permeable boundaries* that allow information to come into the system, be processed, and incorporated. When a system has *rigid boundaries*, information is not able to easily flow into or out of the system, and change becomes a difficult process. Alternatively, a system that has *diffuse boundaries* allows information to flow too easily into and out of the system, causing the individual components of the system to have difficulty maintaining a sense of identity and stability (Nichols & Schwartz, 2009; Turner & West, 2006). Rigid boundaries will often lead to disengagement on the part of family members and a heightened sense of autonomy. In extreme cases, such families will

BOX 6.1

Joyce and Antonio: A Positive Feedback Loop

In the dialogue below, Joyce and Antonio are discussing going out to a play. As they realize that their expectations about the evening differ, they begin to get angry at each other. Eventually, there is an altercation, at which point Antonio defuses the situation by leaving.

Joyce: *Are you going to the play with me tonight?*

Antonio: *Well, I was actually thinking I might go out with my friends. You know, I haven't really seen them for a while. Besides, I didn't really think that I committed myself to the play.*

Joyce: *Well, you did say you thought you would go with me.*

Antonio: *I don't remember saying that. I was thinking all along that I would go out with my buddies.*

Joyce: *I remember distinctly you telling me you would go. It's clear as day to me. You're either lying or have early dementia.*

Antonio: *Look, I don't want to get into a fight. You're always forcing me to get into a fight with you. I don't know why you egg me on like this. You must have a need to fight with me. I bet it has to do with the fact that you never felt loved by your father—you know, we've talked about that before.*

Joyce: *Not being loved by my father! Who are you kidding? The only one I don't feel loved by is*

you. At least my father was around. You just take off whenever you damn please! Half of the time you leave me with the kids, as if you have no responsibility around here. You just go out, get blasted and God knows what else.

Antonio: *Look, I'm no slacker around here. You don't do a damn thing around this house. Look at it. It's a mess. I do plenty, and you can't even keep this house together. I work hard to fix this place up, and you can't even run a vacuum once in a while. You . . . it's disgusting!*

Joyce: *Don't call me disgusting!*

Antonio: I didn't! I said *it's* disgusting—the house.

Joyce: *No, I heard you, you were going to say I'm disgusting. I hate you! You and your drinking, you and your friends. You and those sluts you hang out with at work. I know what you're doing behind my back!*

Antonio: *Screw you!*

Joyce: *Go to hell! (Swings at him.)*

Antonio: *(Grabs her arm as she swings and throws her on the floor.)*

Joyce: *You abusive bastard!*

Antonio: *Screw you. . . . I'm getting out of here. (Leaves the house.)*

Joyce: *(Sobs as Antonio leaves.)*

have family secrets (e.g., child abuse), with their rigid boundaries maintaining the secret within the family. Diffuse boundaries, on the other hand, often lead to lack of a sense of self, enmeshment, and dependence on one another.

American culture allows for much variation in the permeability of various systems, but systems that have boundaries that are too diffuse or too rigid tend toward dysfunction. In the United States, it is common to find couples, families, and community groups (e.g., some religious organizations) with a fairly rigid set of rules that maintain their functioning in relatively healthy ways. Alternatively, we may also find couples, families, and community groups that allow for a wide range of behaviors within a fairly diffuse system (e.g., communes). Unfortunately, all too often, we have seen the dysfunction that results from a system whose boundaries are too rigid or too diffuse (see Box 6.2).

BOX 6.2

Jim Jones and the Death of a Rigid System

During the 1950s and early 1960s, Jim Jones was a respected minister in Indiana. However, over the years, he became increasingly paranoid and grandiose, believing he was Jesus. He moved his family to Brazil and later relocated to California, where approximately 100 of his church followers from Indiana joined him. In California, he headed the "People's Church" and began to set rigid rules for church membership. Slowly, he became more dictatorial and continued to show evidence of paranoid delusions. Insisting that church members prove their love for him, he demanded sex with female church members, had members sign over their possessions, sometimes had members give their children over to him, and had members inform on those who went against his rules. In 1975, a reporter uncovered some of the tactics Jones was using and was about to write a revealing article about the church. Jones learned about this and, just prior to publication of the article, moved to Guyana, taking a few hundred of his followers with him. As concerns about some of the church practices reached the United States, California Congressman Leo Ryan and some of his aides went to Guyana to investigate the situation. Jones and his supporters killed Ryan and the aides, and Jones then ordered his followers to commit suicide. Hundreds killed themselves. Those who did not were murdered.

Jim Jones had developed a church with an extremely rigid set of rules. The writing of a revealing article as well as the congressman's flying into Guyana were perceived as threats to the system. As with many rigid systems, attempts at change from the outside were seen as potentially lethal blows to the system. Jones dealt with the reporter's threat to the system by moving his congregation to Guyana. Then, rather than allow new information into the system, Jim Jones killed off the system, first killing the congressperson and then ordering the church members to commit suicide. The members had become so mired in the rules of the system that nearly 900 of them ended up committing suicide or being murdered. (Axthelm, 1978)

Rules and Hierarchy

Families have *universal* and *idiosyncratic rules*, which can be overt or covert, and are partly responsible for determining the nature of the couple or family. Universal rules are those rules that all couples and families tend to follow and are often related to hierarchical structure. For instance, almost all cultures have a hierarchy in which parents, guardians, or an older "wise" person is on a higher level of authority than children. Not following this rule has a consequence, although the kinds of consequences will vary as a function of the culture. Idiosyncratic rules are unique to the family. For instance, a family might have a rule that whenever there is tension in the couple's relationship, the youngest child is yelled at for doing something wrong. In a situation such as this, it is likely that the child is being *scapegoated* in an effort to diffuse tension between the couple. There are an infinite number of idiosyncratic rules, and they usually happen in an automatic manner.

Communication Theory

Understanding the complexities of human communication helps counselors recognize the unique characteristics of couples and families and is often the first step toward developing a plan for change. Some of the principles of communication highlighted in the early 1970s by Watzlawick and others (cf. Watzlawick, Beavin, & Jackson, 1967;

Watzlawick, Weakland, & Fisch, 1974) at Palo Alto greatly changed the way couples and family counselors view their clients and are listed below (Barker, 2007; Turner & West, 2006):

1. "Normal" or "abnormal" is a contextual phenomenon, not an objective state of being.
2. Behaviors tell a story about communication between people and are often more a sign of what's going on than the actual words that are communicated.
3. One cannot *not* communicate. Not saying anything is a communication about communication.
4. A message sent is not necessarily the message received. A person might send one message, but a different message might be heard.
5. Communication has two ways of expression: *digitally*, or the exact meaning of the words, and *analogically*, or the meaning about the meaning, often expressed nonverbally. For example, a person may be angry and say, "I love you" in an angry tone. The digital message "I love you" is at odds with the analogical message.
6. Communication makes a statement about the content of the conversation and about the relationship one is in. In other words, each statement a person makes is an expression about the relationship.
7. A series of communications gives important meaning about the relationship (a husband might always discuss issues with a flat affect to his wife; this continual flat message may be more important than the actual words he says).
8. Any intervention made within the system, be it with one or more of the family members, will reverberate throughout the system.
9. The unconscious is not an important factor in working with individuals; instead, what is important are the current behaviors people are exhibiting.
10. The *whys* are not as important as *what* is going on between people.

Scapegoating and Identified Patients

All couples bring unfinished business to their relationship. The more serious the issues, the more likely they will affect their relationship and others in the family. For instance, a wife who was sexually molested as a child, and as a result feels mistrust toward men, may choose a man who is emotionally distant (and safe). Perhaps he is a workaholic. Alternatively, a man who has fears of intimacy might choose a wife who allows him to be distant (and safe). Perhaps she was sexually molested and distrusts men. As the relationship unravels, issues that each spouse brings to the marriage are played out on one another or on the children. The emotionally distant workaholic husband may become stressed at work, irritable, and nasty toward his wife and/or children. The distrustful wife may become discontented with her marriage due to its lack of intimacy and subsequently become depressed and nonresponsive toward her husband and children. Is it surprising that there are so many affairs and divorces?

When family members are discontented with one another and when they directly or indirectly take out this unhappiness on a specific family member, that member is said to have been *scapegoated* (Nichols & Schwartz, 2009). Sometimes, when a family member is scapegoated, that person takes on the role of *identified patient* (IP), or the family member who is believed to have the problem. System theorists, however, view the whole family

as having the problem. For instance, when a child acts out in the family, in school, or in the community, couples and family counselors will typically view that child as the family member who is carrying the pain for the family. Why is someone in a family scapegoated? Usually, it is because it has become too painful for the couple to look at some other, more painful issue (Hull & Mather, 2006). Rather than sharing their concerns within the family or seeking marital counseling, the couple scapegoats a member of the family, often a child.

> *Psychotherapy, particularly marital psychotherapy, threatens to "uncover" the anxious turmoil in the marriage. "If we seek help as a couple," the partners say silently to themselves, "it will all come out." The anger, the bitterness, the hurt, the sense of self-blame that each carries—this will be the harvest of the opening up to each other. "Maybe it will destroy what we have" is their fear. They dread not only losing the stability of the marriage, but damaging their fragile self-images. Rather than risk their painful and tenuous security, they suppress the possibility of working on their marriage together.* (Napier & Whitaker, 1978, p. 148)

Stress

Living is stressful, and at some point in the life of the couple or family, it will be faced with mild to oppressive stress. Families with semi-permeable boundaries, clearly defined subsystems and suprasystems, little scapegoating, good communication skills, and a healthy hierarchical structure will have an easier time managing stress (see Box 6.3). On the other hand, families with ill-defined boundaries and poor communication skills will tend to blame others for their problems, not take responsibility for their feelings and actions, and have a difficult time dealing with stress. Minuchin (1974) identified four types of stress with which families typically struggle at some point in their development:

- *Stressful contact of one member with extrafamilial forces* (e.g., difficulty at work)
- *Stressful contact of the whole family with extrafamilial forces* (e.g., a natural disaster such as a hurricane)
- *Stress at transitional or developmental points in the family* (e.g., puberty, midlife crises, retirement, aging)
- *Idiosyncratic (situational) stress* (e.g., unexpected illness)

BOX 6.3

A Situational Family Crisis

When I was between the ages of 8 and 13, I had a heart disorder called pericarditis. This was a somewhat debilitating illness that enlarged my heart, caused me much chest pain, and left me periodically bedridden with a resulting mild depression. Although not considered extremely serious, this illness certainly affected my life in a major way. However, it also affected my parents' lives and the lives of my siblings.

Although my illness potentially could have been a threat to the homeostasis in the family, it became clear that the family was healthy enough to deal effectively with this situation. As my parents' marriage was solid, the added stress did not dramatically affect their relationship. In addition, they were able to maintain the functioning of the family in a relatively normal way. This normalization of family patterns during a period of stress speaks highly of the health in the family.

Developmental Issues

All couples and families face developmental milestones that will result in some amount of stress. Becvar and Becvar (2009) suggest that families traverse nine stages of a family cycle, each of which has its own critical emotional issue and tasks that need to be addressed (see Table 6.1).

Whereas some couples and some families have developed ways of communicating that allow them to effectively deal with stressful situations, others have not (Turner & West, 2006). One function of the couples and family counselor is to be aware of potential *developmental crises* that may affect couples and families and understand how they tend to respond to stress that results from these normal developmental tasks. Helping couples and families develop healthy responses to stressful situations caused by developmental milestones is an important role of the couples and family counselor.

Text not available due to copyright restrictions

Social Constructionism

> *The addition of social construction to systems theory, then, helps address the criticism that systems theory focuses too much on stability, ignores cultural context, and operates as though the research can find objective truth.* (Turner & West, 2006, p. 70)

In recent years, some couples and family counselors have shifted their understanding of how couples and families are formed and make sense of themselves (Tomm, 1998; Turner & West, 2006). Having a *social constructionist philosophy*, these counselors believe that systems theory, and its close cousin, cybernetics, placed too much emphasis on causal factors and did not stress cultural context enough. The *social constructionists* suggested that earlier couples and family counselors tended to see themselves as experts and objective observers who make interventions *on* the couple or family. In contrast, the social constructionists focus on the ongoing, changing manner in which couples and family members come to understand themselves. They believe that couples and families continually co-construct (construct together through ongoing dialogue and nonverbal interactions) their understanding of who they are, and that this construction is a function of the language used by the couple or family, and beliefs from their culture and society. Change occurs, therefore, by the counselor exploring, in a respectful way, how the couple or family co-constructs a sense of meaning for themselves. Then, through the use of thoughtful and respectful questioning, social constructionists believe that they and the couple or family can co-construct a new language that is positive and focuses on solutions. Although many couples and family counselors today integrate this perspective into their existing systems framework (Becvar & Becvar, 2009), some, such as the narrative and solution-focused purists, question these earlier theories (e.g., systems theory, communication theory) and discard them for a belief in the importance of how language defines the person, the couple, and the family.

Models of Couples and Family Therapy

The key concepts just discussed drive the various approaches to couples and family counseling. As some approaches adhere more to certain concepts than others, as you read the theories, reflect on which key concepts tend to drive a particular theory. With many theories of couples and family counseling to choose from, included in this chapter are the most popular ones as well as those that are most associated with some of the major players in the history of couples and family therapy. The theories we will look at include the human validation process model, structural family therapy, strategic family therapy, multigenerational approaches, experiential family therapy, psychodynamic family therapy, cognitive–behavioral family counseling, narrative family therapy, and solution-focused family therapy.

Human Validation Process Model

> *All of the ingredients in a family that count are changeable and correctable—individual self-worth, communication, system, and rules—at any point in time.*
> (Satir, 1972a, p. xi)

Virginia Satir

Considered one of the pioneers of couples and family therapy, Virginia Satir's *human validation process model*, which has also been called a *communication theory* and a *change process model*, integrates many ideas from family systems theory and communication theory, while adding a sense of caring and a focus on self-esteem that is emphasized by the existential–humanistic approaches (Satir, 1972b).

Satir believed that a *primary survival triad* exists that includes parents and the child, with each child's sense of well-being and self-esteem the result of this triad. Individuals with low-self-esteem yield one of four unhealthy universal communication patterns: (1) *the placater*, who appeases people so others won't get angry at him or her; (2) *the blamer*, who accuses others in an effort to diffuse hurt; (3) *the computer*, who acts cool, calm, and collected in an attempt to deal with the world as if nothing could hurt him or her; and (4) *the distracter*, who goes off on tangents in an effort to treat threats as if they do not exist (Satir, 1972a). On the other hand, Satir also believed that children who had healthy parenting would grow into congruent adults who were in sync with their feelings, thoughts, and behaviors and could communicate clearly with others.

Believing that communication and behavioral patterns are a result of complex interactions among family members and the legacy from past generations, Satir felt it was important to obtain graphic information about important past events in one's family. Thus, she would often have families complete a *family life fact chronology*, which is a history of important events within the extended family. Similar to a genogram, the family life fact chronology could be analyzed and reflected upon by all involved in therapy. Additionally, Satir was one of the first therapists to use *family sculpting* in an effort to bring forth blocked and unexpressed emotions (Piercy, Sprenkle, & Wetchler, 1996). This experiential work involves each family member taking a physical position that nonverbally represents how that member interacts with the rest of the family. For instance, a child who is withdrawing might stand near a door as if she were about to leave the room; a mother trying to control her son might stand over him with her finger pointed at him; and a father who is detached through drinking might sit at a table with a make-believe glass of beer in his hand.

Satir believed that a couples and family counselor should be caring and respectful, believe in the ability of the couple or family to heal, actively encourage the couple or family to change, be spontaneous, and act "as a facilitator, a resource person, an observer, a detective, and a model for effective communication" (Becvar & Becvar, 2009, p. 199). By creating a trusting atmosphere that encouraged the letting-down of defenses, Satir hoped to open up communication patterns, look at past hurts, and help clients learn how to be more effective and open communicators. Ultimately, through this process, Satir hoped that individuals in couples and families could have mature relationships in which each person could (Satir, 1972a):

- Be responsible for oneself and have a strong sense of self.
- Make decisions based on an accurate perception of self, others, and the social context.
- Be able to make wise choices for which one takes full responsibility.
- Be in touch with one's feelings.
- Be clear in one's communication.
- Be able to accept others for who they are.
- See differences in others as an opportunity to learn, not as a threat. (adapted from Satir, 1967, p. 91)

Structural Family Therapy

Courtesy of Minuchin Center for the Family
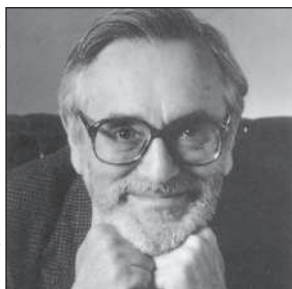
Salvador Minuchin

Although many well-known family therapists see themselves in the *structural school*, certainly the most renowned is Salvador Minuchin (1974, 1981). Minuchin (1974) states that all families have *interactional* and *transactional rules* that are maintained by the kinds of boundaries in the family, as noted through the structure and hierarchy that exists. He also asserts that all couples and families experience stress, which is handled differently as a function of the existing rules, boundaries, structure, and hierarchy in the couple or family. In order to make change, structural family counselors join with the family, map the family, and provide interventions for restructuring.

Joining

Joining is when the counselor is accepted by the family and wins its confidence. Similar to building a working alliance as described in Chapter 1, joining can be done in many ways, such as through empathy, being friendly, or sharing common stories with the family. Joining the family allows the counselor to understand the family's rules, boundaries, structure and hierarchy, and stress. It is only then that the counselor can begin the process of mapping and later restructuring the family.

Mapping

Mapping a family can be done formally or informally, and involves an examination of how the family communicates, who is in charge, rules used in the family to maintain its homeostasis, and an understanding of the structure and hierarchy of the family. Mapping is the first step toward restructuring, as the counselor cannot facilitate change unless he or she understands the current way in which the family relates.

Restructuring

Restructuring the family occurs after the counselor has joined the family and mapped its structure. It involves creating healthier boundaries and changing structure and hierarchy in order to help the family deal with stress and function in a healthier manner. Restructuring can occur in numerous ways. Box 6.4 shows the restructuring of one family.

Structural family therapy is a deliberate and purposeful approach to working with families and relies on many of the basic principles discussed under "Key Concepts." Many family therapists who are first starting out are trained in this approach, as it helps the therapist view the family from a systemic perspective.

Strategic Family Therapy

The steps involved in *strategic therapy* are based on an understanding of communication and systems theory; and, because unconscious motivations play little if any role in this type of therapy, the approach is relatively pragmatic. Relative to the therapeutic process, the strategic approach is not particularly concerned with feelings (although the therapist wants the client to end up having good feelings!). This approach is based on how individuals communicate with one another, how communication sequences can be changed to help people feel better, and how power is dispersed in the family. Power for the strategic therapist is defined in some very nontraditional ways:

Power tactics are those maneuvers a person uses to give himself influence and control over his social world and to make that world more predictable. Defined thus broadly, a man has power if he can order someone to behave in a certain way, but he also has power if he can provoke someone to behave that way. One man can order others to lift and carry him while another might achieve the same end by collapsing. (Haley, 1986, p. 53)

BOX 6.4

An Example of Family Restructuring

Mom and Dad have three children, aged 15, 12, and 1. Since the birth of their new child, the two oldest children have been fighting constantly and having problems at school. The husband and wife seem depressed. Assessing the situation, you find that the whole family is dealing with transitional and idiosyncratic stress. The baby was not planned, and the family is stretched financially. The therapist notes that the family hierarchy has changed, that the spousal subsystem is showing depression, and that the parental subsystem is not able to maintain control over the two older children. The therapist wants to strengthen the spousal and parental subsystems. The current map of the family is shown below.

Dad

Mom and Infant }

Child �కీ Child
(15)   (12)

Legend

} = Cutoff

⎯⎯ = Rigid boundary

�కీ = Conflict

- - - - = Permeable boundary

↘ ↕ = Temporarily in other subsystem
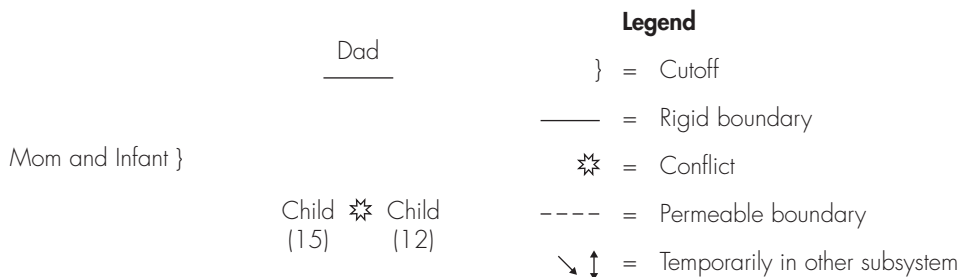
The family therapist prescribes the following actions:

- Have the oldest child take a certification course in babysitting to assist with child care.
- Ask the grandmother to assist with child care to relieve some pressure on Mom.
- Have Dad take on some of the responsibilities related to the problems with the oldest children. He must meet with the teachers and school counselors.
- Suggest that Mom, who now has assistance with child care, take on a part-time job to relieve some of the economic stress (she has always worked in the past).
- Establish one evening a week when the grandmother or oldest child will watch the other two children so the parents can go out.

The goal is to reestablish the spousal subsystem while strengthening the parental subsystem. The grandmother and oldest child will periodically take on a position of power in the family, with their power being time-limited. The extra money and reduction of stress for Mom will result in reduced stress in the family. The family map eventually looks like the following diagram:

Grandmother ↘

Dad   Infant - - - Mom and Dad ↔ (Husband and Wife)
Mom and Infant }   - - - - - - - - - - -
Child �కీ Child   ➡   ↕
(15)   (12)   Child   Child
                           (15)   (12)
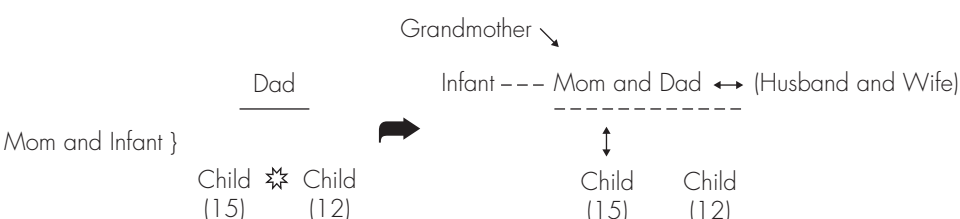
Jay Haley

Cloé Madanes

The therapist most associated with the strategic approach has been Jay Haley (1973, 1976), although others, like Cloé Madanes and the Milan Group, have also become well known. Haley was greatly affected by Milton Erickson, a legend as a therapist because of his uncanny ability to induce change in clients. In Haley's 1976 book, *Problem-Solving Therapy*, he describes four stages of the first interview that lay the groundwork for the change process. Although unique to the way Haley implements strategic therapy, these stages provide a picture of how all strategic family therapists work.

Haley's Stages of the First Interview

1. *The Social Stage.* This initial stage has the counselor inviting . . . the couple or family to counseling and asking each member to introduce him- or herself. At this point, the counselor can observe where individuals sit, the interactions of couple and family members, and the overall mood of the couple or family. During this stage, the counselor should not share his or her observations with the couple or family, and all formulations about them should be tentative.
2. *The Problem Stage.* During the problem stage, each couple or family member is asked to describe his or her perceptions of the problem. The therapist should carefully listen, as the problem is often defined differently. Interactions among couple or family members should be carefully observed, and counselor interpretations about the problem should not be shared.
3. *The Interaction Stage.* The interaction stage is highlighted by the therapist's attempt to get the couple or family to interact during the session in the same manner as would happen at home. This process assists the counselor in viewing how the couple or family is organized around the problem.
4. *Goal-Setting Stage.* During this stage, the couple or family is asked to be clear about what they would like to change, and, in collaboration with the counselor, a problem is agreed upon. This problem is important and needs to be addressed; however, it also tells us something about how the couple or family communicates and the hierarchies in the family (Foster & Gurman, 1985; Haley, 1973, 1976). Therefore, how the counselor addresses the problem may vary based on an assessment of the structure and communication sequences. Remember, the focus is on having people change the way they communicate so they will feel better, and sometimes what the couple or family thinks they *should* do will actually make the problem worse. Thus, the role of the counselor is to help the couple or family change based on the counselor's understanding of the communication problems and of how power is used (and abused). The couple or family need not know why the counselor is prescribing certain tasks, but they do need to "buy into" the change process. Haley addresses this change process through the use of *directives*.

Directives

It is important to emphasize that directives can be given directly or they can be given in a conversation implicitly by vocal intonation, body movement, and well-timed silence. Everything done in therapy can be seen as a directive. (Haley, 1976, p. 50)

Directives are the kinds of instructions given to individuals to foster change. If enough progress has been made, directives can be made at the end of the first session, although sometimes it may take two or three sessions. Haley (1976) identifies two types of directives: "(1) telling people what to do when the counselor wants them to do it, and (2) telling them what to do when the therapist does not want them to do it because the therapist wants them to change by rebelling" (p. 52).

In the first case, a counselor can either give good advice or give a directive that changes the structure of the couple or family. Haley admits that advice, even good advice, is rarely followed by individuals. Therefore, he suggests giving directives in which couples or family members want to participate; directives that will address the presenting problem as well as the broader problems inherent as revealed by the communication sequencing of the couple or family. The counselor generally does not reveal his or her agenda of restructuring the couple or family dynamics, as this is not generally found to expedite change. For instance, parents might identify a problem as their daughter's use of drugs. However, in therapy, it soon becomes clear that the family isolates and cuts off the daughter from the rest of the family. The counselor could give good advice, such as suggesting to the daughter that she take a drug education class. However, this would most likely be a wasteful suggestion, as it is unlikely to be followed by the rebellious daughter. Therefore, it would be more useful to offer a directive that deals with the drug use *and* the family organization—a directive in which all would participate. For example, the counselor might ask the family to include the daughter in as many family activities as possible in an effort to ensure that she is not doing drugs. The parents would appreciate this directive, as it is dealing with the problem, and the daughter would appreciate it, as she is finally being included in the family.

The second type of directive, called a *paradoxical directive*, involves asking clients to do something opposite of what might seem logical, with the expectation that the directive is likely to fail and that this failure will lead to success in therapy. Put simply, "some clients are more invested in the 'cons' of change, not the 'pros' of change" (Jack Grimes, personal communication, July 14, 2009). If clients actually do follow the directive, success is also ensured. For instance, a family has a child who is constantly angry and screaming. The counselor might reframe the situation by stating that this child is actually quite healthy in that he is expressing his feelings. The counselor suggests that listening to the child's feelings is not helpful because the child needs to release his healthy anger. Probably, the counselor remarks, it would be helpful instead to encourage the child to scream more. Parents who rebel against this suggestion end up listening to the child. On the other hand, parents who go with the suggestion are now compliant clients who have reframed the problem into a healthy behavior and are praised at the next session for being good clients.

Another technique to induce change of this kind is through the use of *metaphor*. Look at how Haley (1976) uses metaphor to deal with a couple's uncomfortable feelings about talking directly to their son about his being adopted:

> *[The counselor] talked to the boy about "adopting" a dog who had a problem of being frightened. . . . When the boy said the family might have to get rid of the dog if he became ill and cost doctor bills [the boy had been ill], the therapist insisted that once adopted the family was committed to the dog and would have to keep him and pay his doctor bills no matter what. Various concerns the boy might have had about*

himself as well as the parents' concerns about him were discussed in metaphoric terms in relation to the proposed adoption of the puppy. (p. 65)

The use of such metaphors, as noted above, allows couples and families to consider situations abstractly, thereby lessening the likelihood that resistance (which often occurs when counselors give advice) will occur.

Course of Treatment

Strategic therapy tends to be a short-term approach to counseling because it focuses almost exclusively on presenting problems, does not spend time dealing with intrapsychic processes, and uses directives to facilitate the change process (Carlson, 2002). Usually, directives can be made within the first few sessions, with follow-up and revision to the original directives sometimes calling for only a few more sessions.

To be a strategic therapist takes a great deal of training and confidence in one's ability to suggest effective directives. It is interesting to watch some of the more well-known strategic therapists work. Criticized as manipulative by some, today's strategic therapists stress collaboration, not manipulation (Carlson, 2002). In fact, their directives, even ones with hidden agendas, appear to come from a real and caring place for these master therapists.

Multigenerational Family Therapy

Couples and family counselors who take on a *multigenerational approach* focus on how behavioral patterns and personality traits from prior generations have been passed down in families. Therefore, many multigenerational couples and family counselors encourage bringing in parents, grandparents, and perhaps even cousins, uncles, and aunts.

Although multigenerational couples and family counselors focus on intergenerational conflicts, the way they go about this may differ. For instance, Ivan Boszormenyi-Nagy (1973, 1987) believed that couples and families are relational systems in which *loyalties,* a sense of *indebtedness,* and *ways of relating* are passed down from generation to generation. Couples enter relationships with a ledger of indebtedness and *entitlements* based on their families of origin and what was passed down to those families. A couple who enters a relationship with an imbalanced ledger will invariably attempt to balance the ledger with each other. This is almost always unsuccessful, as the imbalance is a result of unfinished business from the family of origin, not from the spouse. For instance, one who felt unloved by his mother might attempt to settle his account by trying to have his wife shower him with love. However, because this is unfinished business with the mother, the husband will continue to feel a sense of emptiness, even if the wife fulfills this request. Boszormenyi-Nagy believed that it is crucial for all couples and family members to gain the capacity to hear one another, communicate with one another, and have the ability to understand their interpersonal connectedness to their partner, their current family, as well as their families of origin.

When each generation is helped to face the nature of the current relationships, exploring the real nature of the commitments and responsibility that flow from such involvements, an increased reciprocal understanding and mutual compassion between the generations results. (Friedman, 1989, p. 405)

Murray Bowen

© Cengage Learning

Another multigenerational couples and family therapist, Murray Bowen, believed that previous generations could dramatically affect one's ability to develop a healthy ego. He considered the ultimate goal of couples and family therapy to be the *differentiation of self*, which included differentiation of self from others and the differentiation of one's emotional processes from one's intellectual processes (Bowen, 1976, 1978; Guerin & Guerin, 2002). He believed that there was a *nuclear family emotional system* made up of all family members (living, dead, absent, and present), which continues to have an emotional impact upon the system. Such an emotional system, said Bowen, is reflective of the level of differentiation in the family, and is called the *undifferentiated ego mass*. Thus, previous generations could continue to have an influence on current family dynamics (Klever, 2004). Bowen used the *genogram* to examine details of a family's functioning over a number of generations. Although the basic genogram includes such items as dates of birth and death, names, and major relationships, along with breakups or divorces, the counselor will usually also ask the couple or family to include such things as where various members are from, who might be scapegoated and/or an identified patient, mental illness, physical diseases, affairs, abortions, and stillbirths. Such genograms are excellent tools for examining how families evolve over time and for identifying current issues in families (McGoldrick, 2005) (see Figure 6.1).

Bowen believed that individuals find others of similar psychological health with whom to form significant relationships. Therefore, an undifferentiated person will find a person with a similar level of undifferentiation, each hoping he or she will find completeness in the other. What initially seems like a perfect fit usually ends up as a major disappointment and often ends in divorce. When undifferentiated parents do not deal with their issues, which by their very nature are frequent, a *family projection process* occurs in which parents unconsciously *triangulate* their children or project their own issues onto the children. The purpose of this projection process is to reduce stress within the parental relationship while maintaining each spouse's level of undifferentiation. This allows the couple to continue to avoid their issues. An unhealthy relationship obviously leads to problems with child rearing, and ultimately the child grows into an undifferentiated self, thus continuing the cycle. This process could continue *ad infinitum* (see Box 6.5).

From a Bowenian perspective, counselors should be detached and take on the role of teachers and consultants, helping their clients to understand family dynamics and systems theory from an intellectual framework. Bowen mostly worked with couples, generally did not include children in the process, and kept emotionality at a minimum during the sessions by having the clients talk to and through the counselor. Bowen's goal was to help couples and family members see themselves as they truly are and to help them move toward differentiation of self.

Experiential Family Therapy

As the name implies, experiential family therapy stresses the experience of self, of one another, and of the counselor within the family therapy milieu (Napier, 2002). Based mostly on humanistic and existential psychology, this type of therapy has a positive view of human nature, believes that the individual (and the family) has a natural growth tendency, and relies on the relationship between the counselor and the couple or family to induce change. The most well-known experiential family therapist is Carl Whitaker, who prided himself on his lack of a theoretical approach: "I have a theory that theories are

FIGURE 6.1
Figure 6.1: Williams-Neukrug Genogram
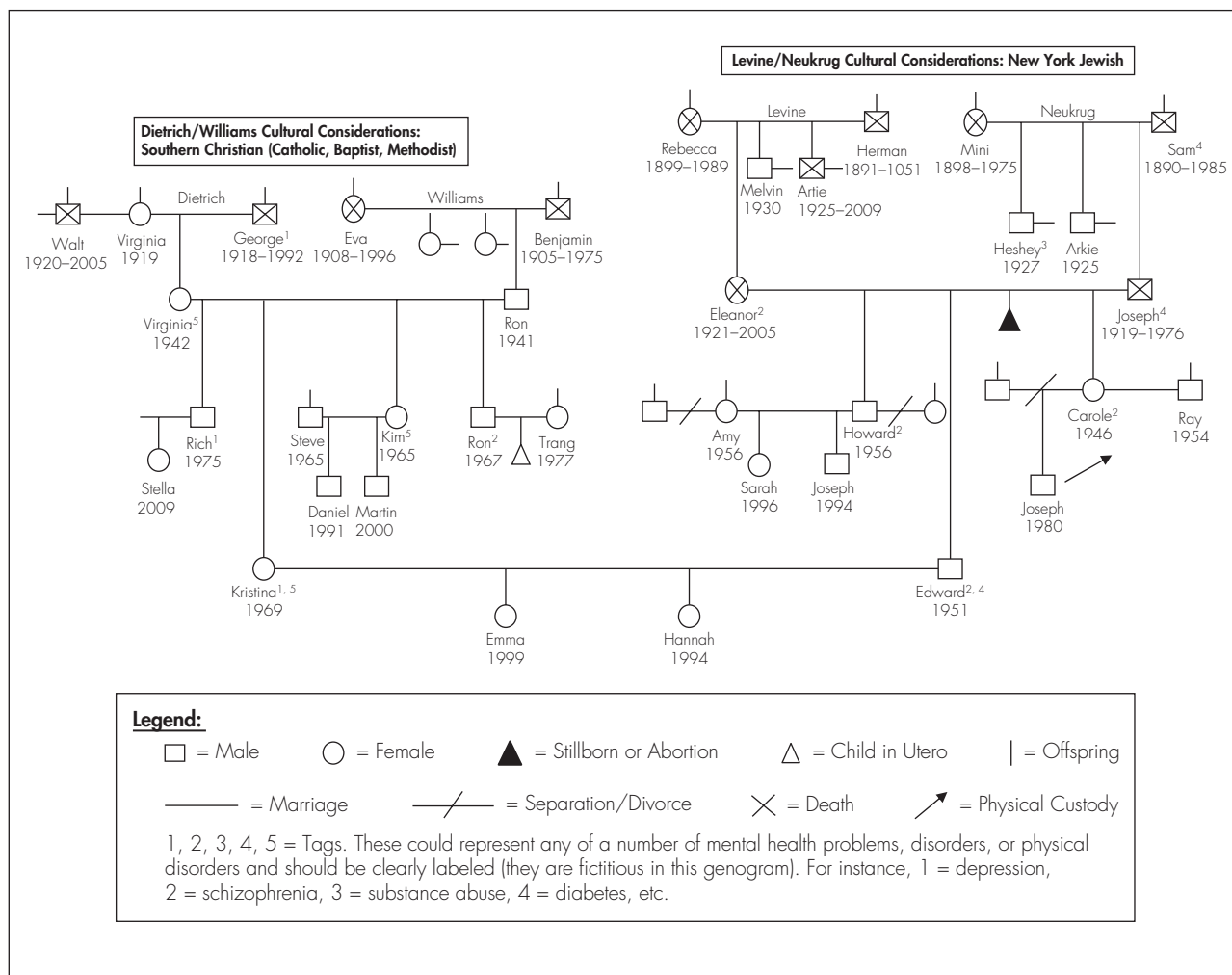
destructive and I know that intuition is destructive" (Whitaker, 1976, p. 154). Despite this bold statement, it is clear that when working with couples and families, Whitaker conceptualized families from a systems perspective:

> *The major problem we see in the individual approaches is they fail to take into account the powerful interdependence between family members. . . . The "symptom" is merely a front for the family's larger stress.* (Napier & Whitaker, 1978, pp. 270–271)

In fact, if you read any of Whitaker's writings, it quickly becomes evident that his approach is strongly influenced by humanistic psychology with a touch of psychodynamic theory. For instance, Whitaker believes that counselors should:

BOX 6.5

Who's More Dysfunctional?

Bowen's belief that individuals generally find others of similar psychological health has always intrigued me. Many times, I have seen clients come for therapy, complaining and even diagnosing their lover or spouse whom they have left. At these times, I've often thought that if the partner were there, that person would likely have a comparable complaint or diagnosis. And it certainly makes some intuitive sense. After all, why would someone who is psychologically healthier than my clients want to be with them? (Or, for that matter, why would someone psychologically healthier than you, or me, want to be with us?) And why would my clients choose to be with someone less healthy than them? (Or, why would we choose to be with those less healthy than us?) Have you ever found yourself diagnosing a person you are with or used to be with? Any thoughts about what they may have been saying about you?

© Cengage Learning

Carl Whitaker

- Respect each member's self-actualizing process.
- Respect the couple and family's ability to unravel itself if placed in a trusting environment.
- Create an atmosphere of oneness and nondefensiveness in order to make it difficult for the couple or family to flee into defensive patterns.
- Assist couples and families in resolving the pain and anger that brings them to therapy.
- Assist couples and families in looking at their ghosts from the past.
- Be powerful enough to "invade the family" in order to be part of the family and assist in breaking roles that have become solidified over time (Whitaker, 1976, p. 163).
- Have an "I–Thou" relationship with co-therapists and the family. This real relationship models openness and the ability to dialogue and to express feeling. "Why should the family expose their tender underbelly if the therapist plays coy and self-protective?" (Whitaker, 1976, p. 164).
- Not offer any particular framework or preconceived way in which the couple or family should operate, in an effort to have the family develop their own structure.
- Model playfulness, craziness, and genuineness, in an effort to get couple and family members to loosen up and be themselves, and ultimately push them toward individuation.
- Assist families in establishing a generation gap, or boundaries between parents and children.

Sometimes sounding strikingly like Carl Rogers, Whitaker suggests that at first, the couple or family is defensive and closed to the counselor. As the counselor joins with the couple or family, they begin to see the counselor as a genuine person and start to open up. This is when past inner hurts and conflicts begin to emerge, and it is at this point that the counselor can facilitate exploration of these hurts and help couple and family members understand how this pain has affected each of them. Each individual can now begin to work on his or her own problems and move toward individuation. In fact, Napier and Whitaker (1978) note that the later stages of couple or family work seem more like individual sessions occurring at the same time:

> *At the end of therapy the family should have resolved their major relationship conflicts, and the individuals should really be individuals in a psychological sense.* (Napier & Whitaker, 1978, p. 274)

In family counseling, Whitaker suggested having a co-therapist, as this allows counselors to model the I–Thou relationship. In addition, such a "real" relationship enables counselors to discuss their understanding of the family with each other—usually in front of the family (Napier & Whitaker, 1978). Also, because of the sheer numbers of people involved in family therapy, co-therapy enables counselors to periodically attend to each member of the family. Showing his psychodynamic leanings, Whitaker also suggested that co-therapists will often be perceived as the "parents" of the family, allowing families to make analogies to their families of origin, which can then be discussed. However, co-therapists can also be perceived in other roles, allowing family members to project their issues onto them (Napier & Whitaker, 1972):

> *Carl can be a very big-breasted, tender mother at times and a stern, tough grandfather at others, and I myself don't make a bad rebellious adolescent at times. It's a lot more complicated than the simplistic way in which we often identify personality with biology.* (Napier & Whitaker, 1978, p. 92)

If you watch a DVD of Whitaker's work, you would see a master therapist who was witty, bright, reflective, real, strong, and willing to take risks. Despite the fact that he insisted he had no theory, you saw consistency in his work, a consistency in the way he presented himself to the family that allowed the family to grow, learn, deal with painful issues, dialogue, and ultimately change.

Psychodynamic Family Therapy

Psychodynamic couples and family therapy merges concepts from systemic thinking with psychodynamic theory. For instance, when viewing psychoanalysis contextually, couples and family dynamics is seen as a reflection of each member's personality development through the psychosexual stages. The major difference between psychodynamic couples and family counseling and traditional, individual-oriented psychodynamic counseling is that the couples and family counselor places great emphasis on how the client projects his or her internal world onto his or her partner or family and the subsequent interactional processes that take place, whereas the individual-oriented counselor almost exclusively emphasizes the internal world of the client and projections onto the counselor (Becvar & Becvar, 2009).

Nathan Ackerman (1958, 1966) and Robin Skynner (1976, 1981) are two well-known psychodynamic family therapists. Like Ackerman and Skynner, most psychodynamically oriented counselors have generally been trained in traditional psychoanalytic methods but also saw value in taking a systemic view when working with clients. Most converts to the systems approach have found that this combination offers a broader perspective that allows for direct involvement with the cast of characters, and speeds up the usual slow process of most psychodynamically oriented individual approaches.

For the psychodynamic couples and family counselor, there is generally an emphasis on how effective parents were in assisting their children through the developmental stages (Foster & Gurman, 1985). It is also assumed that unresolved issues through the stages are projected onto the other member of the couple or on to the family members in unconscious

Nathan Ackerman

ways and reflected in their interactions (Nichols & Schwartz, 2008).Therefore, the major thrust of counseling is to have the couple or family explore their interactions and begin to understand how their behaviors result from these unresolved conflicts. These conflicts may be multigenerational, in the sense that the parents pass on their conflicts to their children. It is therefore common for psychodynamically oriented couples and family counselors to encourage their clients to bring in grandparents or other extended family members for a session or more and to encourage clients to continue to discuss unresolved issues while at home with their immediate and extended family members.

Cognitive–Behavioral Family Counseling

Much like individual approaches to behavior therapy, *cognitive-behavioral family counseling* is oriented toward symptom relief and does not focus on intrapsychic processes, underlying issues, or the unconscious. This approach tends to be highly structured and focuses on specific behaviors and techniques. As in individual behavior therapy, the cognitive-behavioral family counselor has at his or her disposal a wide array of techniques taken directly from *operant conditioning*, *classical conditioning*, and *social-learning theory* or *modeling*. Also, as in individual behavioral therapy, in recent years there has been a trend toward the inclusion of *cognitive therapy*, thus, the name "cognitive-behavioral" family counseling, rather than just "behavioral family counseling." (Becvar & Becvar, 2009). For instance, today's cognitive-behavioral family counselors believe that mediating cognitions can greatly affect couples and family members and therefore should be addressed in treatment. For example, when a parent is continually dismissive of a child, this child begins to make negative self-statements concerning his or her self-worth. Therefore, in addition to behavioral change for the parents, cognitive-behavioral family counselors believe that the child's *negative automatic thoughts* also need to be addressed.

Whereas many traditional behavioral therapists have viewed problem behaviors in a linear, cause-and-effect fashion, today, this approach integrates systems theory with cognitive and behavioral theory and views problem behaviors as the result of a number of feedback loops in which the dysfunctional behavior becomes reinforced from a number of different sources, including the couple and family (Barker, 2007; Goldenberg & Goldenberg, 2008). Because the cognitive-behavioral family counselor is dealing with more than just one individual, it is particularly important to identify symptoms and target behaviors that all members will agree are important to change, and to understand how various behaviors are reinforced in the system:

> The cognitive–behavioral approach is compatible with systems theory and includes the premise that members of a family simultaneously influence and are influenced by each other. Consequently, the behavior of one family member triggers behavior, cognitions, and emotions in other members, which in turn elicit reactive cognitions, behavior, and emotions in the original member. As this process plays out, the volatility of family dynamics escalates, rendering the family vulnerable to negative spirals of conflict. (Nichols & Schwartz, 2008, p. 284)

Some common elements that are typically identified in this approach include the following (Foster & Gurman, 1985; Gladding, 2007; Goldenberg & Goldenberg, 2008; Nichols & Schwartz, 2008):

1. The importance of building a working relationship
2. Viewing counseling as an active approach that elicits the collaboration of the couple and family
3. Believing that basic learning theory principles can be applied in a systems framework
4. Viewing counseling as brief and time-limited
5. Focusing on specific behaviors or cognitions that will be targeted in treatment
6. Stressing the increase of positive behaviors over the elimination of negative behaviors
7. Teaching and coaching clients about the relationships among events in their lives, behaviors, cognitions, and consequences (e.g., negative or positive feelings)
8. Setting goals that are clear, realistic, concrete, and measurable
9. Actively teaching and supervising the change process within the family
10. Helping couples and families to learn how to self-manage and monitor changes in behaviors and cognitions
11. Evaluating the effects of specific techniques in an effort to measure progress

Whereas some family counselors believe it is always important to include the whole family in treatment, regardless of the problem (Napier & Whitaker, 1978; Satir, 1967), cognitive–behavioral family counselors take into account what the presenting problem is and tend to include only those members who seem to be directly related to the change process (Nichols & Schwartz, 2008). For instance, if a child is having behavior problems at home and correction of the problem involves only parenting skills training, there may be no need to include the child. Similarly, if a couple is having marital problems, although their problems will be spilling over to the children, the correction of the problem may not be directly involved with the children, and therefore they may not have to be included. In this process, it is most important for the cognitive–behavioral family counselor to make a thorough assessment of the problem in an effort to determine correct treatment strategies and decide which members of the couple or family should be included in counseling (Becvar & Becvar, 2009; Nichols & Schwartz, 2009).

Narrative Family Therapy

Photo by Jill Freedman

Michael White

The person or the family is not the problem; the problem is the problem. (Michael White, paraphrased)

This quote speaks to one of the newest trends in family therapy—*narrative family therapy*. Based on some of the most recent developments in the counseling field, such as *social constructionism*, *post-modernism*, and what is called *narrative reasoning* (Gladding, 2007), narrative family therapy has at its core the belief that there are no absolute truths and that it is critical to understand the stories that people and families tell in order to help them *deconstruct* how they come to understand their family. Ultimately, the goal of narrative family therapy is to recreate how the family comes to understand itself.

Two of the early founders of narrative family therapy were Michael White and David Epston (White, 1995; White & Epston, 1990), both of whom decided to discard some of the rule-based procedures found in the more traditional family therapy techniques that tended to follow systems and cybernetic theory (Nichols & Schwartz, 2009). This
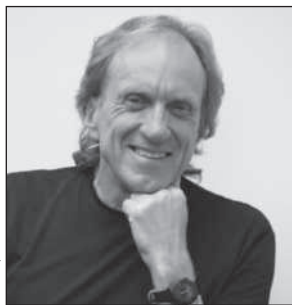
Courtesy of David Epston

David Epston

approach has some similarities to solution-focused therapy in that it takes an optimistic, proactive, future-oriented approach to working with people. Counselors who practice this kind of therapy tend to do the following (Fenell & Weinhold, 2003; Nichols & Schwartz, 2009):

1. Show interest and develop a strong collaborative relationship with the couple or family.
2. Understand the couple or family's history through the stories they tell and examine how the problem has been dysfunctional for the couple or family.
3. Ask questions in a nonjudgmental manner in order to understand the issues in the couple or family and to begin to help the couple or family redefine the problem.
4. Have individuals, couples, or the family externalize the problem. For instance, instead of defining the problem as "people in the family don't value each other," the problem becomes "time"—there's not enough *time* for everyone to show each other how much they care.
5. Begin to look for exceptions to the problem.
6. Find evidence in the couple or family's history to show how they have been competent and resourceful and able to combat problems such as this.
7. Help the couple or family reframe the role the problem has played and help them redefine or *re-author* their understanding of themselves by helping them focus on their existing strengths and their possibilities for the future.
8. Help the couple or family reinforce existing strengths and newfound narratives through *ceremonies* and other ways of acknowledging the changes that have been made.

The end goal of narrative family therapy is to help couples and families understand how their narratives (the stories about the family) have defined who they were and how they interacted, and to help them find their own unique, new stories that can re-define them in more positive ways. Ultimately, the couple or family decides what is considered a healthy way of functioning as they deconstruct their past ways of being and find new and better ways of relating.

Solution-Focused Family Therapy

Photos courtesy of the Brief
Family Therapy Center

*Insoo Kim Berg and Steve
de Shazer*

Solution-focused family therapy was originated by Insoo Kim Berg, Steve de Shazer, Bill O'Hanlon, and others (Berg, 1994; de Shazer, 1982) and is a pragmatic and future-oriented approach that assumes that clients can change quickly. Because the approach focuses on *solutions*, not problems, discussion of the past is very limited, as such discussion is believed to keep the client mired in the problem. Viewing the client as the expert, this approach asserts that the client has strengths that can be expanded upon. Somewhat based on *social constructionism* and *post-modernism*, the solution-focused counselor helps the client create a new, *problem-free language* associated with new behaviors as he or she finds *exceptions to the problem*, develops solutions, and moves toward creating a new reality.

Like narrative family therapy, but unlike most other forms of family therapy we examined in this chapter, solution-focused family therapy does not rely on the assumptions of general systems theory, cybernetics, boundary or information flow, or many of the other theoretical underpinnings listed at the beginning of this chapter (Nichols & Schwartz,

2009). In fact, solution-focused counselors question the "truth" of those who rely on such theory and do not view problems as being inherently caused by flaws in the couple or family's structure. Instead, they believe that *language* and *perception of problems* are related to the development of problems. Therefore, solution-focused counselors have clients examine alternative ways of viewing themselves and they focus solely on helping clients find solutions to their problems based on their existing strengths. Since each member can do this on his or her own, solution-focused counselors do not need to see the couple or whole family together in therapy, but rather only those who want to work on their own solutions. Underlying assumptions of this type of therapy include:

1. Change is constant and inevitable.
2. The client is the expert on his or her experience.
3. Clients come to us with resources and strengths.
4. If it ain't broke, don't fix it.
5. If it works, do more of it; if it's not working, do something different.
6. Small steps can lead to big changes.
7. There is not necessarily a logical relationship between the solution and the problem.
8. The language for solution development is different from that needed to describe a problem.
9. No problems happen all the time; there are always exceptions that can be used.
10. The future is both created and negotiable.

Solution-focused therapy can be viewed through a series of six stages that include *pre-session change, forming a collaborative relationship, describing the problem, establishing preferred outcomes, problem-to-solution focus, reaching preferred outcomes*, and *ending therapy*. With therapy occurring rapidly, the counselor enters the initial session asking if any pre-session changes were noted, and takes an *ambassador* position with the client in which he or she is *curious, respectful*, and *accepting*. Using *listening* and *empathy* skills and *being tentative* in his or her approach, the solution-focused counselor forms a *collaborative relationship* and slowly moves the client from a description of the problem toward the establishment of *preferred outcomes*. Solutions are eventually determined through the use of a number of questioning techniques that include asking *preferred outcome questions, evaluative questions, coping questions, exception-seeking questions*, and *solution-oriented questions*. In addition, counselors will also *reframe* client responses to view them in a positive light, *amplify exceptions, compliment clients* around solutions that work, and help clients assess progress through the use of *scaling*, where clients subjectively rate their progress on a scale from 0 to 10.

▨ *Multicultural/Social Justice Focus*

Points to Consider when Working with Minority Families

> *Any comprehensive attempt to understand personal or family functioning must take into account the fundamental influences of gender, culture, and ethnicity in shaping the lives and experiences of men and women.* (Goldenberg & Goldenberg, 2008, p. 54)

Regardless of theoretical approach, when working with couples and families from diverse cultures and religious orientations, a number of issues should be considered (Goldenberg & Goldenberg, 2008; Hines, Petro, McGoldrick, Almeida, & Weltman, 2005; Ho, Rasheed, & Rasheed, 2004; McGoldrick, Giordano, & Garcia-Petro, 2005). The following highlights but a few of the major concerns:

- Racism, poverty, and lower-class status are widespread for many clients from nondominant groups and can dramatically affect how couples and families feel about themselves and their relationship to the counselor.
- Language used by the dominant culture is often covertly or overtly oppressive of culturally and ethnically diverse couples and families and affects how others see them, how they see themselves, and how they live in society.
- Couples and families from nondominant groups will invariably experience some forms of racism and discrimination and this must be taken into account when working with them.
- Many culturally and ethnically diverse couples and families are bicultural and face issues surrounding conflicting value systems between their culture of origin and the larger culture.
- Language differences may cause problems of miscommunication and even misdiagnosis for couples and families in counseling.
- Clients from culturally and ethnically diverse couples and families are less likely to attend counseling and more likely to end therapy early. Therefore, counselors need to be vigilant about reaching out to such clients and ensuring that they are treating them effectively.
- Gender role issues play an increasingly large role in couples and families from all cultures.
- Sexual orientation plays an increasingly large role in couples and families from all cultures.
- Religion, religious values, and spirituality play significant roles in many cultures, and it behooves the effective counselor to understand the impact religion and spirituality has on the couple or family.
- Couples and families may differ dramatically around a number of key elements, including how the couple and family dress and value appearances, embrace specific beliefs and attitudes, relate to family and significant others, play and make use of leisure time, learn and use knowledge, communicate and use language, embrace certain values and mores, use time and space, eat and use food in its customs, and work and apply themselves.

The astute cross-cultural couples and family counselor needs to have the knowledge necessary to work with different kinds of families, the awareness of his or her cultural biases, and the unique skills needed to work with couples and families from diverse backgrounds.

Why Are the Professional Associations Not Being Inclusive?

You'll notice that the title of this chapter is "Couples and Family Counseling," not "Marriage and Family Counseling." This is because the term *marriage therapy* excludes all of those thousands of gay and lesbian couples who still cannot become married in

this country as well as hundreds of thousands of couples who live together and choose not to get married. Thus, I have used a more inclusive term, "Couples Counseling." This term is also in sync with the American Counseling Association's, American Psychological Association's, and National Association of Social Worker's stands on the normalization of homosexuality. One has to wonder why the American Association of *Marriage* and Family Therapists and the International Association of *Marriage* and Family Counselors have continued to use titles that are exclusive of a substantial portion of our population.

Ethical, Professional, and Legal Issues

Ethical Concerns

There are many unique ethical concerns related to the practice of couples and family counseling, not all of which can be covered in this short section. However, some issues that stand out have to do with withholding treatment, informed consent, confidentiality, and multiple relationships (AAMFT, 2001; IAMFC, 2005; Wilcoxon, Remley, Gladding, & Huber, 2007):

Withholding Treatment

> *Marriage and family counselors have an obligation to determine and inform counseling participants who is identified as the primary client. The marriage and family counselor should make clear when there are obligations to an individual, a couple, a family, a third party, or an institution.* (IAMFC, 2005, Section A.7)

Because some couples and family counselors insist on seeing the whole couple or family rather than one member of the couple or a portion of the family, withholding treatment if one or more members balk at coming into therapy is not unusual. Although most ethical guidelines state that counselors cannot refuse services unless other arrangements are made for the client, a counselor can justify withholding treatment if he or she believes counseling will succeed only if both members of a couple or the whole family is present. However, if such a position is taken, a couples and family counselor should be able to defend this position from both a pragmatic and theoretical perspective.

Informed Consent

> *Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients.* (AAMFT, 2001, Section 1.2)

It is the counselor's ethical obligation to ensure that knowledge about the counseling process be given to all clients, and all must willingly agree to participate in such a relationship

prior to initiating the counseling relationship. Thus, each family member present must understand the nature of counseling, what might be expected of him or her, and any risks that might occur as a result of counseling.

Confidentiality

Couples and family counseling offers some unique challenges to the ethical obligation one has for confidentiality. For instance, if one member of a couple or family is seen individually and reveals information he or she does not wish discussed with his or her partner or with the family, and if the counselor thinks this information is critical to the resolution of the problem, should the counselor break confidentiality? Is the client the individual, or the couple or family? Confidentiality also becomes problematic in that one cannot ensure that each member of a couple or all family members will honor it.

> *In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual's right to confidentiality and any obligation to preserve the confidentiality of information known.* (ACA, 2005, Standard B.4.b)

Dealing with such complex issues that don't always have clear-cut answers requires a wise and sensitive counselor. Having clear ground rules before counseling begins can help to avoid these problems.

Multiple (Dual) Relationships

> *Marriage and family counselors inform clients that statements made by a family member to the counselor during an individual counseling, consultation, or collateral contact are to be treated as confidential. Such statements are not disclosed to other family members without the individual's permission. However, the marriage and family counselor should clearly identify the client of counseling, which may be the couple or family system. . . . Some marriage and family counselors choose to not meet with individuals, preferring to serve family systems.* (IAMFC, 2005, Standard B.7)

At times, a couples and family counselor may begin to see one member of a couple or of a family, and, only later, decide to see the couple together or the whole family. In other cases, the couples or family counselor might begin by seeing the couple or the whole family, and later see only one member or one part of the family (e.g., the spouses). At other times, individual consultations with one member of the couple or family might occur outside of the couple or family session. You can see why keeping boundaries is important in such counseling relationships, and it is wise to have clear ground rules about whether or not clients can see the counselor outside of the couple or family session. These multiple relationships can be a difficult switch to make, and the couples and family counselor must consider how this will affect all individuals involved.

Professional Issues

Individual or Family Therapy?

When should a member of a family be referred to individual counseling as opposed to the whole family being referred for family counseling? Although some therapists have suggested it is always appropriate to refer the whole family for counseling (Napier & Whitaker, 1978; Satir, 1967), most therapists today agree that it is often a matter of making a wise decision based on a careful assessment of the situation. For instance, a child who comes from an extremely dysfunctional family may be better off seeing a counselor individually, because working with the whole family may be seen as an extremely long process whereas individual counseling may give some immediate relief for the child. Or it may be prudent to refer a spouse for individual counseling to work on her unfinished business while the family undergoes family treatment. This might accelerate the treatment process for everyone.

My own bias for determining individual or family counseling is based on how much the presenting problem seems to reverberate throughout the family. When problems in the family seem to be seriously affecting all family members, I would suggest seeing the whole family. However, if a family member is experiencing a large amount of pain, and he or she is attempting not to let this spill into the family (it always spills over to some degree), then I might opt for individual counseling.

Professional Associations

AAMFT or IAMFC—which professional association should you join? Although there are many more similarities than differences between these two associations, IAMFC (n.d.) and AAMFT (2002) do suggest different graduate curricula, have different codes of ethics, support slightly different clinical and supervisory experience for licensing, and at times endorse different licensing initiatives. The professional couples and family counselor should investigate both associations to see which seems to have the best fit. Then again, why not join both?

Accreditation and Credentialing

Today, two groups accredit couples and family graduate therapy programs: the Commission on Accreditation for Marital and Family Therapy Education (COAMFTE, 2002), which is associated with AAMFT; and the Council on the Accreditation of Counseling and Related Educational Programs (CACREP), which has a specialty accreditation in marriage and family counseling and is affiliated with ACA (CACREP, 2010).

In 1987, the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) was established by AAMFT to address licensure and certification issues; today, all 50 states have licensing laws that cover marriage and family counselors. Rather than following the guidelines of AMFTRB, some state licensure boards have subsumed the marriage and family credential under the counseling board or other related mental health licensing boards. In addition to licensing, the International Association of Marriage and Family Counselors (IAMFC), a division of ACA, developed a certification process through the National Credentialing Academy (NCA, n.d.) that enables a marriage or family therapist to become a Certified Family Therapist (CFT).

Legal Concerns

Knowing the Law and Being an Expert

Ethical and effective couples and family counselors know how the knowledge they gain from their sessions could be used in a court of law (Wilcoxon, Remley, Gladding, & Huber, 2007). Information gained relative to child abuse, spousal abuse, family abuse, child custody issues, separation and divorce of partners, and more, can often be accessible to courts. It is critical that couples and family counselors not assume that information is privileged, know the limits of confidentiality, and know how information gained in sessions could be used in court.

> *Marriage and family counselors inform clients of exceptions to the general principle that information will be kept confidential or released only upon written client authorization. Disclosure of private information may be mandated by state law. For example, states require reporting of suspected abuse of children or other vulnerable populations. Couple and family counselors may have sound legal or ethical justification for disclosing information if someone is in imminent danger. A court may have jurisdiction to order release of confidential information without a client's permission. However, all releases of information not authorized by clients should be minimal or narrow as possible to limit potential harm to the counseling relationship.* (IAMFC, 2005, Section B.1)

Finally, it is important that counselors know how such information is likely to be treated in the state where they work and that they communicate to their clients the limits of confidentiality.

Insurance Fraud

> *Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.* (AAMFT, 2001, Section 7.4)

With cutbacks in the number of sessions allowable for mental health services, and with some insurance companies not paying for couples or family counseling, some counselors will list one family member as their patient, and when his or her insurance benefits run out, list a second family member, and so on. Unfortunately, in many cases this and similar practices may very well be illegal (Crews & Hill, 2005a, 2005b). With insurance fraud being one of the most often-made complaints against licensed therapists (Neukrug, Milliken, & Walden, 2001), couples and family counselors need to be aware of the idiosyncratic rules of insurance companies as well as state laws that might restrict this practice.

■ The Counselor in Process: Understanding Our Client's Family, Understanding Our Family

Although many counselors will start out individually oriented and slowly develop the skills to work with couples and families, the effective counselor, whether working individually or with couples and families, understands the contextual nature of the world

in which clients interact. This wise counselor understands that the individual has a dramatic impact on the life of his or her family, understands how the family affects the individual, and sees the interconnectedness between all families and the community and society at large. However, awareness of a client's contextual world is not enough. The effective couples and family counselor has also examined his or her own family of origin, for the counselor who has avoided a family self-examination risks having his or her issues interfere with the effective treatment of clients and families. Although we can never fully know our family as they were, we can continually strive to know ourselves as we become.

Summary

This chapter began with a brief history of the development of couples and family counseling. We started with a discussion of how Charity Organization Societies and "friendly visitors" led to a systemic view of problems in families and communities. We noted that Alfred Adler was one of the first to include the family when treating individuals, although family members were usually in separate rooms from the client. We noted that the hold psychodynamic approaches had on the individual perspective of doing counseling was strong, and that early family therapy approaches tried to adapt this individual approach to working with couples and families. The shift toward couples and family counseling being acceptable was probably related to the impact of those who worked at Palo Alto. The work at Palo Alto, as well as the subsequent research at MRI, influenced the development of a number of family therapy approaches, including strategic family therapy, structural family therapy, and the human validation process model. At around the same time, other approaches to couples and family work evolved, including multigenerational family therapy and experiential family therapy. Later, at MRI, the Brief Family Therapy Center at Palo Alto was formed and became the impetus for the development of solution-focused family therapy. Other approaches to family therapy that later took hold included cognitive–behavioral family counseling, and narrative family therapy.

As the chapter continued we examined the view of human nature commonly held by many couples and family counselors and then elucidated a number of key concepts, including general systems theory, cybernetics, boundaries and information flow, rules and hierarchy, communication theory, scapegoating and identified patients, stress in families, developmental issues, and social constructionism.

We examined the more popular approaches to couples and family therapy, including the human validation process model of Virginia Satir; strategic family therapy used by Jay Haley, Cloé Madanes, and the Milan Group; structural family therapy popularized by Salvador Minuchin; multigenerational family therapy as practiced by Murray Bowen and Ivan Boszormenyi-Nagy; experiential family therapy of Augustus Napier and Carl Whitaker; psychodynamic family therapy as suggested by Nathan Ackerman and Robin Skynner; cognitive–behavioral family counseling; narrative family therapy of White and Epston; and solution-focused family therapy as popularized by Berg, de Shazer, and O'Hanlon.

After examining different approaches to couples and family work, we focused on multicultural and social justice issues. We pinpointed a number of concerns when working with couples and families from diverse cultures and religious orientations and we pondered why the professional associations have kept the word "marriage" in their titles rather than being more inclusive of all couples.

Some ethical concerns we discussed included: withholding treatment of some family members in order to see the whole family, the importance of having all family members give informed consent, the complexities of confidentiality in couples and family counseling, and the intricacies of multiple relationships in couples and family counseling such as when the counselor switches from individual counseling with a client to family counseling with that same client. We also highlighted some professional issues such as when individual counseling may be preferred over family counseling, which professional association to join, and the status of accreditation, licensing, and certification of couples and family counselors. Some legal concerns we noted included: knowing the complexities of legal issues relative to couples and family work and not becoming involved in insurance fraud by knowing the rules of insurance companies with who couples and family counselors work. We concluded the chapter with a discussion about the importance of examining one's own family of origin, particularly with how it can impact on one's work with couples and families.

◼ *References*

Ackerman, N. W. (1958). *The psychodynamics of family life*. New York: Basic Books.

Ackerman, N. W. (1966). *Treating the troubled family*. New York: Basic Books.

Addams, J. (1910). *Twenty years at Hull House*. New York: Macmillan.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Association of Marriage and Family Therapists. (2001). *AAMFT code of ethics*. Retrieved from http://www.aamft.org/resources/lrm_plan/ethics/ethicscode2001.asp

American Association of Marriage and Family Therapists. (2002). *About AAMFT*. Retrieved from http://www.aamft.org/about/index_nm.asp

American Association of Marriage and Family Therapy. (2009). *Directory of MFT licensure and certification boards*. Retrieved from http://www.aamft.org/resources/Online_Directories/boardcontacts.asp

Axthelm, P. (1978, December 4). The emperor Jones. *Newsweek*, pp. 54–60.

Barker, P. (2007). *Basic family therapy* (5th ed.). Ames, IO: Blackwell Science Ltd.

Baruth, L. G., & Huber, C. H. (1984). *An introduction to marital theory and therapy*. Pacific Grove, CA: Brooks/Cole.

Becvar, D. S., & Becvar, R. J. (2009). *Family therapy: A systemic integration* (7th ed.). Boston: Allyn & Bacon.

Berg, I. K. (1994). *Family based services: A solution-focused approach*. New York: W. W. Norton.

Bitter, J. R. (2009). *Theory and practice of family therapy and counseling*. Belmont, CA: Brooks/Cole.

Boszormenyi-Nagy, I. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy*. New York: Harper & Row.

Boszormenyi-Nagy, I. (1987). *Foundations of contextual therapy*. New York: Brunner/Mazel.

Bottome, P. (1957). *Alfred Adler: A portrait from life*. New York: The Vanguard Press.

Bowen, M. (1976). Theory in the practice of psychotherapy. In P. J. Guerin (Ed.), *Family therapy: Theory and practice* (pp. 42–90). New York: Gardner Press.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Burger, W. (2011). *Human services in contemporary America* (8th ed.). Belmont, CA: Brooks/Cole.

Cade, B. (2007). Springs, streams, and tributaries: A history of the brief, solution-focused approach. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 25–64). New York: The Haworth Press.

Carlson, J. C. (2002). Strategic family therapy. In J. Carlson & D. Kjos (Eds.), *Theories and strategies of family therapy* (pp. 80–97). Boston: Allyn & Bacon.

Crews, J. A., & Hill, N. R. (2005a). Diagnosis in marriage and family counseling: An ethical double bind. *The Family Journal: Counseling and Therapy for Couples and Families, 13,* 63–66.

Crews, J. A., & Hill, N. R. (2005b). The application of an ethical lens to the issue of diagnosis in marriage and family counseling. *The Family Journal: Counseling and Therapy for Couples and Families, 13,* 176–180.

Commission on Accreditation for Marital and Family Therapy Education. (2002). *Commission on accreditation for marriage and family therapy education.* Retrieved from http://www.aamft.org/about/COAMFTE/AboutCOAMFTE.asp

Council on the Accreditation of Counseling and Related Educational Programs. (2010). *Home page.* Retrieved from http://www.cacrep.org

de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach.* New York: The Guilford Press.

Fenell, D. L., & Weinhold, B. K. (2003). *Counseling families: An introduction to marriage and family therapy* (3rd ed.). Denver, CO: Love.

Foster, S., & Gurman, A. S. (1985). Family therapies. In S. J. Lynn & J. P. Garske (Eds.), *Contemporary psychotherapies: Models and methods* (pp. 377–418). Columbus, OH: Merrill.

Friedman, M. (1989). Martin Buber and Ivan Boszormenyi-Nagy: The role of dialogue in contextual therapy. *Psychotherapy, 26,* 402–409.

Gladding, S. T. (2007). *Family therapy: History, theory, and practice* (4th ed.). Upper Saddle River, NJ: Pearson.

Goldenberg, H., & Goldenberg, I. (2008). *Family therapy: An overview* (7th ed.). Belmont, CA: Brooks/Cole.

Guerin, P. (1976). Family therapy: The first twenty-five years. In P. J. Guerin (Ed.), *Family therapy: Theory and practice* (pp. 2–23). New York: Gardner Press.

Guerin, P., & Guerin, K. (2002). Bowenian family therapy. In J. Carlson & D. Kjos, *Theories and strategies of family therapy* (pp. 126–157). Boston: Allyn & Bacon.

Haley, J. (1973). *Uncommon therapy.* New York: Norton.

Haley, J. (1976). *Problem-solving therapy.* San Francisco: Jossey-Bass.

Haley, J. (1986). *The power tactics of Jesus Christ and other essays* (2nd ed.). Rockville, MD: Triangle.

Haley, J. (2009). *Jay Haley: The family therapist.* Retrieved from http://www.jay-haley-on-therapy.com/html/family_therapy.html

Hines, P. M., Petro, N. G., McGoldrick, M., Almeida, R., & Weltman, S. (2005). Culture and the family life cycle. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 69–87). Boston: Allyn & Bacon.

Ho, M. K., Rasheed, J. M., & Rasheed, M. N. (2004). *Family therapy and ethnic minorities* (2nd ed.). Thousand Oaks, CA: Sage.

Hull, G. H., & Mather, J. (2006). *Understanding generalist practice with families.* Belmont, CA: Brooks/Cole.

International Association of Marriage and Family Counseling. (n.d.). *Welcome to IAMFC.* Retrieved from http://www.provisionsconsultingcms.com/~iamfc/

International Association of Marriage and Family Counseling. (2005). *Ethical code*. Retrieved from http://www.iamfconline.org/

Klever, P. (2004). The multigenerational transmission of nuclear family processes and symptoms. *The American Journal of Family Therapy, 32*, 337–351.

Leiby, J. (1978). *A history of social welfare and social work in the United States*. New York: Columbia University Press.

Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.

McGoldrick, M. (2005). History, genograms, and the family life cycle: Freud in context. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 47–68). Boston: Allyn & Bacon.

McGoldrick, M., Giordano, J., & Garcia-Petro, N. (2005). *Ethnicity and family therapy* (3rd ed.). New York: Guilford Press.

Mental Research Institute. (2008). *About us*. Retrieved from http://www.mri.org/about_us.html

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Minuchin, S. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

Napier, G. (2002). Experiential family therapy. In J. Carlson & D. Kjos, *Theories and strategies of family therapy* (pp. 296–316). Boston: Allyn & Bacon.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*(1), 57–70.

Napier, A., & Whitaker, C. (1972). A conversation about co-therapy. In A. Ferber, M. Mendelsohn, & A. Napier (Eds.), *The book of family therapy* (pp. 480–506). New York: Jason Aronson.

Napier, A., & Whitaker, C. (1978). *The family crucible*. New York: Harper & Row.

National Credentialing Academy. *Certified family therapist*. Retrieved from http://nationalcredentialingacademy.com/

Nichols, M. P., & Schwartz, R. C. (2008). *Family therapy: Concepts and methods* (8th ed.). Boston: Allyn & Bacon.

Nichols, M. P., & Schwartz, R. C. (2009). *The essentials of family therapy* (4th ed.). Boston: Allyn & Bacon.

Palazzoli, S. M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox*. New York: Jason Aronson.

Piercy, F. P., Sprenkle, D. H., & Wetchler, J. L. (1996). *Family therapy sourcebook* (2nd ed.). New York: Guilford.

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.

Satir, V. (1972a). *Peoplemaking*. Palo Alto, CA: Science and Behavior Books.

Satir, V. (1972b). Family systems and approaches to family therapy. In G. D. Erickson & T. P. Hogan (Eds.), *Family therapy: An introduction to theory and technique* (2nd ed., pp. 211–225). Pacific Grove, CA: Brooks/Cole. (Original work published 1967)

Sherman, R. (1999). Family therapy: The art of integration. In R. E. Watts (Ed.), *Intervention and strategies in counseling and psychotherapy* (pp. 101–134). Philadelphia: Taylor and Francis.

Skynner, A. C. R. (1976). *Systems of marital and family psychotherapy*. New York: Brunner/Mazel.

Skynner, A. C. R. (1981). An open-systems, group-analytic approach to family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 39–84). New York: Brunner/Mazel.

Tomm, K. (1998). A question of perspectives. *Journal of Marital and Family Therapy, 24*(4), 409–413.

Turner, L. H., & West, R. (2006). *Perspectives on family communication* (3rd ed.). Boston: McGraw-Hill.

von Bertalanffy, L. (1934). *Modern theories of development: An introduction to theoretical biology*. London: Oxford University Press.

von Bertalanffy, L. (1968). *General systems theory*. New York: Braziller.

Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes*. New York: Norton.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change; Principles of problem formation and problem resolution*. New York: Norton.

Whitaker, C. (1976). The hindrance of theory in clinical work. In P. J. Guerin (Ed.), *Family therapy* (pp. 154–164). New York: Gardner Press.

White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wilcoxon, S. A., Remley, T. P., Gladding, S., & Huber, C. H. (2007). *Ethical, legal, and professional issues in the practice of marriage and family therapy* (4th ed.). Upper Saddle River, NJ: Pearson.

Group Work

I decided I wanted to have a group counseling experience. It was 1975, and I had recently finished my master's degree and started a job at a mental health center. I found a counselor whom I trusted who was putting together a group with another counselor. There were eight of us, four men, four women—oh yeah, and the two counselors, that makes ten. But the counselors didn't really count as real people! Meeting once a week, it took a while to build trust. However, within a couple of months it seemed as though things were really taking off. We began to share deeper parts of ourselves. I heard people reveal things about themselves they had never mentioned to anyone else. I saw transformations take place as members began to work through their unfinished business. I saw the leaders, a man and a woman, model shared group leadership skills and openly work through their own conflicts in front of us.

After we had been meeting for about a year, the leaders suggested having a marathon group that would last from a Friday evening to late Sunday afternoon. I had always heard about such groups and was apprehensive about meeting for such an extensive amount of time. But at the same time, I was excited about what lay ahead for me. The weekend was incredible, as people shared deep parts of themselves.

The group continued for a year longer. It was painful to say goodbye, but necessary. We were finished, at least for now. We had done our work and now were ready to move on in life. We laughed, we cried, we hugged. For a while, some of us continued to maintain contact; others did not. Over time, I lost contact with everyone in the group. I wonder now what those other seven people are doing. Oh yeah, and the two counselors also.

That group experience was crucial for me. It helped me work through unfinished business. It showed me how effective group counseling could be. Watching the counselors taught me how to run groups, and it gave me an appreciation of the group process as the unique unfolding of a group that must be nurtured if it is to blossom.

Since that time I have participated in other groups and have run a number of them myself. I had a brief flirtation with EST (now Landmark Forum), a very large (250 people) marathon group with a confrontational focus; I joined a leaderless men's support group; I visited some AA groups; I ran a weight-loss group; I ran groups as part of graduate group counseling classes (which has some ethical complications); I ran a support group for

individuals who had been hospitalized for a psychotic disorder; and I ran psychoeducational groups for high school students.

Groups come in all shapes and sizes. They last for different lengths of time. They have different numbers of people in them, and they focus on different things. Groups can seem so different, yet they all share many common elements. Groups! This chapter will examine groups—how they are different and how they are the same.

We will begin the chapter by explaining groups from a systemic perspective and then discuss the purpose of group counseling. We will then review how groups evolved during the twentieth century. We will explore the differences among self-help groups, task groups, psychoeducational groups, counseling groups, and therapy groups, and we will look at how theory is applied to group work. We will examine the stages of group development and discuss group leadership skills, particularly as they relate to these stages. Finally, we will take a look at some important multicultural, social justice, ethical, professional, and legal issues related to group work. We will conclude with a brief discussion on the importance of letting groups unravel naturally.

Groups: A Systemic Perspective

In our therapeutic roles with groups, it is important to understand group systems thinking because a systems perspective adds qualities such as boundary conditions; communication inflow, outflow, and between-flow; and group change management to our consideration.
(Connors, & Caple, 2005, p. 94)

Groups, like families, can be viewed from a *systemic perspective* in which individuals in the group can be understood by examining the dynamic interaction of its members and how that interaction results in specific *communication patterns*, *power dynamics*, *hierarchies*, and the system's unique *homeostasis* (Agazarian, 2008; Napier & Gershenfeld, 2004). The effective group leader is able to work with the unique issues that the individual brings to the group, and at the same time, understands how system dynamics are a reflection of how these issues are played out in the group. Thus, the group leader must be able to both focus with the intensity of a laser beam on each group member and pull back as if he or she is viewing the whole group through a wide-angle lens. In a sense, the effective group leader must see him- or herself as an individual counselor and a systems expert. In addition, an effective group leader not only sees the group as a system, but understands the place that groups play in larger systems. Thus, at times this individual may attempt to effect change by working with the larger or *macro* system, such as advocating in communities or for legislative change (Roysircar, 2008).

Many of the same theories discussed in Chapter 6 that illuminate what occurs in families (e.g., *general systems theory*; *cybernetics*), can be applied to an understanding of groups (Agarazian, 2008; Napier & Gershenfeld, 2004). However, one major difference

is that in families our goal is to undo a problematic system and rebuild it so that it's healthier. In groups, there is no prior history to the system, so from the beginning we are building the system in a manner that will lead the individuals within that system to healthy functioning.

Why Have Groups?

Today, groups are used by all types of counselors and are an important and frequently used intervention method that rivals individual and family counseling (AMHCA, n.d.; ASCA, 2009: CACREP, 2010; Perusse, Goodnough, & Lee, 2009). But why should a counselor choose a group over other treatment methods? Table 7.1 summarizes some of the *advantages and disadvantages of group work* (Corey, 2008; Jacobs, Masson, & Harvill, 2009).

Deciding whether individual, family, or group counseling is most beneficial is an important counselor responsibility and should be based on a careful assessment of client needs (Ward, 2004). Based on this assessment, it is sometimes important to offer only individual, group, or family counseling. Other times, group work is an adjunct to individual or family counseling. In addition, if individual or family counseling is not available to the client (e.g., cost of individual counseling is too high; not being able to bring family members together), group work can be a viable alternative.

In the history of counseling and therapy, group work is the newest treatment method. Because of this, some consider the training of group counselors to be lagging

TABLE 7.1

Advantages and Disadvantages

ADVANTAGES	DISADVANTAGES
1. *More efficient:* More clients can be seen in a shorter amount of time.	1. *Less focused time:* As compared to individual counseling, each group member has less focused time with the counselor.
2. *Economical:* Group work almost always costs less than individual counseling.	2. *Less intensity with leader:* Groups do not offer the same amount of intense one-on-one time with the group leader as in individual counseling.
3. *Sense of belonging:* Groups offer contact with other people on a deeply personal level.	3. *More intimidation:* Some individuals are intimidated by the group setting.
4. *General support:* Groups can offer foundational support for many clients.	4. *Fear of disclosure:* Some clients will not reveal deeply personal matters in a group setting.
5. *Microcosm of society:* Groups mimic society and offer a "lab" of how others might react to the individual.	5. *Therapeutic effectiveness:* Some problems may be more effectively dealt with in a family or individual setting.
6. *Support for commitment to change:* Groups provide atmosphere where members will support one another as they define goals and follow through on new behaviors.	6. *Increased time commitment:* Generally, clients have to commit more time to group counseling than other forms of counseling—time they may not have.
7. *Vicarious learning:* Through modeling, group members can learn from one another and from the leader.	7. *Lack of flexibility:* One can generally change the meeting times of individual sessions more easily than group sessions.
8. *Feedback:* Groups offer an increased number of people to gain feedback from.	8. *Inability to assure confidentiality:* Leaders cannot assure group members that everyone will keep information confidential.
9. *Practice:* Groups provide a place to practice newly learned behaviors within a trusting environment.	9. *Diversion of focus:* One member could sometimes take up much of group time.
10. *Systemic understanding:* Groups provide information to members about how they react in systems, information that can often be related to family of origin issues.	10. *Psychological harm:* If a leader cannot control one or more destructive members, a member could be harmed psychologically.

behind its demand (Corey, Corey, & Corey, 2010; Markus & King, 2003; Ward, 2007). The following section will review how group work has developed and pay special attention to its relatively recent increase in popularity.

The History of Group Work

What occurs in a group has often been described as a microcosm of society (Yalom, 2005); that is, the kinds of values and behaviors exhibited are reflective of how group members act in society. Perhaps, then, it is not surprising that the ways in which groups have been conducted over the years have reflected the values in society of those times. Let's take a closer look at how some of these groups evolved.

Early History

Gladding (2008) notes that prior to 1900 the purpose of group treatment was to assist individuals in ways that were functional and pragmatic. This often revolved around helping people with daily living skills and arose out of the social group work movement, where individuals like Jane Addams organized group discussions that often had moralistic overtones and centered on such things as personal hygiene, moral behavior, nutrition, and self-determination (Andrews, 2001; Pottick, 1988). Using groups as their vehicle, social reformers like Addams and Mary Richmond were particularly concerned with community organizing as an effort to empower the poor (Garvin, 1997; Shaffer & Galinksy, 1989).

At the turn of the last century, a number of parallel movements began to discover the power of groups. For instance, schools began to offer vocational and moral guidance in group settings. Although they were often preachy in their nature, and despite the fact that there was little opportunity for group members to discuss personal matters in reflective ways, these group guidance activities acknowledged the importance of groups. At around the same time, Dr. Joseph Henry Pratt became one of the first to practice group treatment with patients. Meeting with about 30 tuberculosis patients weekly, he would start out with a lecture, which eventually led to patients revealing their personal stories and offering encouragement to one another. With little if any group theory available at that time, Pratt followed what his predecessors did and practiced a little moral guidance by using persuasion and reeducation (Andrews, 1995; Barlow, Burlingame, & Fuhriman, 2000; Pinney, 1970/1995; Singh & Salazar, 2010a).

At the beginning of the twentieth century, a number of psychoanalytical principles such as primal urges, instincts, and parental influences were used to explain group dynamics (Andrews, 1995; Anthony, 1972; Lonergan, 1994). For instance, some believed that the tendency for group behavior represented a *herd instinct* where people sought out others for survival purposes. Others believed a *mob instinct* could emerge from group activities, where the natural aggressiveness of people would come out, and still others believed that one could find in groups a *recapitulation of early family patterns* and that group members would often blindly give their power over to the group leader (their parent). Although Freud (1975/1922) wrote a book on groups, *Group Psychology and the Analysis of the Ego*, his attachment to individual therapy prevented him from taking his ideas one step further, to develop and practice a broad-reaching theory of group therapy.

In 1914, J. L. Moreno, who was the originator of *psychodrama* and the individual given credit for coining the term group psychotherapy, wrote one of the first papers on the subject (Barlow et al., 2000; Fox, 1987; Singh & Salazar, 2010a). Although not considered formal group counseling, psychodrama focused on individuals acting out their experiences in front of an audience. This form of therapy emphasized role playing, here-and-now interaction, expression of feeling, and feedback from the audience (the group), and is considered by some the forerunner of group counseling (Gladding, 2008).

The 1920s and 1930s saw the spread of *Adlerian therapy*, with its emphasis on birth order and the importance of social connectedness. These concepts seemed to fit well in family and group settings, and Adler was one of the first individuals to practice early forms of family and group work as he and his colleagues worked with prisoners and groups of children in child guidance clinics (Gazda, 1989; Gladding, 2008). However, their techniques were far from what would be considered group or family counseling today, as they did not fully take into account aspects of group dynamics and group process, so important to current day group work. At around the same time, the spread of psychotherapeutic theory and sociological concepts concerning group interactions led to some of the first nonpsychoanalytically oriented counseling and therapy groups (Gladding, 2008).

The 1930s saw an increased use of group guidance activities in schools. Mostly performed by homeroom teachers, these guidance activities focused on "helping to establish relationships, determining student needs and abilities, and developing proper attitudes" (Vander Kolk, 1990, p. 5). Continuing into the 1950s, these guidance activities were the forerunner of the psychoeducational groups we see in schools today.

The Emergence of Modern-Day Groups

The 1940s saw the emergence of the modern group movement. In 1947, Kurt Lewin (a founder of modern-day social psychology) and other theorists developed the National Training Laboratory (NTL) to examine how group dynamics could help individuals increase self-understanding (NTL, 2008). Still operating today, NTL strives to help individuals become more aware of self and others through group dialogue that focuses on openness and an understanding of group dynamics. NTL has become particularly popular in business and industry in helping individuals understand communication in groups, group process, and how these relate to organizational goals.

It was also during this decade that Carl Rogers, while working at the Counseling Center at the University of Chicago, was asked by the Veterans Administration to run training sessions for counselors who might be working with returning GIs from World War II. Running the group training using his *person-centered* style, he found that there was increased self-disclosure, deepening expression of feeling, and increased awareness of self. Thus began the *encounter group movement* (Rogers, 1970).

> The key difference between the NTL groups and the Chicago groups was that the former had as their major focus the professional training of leaders, with the personal growth of the participants being a secondary gain; while the latter had the personal growth of the participants as its major focus, with the expectation that this personal growth would enable the individual to become more effective in their helping relationships. (Kirschenbaum, 2009, p. 340)

During this period, we also saw the founding of the American Group Psychotherapy Association (AGPA), one of the first professional associations to focus on group counseling. However, few then realized the far-reaching effects that groups were about to have on American society.

The Popularity of Groups Surges

The 1960s were tumultuous times: The Vietnam War, the War on Poverty, the civil rights movement, and the assassinations of our heroes are but a few of the events that characterized this period of uncertainty. The country was in upheaval, and this chaos was perhaps society's way of saying, "Free us." Free us from racism. Free us from war. Free us from poverty, and let us be free to love. Led by *the encounter group movement*, groups were soon to reflect this need for freedom and love. One outgrowth of this movement was the development of *Esalen* in Big Sur, California, by Michael Murphy. Murphy, who became involved in the encounter group movement, moved to an ashram in India for a year and a half and subsequently came back and established Esalen. A description of Esalen, written in the mid-1970s by Murphy's guru, is still applicable as Esalen continues to offer workshops and related activities today:

> *This was a very interesting experimental community, attempting to combine the ideal of self-realization and technology, drawing upon Eastern spirituality and Western thought. The emphasis was on the transformation of your personal life into the divine nature in our language, trying to evoke higher spiritual possibilities out of all your life.* (Gusataitis, as cited in Verny, 1974, p. 10)

It was not unusual to find Carl Rogers, Abraham Maslow, and famous philosophers like Paul Tillich at Esalen. Esalen, and other institutes that began to follow its model, were to attract counselors and therapists from around the world, some of whom would eventually become famous in their own right. Fritz Perls, for instance, started doing workshops at Esalen, and his notoriety there, along with his soon-to-be published books, was to make him a well-known figure (Neukrug, 2011). At Esalen, Perls began to put some of his *Gestalt therapy* ideas into a group framework. Others also applied their theories to the groups at Esalen. Individuals like Bill Schutz, a Harvard faculty member and originally an NTL devotee, were to develop group physical-contact games and group imagery exercises that had an emphasis on self-awareness:

> *Schutz will suggest to one or all members of the group simultaneously that they take a trip through their bodies. They are to enter their bodies by whatever orifice they wish. . . . I recall one lady who entered her body through her vagina and within a few seconds turned into a rat chewing away at herself. Naturally, when she came back from this nightmare it provided us with a lot of material with which to investigate her sexual identity, sexual relations, and related problems.* (Verny, 1974, p. 17)

Esalen, and the encounter group movement in general, had a particular emphasis on "getting in touch" with one's feelings, and this eventually led to the formation of a number of different types of affect-oriented groups. Some of the more popular types included *marathon groups*, where individuals might spend 48 hours intensely sharing feelings and experiences; *confrontational groups*, like the ones modeled after *Synanon*, a drug and

alcohol rehab program where it was common for group members to attack one another verbally in an effort to break down defenses; *Gestalt and sensitivity groups*, which stressed the expression of feelings in order to get to deeper issues; and *nude encounter groups* in an effort to free oneself from our restraints—clothes being one of them. This ever-expanding push to express feelings and get in touch with oneself stretched traditional values and lured group members to deal with deep-seated issues. However, the effects of such groups were not always positive. With increasingly larger numbers of groups being run by untrained individuals, and with some people reporting negative results from their experiences, the American Psychological Association (APA) in 1973 published *Guidelines for Psychologists Conducting Growth Groups*, which limited what a professional could do in groups (APA, 1973).

The 1960s and 1970s also saw the spread of texts on the theory and practice of group counseling. In addition, professional associations began to establish divisions for members interested in group work. One such association, the Association for Specialists in Group Work (ASGW), was formed in 1973 and is now one of the larger divisions of the American Counseling Association (ACA).

Recent Trends

As groups became more commonplace, helping professionals began to use group counseling as an alternative or additional treatment to individual and family counseling. Group courses became more prevalent in training programs, to the point where it is now unusual for a helping professional to *not* have course work and field experience in group work. As you might expect, group work is one of the content areas required by the Council Accreditation of Counseling and Related Educational Programs (CACREP, 2010). Whereas the past 30 years have seen a decline in some of the more outrageous groups of the 1960s and 1970s, there has also been a rise in group counseling and therapy run by well-trained and experienced counselors.

In recent years, the focus of professionally run counseling groups has changed. Whereas the typical counseling group used to be an ongoing, heterogeneous group of individuals who sought increased self-awareness and personality change, today one is more likely to find *common-theme groups* with a specialized focus (e.g., eating disorders), *task groups* that emphasize conscious behaviors and focus on how group dynamics affect the successful completion of a product, and *time-limited, brief-counseling groups* (usually fewer than 20 sessions) (Gladding, 2008; Southern, Erford, Vernon, & Davis-Gage, 2011; Delucia-Waack, Gerrity, Kalodner, & Riva, 2004). In addition, there has been a steady rise in the popularity of *self-help groups*. These grassroots groups have supported millions of Americans who have struggled with a variety of problems. Whereas the counselor of 30 years ago would rarely refer a client to a self-help group as an adjunct to counseling, the counselor of today who does not refer to a self-help group in certain instances (e.g., alcoholism, eating disorders) may be acting unethically (Klaw & Humphreys, 2004).

With the continued popularity of group work, ASGW has developed *Best Practice Guidelines* as well as *Professional Standards for the Training of Group Workers* (ASGW, 2000, 2007). The *Best Practice Guidelines* are "intended to clarify the application of the ACA Code of Ethics to the field of group work" (ASGW, 2007, preamble). The training standards define the knowledge, skills, and experiences necessary for the training of group leaders and delineate four specialty areas: *task groups, psychoeducational groups, counseling*

groups, and *psychotherapy groups*. The importance of training using these standards has become increasingly recognized in recent years as larger numbers of counselor education programs adhere to the standards (Wilson & Newmeyer, 2008).

Today, group counseling is used in most counseling settings. Although the type of group that a counselor conducts will vary as a function of the specialty area and counseling setting, all counselors need to be familiar with the four types of professional groups and be able to conduct such groups or refer to appropriate groups when necessary.

■ *Defining Modern-Day Groups*

Today, most groups can be placed into one of five categories: *self-help groups*, *task groups*, *psychoeducational groups*, *counseling groups*, and *therapy groups*, with all but self-help groups being seen as professional groups that counselors may at some point conduct (ASGW, 2000). Although these groups are different in many ways, they all are affected by *group dynamics* and have a unique *group process* (Trotzer, 2006). Group dynamics refers to the ongoing interactions and interrelationships among the group members and between the leader and group members (Gladding, 2006). These interactions are a function of conscious and unconscious forces and are influenced by such things as the structure of the group, the theoretical orientation of the leader, the unique personalities of the leader and the members, and a myriad of other influences such as drives, needs, gender, age, power issues, culture, and other known and unknown factors (Gladding, 2008; Jacobs et al., 2009). Group process refers to the changes that occur in a group as a function of the developmental stages through which the group will pass (APGA, 2007; Gladding, 2006). Group process can be affected by the dynamics in the group but is ongoing and positive if the group is led effectively. The following are brief descriptions of self-help groups, task groups, psychoeducational groups, counseling groups, and therapy groups. All of these groups are affected by group dynamics and group process.

Self-Help Groups

Although *self-help groups* have been around for more than 50 years, their growth has been phenomenal over the past 30 years (Southern et al., 2011). From Alcoholics Anonymous (AA), to codependency groups, to eating disorder and diet groups, to men's and women's groups, to groups for the chronically mentally ill, the kinds of self-help groups that have emerged seem endless. Self-help groups tend to espouse a particular philosophy or way of being in the world and generally attract individuals who share a particular diagnosis, symptom, experience, or condition (Lieberman & Keith, 2002). Their purpose is the education, affirmation, and enhancement of existing strengths of the group members. Generally, there is a nonpaid volunteer leader who focuses the discussion and assists in defining the rules of the group (Humphreys, 2004). However, sometimes there may be no leader at all. Self-help groups are generally free or have a nominal fee and can be facilitated by a trained layperson or mental health professional (see Box 7.1).

Self-help groups are not in-depth psychotherapy groups and generally do not require a vast amount of member self-disclosure. In fact, because self-help groups tend to be open groups, which means members may come and go as they please, it is sometimes

BOX 7.1

A Men's Self-Help Group

For one and one-half years, I was a participant in a men's support group established by ten men. The purpose of the group was to have a supportive group of men with whom we could share our feelings, thoughts, and concerns around a wide range of issues, particularly issues that were relevant to men. The group was leaderless, although we all periodically would take a leadership role. For one and one-half years, we shared some of our most intimate details about such issues as divorces and marriages, our sexuality, our families of origin, and relationship concerns. But perhaps most important, not having a female present enabled us to share in a way that we probably would not have shared otherwise. Although I did not remain in the group, the group continued for seven years with most of its original members.

difficult to build group cohesion, a critical element for in-depth work. Usually, individuals in self-help groups are encouraged to share only the amount that feels comfortable. Some self-help groups even discourage intense self-disclosure, as that would be seen as more appropriate for individual or group counseling.

With self-help groups, the number of group members, length of meeting times, and atmosphere of the group setting can vary considerably. Some groups might have 200 members, while others might be limited to just a few people. Some groups might meet in the basement of a church, while others might meet in the comfort of the office of a counselor who has loaned the group space. Some self-help groups may be ongoing, others may be time limited; some might demand confidentiality, while others will not.

Although self-help groups are not generally led by counselors, they have become an increasingly important referral source and are often used as an adjunct to counseling (Klaw & Humphreys, 2004). For these reasons, it has become increasingly important for counselors to be aware of the types of self-help groups available in their communities.

Task Groups

Task groups emphasize conscious behaviors and focus on how group dynamics affect the successful completion of a product (Southern et al., 2011; Gladding, 2008). The formation of the *National Training Laboratory* (NTL) was the first systematic effort to understand the dynamics of groups in business and industry, and much of the knowledge learned from NTL is today applied to our understanding of task groups (Gazda, 1989; Hulse-Killacky, Killacky, & Donigian, 2001). Task group specialists utilize:

> *principles of normal human development through group based educational, developmental, and systemic strategies applied in the context of here-and-now interaction that promote efficient and effective accomplishment of group tasks among people who are gathered to accomplish group task goals.* (ASGW, 2000, Section on Specialization Training in Group Work)

Task group specialists enter a system (e.g., agency or organization) and attempt to analyze and diagnose problems. Then, they facilitate change in the dynamics of the system with the goal being the successful completion of tasks (Gazda, 1989). Many times

BOX 7.2

A Task Group at a Bank

Ed, a private practice licensed professional counselor who consults with business and industry, has been approached by the vice-president of the local bank because of bickering going on between various bank managers. The conflict seems to have affected their ability to work effectively. Ed decides to meet with the managers for four small group meetings and analyze some of their interactions. During the first meeting, Ed establishes rapport and asks the managers to define the problem. The next two meetings are spent doing role-play problem-solving activities, selected by Ed. He watches the group carefully as they go through the problem-solving process. He is particularly aware of issues of control, hierarchies, and boundaries, especially in relationship to sexism and gender differences, prejudice and cross-cultural style differences, ageism and age style differences, and personal style differences. During the last meeting, he shares what he has seen; and, based on his feedback, he asks the group to develop some problem-solving techniques to work through their interpersonal issues. He tells the group that he will come back in a month to see if they have followed through on their ideas.

difficulties within systems are related to problems in differing values and social norms that negatively affect work groups within the system. Such differences among individuals can lead to problems in communication, feelings of dissatisfaction at work, low motivation, low productivity, sexual harassment, cross-cultural problems, and so forth (see Box 7.2).

Psychoeducational Groups

Psychoeducational groups (formerly called guidance groups) attempt to increase self-understanding, promote personal growth and empowerment, and prevent future problems through the dissemination of mental health education in a group setting (ASGW, 2000; Aasheim, 2010). A few examples of the many topics that psychoeducational groups have focused upon include sex education, bullying, conflict resolution, AIDS awareness, career awareness, communication skills, diversity issues, chemical dependence, and stress management.

Today, the term *psychoeducational groups* is generally used instead of *guidance groups* because the latter term held negative connotations in that they were misconstrued as being highly advice oriented and as having a moral imperative (Gladding, 2008; Kottler, 1994). Although psychoeducational groups had their origins in schools, today such preventive and educational groups can be found in many additional settings, such as business and industry, community centers, and community agencies. Psychoeducational group specialists utilize:

> the principles of normal human development and functioning through group based educational and developmental strategies applied in the context of here-and-now interaction that promote personal and interpersonal growth and development and the prevention of future difficulties among people who may be at risk for the development of personal or interpersonal problems or who seek enhancement of personal qualities and abilities. (ASGW, 2000, Section on Specialization Training in Group Work)

Psychoeducational groups always have a designated, well-trained group leader and focus mostly on *preventive education* and the support of the group members. Leaders will usually offer a didactic presentation and generally there is limited client self-disclosure, although there is usually an opportunity for discussion and/or some personal sharing. Such

BOX 7.3

A Psychoeducational Group in the Schools (Classroom Guidance)

Jawanda is an elementary school counselor. Her school system requires her to conduct psychoeducational groups four times a year in each class. Each group is followed by four group sessions run by the teacher of the class who is coached by the school counselor. Some of the classroom guidance activities she does are "how to handle a bully," "friendship," and "drug awareness."

Jawanda spends approximately one hour in the class, which is split between a presentation, a series of pre-set questions that she has for the students, and time for discussion and processing at the end of the group. The students seem to particularly enjoy the discussion aspect of the program and become quite active in sharing their experiences and views.

groups may be ongoing or can occur on a one-time basis. Psychoeducational groups can vary dramatically in size and the number of times they meet, although they are generally short-term, sometimes meeting only once. As with self-help groups, there is little or no charge to participants (see Box 7.3).

Counseling Groups

As with individual counseling and therapy, many people differentiate between *group counseling* and *group therapy* (Capuzzi & Gross, 2010; Gazda, 1989; Gladding, 2008). Usually, group counseling is focused on prevention and wellness, self-enhancement, increased insight, self-actualization, and conscious as opposed to unconscious motivations. Clients in group counseling may be struggling with adjustment problems in life such as the breakup of relationships, deaths, and job transitions. They generally are not dealing with severe pathology or a debilitating psychological problem. Group counseling specialists utilize:

> *principles of normal human development and functioning through group based cognitive, affective, behavioral, or systemic intervention strategies applied in the context of here-and-now interaction that address personal and interpersonal problems of living and promote personal and interpersonal growth and development among people who may be experiencing transitory maladjustment, who are at risk for the development of personal or interpersonal problems, or who seek enhancement of personal qualities and abilities.* (ASGW, 2000, Section on Specialization Training in Group Work)

Group counseling tends to be shorter in duration than group therapy but longer than psychoeducational groups. The group leader needs to be well trained in group process and group dynamics. As in group therapy, group counseling is a small-group experience, usually involving four to twelve members. In recent years, short-term, action oriented counseling groups that focus on common themes have become increasingly popular (Ivey, Pedersen, & Ivey, 2001).

Group Therapy

In contrast to counseling groups that tend to be preventive in nature and wellness oriented, *group therapy* typically focuses upon deep-seated, long-term issues; remediation of severe pathology; and personality reconstruction (see Box 7.4).

BOX 7.4

A Therapy Group

The group discussed at the beginning of the chapter, in which I participated for two years, I consider to have been a therapy group, although some might call it group counseling (see Figure 7.1). Often, there is a fine line between the two. Although I would not consider any member of the group as having had serious pathology, it was clear that many of us were dealing with major issues in our lives. There was a great push in the group for self-disclosure, insight, and change, and much of the time in the group was spent talking about past issues and uncovering conflicts, as group members attempted to work through unfinished business.

Individuals who participate in therapy groups may suffer from severe emotional conflicts, deep-seated problems, neurotic and deviant behaviors, and severe problems that would need long-term treatment. Group therapy specialists utilize:

> *principles of normal and abnormal human development and functioning through group based cognitive, affective, behavioral, or systemic intervention strategies applied in the context of negative emotional arousal that address personal and interpersonal problems of living, remediate perceptual and cognitive distortions or repetitive patterns of dysfunctional behavior, and promote personal and interpersonal growth and development among people who may be experiencing severe and/or chronic maladjustment.* (ASGW, 2000, Section on Specialization Training in Group Work)

As with group counseling, the therapy group leader needs to be well trained in group dynamics and group process and able to handle clients who might have extreme emotional responses to a group meeting (Jacobs et al., 2009). In addition, as with group counseling, group therapy has a limited number of members, and continuity of membership is crucial for the development of the group process.

Despite the fact that most authors differentiate counseling groups from therapy groups, there are many similarities. For instance, both counseling and therapy groups have designated highly trained leaders, and generally, there are between four and twelve group members. Also, usually such groups meet for a minimum of eight sessions although some may continue to meet on an ongoing basis. Most counseling and therapy groups meet at least once a week for one to three hours, and confidentiality of the group is particularly crucial. Although leadership styles may vary, usually there is some expectation on the part of the leader that members will have the opportunity to freely express their feelings and work on change.

Comparing Psychoeducational, Counseling, and Therapy Groups

Today, counselors can be found running all kinds of groups in a wide range of settings, although master's level counselors are generally more often found conducting psychoeducational, counseling, and therapy groups. Figure 7.1 compares the major differences between these kinds of groups.

FIGURE 7.1
Comparison of Psychoeducational, Counseling, and Therapy Groups

Relative Strength of Factors as a Function of Type of Group		Psychoeducational	Counseling	Psychotherapy
	High	**Psychoeducational**	**Counseling**	**Psychotherapy**
		Wellness Prevention Education	Group process Group dynamics Insight Wellness Self-disclosure Prevention Change	Insight and change Past Group process Group dynamics Pathology Severe distress Unconscious motivation Self-disclosure
	Medium	Insight Group process Group dynamics Self-disclosure Change	Education Past	
			Unconscious motivation Severe distress Pathology	Wellness Prevention Education
		Past Unconscious motivation Severe distress Pathology		
	Low	**Psychoeducational**	**Counseling**	**Psychotherapy**

The Use of Theory in Group Work

Theory is as important in group counseling as it is in individual counseling. As Corey et al. (2010) point out, "Leading groups without having an explicit theoretical rationale is like flying a plane without a flight plan. You may eventually get there, but you are equally likely to become confused, waste a lot of time, and become frustrated" (p. 8). As in individual counseling, theory in reference to group counseling (1) gives us a comprehensive system of doing counseling, (2) assists us in understanding our client, (3) helps us in deciding which techniques to apply, (4) is useful in predicting the course of treatment, and (5) is researchable, and thus can provide us information about its efficacy. If applied to group work, a counselor's theoretical model should be an extension of that person's personality, for a theory discordant with one's view of human nature will feel awkward and be applied poorly.

Although the vast majority of theories of counseling and psychotherapy were initially developed for individual counseling, most have been applied to group work, with each having advantages and disadvantages when applied to a group setting (Gladding, 2008). The following are brief examples of group counseling as applied by four counseling theories, one from each of the four conceptual orientations we examined in Chapter 4: *psychodynamic, existential–humanistic, cognitive–behavioral,* and *post-modern.* More specifically, we will briefly review psychoanalysis group therapy, person-centered group counseling, cognitive–behavioral group therapy, and solution-focused group therapy.

Psychoanalytic Group Therapy

Psychoanalytic group therapy tends to stress many of the same issues as individual psychoanalysis, including a focus on the past, unconscious motivations, insight and self-examination, intrapsychic processes, and issues of transference and resistance (Wolf, Schwartz, McCarty, & Goldberg, 1972). In group psychoanalytic therapy, it is assumed that group members will unconsciously reenact family-of-origin issues within the group. The group, therefore, offers members a rich opportunity to work on past issues that affect current functioning. This occurs through *transference*, a process where group members distort the personality of other group members, or of the group leader, and react to them as if they were significant persons from their past. The counselor or the group members can subsequently interpret this distortion in an effort to help the client understand past relationships. As Corey (2008) states, this kind of group "focuses on re-creating, analyzing, discussing, and interpreting past experiences and working through defenses and resistances . . ." (p. 132). Some of the advantages to group analytic therapy over individual therapy include:

1. The sheer number of individuals in a group allow more opportunity to re-create past family issues through transference.
2. There is an increased opportunity for feedback concerning defenses and resistances.
3. There is less chance of extreme dependency on the therapist, because some of the authority is dispersed among other group members.
4. Seeing others work through similar issues helps to reduce defensiveness.
5. Observing other members working through resistances can be an encouragement to the client to do the same.

Although the basic techniques used in individual analysis are also used in group analytic therapy, some adjustments are made for the group dynamics. For instance, in a process called *going around*, all group members participate in *free association* in which they are encouraged to share all their thoughts and feelings willingly and spontaneously in the group (Wolf & Schwartz, 1972). This allows members to move quickly beyond their *defenses* and helps to create group cohesion as members all share deeply personal issues. This sharing can later be interpreted by members and/or the group leader:

> It quickly became clear that the encouragement to express associations, thoughts, and feelings freely led to much interaction of a highly charged quality. These interpersonal responses were both appropriate and inappropriate. Patients became increasingly familiar with the characteristic distortions each made and traced these distortions in time to specific familial antecedents. In the course of working through, the

patients were encouraged to choose more reasonable alternatives in reality. (Wolf & Schwartz, 1972, p. 42)

Other psychoanalytic techniques are also easily used in the group setting (Gladding, 2008). For instance, when using *dream analysis*, group members have the opportunity to offer possible interpretations to the dream. Sometimes these meanings may be on target; other times they are projections of the member's own issues, which also can be worked on. Transference can be directed at the leader or the members of the group, and both the leader and the group members can interpret this transference. Finally, *resistance* may occur within a member or with the whole group (e.g., attempting to accuse the leader of poor group skills), and this too can be interpreted by the group leader or by other members.

When psychoanalytic group therapy was originated, groups generally met three times a week for about one and a half hours and most of the techniques mimicked what occurred in individual counseling (Wolf & Schwartz, 1972). In recent years, however, analysts have tended to meet less frequently with their clients and have adapted new techniques to the group setting. For instance, today some analysts feel comfortable sharing their own inner experience of the client within the group setting and also encourage increased sharing by clients (Levenkron, 2009; Zeisel, 2009).

Although most groups today are not psychoanalytically oriented, many groups borrow some of the tenets and techniques of psychoanalytic group therapy. For instance, the analysis of dreams, discussion of resistances and transference issues, and acknowledgment of the unconscious are commonly discussed in groups of many orientations.

Cognitive–Behavioral Group Therapy

Cognitive–behavioral group therapy combines the best of behavioral therapy and cognitive therapy into one broad counseling approach that relies on learning theory. If you remember from Chapter 4, behavior therapy was developed from three learning paradigms: *classical conditioning*, *operant conditioning*, and *modeling* or *social learning*. Over the years, cognitive approaches were developed that also relied on learning theory and asserted that in addition to behaviors, deeply embedded *cognitive structures*, or *illogical and irrational thinking* can also be conditioned (Neukrug, 2011). Believing that cognitions and behaviors could both be conditioned, counselors began to integrate the two paradigms into what is now called cognitive–behavioral therapy.

Today, many cognitive–behavioral therapists start by addressing a client's *irrational thoughts* or *cognitive distortions* (I must be perfectly capable in everything that I do!) (Corey, 2008; Neukrug, 2011). As in individual therapy, connections between a client's belief system and his or her actions, feelings, and physiological responses are identified. Clients can then take a multi-pronged approach to dealing with their problems as they challenge their irrational thinking or cognitive distortions, practice new behaviors, and experiment with new feelings. Because cognitive–behavioral therapy relies on a number of learning theory paradigms, there is a whole range of techniques that can be used (Day, 2007).

Clients of cognitive–behavioral group therapy experience a similar counseling process as do those who participate in individual cognitive–behavioral therapy, with the added benefit of having group members offer assistance through the change process. Initially, the group leader has to ensure that the members experience a sense of group cohesion. This is generally accomplished through the leader's use of foundational skills

to build a trusting relationship. Next, the problem has to be clearly defined. Based on problem identification, goals are specified and appropriate techniques are chosen. Evaluating the success of those techniques and working on termination and follow-up issues are the final stages of this process (Corey, 2008; Day, 2007).

There are many advantages to cognitive–behavioral work within a group setting. First, the establishment of group cohesion early in the process allows each group member to receive feedback from other group members concerning problem identification and strategies for change. Second, because relationships are formed, the leader will encourage the group to reinforce the changes made by the members. Third, group members can rehearse new ways of thinking and behaving in the group prior to trying them in the real world. Fourth, group members can act as models for other group members, thereby offering more opportunity to learn from others. Finally, coaching of new behaviors can be offered by the group leader or by group members. In this case, the coach will often sit behind the group member and offer continual feedback concerning a specific behavior being practiced in front of the group.

Leaders of cognitive–behavioral groups are active and directive as they assist clients in working on their cognitive–behavioral goals and assist the group in learning how to respond to one another (Corey, 2008). Such group leaders tend to downplay intrapsychic processes and stress how current cognitions and behaviors are affecting the client. Finally, because cognitive–behavioral therapy does not harp on the past or on intrapsychic and unconscious processes, it is a much shorter process than many other approaches to counseling.

Person-Centered Group Counseling

As with the other approaches we have examined thus far, *person-centered group counseling* uses the basic premises of person-centered counseling and applies them in a group setting (Gladding, 2008). Thus, the person-centered group counselor relies on the qualities of *empathic understanding*, *genuineness*, and *unconditional positive regard* to guide the group process (see Chapter 4).

Person-centered group counselors are not concerned about unconscious motivations, instincts, transference, or spending an inordinate amount of time working on past issues. However, they do believe that increased self-awareness and insight will be achieved through this approach. They believe that the core conditions of empathy, genuineness, and unconditional positive regard are *necessary and sufficient* to the effectiveness of group counseling. If applied properly, they say, there will be a tendency for the group to move toward health and wholeness.

After leading many groups, Rogers (1970) noted that the same process generally transpired in groups. This process could be described in a series of steps in which clients (1) initially mill around and resist personal expression; (2) begin to share past feelings and negative feelings—feelings that are relatively safe to express; (3) slowly express personally meaningful feelings, deeper parts of self, and feelings about one another in the group; (4) begin to accept all parts of self and find a healing capacity within; (5) are increasingly able to hear feedback about self and let down their facades; (6) become healers themselves and begin to assist others inside and outside of the group; (7) are able to encounter another person fully in an "I–Thou" relationship; and (8) begin to look and act differently inside and outside the group.

The person-centered approach to group counseling is nondirective and worked effectively for Carl Rogers as he traveled the world running groups for peoples in conflict with one another, such as Catholics and Protestants in Northern Ireland (Kirschenbaum 2009). However, the total lack of directiveness, as portrayed by Rogers, is difficult for many counselors. Other existential–humanistic approaches, such as Gestalt therapy and existential therapy, tend to be more directive and have many of the same goals and ideals of the person-centered approach.

Solution-Focused Group Counseling

If you remember from Chapter 4, solution-focused therapy is loosely based on *social constructionism* and *post-modernism*, which assert that reality is a social construction and that problems can be viewed as challenges created by language. Seen from this perspective, how the counselor brings him- or herself into the relationship is critical to helping the individual overcome his or her problems as the counselor attempts to focus on solutions, not harp on problems.

The solution-focused group counselor rejects the notion that individuals have an inherent tendency toward mental health problems or illnesses and focuses almost exclusively on solutions and client strengths, not client deficits or problems (Fernando, 2007). This approach is *pragmatic*, *optimistic*, *anti-deterministic*, and *future-oriented* and believes in the ability of clients to change quickly, find *exceptions* to their problems, and build on those exceptions to find new ways of living in the world (O'Hanlon & Weiner-Davis, 2003). Some of the assumptions of solution-focused group counseling that underlie this approach include the following:

1. All clients have resources and strengths.
2. If what you are doing is working, do more of it.
3. If what you are doing is not working, try something different.
4. Problems are not constant—there are times when they are not affecting the client.
5. Big problems do not necessarily require big solutions.
6. Change in one area will affect other areas.
7. The client is the expert on the problem.
8. Solutions are not necessarily directly related to the problem.
9. Change is inevitable. (adapted from Colley, 2009, Chapter 2)

Using these assumptions as its basis, solution-focused group counseling can be viewed through the following stages (Coe & Zimpfer, 1996):

Pregroup Stage: In this stage, the counselor selects potential group members and prepares them for group counseling. Here, the counselor informs potential clients about the norms of the group, begins to set expectations based on the nine assumptions above, and sets an expectation that there will be a sense of trust in the group. Also, the counselor will talk with the potential client about the group in a manner that assumes change will occur quickly and that the client has the resources to change. In addition, the counselor might use *presuppositional questions* that offer hope, such as: "What do you think you will do differently between now and the time we first meet?"

Initial Stage: Although the expectation that the counselor will build trust with the group is set during the pregroup stage, during the initial stage the client actually

experiences trust being built. As trust is built, clients begin to work on setting goals. A few of the many techniques that might be included in an effort to set goals include: *encouraging clients to write down goals*, *helping clients find exceptions to problems*, *identifying client resources*, *defining strengths*, and the *miracle question:*

> *Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?* (de Shazer, 1988, p. 5)

Working Stage: In this stage clients practice, inside and outside of group, working on their solutions while group members encourage and compliment one another. The group leader assures that a pathology mindset is not reinforced ("I can't change because I'm a major depressive"). Also, members are encouraged to experiment with new behaviors, and they measure their change through a process called *scaling* in which they identify how close they are to accomplishing their goals by selecting a number on a scale (1 = no progress up to 10 = very much progress).

Termination Stage: Since clients are encouraged early on to become independent and to change quickly, a great deal of time dealing with issues of closure and termination is not necessary. Termination occurs when change occurs and when clients and group members agree that goals are being successfully worked upon. During this stage clients can be given the option of returning in the future to follow-up and amplify any changes that have occurred.

Solution-focused group counseling is a short-term, positive approach to working with clients that assumes that clients can change quickly, that clients have the resources and ability to change, and that change can be long lasting.

Preparing for the Group

Prior to starting a group, there are a number of practical issues that the effective group leader should consider in order to build the most conducive climate for the group. Some of these include how to recruit members, the composition of the group, whether the group is closed or open, the size of the group, the duration and frequency of meetings, the atmosphere of the meeting place, and the leadership style of the group leader (Corey et al., 2010; Posthuma, 2002; Yalom, 2005).

Getting Members

What if I ran a group and nobody came? Believe me, this is a question that has been asked by many counselors who are considering running a group. There are a number of ways that members can be obtained, including advertising; seeking referrals from colleagues; seeking referrals from appropriate sources (e.g., teachers, academic advising offices, physicians); placing signs, if appropriate (e.g., a sign in a residence hall); and referring appropriate clients from one's own caseload. Of course, the type of person that the leader wants in the group (group composition) will greatly affect how members are obtained.

Group Composition

The composition of a counseling or therapy group can be a crucial factor in its success. Most significantly, leaders need to decide whether the group will be homogeneous or heterogeneous. In considering this important factor, leaders will reflect on the following factors: age, sex, cultural background, level of functioning, problem focus, and diagnosis of the members. Although research on the effects of group composition on group success is mixed, group leaders need to consider all of the potential problems and advantages that might affect the particular group they will be running (Garvin, 1997; Posthuma, 2002).

Closed or Open Group

Groups that do not allow new members to join are called *closed groups*, and cohesion in these groups generally occurs more quickly than in *open groups*. Sometimes group leaders will decide to have a modified closed group, where the leader will replace a member as other members leave. This is particularly useful when running small groups, especially if there is an expectation of members leaving the group at some point. Open groups, such as AA and other self-help groups, generally have members freely joining or leaving.

Size of Group

The size of the group usually depends on the purpose and type of group one is running. Whereas some self-help groups and psychoeducational groups may have large numbers of individuals, sometimes well over 25, the ideal size for counseling and therapy groups ranges from around 4 to 12 members. Clearly, when the focus of a group is on the sharing of deeply personal issues, a smaller number of clients makes intuitive sense as small numbers allow for the building of trust in an intimate setting. Other factors that should be considered when determining the size of the group include whether or not there is a co-leader, the length of time that the group meets, the size of the space where the group is meeting, and the focus of the group.

Duration of Meetings

Groups can generally run from 30 minutes to 3 hours long, with the most common length being 90 minutes to 2 hours (Jacobs et al., 2009). Factors to consider when deciding the length of group sessions include the amount of time available (e.g., school counselors usually have limited time), the focus of the group, the energy level of the leader, the energy level of the participants, and whether or not there is a co-leader.

Frequency of Meetings

Some groups meet daily, others monthly (Jacobs et al., 2009). Issues to consider in determining frequency include focus of the problem, availability of space, needs of clients, ability to pay, availability of clients, and the availability of the group leader(s).

Securing an Appropriate Space

As in individual counseling, groups should be led in a comfortable, confidential, safe environment, which has few if any distractions (Posthuma, 2002). Because of the multiple members in groups, this is not always an easy task. For instance, some groups, such as psychoeducational groups in schools, are often conducted in a classroom because a separate space would be difficult to find.

Group Leadership Style

Leadership styles will vary based on the leader's personality and theoretical orientation, and prior to running the group, a good leader should consider the impact that his or her leadership style will have on the group (Corey, 2008; Gladding, 2008). For instance, a leader who is more comfortable with a person-centered approach that includes expression of feelings might want to consider whether he or she would be the best person to run a weight loss or bridge phobia group, both of which generally do better with a cognitive–behavioral focus. In addition, good leaders consider the composition of their group and have adjusted their style to the needs of the group members. Finally, research suggests that an effective group leader "will want to be positive, supportive, provide sufficient structure, attend to the development of group cohesion, allow group members to take ownership of their group, and provide a meaningful context for what occurs in the group" (Riva, Wacthel, & Lasky, 2004, p. 45). Others have suggested that good leadership also entails being emotionally present, having personal power and self confidence, being courageous and willing to take risks, being willing to confront oneself, being sincere and authentic, having an identity or strong sense of self, being enthusiastic and believing in the group process, and being inventive and creative (Corey, 2008).

The Stages of Group Development

The development of a group has been shown to occur in predictable stages (Brabender & Fallon, 2009; Yalom, 2005). Although group experts differ on the terms they use to identify these stages, they tend to describe the characteristics of the stages in fairly consistent ways. One popular series of words, still very much in use today, that describes these stages was developed by Tuckman (1965; Tuckman & Jensen, 1977). Tuckman suggested that the beginning stages have to do with *forming* the group, as members move from a number of separate individuals to the realization that they are together, in a group. The group then moves into the *storming* stage as defensiveness and intragroup struggles heighten as members test the waters to see if they can trust one another. Slowly, as trust is built, the group moves into the *norming* stage, where the group becomes a cohesive unit. Soon after, the group members are in the *performing* stage, and the members begin to work on their issues. Finally, as members wind down and begin to deal with their feelings about leaving the close-knit relationships they have built in the group, they move into the last stage, *adjourning*. As you read through the following stages I have identified, take particular note of how Tuckman's stages might apply.

As you read about the stages, keep in mind that counseling and therapy groups have the continuity of membership to stimulate the development of interpersonal relationships necessary for the full development of the group process through all of the stages. On the other hand, the structure of self-help, task, and psychoeducational groups is such that we are unlikely to see passage through all of the stages.

The Pregroup Stage (Forming)

Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience. (ACA, 2005, Section A.8.a)

As the above quote suggests, the group leader needs to find an effective method of pre-screening potential group members. Some group leaders will have a pregroup meeting with all potential members. Other leaders provide potential members with a thorough written or even videotaped summary of the expectations of the group in an effort to have them screen themselves out. However, probably the most effective and common method is the individual interview. Couch (1995) notes that the interview can assist in identifying needs, expectations, and commitment of the potential group member; challenging myths and misconceptions of the potential member; conveying and procuring information to the potential member; and screening out (or in) potential members. Although all of this occurs prior to the actual first meeting, it is considered the first stage of the group because of its potential impact on the group process.

The Initial Stage (Forming)

When the group actually does begin, the members are often anxious, apprehensive, and want to get started. During this stage, group members are adapting to the rules and goals of the group and are wondering whether they can trust the other group members. Because of the initial apprehension and lack of trust, group members will often avoid talking about in-depth feelings during this stage, and discussions are relatively safe. Therefore, it is common for conversations to be superficial, for members to have a focus on others as opposed to a self-focus, and for discussions to revolve around feelings from the past, not "here and now" feelings (Corey et al., 2010). Many behaviors clients may exhibit are reflective of their early fears about the group process. Sometimes called *resistance*, although I prefer the word "*reticence*," just a few of these behaviors include being silent, laughing or talking excessively, being overly nurturing, monopolizing, intellectualizing, generalizing, being seductive, and so forth.

During this initial stage, group members are often self-conscious, worried about how others might view them, and concerned about whether they will be accepted. Some of the major tasks for the group leader in this stage include defining the ground rules, setting limits, and building a level of trust that will provide members with a sense that they want to continue in the group (Gladding, 2008). If the leader is successful, group cohesion will begin to build by the end of this stage.

In the pursuit of trust and group cohesion, the leader must be able to set limits, assure that members abide by the ground rules, and simultaneously show empathy and

unconditional positive regard. Structure, empathy, and positive regard enable group members to feel psychologically safe, which is the first step toward greater openness. Leaders need to be genuine and only slightly self-disclosing (Corey et al., 2010). This is sometimes a difficult balance, but, ultimately, the leader's purpose is to focus on group members, not self.

From a systems perspective, group leaders should be particularly cognizant of *scapegoating*, as this is a convenient way to keep the focus off oneself (Clark, 2002). Thus, the leader should know appropriate strategies for dealing with scapegoating, as such behavior has the potential of limiting self-disclosure and being destructive to group cohesion.

The Transition Stage (Storming and then Norming)

During the opening phase of the transition stage, group members are beginning to feel comfortable with the technical issues and ground rules of the group. However, anxiety is still felt as trust and safety issues continue. Issues of control, power, and authority become increasingly important in this stage as members position themselves within the system (Corey et al., 2010; Yalom, 2005). What are members trying to accomplish by positioning themselves? Ultimately, they are attempting to be the same person in the group as they are in the rest of their lives:

> *Given enough time, group members will begin to be themselves: they will interact with the group members as they interact with others in their social sphere, will create in the group the same interpersonal universe they have always inhabited.* (Yalom, 2005, pp. 31–32)

As members attempt to find their place in the group, they are likely to experience anxiety, fear, and a myriad of other feelings. At this point in the group process, members may begin projecting onto the group leader and struggle with transference issues (Corey et al., 2010: Yalom, 2005). A dance occurs in the group as members attempt to settle into the group process and simultaneously deal with all the feelings they are having. Attacking and scapegoating are common at this point, as members are fearful of taking ownership of their strong and sometimes confusing feelings and thus blame others for their discomfort. Although empathy and positive regard continue to be important in this stage, it is also vital that the leader actively prevent a member from being scapegoated or attacked as a result of group instability. Failure to do so could prevent the group from progressing further, as members become bogged down with conflict and fail to build cohesion.

If the leader is successful in helping group members pass through the difficult part of this stage, trust will slowly be built, resistances will diminish, and members will begin to settle into their roles and feel safe enough to delve into self and to share personal concerns. Members are now transitioning to a place where they can demonstrate the ability to take ownership of their feelings, have a self- rather than other-focus, talk in the here and now, not blame others for their problems, and have a sense of mutual support and cooperation with the other group members (Yalom, 2005). At this point in the stage, the need for the leader to protect members dramatically decreases as members stop blaming others, stop acting out, and increasingly feel a sense of cohesiveness as a group. Near the end of this stage, group members more clearly identify the goals they would like to achieve. Although goals were probably identified earlier by most group members, defensiveness and lack of clarity of self may have distorted the clients' perceptions of which issues to work on.

From a systems perspective, it is interesting to compare this stage to family counseling. Families come in with a system that has evolved over a number of years. Issues of control, power, and authority have already been decided. Therefore, the purpose of family counseling is to understand the family in order to devise strategies to change the system in a manner that will lead to healthier functioning for all. Groups, on the other hand, are working to build a system (Matthews, 1992), and it is the responsibility of the leader to ensure that strategies are used to develop a healthy, functioning system. Ultimately, the goal for families and groups is the same: to develop a system that has open channels of communications, allows for the sharing of feelings, and rebuffs abuses of power that leave people feeling unsafe and victimized. When families and groups arrive at this place, they are ready to work.

The Work Stage (Performing)

As members gain the capacity to take ownership of their feelings and life predicaments, a deepening of trust and a sense of cohesion emerges within the group. Members are now able to give and hear feedback, focus on identified problems, and take an active role in the change process. For instance, they may attempt new ways of communicating, acting, or expressing feelings. During this stage, conflict lessens; but, when it does occur, it is handled very differently from the way it was dealt with previously. Members now can talk through conflict and take ownership of their own part in it.

As this stage continues, members will begin to identify and work on behaviors they would like to change. As members accomplish their goals, they gain in self-esteem as they receive positive feedback from other members and acquire a sense of accomplishment for the work they have done. As members meet their goals, they are near the completion of the group process.

From a systems perspective, during this stage, the group has developed its own unique homeostasis; however, it is important that the group leader prohibit members from becoming too comfortable in their styles of relating, as this can prevent change and growth. Leaders can best facilitate movement during this stage using a variety of advanced counseling skills such as support and confrontation, higher-level empathy, probing questions, and interpretation.

The Closure Stage (Adjourning)

The last stage of the group process is highlighted by an increased sense of accomplishment, high self-esteem, and the beginning awareness that the group process is near completion. Saying good-bye can be a difficult process for many, and it is important that the leader facilitate this process in a direct yet gentle fashion. Often this is done by the leader encouraging members to share what they have learned about themselves, share what they have learned about others in the group, and express their feelings about one another and the upcoming termination of the group. Using empathy, the leader will often summarize the changes that have taken place and focus on the separation process. This important final stage in the group process allows members to feel a sense of completion and wholeness about what they have experienced.

It is important during this stage to ensure that those who need additional counseling, or others who would like additional counseling, be given appropriate referrals. In

addition, other members may want to develop a method of ensuring the continuation of changed behaviors. Members might decide to meet periodically on their own in a kind of ongoing support group, or there might be periodic planned meetings with the group leader that focus on reinforcement of changed behaviors. Some members might have periodic check-ins with the group leader on an individual basis.

Finally, to assess if the group has been beneficial, many leaders will complete an evaluation of the group. Determining if change has been substantive and continual is often completed during the final group meeting and/or by distributing a follow-up evaluation after a reasonable amount of time has passed after the group has finished.

Multicultural/Social Justice Focus

Principles for Diversity-Competent Group Workers

For group counselors to be effective with all populations, it is critical that they are trained to be culturally competent. (Bemak & Chung, 2004, p. 31)

In an effort to ensure that individuals who do group work are appropriately knowledgeable about multicultural issues, the ASGW developed and endorsed *Principles for Diversity-Competent Group Workers* (ASGW, 1998; 1999; Wilson, Rapin, & Haley-Banez, 2004; see http://www.asgw.org/diversity.htm). These principles speak to the knowledge, skills, and attitudes and beliefs that all diversity-competent group workers should have when working with clients. All professionals who practice group work should be knowledgeable about this document.

Social Justice in Group Work: Understanding the Place of Privilege

One of the increasingly important roles of the counselor who does group work is to understand how privilege impacts individuals (Singh & Salazar, 2010b). It is important that counselors be aware that there is "invisible affirmative action" for a whole range of clients including males, Whites, and heterosexuals and that clients who are not bathed in this invisible cloak are often seen as stupid, lazy, or unwilling to put real effort into "making it" (Smith & Shin, 2008). In groups, privilege, or lack thereof, affects each client. One role of the counselor is to help clients see how privilege, or lack thereof, has affected them and to empower them to be advocates for themselves. In addition, counselors can take positive steps in the community and in society to lessen disparities between the haves and have-nots.

Prejudice and the Group as a Microcosm of Society

Because a group is a microcosm of society, prejudices that occur in everyday life are likely to become evident. Therefore, a culturally diverse group offers the potential for clients to work through unconscious and deep-seated feelings of racism and prejudice. Counselors have the opportunity to help heal deeply held prejudices by considering the cultural background of clients when deciding group membership. By actively seeking out diversity

in group membership, counselors are likely to set the stage for group members to work on their prejudices.

Cultural Differences between a Group Member and the Group Leader

Because misplaced anger is often projected onto the group leader early in the group experience, if a group leader is from a culturally different background from the members, the leader has the opportunity to assist members in understanding their anger, which is sometimes related to deep-seated prejudices but masked as something else. A simple question by a member of "Why aren't we making quicker progress in the group?" can be related to fears about opening up as well as prejudices about the ability of a leader who is from a certain cultural group. A skilled group leader can assist members both in examining their anger, which is a natural part of the group process, and in understanding feelings of prejudice.

Ethical, Professional, and Legal Issues

Ethical Issues

Ethical Code and Best Practices Guidelines

The ethical code of ACA (2005) applies to group work as well as individual counseling. However, because the code does not fully address some issues relative to group work, the Association for Specialists in Group Work (ASGW) developed the *ASGW Best Practice Guidelines* (ASGW, 2007), which helps to clarify the application of the code of ethics "to the planning, implementation, processing, and evaluation in group work practice" (Wilson et al., 2004, p. 20). In addressing ethical and professional concerns, both the code and the *Best Practices Guidelines* should be examined.

Informed Consent and Confidentiality

As with individual counseling, there are a myriad of ethical issues with which the group leader must contend. However, two issues that have particularly stood out over the years include informed consent and confidentiality.

INFORMED CONSENT.   Informed consent becomes a particularly important concern in group work because a number of issues not found in other forms of counseling are at play in group work (Corey, 2008; Corey et al., 2010). At the very minimum, when giving informed consent, group members should know (1) the credentials of the group leader, (2) the general therapeutic style of the group leader, (3) the goals of the group, (4) the general ground rules associated with the group, (5) expectations about self-disclosure on the part of the leader and potential members, (6) whether members are free to withdraw from the group at any time and the responsibility they have to the other group members when terminating, (7) the limits of confidentiality, (8) any psychological risks that may arise as a function of the group experience, (9) fees involved, and (10) how the group may or may not be in sync with the values or cultural beliefs of the member.

CONFIDENTIALITY

> *In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.* (ACA, 2005, Section B.4.a)

As in all forms of counseling, the group leader must assure group members about the confidential nature of counseling but also inform them of any limits to confidentiality. Such limits include what the leader might do if he or she suspected foreseeable harm to a client or to others, the fact that the group leader cannot ensure that members of the group will keep information confidential (see "Legal Issue: Confidentiality and the Third-Party Rule"), or any other potential issues that might affect confidentiality (e.g., parents right to know, subpoenas from the courts).

Professional Issues

Professional Associations

Although a number of professional associations focus on group issues, the major professional association for counselors interested in group work is ASGW, a division of ACA. Its purpose is

> *. . . to establish standards for professional and ethical practice; to support research and the dissemination of knowledge; and to provide professional leadership in the field of group work. In addition, the Association shall seek to extend counseling through the use of group process; to provide a forum for examining innovative and developing concepts in group work; to foster diversity and dignity in our groups; and to be models of effective group practice.* (ASGW, 2010, para.2)

A few of the many benefits of ASGW include:

- *Best Practice Guidelines* to augment the ACA ethical guidelines
- Professional Standards for the Training of Group Workers
- *The Principles for Diversity-Competent Group Workers*
- Publishing a newsletter as well as the *Journal for Specialists in Group Work*
- Scholarships for students and group work specialists
- The sponsoring of workshops and conferences specific to group issues
- The opportunity to be mentored and learn about supervisory practices relative to group work

Group versus Individual Counseling

When does one refer a client to group counseling as an alternative or adjunct to individual counseling? With the most current research indicating that group counseling is as effective as individual counseling, some suggest that group work should always be considered as an alternative to individual treatment (Burlingame & Krogel, 2005; Burlingame, MacKenzie, & Strauss, 2004). Although there is no easy method of determining when to use group or individual counseling, a few guidelines might help. For instance, it might be smart to refer to group counseling when:

- A client cannot afford the cost of individual counseling
- The benefits for a client of individual counseling have gotten so meager that an alternative treatment might offer a new perspective
- A client's issues are related to interpersonal functioning, and a group might facilitate working through these issues in a real-life manner
- A client needs the extra social support that a group might offer
- A client wants to test new behaviors in a system that will support him or her while simultaneously receiving realistic feedback about the new behavior
- The experiences of others who are working through similar issues can dramatically improve the client's functioning (e.g., alcoholism or depression)

Legal Issue: Confidentiality and the Third-Party Rule

Group workers have the responsibility to inform all group participants of the need for confidentiality, potential consequences of breaching confidentiality and that legal privilege does not apply to group discussions (unless provided by state statute). (ASGW, 2007, Section A.7.d)

Although group members might justifiably expect that other group members and the leader would respect their right to confidentiality, the legal system generally does not view information revealed to more than one person as confidential (in the legal system this is called the *third-party rule*) (Swenson, 1997). Thus, if a group member were to break confidentiality, such as reveal information about the group in a court of law, the court might then deem it desirable, and possible, to obtain information from other group members. In addition, if the leader does not hold *privileged communication* status, he or she can also be forced to reveal information disclosed in the group.

The Counselor in Process: Allowing Groups to Unfold Naturally

Push a group to open up to quickly, and it will push back. The members will resist, protest, confront, and perhaps even leave. A group needs to unfold in its own way as the counselor slowly facilitates the development of the group process. Thus, the counselor's challenge is to facilitate deep knowing on the part of clients as they traverse the stages of group counseling without pressuring them to the point where they will want to leave the group. This delicate balance is not always easily achieved. Perhaps hearing some thoughts shared by Carl Rogers more than 40 years ago can remind us that groups need to move at their own pace:

. . . Often there is consternation, anxiety, and irritation. . . . Only gradually does it become evident that the major aim of nearly every member is to find ways of relating to other members of the group and to himself. Then as they gradually, tentatively, and fearfully explore their feelings and attitudes toward one another and toward themselves, it becomes increasingly evident that what they have first presented are facades, masks. Only cautiously do the real feelings and real person emerge. . . . Little by little, a sense of genuine communication builds up. . . . (Rogers, 1970, p. 8)

■ *Summary*

This chapter began by noting that groups, like families, are affected by systemic principles, and we then highlighted the fact that group work offers some advantages and disadvantages over other forms of counseling. We discussed how group work has changed over the twentieth century from its early moralistic and preaching orientation, to a rigid psychoanalytic focus, to encounter and training groups that arose in the 1940s. We highlighted some of the well known individuals who first experimented with different forms of group work, such as Addams, Richmond, Pratt, Freud, Moreno, Adler, Lewin, and Rogers. We discussed the early beginnings of NTL and of encounter groups and noted that today, most groups can be classified as one of five types: self-help groups, task groups, psychoeducational groups, counseling groups, and therapy groups. We provided descriptions of each of these types of groups and noted that counselors generally are involved in conducting all but self-help groups.

In this chapter, we discussed the importance that theory has in group counseling and noted that a group leader tends to embrace a theory that is an extension of his or her personality. We examined one theory from each of four conceptual orientations, including psychoanalysis group therapy from the psychodynamic tradition, cognitive–behavioral group counseling from the cognitive–behavioral tradition; person-centered group counseling from the existential–humanistic focus, and solution-focused group counseling from post-modern therapy. We stated that regardless of the theory chosen, all groups will be affected by group dynamics and reflect group process.

As the chapter continued, we discussed issues to consider when preparing to run a group, including group leadership style, the composition of the group members, whether the group is closed or open, the size of the group, the duration and frequency of meetings, and the atmosphere of the place in which the group meets. We then identified Tuckman's stages of group development (i.e., forming, storming, norming, performing, and adjouring) and showed how they applied to five stages of group development that were discussed: pregroup, initial, transition, work, and closure. We noted that passage through all these stages generally occurs only in counseling and therapy groups and not in self-help groups, task groups, and psychoeducational groups.

In looking at groups from a multicultural/social justice focus, we noted that ASGW has developed *Principles for Diversity-Competent Group Workers*, which can assist in the cross-cultural training of group workers. We next highlighted the place that privilege plays in group counseling and how counselors can address privilege. Next, we noted that because the group is a microcosm of society, prejudice can be sometimes found in groups and groups can be a place to examine such underlying biases. We also pointed out that if group members are culturally different from the group leader, there is a unique opportunity for group members to safely examine their biases and prejudices as they become projected onto the leader.

We noted that most ethical and legal concerns found in individual counseling are also found in group work. However, we highlighted two ethical and legal concerns that are particularly important to group work: informed consent and confidentiality. For instance, we pointed out the increased importance of informed consent in group work due to the many risks involved. In addition, we stated that in group counseling confidentiality is much less assured, and as reflected in the "third party rule," cannot be guaranteed through our legal system.

Near the end of the chapter, we discussed some professional issues related to group work. First, we identified the purpose of ASGW, the group work division of ACA. Here, we highlighted some benefits of joining ASGW, such as the fact that they have developed The *Best Practice Guidelines*, the Professional Standards for the Training of Group Workers, and the *Principles for Diversity-Competent Group Workers*. In addition, we noted that they have a newsletter and a journal, sponsor workshops and conferences, and offer scholarships. Then we identified some guidelines for choosing group work over individual counseling. Finally, we concluded the chapter with a brief discussion of the importance of allowing groups to unfold naturally.

■ *References*

Aasheim, L. L. (2010). Guidance/psychoeducational groups. In D. Capuzzi, D. R. Gross, & M. D. Stauffer (Eds.), *Introduction to group work* (5th ed., pp. 282–307) Denver, CO: Love Publishing.

Agazarian, Y. M. (2008). Introduction to a theory of living human systems and systems-centered practice. In G. M. Saiger, S. Rubenfeld, & M. D. Dluhy, (Eds.). *Windows into today's group therapy* (pp. 23–31). New York: Routledge.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Mental Health Counselors Association. (n.d.). *Facts about mental health counselors*. Retrieved from http://www.amhca.org/about/facts.aspx

American Group Psychotherapy Association. (2007). *Practice guidelines for group psychotherapy: Group process*. Retrieved from http://www.agpa.org/guidelines/groupprocess.html

American Psychological Association. (1973). Guidelines for psychologists conducting growth groups. *American Psychologist, 28,* 933. doi: 10.1037/h0035596

American School Counselor Association. (2009). *The role of the professional school counselor*. Retrieved from http://www.schoolcounselor.org/content.asp?pl=325&sl=133&contentid=240

Andrews, H. B. (1995). *Group design and leadership: Strategies for creating successful common theme groups*. Boston: Allyn & Bacon.

Andrews, J. (2001). Group work's place in social work: A historical analysis. *Journal of Sociology & Social Welfare, 28*(4), 45–65.

Anthony, E. J. (1972). The history of group psychotherapy. In H. I. Kaplan & B. J. Sadock (Eds.), *The origins of group psychoanalysis* (pp. 1–26). New York: Jason Aronson.

Association for Specialists in Group Work. (1998). *Principles for diversity-competent group workers*. Retrieved from http://www.asgw.org/PDF/Principles_for_Diversity.pdf

Association for Specialists in Group Work. (1999). Principles for diversity-competent group workers. *Journal for Specialists in Group Work, 24,* 7–14. doi: 10.1080/01933929908411415

Association for Specialists in Group Work. (2000). *Professional standards for the training of group workers*. Retrieved from http://www.asgw.org/PDF/training_standards.pdf

Association for Specialists in Group Work. (2007). *ASGW best practices guidelines*. Retrieved from http://www.asgw.org/PDF/Best_Practices.pdf

Association for Specialists in Group Work. (2010). *Purpose of ASGW*. Retrieved from http://www.asgw.org/purpose.asp

Barlow, S., Burlingame, G., & Fuhriman, A. (2000). Therapeutic applications of groups: From Pratt's "thought control classes" to modern group psychotherapy. *Group Dynamics: Theory, Research, and Practice, 4*(1), 115–134. doi: 10.1037/1089-2699.4.1.115

Bemak, F., & Chung, R. C. (2004). Teaching multicultural group counseling: Perspectives for a new era. *The Journal for Specialists in Group Work, 29,* 31–42. doi: 10.1080/01933920490275349

Brabender, V., & Fallon, A. (2009). *Group development in practice: Guidance for clinicians and researchers on stages and dynamics of change*. Washington, DC: American Psychological Association.

Burlingame, G., & Krogel, J. (2005) Relative efficacy of individual versus group psychotherapy. *International Journal of Group Psychotherapy, 55*(4), 607–611. doi: 10.1521/ijgp.2005.55.4.607

Burlingame, G. M., MacKenzie, K. R., & Strauss, B. (2004). Small group treatment: Evidence for effectiveness and mechanism of change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 647–696). New York: Wiley.

Capuzzi, D., & Gross, D. R. (2010). Group work: an introduction. In D. Capuzzi, D. R. Gross, & M. D. Stauffer (Eds.), *Introduction to group work* (5th ed., pp. 3–38). Denver, CO: Love Publishing.

Clark, A. J. (2002). Scapegoating: Dynamics and interventions in group counseling. *Journal of Counseling and Development, 80,* 271–276.

Coe, D. M., & Zimpfer, D. G. (1996). Infusing solution-oriented theory and techniques into group work. *The Journal for Specialists in Group Work, 21,* 49–57. doi: 10.1080/01933929608411358

Colley, L. (2009). *The power of groups: Solution-focused group counseling in the schools.* Thousand Oaks, CA: Corwin.

Connors, J., & Caple, R. (2005). A review of group systems theory. *Journal for Specialists in Group Work, 30*(2), 93–110. doi: 10.1080/01933920590925940

Corey, G. (2008). *Theory and practice of group counseling* (7th ed.). Belmont, CA: Brooks/Cole.

Corey, M. S., Corey, G.., & Corey, C. (2010). *Groups: Process and Practice* (8th ed.). Belmont, CA: Brooks/Cole.

Couch, R. D. (1995). Four steps for conducting a pregroup screening interview. *The Journal for Specialists in Group Work, 20*(1), 10–25. doi: 10.1080/01933929508411321

Council Accreditation of Counseling and Related Educational Programs. (2010). *2009 standards.* Retrieved from http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Day, S. X. (2007). *Groups in practice.* Boston: Houghton Mifflin.

DeLucia-Waack, J. L., Gerrity, D. A., Kalodner, C. R. & Riva, M. T. (Eds.). (2004). *Handbook of group counseling and psychotherapy*. Thousand Oaks, CA: Sage Publications.

de Shazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*. New York, NY: W. W. Norton & Company.

Fernando, D. M. (2007). Existential theory and solution-focused strategies: Integration and application. *Journal of Mental Health Counseling, 29*(3), 226–241.

Fox, T. (1987). *The essential Moreno: Writings on psychodrama, group method, and spontaneity.* New York: Springer.

Freud, S. (1975). *Group psychology and the analysis of the ego* (J. Strachey, trans.). New York: Norton. (Original work published 1922)

Garvin, C. (1997). *Contemporary group work* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Gazda, G. M. (1989). *Group counseling: A developmental approach* (4th ed.). Boston: Allyn & Bacon.

Gladding, S. T. (2006). *The counseling dictionary: Concise definitions of frequently used terms* (2nd ed.). Upper Saddle River, NJ: Pearson.

Gladding, S. T. (2008). *Groups: A counseling specialty* (5th ed.). New York: Merrill.

Holcomb-McCoy, C. (2008). A response to "social privilege, social justice, and group counseling: an inquiry." *Journal for Specialists in Group Work, 33*(4), 367–369. doi: 10.1080/01933920802424423

Hulse-Killacky, D., Killacky, J., & Donigian, J. (2001). *Making task groups work in your world.* Upper Saddle River, NJ: Merrill.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions.* New York: Cambridge University Press.

Ivey, A. E., Pedersen, P. B., & Ivey, M. B. (2001). *Intentional group counseling: A microskills approach.* Belmont, CA: Brooks/Cole.

Jacobs, E. E., Masson, R. L., & Harvill, R. L. (2009). *Group counseling: Strategies and skills* (6th ed.). Belmont, CA: Brooks/Cole.

Kirschenbaum, H. (2009). *The life and work of Carl Rogers*. Alexandria, VA: American Counseling Association.

Klaw, E., Humphreys, K. (2004). The role of peer led mutual help groups in promoting health and well-being. In L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 630–640). Thousand Oaks, CA: Sage Publications.

Kottler, J. A. (1994). *Advanced group leadership*. Pacific Grove, CA: Brooks/Cole.

Levenkron, H. (2009). Engaging the implicit: Meeting points between the Boston Change Process Study Group and relational psychoanalysis. *Contemporary Psychoanalysis, 45*(2), 179–217.

Lieberman, M. A., & Keith, H. (2002). Self-help groups and substance abuse: An examination of alcoholics anonymous. In. D. W. Brook & H. Spitz (Eds.), *The group therapy of substance abuse* (pp. 203–221). New York: Haworth Press.

Lonergan, E. C. (1994). Using theories of group therapy. In H. S. Bernard & K. R. MacKenzie, *Basics of Group Psychotherapy* (pp. 191–216). New York: Guilford.

Markus, H. E., & King, D. A. (2003). A survey of group psychotherapy training during predoctoral psychology internship. *Professional Psychology: Research and Practice, 34*(2), 203–209. doi: 10.1037/0735-7028.34.2.203

Matthews, C. O. (1992). An application of general system theory (GST) to group therapy. *The Journal for Specialists in Group Work, 17*(3), 161–169. doi:10.1080/01933929208413725

National Training Laboratory. (2008). *About NTL*. Retrieved from http://www.ntl.org/inner.asp?id=177&category=2

Napier, R. W., & Gershenfeld, M. K. (2004). *Groups: Theory and experience* (7th ed.). New York: Houghton Mifflin Company.

Neukrug, E. (2011). *Counseling theory and practice*. Belmont, CA: Brooks/Cole.

O'Hanlon, B., & Weiner-Davis, M. (2003). *In search of solutions: A new direction in psychotherapy* (rev. ed.). New York: Norton.

Perusse, R., Goodnough, G., & Lee, V. V. (2009). Group counseling in the schools. *Psychology in the Schools, 46*(3), 225–231. doi: 10.1002/pits.20369

Posthuma, B. W. (2002). *Small groups in counseling and therapy: Process and leadership* (4th ed.). Boston: Allyn & Bacon.

Pinney, E. L. (1995). *A first group psychotherapy book*. Springfield, IL: Charles C. Thomas. (Original work published 1970)

Pottick, K. J. (1988). Jane Addams revisited: Practice theory and social economics. *Social Work with Groups, 11,* 11–26. doi: 10.1300/J009v11n04_04

Riva, M. T., Wachtel, M., & Lasky, G. B. (2004). Effective leadership in group counseling and psychotherapy: Research and practice. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 37–48). Thousand Oaks, CA: Sage Publications.

Rogers, C. R. (1970). *Carl Rogers on encounter groups*. New York: Harper & Row.

Roysircar, G. (2008). Response to "social privilege, social justice, and group counseling: An inquiry": Social privilege: counselors' competence with systemically determined inequalities. *Journal for Specialists in Group Work, 33,* 377–384. doi: 10.1080/01933920802424456

Shaffer, J. B. P., & Galinsky, M. D. (1989). *Models of group therapy and sensitivity training*. Englewood Cliffs, NJ: Prentice Hall.

Singh, A. A., & Salazar, C. F. (2010a). The roots of social justice in group work. *Journal of Specialists in Group Work, 35*(2), 97–104. doi: 10.1080/01933921003706048

Singh, A. A., & Salazar, C. F. (Eds.). (2010b). Social justice issues in group work, part I [Special issue]. *Journal of Specialists in Group Work, 35*(2). doi: 10.1080/01933921003706048

Smith, L., C., & Shin, R. Q. (2008). Social privilege, social justice, and group counseling: An inquiry. *Journal of Specialists in Group Counseling, 33,* 351–366. doi: 10.1080/01933920802424415

Southern, J. A., Erford, B. T., Vernon, A., & Davis-Gage, D. (2011). The value of group work: Functional group models and historical perspective. In B. T. Erford (Ed.), *Group work: Processes and applications* (pp. 1–19). New York: Pearson.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Trotzer, J. P. (2006). *The counselor and the group: Integrating theory, training, and practice* (4th ed.). New York: Routledge.

Tuckman, B. W. (1965). Developmental sequence in small groups. *Psychological Bulletin, 63*, 384–399. doi: 10.1037/h0022100

Tuckman, B. W., & Jensen, M. A. C. (1977). Stages of small-group development revisited. *Group and Organization Management, 2*, 419–427. doi: 10.1177/105960117700200404

Vander Kolk, C. J. (1990). *Introduction to group counseling and psychotherapy.* Prospect Heights, IL: Waveland Press.

Verny, T. R. (1974). *Inside groups: A practical guide to encounter groups and group therapy.* New York: McGraw-Hill.

Ward, D. E. (2004). The challenge of defining techniques in group work. *The Journal for Specialists in Group Work, 29*, 155–158. doi: 10.1080/01933920490437925

Ward, D. E. (2007). The evidence mounts: Group work is effective. *The Journal for Specialists in Group Work, 32*, 207–209. doi: 10.1080/01933920701431719

Wilson, F. R., & Newmeyer, M. D. (2008). A standards-based inventory for assessing perceived importance of and confidence in using ASGW's core group work skills. *The Journal of Specialists in Group Work, 33*, 270–289. doi: 10.1080/01933920802196146

Wilson, F. R., Rapin, L. S., & Haley-Banez, L. (2004). How teaching group can be guided by foundational documents: Best practice guidelines, diversity principles, training standards. *The Journal for Specialists in Group Work, 29*, 19–29. doi: 10.1080/01933920490275321

Wolf, A., & Schwartz, E. K. (1972). Psychoanalysis in groups. In H. I. Kaplan & B. J. Sadock, *The origins of group psychoanalysis* (pp. 41–100). New York: Jason Aronson.

Wolf, A., Schwartz, E. K., McCarty, G. J., & Goldberg, I. A. (1972). Psychoanalysis in groups: Comparison with other group therapies. In C. J. Sager & H. S. Kaplan (Eds.), *Progress in group and family therapy* (pp. 47–53). New York: Brunner/Mazel.

Yalom, I. D. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Zeisel, E. (2009). Affect education and the development of the interpersonal ego in modern group psychoanalysis. *International Journal of Group Psychotherapy, 59*(3), 421–432. doi:10.1521/ijgp.2009.59.3.421

Consultation and Supervision

*T*he principal of an elementary school asked me to spend a morning with a third-grade class. He wanted to discuss the students' feelings about having had a developmentally delayed young man, who was quadriplegic, mainstreamed into their classroom for six weeks. This was consultation.

Because I was concerned that a client of mine might have an emotional disorder or be learning disabled, I gave him a series of psychological and educational tests. I subsequently met with a colleague of mine to assist me in reviewing the results. This was consultation.

Administrators from a local social service agency asked a colleague of mine to meet with them concerning communication problems at their agency. Following the meeting, they hired him to come to the agency, assess problems, and suggest strategies for change. This was consultation.

Our counseling program invited a counselor educator, who had expertise with the accreditation standards of the Council for the Accreditation of Counseling and Related Programs (CACREP) to review the program's strengths and weaknesses before we applied for CACREP accreditation. This too was consultation.

During my counseling career, I have had numerous supervisors. For instance, when I worked as a counselor at a mental health center, I would meet weekly with my supervisor to discuss my cases. Also, while in private practice, our group hired a local psychologist to meet weekly with us for supervision. Another time, while in private practice, I contracted with a master therapist for bi-weekly supervision meetings. This was supervision, a special kind of—you guessed it—consultation.

The preceding examples show that consultation and supervision have become common aspects of every counseling specialty area. As you might surmise, in the CACREP (2010) standards, consultation and supervision are both highlighted as essential skills to master.

In this chapter, we will examine the current status of consultation and supervision. Although supervision may be seen as a type of consultation, there are enough differences between the two to justify discussing them separately. Therefore, the chapter will focus first on consultation and later on supervision.

■ *Consultation*

Consultation Defined

. . . me and you talking about him or her with the purpose of some change. (Fall, 1995, p. 151)

Although I personally like the simple definition offered above, perhaps a more professional one that I might suggest is:

> *When a professional (the consultant), who has specialized expertise, meets with one or more other professionals to improve the professionals' work with current or potential clients.*

Although the *consultee* is often referred to as any professional who meets with a *consultant*, in actuality, the consultee is the point person, or the person identifying and inviting the consultant to consult. In fact, in some cases it is not appropriate for the consultee to be included in the consultation. For instance, the administrative head of an agency may hire a consultant to work with all the counselors, but because the administrator is not a counselor, it may be inappropriate for that administrator to be in included in certain types of consultation (e.g., a workshop on a new counseling technique). However, don't be surprised if you see the word "consultee" used rather liberally and meaning any person who meets with the consultant.

Although consultants can be hired from outside an agency or institution, the above definition allows for internal consultants. Thus, a person who has specialized expertise within an agency or institution may be able to pass on his or her knowledge to others within that agency or institution (e.g., school counselors often consult with teachers).

As you have probably surmised, consultation involves a *triadic relationship* in which the work that the consultant does not only affects those who meet with the consultant (e.g., counselors at an agency) but indirectly affects a third party, which can be an individual (e.g., clients) or a system (e.g., an agency) (Kampwirth, 2006). Thus, consultation might include:

- A principal asking a school counselor to meet with all school staff to help them create a more sensitive multicultural school environment
- A mental health agency director hiring an individual to meet with agency personnel to help them better understand changes in the upcoming DSM-5
- A school system's counseling director hiring an individual to do a workshop for school counselors so they can learn more about how to respond to bullying
- A supervisor meeting with a counselor about his or her clients
- An administrative director of an agency inviting a consultant to meet with agency personnel to lessen infighting with the goal being a better run, friendlier agency
- A director of a college counseling center asking one of his counselors to develop a workshop for professors to alert them on how to identify and refer depressed students
- A clinical director asking a senior counselor to run a series of workshops for junior counselors on new government regulations concerning confidentiality

FIGURE 8.1
A sample of the Many Subsystems in Consultation
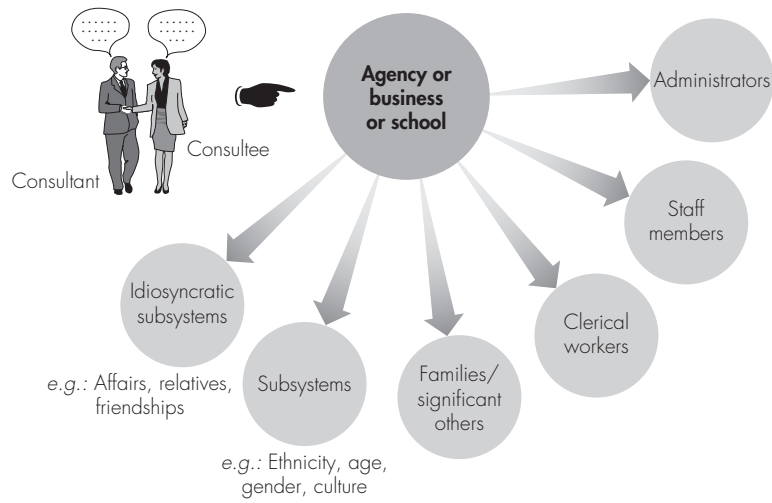
Consultation involves some change in the knowledge, skills, or self-understanding of those with whom the consultant meets, and although consultation can impact individuals in important and meaningful ways, consultation is not therapy. Consultation is *not* a one-to-one, intense counseling experience.

Today, consultants can be asked to intervene on one of three levels: *primary*, which is oriented to education and prevention; *secondary*, which is focused on remediation of nonsevere mental health problems; or *tertiary*, which is concentrated on addressing serious mental health problems (Gladding, 2009; Kampwirth, 2006). In addition, consultation today is *developmental* in the sense that it generally occurs over a series of fairly predictable stages and, *systemic* in that the effective consultant is able to see the multiple ways that individuals within a system view a problem and realizes that any changes made in the system can impact the lives of many other people (Sears, Rudisill, & Mason-Sears, 2006; Senge, 2006) (see Figure 8.1).

A Brief History of Consultation

The decades of the 1940s and 1950s are considered the beginning of modern-day consultation methods (Kurpius & Robinson, 1978). At that time, a consultee, who was generally a supervisor or administrator of an organization, would invite a consultant to his or her setting with the expectation that the consultant, "the expert," would solve an existing problem. After coming to the setting, the consultant would have little contact with the consultee and was pretty much left to his or her own devices to solve the problem. This became known as the *direct-service approach* to consultation (Kurpius & Robinson, 1978).

Example. *A principal finds that many parents are complaining about not being able to understand the test scores of their children. The principal asks an expert on assessment to come in and take care of this situation. The consultant decides to run a*

workshop for parents and designates the counselor to do future workshops for parents. He goes over the test material with the counselor to ensure that she is adequately prepared. The principal remains uninvolved.

By the end of the 1950s, the consultee would generally be included in the consultation process along with the staff. This would help to ensure that if similar issues were to arise, the consultee would have the training to deal with the problem.

Example. After finding a number of insurance forms returned for misdiagnosis, and believing that some clients may have been placed on the wrong medication due to similar errors, the clinical director of an agency asks a consultant to come in and teach the staff about the Diagnostic and Statistical Manual (DSM). The clinical director sits in on the workshops to also gain knowledge and avoid future problems.

As consultation models evolved, consultation was increasingly seen as a process in which the consultant would train others or "give away" his or her expertise to staff (Dougherty, 2009; Kurpius & Robinson, 1978).

Example. With violence on college campuses increasing in recent years, the director of a college counseling center is concerned that her staff is not adequately trained in crisis counseling and trauma work. Thus, she hires a consultant to come in and train the staff in such counseling. At the end of the weeklong workshop, the staff now feels competent to do such work.

The latter part of the twentieth century also brought a proliferation of theories of consultation. Many of these theories are similar to the counseling theories examined in Chapter 4 but applied within a consulting framework. Unlike the models of consultation that speak to the consultant's general style, the consultant's theoretical perspective represents the prism through which the consultant will come to understand the system, and it affects how he or she will devise strategies for change. Some of these theories will be discussed later in the chapter.

Today, we find an array of models of consultation that speak to how a consultant brings him- or herself into the consulting relationship and are reminiscent of the various models developed over the years. Often these models are integrated with the particular theoretical orientation of the consultant. These models can be viewed through two prisms: *consultant-centered* or *system-centered.*

Consultant-Centered Consultation

1. EXPERT CONSULTATION MODEL.   Here the consultant is specifically brought into an organization because of his or her expertise in a specific area and asked to use this knowledge to provide solutions to specific problems (Schein, 1969, 1999).

2. PRESCRIPTIVE CONSULTATION MODEL (DOCTOR-PATIENT MODE).   Here the consultant collects information, diagnoses the problem, and makes recommendations to the consultee on how to solve the problem (see Dougherty, 2009; Schein, 1969, 1999).

3. TRAINER/EDUCATOR CONSULTATION MODEL.   Often used in what has come to be known as "staff development" (Dougherty, 2009), in this mode, the consultant is hired to come into a system and teach or train the staff.

System-Centered Consultation

1. COLLABORATIVE CONSULTATION MODEL.   In this type of consultation, a partnership develops in which the consultant offers expertise but also relies on the expertise of individuals in the system to offer input into the problems and solutions (Idol, Nevin, & Paolucci-Whitcomb, 2000). This shared expertise model tends to focus on joint decision-making (Kampwirth, 2006).

2. FACILITATIVE CONSULTATION MODEL.   Here, the consultant plays a facilitative role by helping individuals within the system communicate with one another, understand each other, and resolve conflicts among themselves (Dougherty, 2009; Rubenstein, 1973; Schein, 1999).

3. PROCESS-ORIENTED CONSULTATION MODEL.   This consultant believes either that he or she does not have the answer or withholds expertise with the belief that the most effective resolution, resulting in the highest self-esteem and sense of ownership of the problem, would be for the system members to find their own solution. The consultant has faith that system members can change if the consultant is able to develop a trusting environment (Dougherty, 2009; Schein, 1969, 1999).

In choosing a model, the consultant needs to know his or her personality style, the people with whom he or she is working, and the problem to be addressed. For instance, one would likely not use an expert model if consulting with master therapists. A consultant whose natural style is directive would have a more difficult time taking on a system-centered style. And a consultant working with counselors who are providing less-than-adequate care on a suicide hotline might start with a consultant-centered style as it would quickly resolve some issues, which is critical when people's lives are at stake.

Theories of Consultation

While models of consultation speak to how the consultant brings him- or herself into the consulting relationship, theories of consultation provide a conceptual framework from which the consultant practices. Sometimes there is overlap between models and theories. For instance, a person-centered consultant might find it difficult to take on a consultant-centered style.

Practically any theory of counseling could be applied to consultation. What appears most important in choosing a theory is how it: (1) defines itself relative to consultation, (2) is used to conceptualize the consultee's problem, (3) uses intervention strategies to solve problems, (4) deals with problems unique to that theory, and (5) handles termination and follow-up (Brack, Jones, Smith, White, & Brack, 1993). Keep in mind that almost all consultants today integrate their model of consultation with their theoretical orientation while maintaining a systemic and developmental approach.

The following are a few brief examples of theories that have been applied to consultation, but be reminded that other approaches also exist. Within this section, I took the liberty of matching what I consider to be the best style (system-centered or consultant-centered) with each theory noted. As you read the theories, consider the approach with which you most easily identify.

Person-Centered Consultation

By its very nature, person-centered consultation is system-centered, because it is the purpose of the person-centered consultant to facilitate the change process in a nondirective fashion.

This consultant would enter a system and attempt to understand each person's perspective on the nature of the system. The use of the basic core conditions of *empathy*, *genuineness*, and *positive regard* are therefore crucial for this consultant. Sometimes the person-centered consultant might run groups within the organization in an attempt to have individuals more effectively hear one another's points of view and with the belief that the natural process of the group will assist the system in healing itself. With the permission of the people in the organization, this consultant might share his or her findings with the whole organization.

Learning Theory Consultation

From a learning-theory perspective, it is crucial that the problem be clearly defined. This requires a careful initial analysis of the system, especially in light of the problem as presented by the consultee. Basic counseling skills are crucial to the beginning of this process. Later, as the problem increasingly becomes defined, the learning-theory consultant can use *behavioral principles, cognitive principles*, and *social learning theory (modeling)* to address identified problem areas and to set identifiable goals. A consultant from this perspective might do well by starting out system-centered and ending by being consultant-centered as he or she designs strategies for change.

Gestalt Consultation

As in Gestalt therapy, the Gestalt-oriented consultant's main goal is to increase awareness of the consultee and others involved in the consultation in an effort to decrease defenses and reduce neurotic behaviors. Gestalt consultants believe that by merely bringing the consultant into the system, change will occur. Therefore, this consultant enters the system with a particular way of being that encourages the *expression of feeling* and the *letting down of boundaries* in an effort to promote increased *awareness* and true *encounters with self* and with one another. This approach generally is a combination of consultant-centered and system-centered; consultant-centered because the consultant directs and teaches others how to express feelings and let down defenses, and system-centered because the consultant continues to facilitate such expression.

Psychoanalytic Approaches to Consultation

A relative newcomer to consultation, psychoanalytic consultation focuses on how unconscious behavior might be affecting the consultee's environment. The main goal of the consultant, therefore, is to make sense of the *unconscious* forces that are at the root of problems (Czander & Eisold, 2003). Problems are seen as *projections* of the individuals' unconscious processes. *Resistance* is seen as an important defense that protects the individual from examining his or her unconscious processes while at the same time protecting the system from undue stress (e.g., "If I really expressed my anger, things would truly get out of hand"). The consultant works cautiously with members in the system, being careful not to abruptly remove members' resistances and cause chaos and mental decompensation. Eventually, consultants will attempt to explain resistances and assist the members in attempting to understand their part in maintaining systemic problems. The psychoanalytic-oriented consultant would do well to start out system-centered as he or she attempts to understand unconscious processes, then move to a consultant-centered approach as he or she explains the resistances in the organization.

Social Constructionist Consultation

Social constructionist consultation has at its core the belief that *realities are co-constructed through language* (Mortola & Carlson, 2003). Thus, there is no one reality and it is critical for consultants to understand the different stories or narratives of the individuals with whom the consultant is working. A consultant such as this uses *respectful curiosity* as he or she inquires about and listens to the expression of *dominant narratives*. The narratives of all individuals are accepted as their current realities and those that are problematic are particularly listened to. The consultant can help individuals expand their understanding of problematic narratives by looking at *exceptions* to the problems, other ways of viewing the problems, and by creating new *solutions* to the problems. Eventually, the consultant works with individuals toward new solutions that include the co-construction of new, healthier narratives (Wachter, 2004). This consultant is clearly systems-centered as he or she tries to understand clients' narratives and facilitates new ways of understanding for all within the system as they co-create new narratives that are healthier.

Chaos Theory Consultation

As opposed to traditional counseling theories that attempt to understand cause and effect in systems, chaos theory assumes that the *world is largely unpredictable* because of the vast number of inputs that can affect the functioning of a system (Peters, 1989). For instance, chaos theory, which has been applied to scientific and social systems, would assume that the dropping of leaves in China would affect, in some unknown ways, the weather across the globe. Therefore, it would be crucial to discover as many *inputs* as possible that affect the system in an effort to reduce the unpredictability of the system while keeping in mind that we all must live with a certain amount of chaos. In this approach, consultants first attempt to understand as much of the chaos in the system as is possible. Then, the consultant takes a proactive role and makes suggestions for change in ways that may be experimental and creative in an attempt to alter the dynamics that have been creating the problematic situation. Although currently a long way from an exact science, chaos theory offers an interesting perspective to consultation. Chaos theory consultants would probably work best starting from a systems-centered perspective and later moving to a consultant-centered approach as they become more proactive and engage individuals in the change process.

The Consulting Process: Stages of Consultation

A number of authors have defined the process of consultation in similar ways as they explain how a consultant enters a system, facilitates change, and leaves (Crothers, Hughes, & Morine, 2008; Levinson, 2009). One such model, by Kurpius, Fuqua, & Rozecki (1993), describes six stages that are similar to the stages of counseling outlined in Chapter 5.

Stage 1: Pre-entry

In the initial stage, the consultant conceptualizes and articulates to self and to others what he or she has been asked to do. The consultant, therefore, must have a clear approach to consultation and understand how this approach may be implemented in the particular situation. This pre-entry stage involves an initial contact with the consulting system in which the consultant explains the purpose of consultation and his or her approach. Some

ways to do this are through letters to employees, pre-entry meetings, or by having the consultee (e.g., an administrator who initially contacted the consultant) or a designated employee explain the purpose.

Stage 2: Entry, Problem Exploration, and Contracting

The second stage of consultation is actually a three-pronged process that includes making contact with the consulting system, exploring the problem, and defining the contract between the consultant and the consulting system. Consultants make contact with the consulting system in many ways. For instance, one consultant might call a series of meetings with all the different work groups, while another consultant might decide to meet individually with each person in the consulting system. A third consultant might do both. These stylistic differences are based largely on the consultant's conceptual model of consultation.

After contacting the members of the system, the consultant needs to probe the system in such a way that he or she will obtain an initial understanding of the problem. This enables the consultant to discuss the contract with the organization. Such issues as confirming fees; setting up meetings; defining materials needed; deciding purpose, objectives, and ground rules; and setting an approximate termination date are just a few of the items to be determined in the contracting phase of the second stage.

Stage 3: Information Gathering, Problem Confirmation, and Goal Setting

The first phase of the third stage, information gathering, is essentially a data-retrieval process. Based on the initial assessment of the problem and the contract decided in the second stage, the consultant is well situated to obtain reliable and valid data. This data-collection process ranges from obtaining specific hard numerical data, to sending out questionnaires to employees, to generating data (information) from small group sharing and individual meetings with individuals in the consulting system. The data are then analyzed, synthesized, and interpreted. This process allows the consultant to confirm, deny, or revise the initial identification of the problem obtained in the second stage. The final identification of the problem allows the consultant to set achievable goals for the organization and to begin to examine methods for change.

Stage 4: Solution Searching and Intervention Selection

During the fourth stage, the consultant begins to determine strategies for change. Although interventions can vary widely as a function of the consultant's style and theoretical orientation, regardless of style or orientation, the problem addressed should more or less be the same. So despite the fact that one consultant may be behaviorally oriented and prescriptive, while another is psychodynamically focused and process oriented, in their unique ways each will be working on the same identified problem. In addition, each consultant will define the problem contextually and push the system to make deep changes that will prevent future problems.

Stage 5: Evaluation

A good consultant wants feedback. He or she wants to know what worked, what didn't work, and what were his or her strengths and weaknesses. Evaluation includes asking participants for their judgments regarding the interventions that were made and whether or

not the stated goals (change processes) were accomplished. Evaluation can be accomplished through a statistical analysis of the behaviors that were to be changed (i.e., *summative evaluation*), and/or completing ongoing evaluations by the members involved in the consultation process as it is happening (i.e., *formative evaluation*). Formative evaluation can be done verbally or in writing. At times, the consultant, who learns through continual feedback that he or she is off track, may need to reevaluate what he or she is doing.

Stage 6: Termination

The final stage of the consultation relationship is termination, which signifies the end of the consulting relationship either because success is pending or because the goals were not met. Termination occurs at a preset time determined during the contract phase of Stage 2, although at times this date will be revised based on new information gathered during the consulting process. Whether the consultation is successful or not, it is important that the consultant reviews, with all parties involved, the results of the consulting relationship. If the intervention was not successful, the consultant and individuals involved should try to process what had occurred so future plans can be made to rectify the situation. In either case, the ending of any relationship involves loss, and individuals involved should be given the opportunity to share feelings about ending the consulting relationship.

The Counselor as Consultant

Counselors have long been consultants. In fact, for some, this is their major role. The list of the professionals with whom the counselor may consult is long and includes other counselors and helping professionals, school administrators, parents, teachers, college student services staff and administrators, college professors, administrators of social service agencies, clinical directors, clerical staff, managers in business and industry, and so forth. Let's take a brief look at some of the consultation activities of counselors who work at college counseling centers, schools, and community agencies.

Consultation and the College Counselor

Consultation has been a part of college counseling centers almost since their inception (Stone & Archer, 1990; Westbrook et al., 1993), and has consistently been found to be one of the most important activities of the college counselor. Listed as one of the main roles and functions of college counseling centers by the *International Association of Counseling Services* (IAC) accreditation standards (IAC, 2000; Much, Wagener, & Hellenbrand, 2010), consultation is particularly important because it is one of the few activities that make the center visible to all those in the college setting (Cooper, 2003).

Consultation by college counselors may be defined as any activity where advice and assistance, based on psychological activities, are provided to a group, office, department, club, and others (Stone & Archer, 1990). The kinds of consultation services offered by college counselors are so diverse that their extent could not be covered here. However, some of the major areas in which college counseling centers have used consultation include (Cooper, 2003; Komives, 2003; Much et al., 2010):

1. Faculty, concerning the emotional distress of college students
2. Administration, over diversity issues on campus

3. Directors of residence life, over potential psychological stressors that students might face
4. Students, about their concerns regarding other students
5. Academic advisors, over high-risk students
6. Disability services, in an effort to increase opportunities for the physically challenged
7. Many aspects of the university community, in an effort to increase communication between employees and supervisors
8. Parents, over concerns about their child (e.g., the child is a victim of date rape)

Consultation at college counseling centers may be consultant-centered or system-centered, depending on the group to which services will be provided. It is, therefore, crucial that the college counselor knows his or her audience and considers the topic to be discussed. Cooper (2003) offers one consultation "cube" model that suggests consultation by college counselors typically addresses one of four audiences: students, faculty, staff or administrators; that their interventions can be focused on the individual, a group, or an organization, and that the type of consultation is generally focused on education or training, offering a program, the "doctor–patient" relationship (diagnosing and prescribing), or is process-oriented (see Figure 8.2) (note the similarities to the "consultant-centered" and "system-centered" models discussed earlier in the chapter).

For instance, where it may be important to come from an education mode if discussing alcohol abuse with students, the same group of students discussing issues of diversity might very well do better with a process orientation. In the same vein, faculty and administrators are likely to be turned off by consultants who take on a doctor-patient role but more open to obtaining specific education and training on certain topics (e.g., date rape, how to handle violence on campus, etc.). Consultants who work with this population may want to be collaborative, which can be a little less threatening to faculty and administrators.

FIGURE 8.2
A Model of College Consultation

Source: Cooper, S. (2003). College counseling centers as internal organizational consultants to universities. *Consulting Psychology Journal: Practice and Research*, 55(4), p. 234.
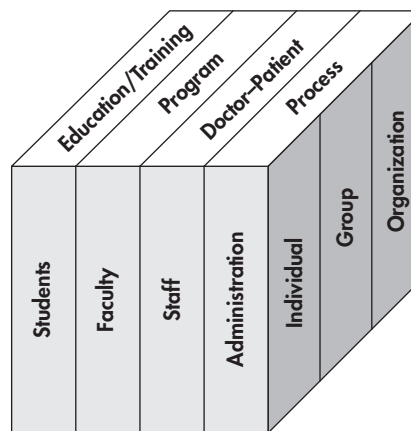
Consultation at college counseling centers is a wide-ranging service that is becoming increasingly popular. It offers the college counselor one more activity in which he or she can positively affect the lives of others.

Consultation and the Agency Counselor

During the 1950s, there were relatively few community mental health agencies in this country. Then, in 1963, Congress passed the *Community Mental Health Centers Act*, and a new era in the delivery of mental health services was upon us. Providing federal funds for the creation of comprehensive mental health centers across the country, the act provided grants for short-term inpatient care, outpatient care, partial hospitalization, emergency services, and consultation and education services. For the first time, there was an acknowledgment that consultation was an important factor in the prevention of mental health problems. The problem was that consultation in reference to community agencies was not yet firmly defined. However, this was soon to change. Consultation in community agencies went in two directions: outward and inward.

CONSULTING OUTWARD   The focus of outward consultation is assisting individuals who have mental health concerns but are not clients directly involved with the agency. For instance, the agency counselor often consults with the parents and teachers of a client (e.g., helping them to cope with a child who has behavioral problems), as well as with other mental health professionals the client might be seeing (e.g., setting up meeting to ensure that future treatment strategies aren't at cross purposes). The community agency counselor may also consult with schools, hospitals, businesses, and other social service agencies in any number of ways. For example, one consultant might assist teachers and counselors from a school system understand mood disorders in children. Another consultant might be asked by a local business to help reduce the general stress level of its employees, and a third consultant might help a social service agency understand some of its employees' internal conflicts.

CONSULTING INWARD   In 1970, Gerald Caplan published his book, *Theory and Practice of Mental Health Consultation*, which became one of the most well-known consultation delivery models. Similar to some of the models of consultation we looked at earlier, Caplan's theory defined the role of the consultant in agencies and made suggestions on ways to intervene in organizations (Caplan & Caplan-Moskovich, 2004). His theory, which is still very much in use today, looks inward at an agency, with the major focus being concern for the clients the agency serves. He described four roles a consultant might take on in an agency (Mendoza, 1993; Erchul, 2009): (1) offering specific suggestions to a counselor who has asked for help in working with a client, (2) assisting a counselor in identifying problems the counselor has in working with a client or a number of clients, (3) facilitating communication in the agency and educating agency staff and administrators on identified problems so that the agency runs more smoothly and clients get better service (see Box 8.1), and (4) working solely with administrators to facilitate communication and to educate them on identified problems.

BOX 8.1

An Example of Program-Centered Consultation at a Mental Health Center

A consultant is called in by the administrative director of a local mental health center. The director is concerned about morale at the center, saying that she has heard that people are unhappy and that there is a depressed mood throughout. Not only is she concerned about morale, but she is worried that the number of billing hours has dropped in the past six months as a result of the mood in the agency. She asks the consultant to evaluate the situation and to make recommendations.

The consultant first writes a letter to all staff and assistants explaining who he is, his consulting style, when he will be coming to the agency, what he will be doing, and approximately how long he will be there. In addition, he discusses the limits of confidentiality, noting that after meeting with everyone at the agency, he will be sharing general feelings, dynamics, and systemic problems that seem to be occurring. He notes that he will keep individual issues confidential, but that his experience as a consultant has shown him that when people begin to discuss personal concerns, things sometimes leak out into the agency. He encourages all agency personnel to avoid this if possible.

Before actually coming to the agency, the consultant develops a hierarchical plan to visit each workgroup. He starts with the administration, meeting separately with the clinical, medical, and administrative directors; next, he meets with the heads of each unit in the center (e.g., outpatient director, day treatment director, and so forth); he then meets with counselors and mental health assistants from each unit, followed by a meeting with the secretarial and clerical staff. He finishes by meeting with the

janitorial staff. Using empathy and basic listening skills, he meets first with each group and then individually with each member. While meeting with the staff, the consultant is also gathering data from the agency on changes in client flow, the economic status of the agency, salaries, types of degrees necessary for varying jobs, information flow (e.g., paperwork trails), and so forth.

Following the consultant's initial contact with each unit and member of the agency, he gathers all his information and spends two or three weeks determining what he considers to be the major problems in the agency. A report is written with the issues defined, and strategies for change are suggested. This report is sent to the agency director and distributed to the agency personnel. Two weeks later, he meets with the whole agency for a feedback session. Based on the feedback, a revision to the report is written and distributed.

After approval from the agency, the consultant begins to implement the strategies for change. Throughout this process, he is receiving process feedback concerning what is working and what is not. He adjusts his strategies based on this feedback. Finally, after a certain amount of change is completed and directions for continuing the change process in the future are determined, the consultant begins his termination from the agency. Closure is made through a series of agency group sessions where all who want to do so can come and give feedback in person. An anonymous written evaluation form is also made available to all personnel. A follow-up evaluation is completed six months later to see if change was indeed maintained.

Inward consultation and outward consultation activities are extremely important components of the community agency counselor's job. Such consultation activities clearly assist in providing better services for clients.

The School Counselor as Consultant

Since the 1960s, consultation has consistently been listed as one of the major responsibilities of the school counselor (ASCA, 2005; Muro & Dinkmeyer, 1977; Schmidt, 2004). With schools becoming increasingly more complex, collaborating with other essential staff in the school is one way that school counselors can help meet the needs of students (Kampwirth, 2006). For instance, if a school counselor can assist teachers in

helping students or assist students in helping other students, then that counselor is expanding the helping relationship from one level to many levels. School counselors act as consultants in many ways, including (Baker & Gerler, 2008; Dougherty, 2009, Kampwirth; 2006; Schmidt, 2004):

1. Assisting teachers in understanding the psychological, sociological, and learning needs of students
2. Assisting teachers in classroom management techniques
3. Assisting teachers, administrators, and parents in understanding the developmental needs of children and how they might affect learning
4. Meeting with students to help them understand developmental concerns, peer relationship issues, personal concerns, and other issues
5. Meeting with other professionals in the community concerning the needs of a particular student with whom the counselor is working
6. Meeting with parents, teachers, and specialists regarding the individual education plan of a special needs student
7. Assisting students in becoming peer counselors and conflict mediators
8. Assisting school staff in setting up a school environment that is conducive to learning for individuals from all cultures
9. Offering organizational consulting skills to assist administrators and others in the efficient running of the schools
10. Offering administrators, parents, teachers, and students assistance in understanding the purpose of assessment instruments and how to interpret their results

In the role as consultant, the school counselor is in much more of a precarious position than the agency or college counselor. A school is a tightly knit organization with clear boundaries between the various professionals. Teachers, administrators, and counselors have very different roles, and they all have responsibilities to the students and their parents. Teachers sometimes don't want to be bothered by counselors or administrators. Counselors sometimes don't want to be bothered by teachers. Parents often have views on their children that differ dramatically from the teacher, counselor, and administrator. The school counselor needs to learn how to balance his or her role as consultant so that each component of the school feels heard and responded to (Kampwirth, 2006). Ultimately, this balancing act is the most challenging part of a school counselor's job. It is, therefore, essential that the school counselor understands the unique systemic qualities of the school where he or she works if change is to take place. The school counselor's training in interpersonal communication skills, consultation skills, and contextual thinking makes him or her particularly able to do this task. When a school counselor is seen siding with the administration, teachers, students, or parents, his or her consultative techniques have gone awry.

Although schools have their own unique systemic qualities, consultation in the schools can follow many of the same models that have been discussed. Therefore, a school counselor as consultant may be found to be consultant-centered at times (e.g., prescribing a communication skill to a parent or a new behavioral management skill to a teacher), or system-centered (e.g., collaborating with the school psychologist, teacher, specialist, and parent on the individualized plan for a student).

Consultation in the schools is one of the main functions of the school counselor and may be the most challenging, invigorating, and creative aspect of the job, as the

counselor attempts to find strategies for change that will lead to an increase in self-esteem and learning for all students while satisfying the needs of parents, teachers, and administrators (ASCA, 2005; Kampwirth, 2006).

Supervision

Whether one is a counselor at a school, agency, or college, supervision has become an expected and crucial part of a counselor's professional responsibility. This is evidenced by (1) licensing boards requiring increasing numbers of hours of clinical supervision, (2) licensing boards setting more rigid standards for clinical supervisors, (3) agency and school administrators increasingly supporting the need for supervision, (4) the infusion of ethical guidelines for supervisor's into ACAs most recent *Code of Ethics* (ACA, 2005), and (5) the adoption by ACA of the Association for Counselor Education and Supervision (ACES, 1990) *Standards for Counseling Supervisors*, which sets standards of preparation and practice of supervisors (Dye & Borders, 1990). But what exactly is supervision, and how is it related to consultation?

Supervision Defined

> . . . *me and you talking about him or her with the purpose of some change.* (Fall, 1995, p. 151)

Remember this simple quote from earlier in the chapter? Although written to define consultation, it aptly speaks to supervision, which also focuses on change in others. Supervision has been defined as an intensive, extended, and evaluative interpersonal relationship in which a senior member of a profession (1) enhances the professional skills of a junior person, (2) ensures quality services to clients, and (3) provides a gate-keeping function for the profession (Bernard & Goodyear, 2009).

Supervision is a type of consultation in which the supervisor consults with the counselor in order to enhance his or her ability to work with clients. Although it is a type of consultation, supervision differs from most other forms of consultation. For instance, whereas most forms of consultation are time-limited, supervision often involves an ongoing relationship between the supervisor and supervisee. Whereas most forms of consultation do not involve an intense interpersonal relationship that focuses on the consultee, supervision generally does, with the consultee being the supervisee. And, whereas in most forms of consultation the consultant generally does not have a direct evaluative responsibility for the consultee, in supervision the supervisor is evaluating the supervisee in one fashion or another (Bernard & Goodyear, 2009; Borders & Brown, 2005; Corey, Haynes, Moulton, & Muratori, 2010).

Because supervision is an intense, interpersonal relationship that sometimes delves into some very personal issues of the supervisee and how they may affect the client, it can sometimes be eye opening and even therapeutic for the supervisee. However, it is important to remember that although supervision can be therapeutic, it is not therapy. When supervision frequently begins to cross over that imaginary line into therapy, the supervisor must decide if a referral to counseling for the supervisee would be appropriate.

Like consultation, supervision by its very nature involves a number of systems. The most basic system is that of the supervisor ↔ (supervisee/counselor) ↔ client. As in all homeostatic mechanisms, if you change one component, the whole system changes. That is the wonderful part of being a supervisor: Impart knowledge to and facilitate growth in your supervisee, and you will see his or her clients change. The system is responding. Take this one step further, and we see other systems change. A rebounding effect occurs where the client now affects the systems in which he or she is involved—perhaps his or her family: "Throw a rock in a pond and the ripples increasingly expand.

The manner in which systems are affected in supervision is complex. First and foremost, the simple act of supervision fine-tunes the counselor's skills and ultimately can have a positive affect on the client and the systems in which he or she is involved. Sometimes a *parallel process* occurs in the supervisory relationship where the client–counselor relationship is mirrored in the supervisor–supervisee relationship (Bernard & Goodyear, 2009; Corey et al., 2010). This generally occurs when the counselor unconsciously takes on the traits of the client, which are repeated in the supervisory relationship (e.g., taking on the client's anxiety and repeating it in supervision). Parallel process is generally viewed as something that should be addressed in supervision and worked through, with the goal being to help the supervisee work effectively with the client (Pearson, 2001). The scenario in Box 8.2 shows how a parallel process to Juan's work with Suzanne is being created in his supervisory relationship with Carla.

Good supervision will curtail the parallel process seen in Box 8.2, whereby the supervisor acts as an effective model for Juan and offers ideas that Juan can use in his work with Suzanne. However, what would happen if Carla suddenly became anxious, believing she could not help Juan? You can see why being an effective supervisor is so important to both the supervisee and to the client.

Sometimes it is argued that a reverse parallel process occurs (Borders & Brown, 2005), such as when positive qualities in a supervisor (e.g., good empathic responding) are taken on by the counselor and subsequently passed on to the client. It is hoped that these qualities will ultimately be passed on by the client to others in his or her life.

Whether it is a simple improvement in the knowledge base of the supervisee or the complexity of parallel process, it is clear that supervision involves a system that can have far-reaching effects.

BOX 8.2

Parallel Process

Juan is in supervision with Carla. One of his clients, Suzanne, is having panic attacks. Suzanne has two children, works full-time, and is in graduate school. Her marriage is "rocky." Economically, she cannot back off from work, and her dream is to finish her graduate degree. She comes to Juan pleading for help, and noting that throughout the day she is having panic attacks and at night she has difficulty sleeping. She is worried about being able to tend to her children and her studies because of her state of mind. A psychiatric consult and subsequent medication has resulted in little relief. She looks at Juan and says, "Please, you've got to help me—what should I do?" Juan is stymied, and at his first opportunity, discusses Suzanne's situation with Carla. Juan notes to Carla, "You know, since I've been working with Suzanne I am filled with anxiety. I feel inadequate because I can't find a solution for her. I am thinking about her situation all the time, cannot stop obsessing about it, and I am having trouble sleeping because I am worrying about her. It's even affecting my relationship with my partner.

Who Is the Supervisor?

The American Counseling Association (ACA) offers the following brief, but succinct definition of supervisors:

> . . . *counselors who are trained to oversee the professional clinical work of counselors and counselors-in-training*. (ACA, 2005, glossary)

Thus, supervisors may be advanced students (e.g., doctoral students) or faculty supervising master's students in a counseling skills class, practicum, or internship. Or, they may be individuals who are designated to supervise counselors at an agency or a school. Or, they could be individuals who are hired by counselors (the supervisees) to provide supervision as part of their requirement to become licensed. Whoever the supervisor is, he or she should have obtained knowledge and competency in the following eleven areas as identified by the *Standards for Counseling Supervisors* (ACES, 1990), with item 12 added by me:

1. Effectiveness as a counselor
2. Healthy personal traits and characteristics
3. Knowledge of ethical, legal, and regulatory issues
4. Knowledge of the nature of the supervisory relationship
5. Knowledge of supervisory methods and techniques
6. Knowledge of counselor development
7. Competency in case conceptualization
8. Competency in the assessment and evaluation of clients
9. Competency in oral and written report writing
10. Ability to evaluate counselors
11. Knowledge of research in counseling and counseling supervision
12. Knowledge of cross-cultural and social justice issues and how they impact the supervisee and the client

The supervisor also has a number of roles and responsibilities, including ensuring the welfare of the client; meeting regularly with the supervisee; assuring that ethical, legal, and professional standards are being upheld; overseeing the clinical and professional development of the supervisee; and evaluating the supervisee (ACA, 2005, Section F). Like the effective counselor, the good supervisor is empathic, flexible, genuine, open, concerned, supportive, and able to build a strong supervisory alliance (Borders & Brown, 2005; Corey et al., 2010). In addition, the good supervisor is competent, able to be an evaluator of the supervisee, and knows appropriate boundaries for supervision. Finally, good supervisors know counseling, have good client conceptualization skills, and are good problem solvers.

Who Is the Supervisee?

The American Counseling Association (ACA) defines the supervisee as:

> . . . *a professional counselor or counselor-in-training whose counseling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional*. (ACA, 2005, glossary)

One role of the supervisor is to evaluate the supervisee. The supervisee, in contrast, is learning from the evaluative process and building a professional identity (Bernard & Goodyear, 2009). Being subject to the evaluation of the supervisor, the supervisee is in a vulnerable

position, and it is inevitable that at some point in the supervisory relationship supervisee resistance will occur. Of course, the amount and kind of resistance can be the result of a number of factors, including (Bernard & Goodyear, 2009; Borders & Brown, 2005):

1. *Attachment and Trust:* The ability to build trust and lower resistance is likely related to personality traits of both the supervisor and supervisee and their ability to form an effective relationship.
2. *Supervisor Style:* Some supervisory styles allow supervisees to feel more in control, less threatened, and result in less supervisee resistance.
3. *Supervisee Sensitivity to Feedback:* Some supervisees are much more sensitive to evaluation and feedback, thus increasing resistance.
4. *Countertransference:* Some client issues will elicit defensiveness from the supervisee and result in inadequate responses by the counselor (supervisee). Similarly, supervisees can arouse defensiveness in supervisors, resulting in poor responses by the supervisor. As you can see, there certainly is enough defensiveness to go around. It is clear that unresolved issues on the part of a supervisee or supervisor can lead to problems in supervision (see Figure 8.3).

FIGURE 8.3
Supervisee and Supervisor Countertransference
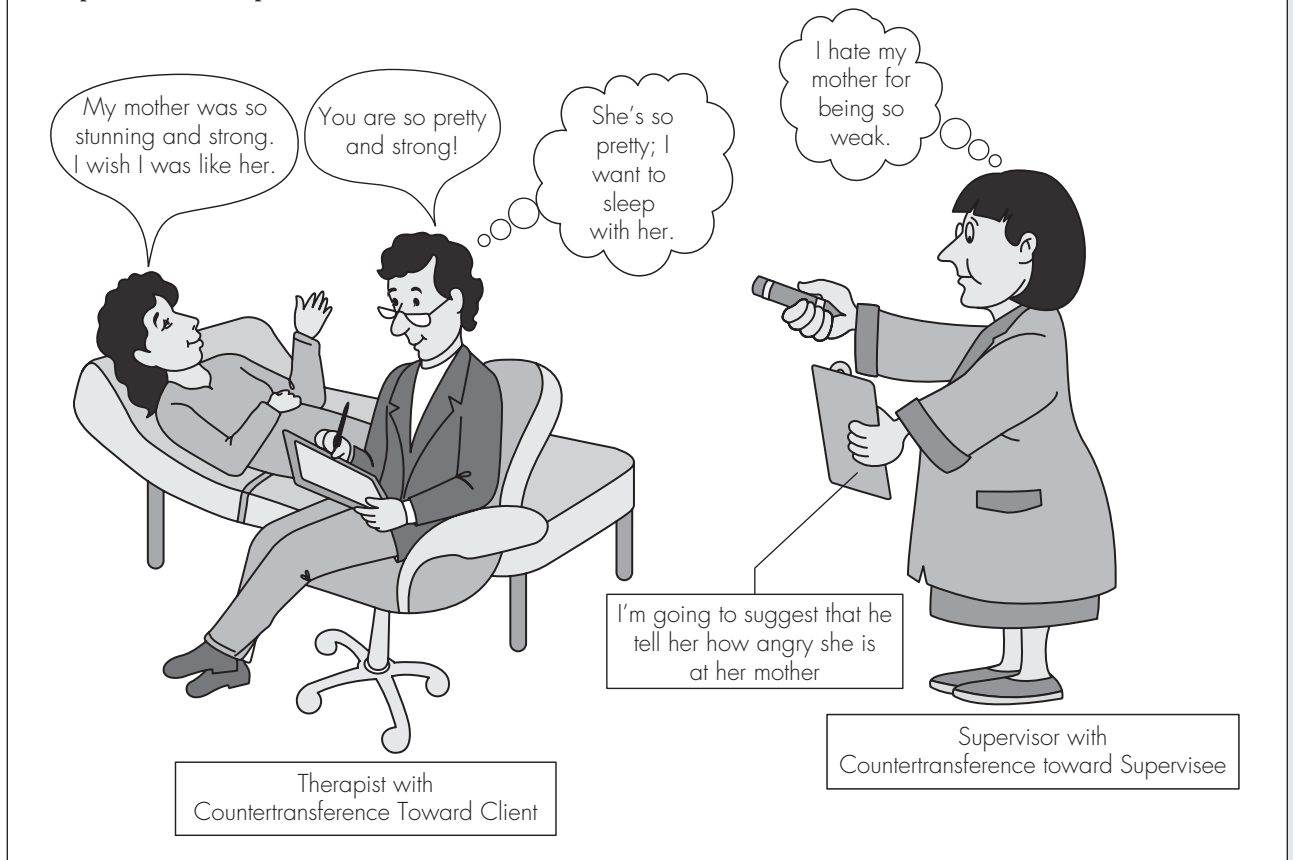
5. *Developmental Level:* Supervisees will tend to become more resistant as they become more autonomous and independent from the supervisor. (See developmental models of supervision later in this chapter.)
6. *Supervisor Characteristics:* A number of characteristics can increase resistance, and sometimes in unknown ways. They include age, race, cultural background, gender, power issues, and a wide variety of relationship dynamics.

Individual, Triadic, or Group Supervision?

Supervision can occur one-on-one, one supervisor with two supervisees (*triadic supervision*), or in small groups, with advantages to each type. *Group supervision* has a number of advantages including exposing supervisees to a large array of client issues, being able to learn how to do supervision by watching others undergo supervision, obtaining feedback from more than one individual, and normalizing experiences by seeing others that are dealing with similar issues (Bernard & Goodyear, 2009; Riva & Erickson Cornish, 2008). In addition, some research has shown that group supervision may be as effective as *individual supervision* in skills development and personal development (Ray & Altekruse, 2000).

From a practical standpoint, group supervision allows a number of supervisees to receive supervision at one time. Therefore, whether taking place in graduate school or at an agency or school, group supervision allows one supervisor to supervise a number of supervisees, usually three to seven. For those who may be paying for supervision, group supervision is generally much less expensive than the $50 to $150 an hour a counselor might charge for individual supervision.

In recent years, triadic supervision has become more popular, probably because it is recognized by CACREP (2010) as one method allowable when supervising students in practicum and internship. In this kind of supervision, two students meet together with their supervisor (Lawson, Hein, & Getz, 2009; Stinchfield, Hill, & Kleist, 2007). When students know one another, the building of trust with the supervisor can occur more rapidly than if the student was alone or with a group of students. Also, with triadic supervision students can learn vicariously from listening to the supervision of their peer. Triadic supervision allows for peer feedback, which sometimes is easier to hear than feedback from a supervisor, and triadic supervision can be a place where a peer can gain his or her first experience learning how to supervise as he or she gives feedback to the other student.

Although there are many benefits to group and triadic supervision, they may not offer the intimacy, intensity, and depth found in individual supervision, and confidentiality is less assured when a number of individuals are involved, even when those individuals are counselors (Bernard and Goodyear, 2009). Also, individual supervision can result in the development of a mentoring process in which the supervisee becomes the student of a master counselor. This is less likely to occur in group supervision.

Models of Supervision

Corey et al. (2010) suggest three broad classes of supervision, which encompass a number of different models. These classes include (1) developmental models, (2) psychotherapy-based models, and (3) integrative models.

Developmental Models

Developmental models view supervision through a series of stages through which the supervisee will pass (Borders & Brown, 2005). Therefore, the supervisor can rely on a certain amount of predictable growth as well as resistance, depending on the stage. Of course, individual supervisees may move faster or slower through these stages based on their personality style, their ability, and their fit with their supervisor. Awareness of developmental stages can assist the supervisor in developing strategies for growth based on the supervisee's particular stage (Stoltenberg, 2005).

Although there have been a number of developmental models over the years, probably the best known is the *Integrated Developmental Model* (IDM) of Stoltenberg and colleagues (Stoltenberg, 2005; Stoltenberg & Delworth, 1987; Stoltenberg, McNeill, & Delworth, 1998). IDM focuses primarily on counselors-in-training and speaks to how trainees will pass through three levels of development as they grow and change in three areas: self- and other-awareness, motivation, and autonomy (see Table 8.1).

IDM proposes that during the course of supervision, counselors-in-training (1) become increasingly aware of client needs and the interventions that might suit them, (2) become increasingly less dependent on the supervisor as faith is gained in their own ability, and (3) go through a roller-coaster ride in motivation, at first feeling very enthusiastic, later feeling less so as trainees doubt their skills, and later again feeling motivated

TABLE 8.1

Trainee Characteristics as a Function of Level of Development in the IDM Model			
	SELF- AND OTHER-AWARENESS	MOTIVATION	AUTONOMY
Level 1	Trainee's focus is primarily on self as he or she attempts to deal with anxiety related to fears of evaluation. Insight and empathy may be difficult due to this anxiety and self-doubt.	High degree of motivation based on keen desire to be a counselor. Wants to help people and learn the correct techniques and strategies to use.	Characterized by dependence on supervisor. Wants to be advised by supervisor and has strong desire to leave major decision making to supervisor.
Level 2	Trainee is better able to focus on the affect and cognitions of client. Trainee might become greatly involved with client's pain and have difficulty detaching. Counselor begins to see the impact he or she has upon client.	Doubt about skill proficiencies arises as counselor begins to understand the complexity of the counseling relationship. Trainee may seesaw between these self-doubts and confidence as he or she becomes increasingly more proficient with interventions and receives positive feedback from the client and supervisor.	Characterized by dependency/autonomy. Conflict as trainee becomes more confident in skills and wants independence but at the same time fears it.
Level 3	Counselor is able to move into the client's world and out of own world and process client's situation. Allows counselor to understand which techniques have the most impact on client change.	Counselor begins to integrate own style of therapy and work on strengths and weaknesses. Seesawing slows, and counselor feels more consistent about skills. Is freely able to receive feedback from supervisor.	Here the trainee feels comfortable about functioning in an independent fashion. When doubts arise, trainee feels as if he or she can consult with others without losing his or her sense of professional identity.

Sources: Stoltenberg, C. D. & Delworth, U., 1987. Supervising counselors and therapists; Stoltenberg, C. D., McNeil, B., & Delworth, U., 1998. IDM Supervision.

FIGURE 8.4
**Integrated
Developmental
Model**
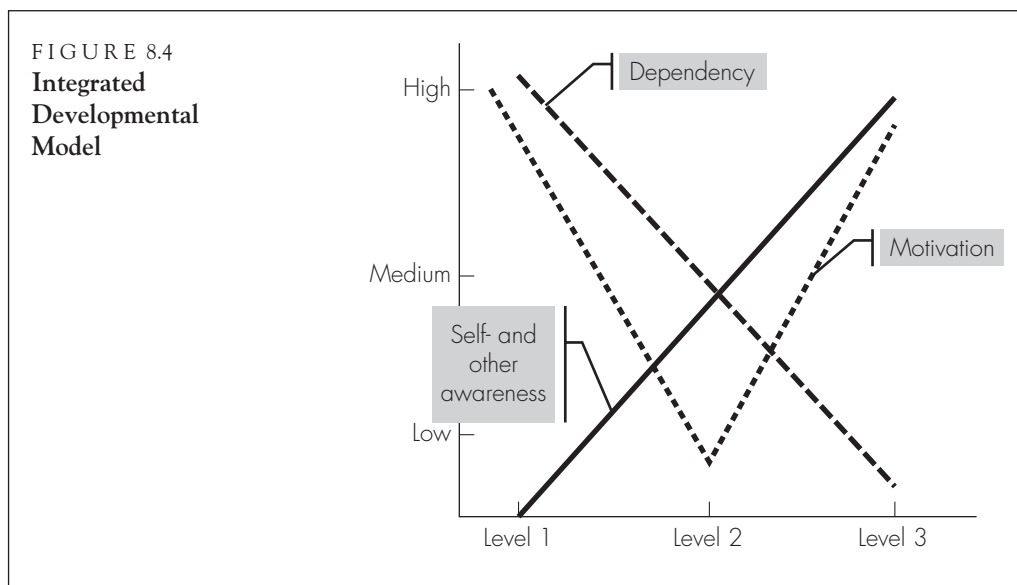
(see Figure 8.4). Although IDM is still being researched (Lovell, 1999), there is some beginning evidence that graduate trainees do undergo positive changes in the three areas identified (McNeill, Stoltenberg, & Romans, 1992; Stoltenberg, 2005).

Psychotherapy-Based Models

Many counselors who practice a particular type of therapy (e.g., Gestalt, person-centered, behavioral, and so forth) believe that it is best to receive supervision from a master thera-pist/supervisor who practices the same approach. There are two ways this can occur (Bernard & Goodyear, 2009). The first is when the supervisor structures the supervision so that it models the particular approach that the supervisee is using in counseling (Bernard, 1992, 1997; Bernard & Goodyear, 2009). Therefore, a behavioral supervisor would model a behavioral approach by identifying problems in supervision, collaboratively setting goals to work on, and then using techniques to reach those goals. The psychoanalytic supervisor would do analysis with the supervisee, while the person-centered supervisor would use empathy, show unconditional regard, and be genuine with his or her trainee.

In the second psychotherapy-based model, the supervisor uses his or her knowledge base to gently guide and teach the supervisee. For instance, if a trainee were working with a client behaviorally and not making progress, the supervisor might offer advice on some new behavioral techniques. A psychoanalytic supervisor might suggest a specific psycho-analytic technique and show the supervisee how to use it (e.g., dream analysis), and a person-centered supervisor might suggest the supervisee work on his or her empathic re-sponses and give specific examples of how to do so.

Integrative Models

Perhaps more appropriately called *meta-theory models*, *integrative models* are not the-ory specific and can be used regardless of the theoretical approach of the supervisee.

One such model *is Bernard's discrimination model* (Bernard & Goodyear, 2009; Borders & Brown, 2005). Dependent on the needs of the supervisee, this model examines three roles that supervisors might adopt at differing times during the supervisory relationship. These include (1) a didactic role in which the supervisor is a *teacher*, (2) an experiential role in which the supervisor is a *time-limited counselor* assisting the supervisee in working through issues that are affecting his or her ability as a therapist, and (3) a *consultant* role in which the supervisor is an objective colleague assisting the supervisee. As supervisors take on these roles, supervisees can focus on one of three domains: (1) the *interventions* they are using or would like to use, (2) *conceptualization*, which focuses on how they are understanding client issues, and (3) *personalization*, that examines what personal issues might affect how they conceptualize client problems and the kinds of interventions they make. Referring back to Box 8.2 (Juan in supervision with Carla), Table 8.2 demonstrates how the supervisor's roles can be applied to each focus of supervision.

Interpersonal process recall (IPR), another integrative model that was developed by Norm Kagan (1980; Kagan & Kagan, 1997), has been particularly popular over the years (Bernard & Goodyear, 2009; Cashwell, 1994). In many ways, this model relies on the trainee to uncover his or her own strengths and weaknesses. In this type of supervision, the supervisor and the trainee meet to review an audio or video recording of the trainee with a client. The trainee, supervisor, or both can control the recording, starting and stopping it when it is believed that there is an important moment in the counseling relationship between the supervisee and the client. The supervisor's role is to attend accurately to the feelings and thoughts of the supervisee and, when

TABLE 8.2

Roles and Foci of Discriminant Model			
	ROLES OF SUPERVISOR		
FOCUS OF SUPERVISION	*Teacher* ↓	*Counselor* ↓	*Consultant* ↓
Intervention →	Teach the supervisee how to implement relaxation techniques.	Supervisor listens to the supervisee's concerns about her feelings of inadequacy relative to this client.	Supervisee requests specific techniques to use with the client and consultant offers a number of options.
Conceptualization →	Note to the supervisee how the origin of panic attacks may be viewed in a number of ways (e.g.., early childhood issues, temperament, situational).	Supervisor connects the supervisee's own childhood issues related to anxiety and wonders if these issues relate to the supervisee's fear of working with the client.	Supervisee asks how temperament can affect anxiety and supervisor responds with research concerning the genetics of temperament and its relationship to anxiety. Possibility of medication to dampen affects of temperament is discussed.
Personalization →	Define parallel process to the supervisee and indicate how that might be at play in this case.	Supervisor listens to the supervisee discuss how her own issues raise anxiety and feelings of inadequacy.	Supervisee asks how parallel process can be halted and supervisor makes a number of suggestions.

appropriate, ask leading questions to deepen the session. The following questions have been used in this inquiry session:

1. What do you wish you had said to him or her?
2. How do you think he or she would have reacted if you had said that?
3. What would have been the risk in saying what you wanted to say?
4. If you had the chance now, how might you tell him or her what you are thinking and feeling?
5. Were there any other thoughts going through your mind?
6. How did you want the other person to perceive you?
7. Were those feelings located physically in some part of your body?
8. Were you aware of any feelings? Does that feeling have any special meaning for you?
9. What did you want him or her to tell you?
10. What did you think he or she wanted from you?
11. Did he or she remind you of anyone in your life? (Cashwell, 1994, p. 2)

In the tradition of some of the humanistic therapies, IPR is a model of supervision that gives the trainee the ability to explore feelings and thoughts about a therapeutic relationship within a trusting and safe environment. The trainee can therefore get in touch with those aspects of him- or herself that are preventing the client from moving forward in counseling.

Each of the above models offers a slightly different take on the supervisory process, and they are not necessarily exclusive of one another. For instance, one can adopt a developmental model and either be orientation-specific or use an integrative approach. In choosing a supervisor, if given the choice, a supervisee should of course pick the supervisor who offers the approach that will best facilitate his or her learning process as well as the therapeutic experience of the supervisee's clients.

Finally, as with the counseling relationship, there is some evidence that the strength of the alliance or bond between the supervisor and supervisee, regardless of model, may be the most crucial factor for effective supervision (Ladany & Friedlander, 1995; Ladany, Walker, & Melincoff, 2001; Sterner, 2009). Thus, the supervisor who has exceptional knowledge of supervision may be ineffective if he or she cannot build a relationship with the supervisee.

Supervision of Graduate Students

Graduate students in CACREP-approved counseling programs—and, we hope, all counseling programs—will have a number of opportunities to receive supervision. Although the manner in which this occurs will vary from program to program, counseling programs generally offer a course early on that provides supervision of basic counseling skills. Within this course, students usually have the opportunity to audio and/or video record a session with a client or with a fellow student. Supervision of the graduate student is generally given by the professor, an advanced graduate student, and/or by peers. In addition, students usually have the opportunity to obtain supervision in a practicum and in the culminating graduate school experience, the internship. Supervision in these courses is usually given by an advanced graduate student, a professor, and/or a field supervisor.

CACREP requires, and most graduate programs offer, supervision of recorded or live sessions. There are a number of ways this can be accomplished (Bernard & Goodyear,

2009; Borders & Brown, 2005; Champe & Kleist, 2003). First, there is the tried-and-true fashion of video recording a counseling session. Although video recording certainly offers broader feedback to the trainee than audio recording, either can be an invaluable tool for supervisor feedback. Although anxiety provoking for many, most counseling programs to-day require some kind of live supervision that offers opportunities for immediate feedback that other kinds of supervision cannot provide.

Today, almost all counseling programs have rooms equipped with one-way windows, live video streaming, or some other technological advance that allow the student to be viewed by supervisors or peers as the student is involved in a live counseling session or role-play. Students can receive immediate feedback through a number of methods such as a telephone or a "bug-in-the-ear." Although effective at offering immediate feedback, these methods can be somewhat intrusive. The use of a computer monitor facing the counselor and next to the client, with the keyboard located on the opposite side of the one-way mirror, is considerably less intrusive (Neukrug, 1991). Using this method, supervisors and/or fellow students can type in feedback via the keyboard to the monitor, which is seen by the counselor in the adjoining room. More recently, the use of e-mail, real-time video linkups, and other promising electronic communication advances offer trainees the opportunity of speaking with supervisors immediately even though they may be hundreds of miles away (Borders & Brown, 2005; Coursol, 2004; Smith et al., 2007). One final method of obtaining feedback about your client is through the time-honored tradition of reviewing written case notes. Well-thought-out and well-written case notes can be invaluable to the counselor-in-training and are one more way in which counselors can obtain feedback from their supervisors (Bernard & Goodyear, 2009; Gould & Bradley, 2001).

Supervision of Practicing Counselors

Although ongoing supervision has become more popular in recent years, the frequency and kind of supervision varies depending on setting. Today, many counselors receive individual supervision, while a substantial number receive group supervision or peer supervision (Borders & Brown, 2005). Some seek out supervision for professional growth and/or as a requirement of credentialing, while others receive it as part of the job. Some counselors receive mandated supervision as the result of an ethical violation or professional concern (Cobia & Pipes, 2002).

School counselors have significantly less clinical supervision than agency, college, or private practice counselors (Dollarhide & Miller, 2006), with one study indicating that close to 75% of them receive no clinical supervision at all, although many do receive administrative supervision (Page, Pietrzak, & Sutton, 2001). In addition, when they do receive supervision, it can often come from many sources and may be less formal than one might hope. For instance, school counselors may receive supervision from their principal (who rarely is trained in counseling and supervision); the director of counseling for the school system, who generally offers only periodic supervision; the head counselor in a school, who often offers sporadic supervision; colleagues for peer supervision, whose supervision can be rather informal; or a private supervisor whom they may hire on their own (Agnew, Vaught, Getz, & Fortune, 2000; Dollarhide & Miller, 2006). Although there has been a call by the counseling profession to develop and implement new, clinical models of supervision in the schools, this kind of systemic change will take time if it happens at all (Kline, 2006).

Although any style of supervision can be applied to any counseling setting, a number of authors have suggested altering supervisory techniques to fit a particular counseling specialty. Couples and family counselors, addiction counselors, school counselors, mental health counselors, college counselors, and so forth all have unique job functions that might call for changes in the supervisory process (see Chang, 2010; Lee, Nichols, Nichols, & Odom, 2004; Pearson, 2006; Somody, Henderson, Cook, & Zambrano, 2008).

Multicultural/Social Justice Focus

Multicultural Consultation within a System

The consultant serves as an agent for change rather than as an agent for maintaining the status quo, and the consultant advocates for both the client and the system rather than advocating for one over the other. (Hoffman et al., 2006, p. 124).

The consultant is in a unique position relative to multicultural issues. Being brought into a system means that one will be dealing with dynamics within the organization and how they may affect the clients who are impacted by the system. Cultural differences will undoubtedly be affecting such dynamics. Thus, when entering a system, the consultant must do his or her best to understand the culture of the system, the culture of subsystems, and the unique background of each individual within the system (Clare, 2009; Homan, 2011).

Because issues of race, ethnicity, and gender are often difficult to broach, there is generally tension related to cross-cultural issues among individuals within the system. Sometimes this tension may simply be a function of ignorance of differing cultural backgrounds. In other cases, deep feelings of hatred and racist attitudes may prevail. The consultant must assess the degree to which cross-cultural issues play a role in the daily functioning of the system and, based on this assessment, include methods of dealing with these issues in his or her strategies for change. To be successful at this, the consultant must have an understanding of his or her biases, knowledge of other cultures, and knowledge of the kinds of intervention strategies that can effect positive change in the system. Ultimately, the consultant is in a unique position as he or she can view the multiple perspectives of the system and advocate for change by empowering those who may be oppressed by the system and by offering new ways to understand the dynamics of the system (Hoffman et al., 2006).

Multicultural Supervision

When conducting supervision, the effective supervisor should be cognizant of the fact that cross-cultural differences (age, race, ethnicity, gender, sexual orientation, spirituality) are usually a major source of tension between the supervisor and supervisee and between the supervisee and the client (Ancis & Ladany, 2001; Daniels, D'Andrea, & Kim, 1999). With this in mind, the following is suggested if supervisors are to work effectively on cross-cultural issues with their supervisees (Bernard & Goodyear, 2009; Corey et al., 2010; Fong, 2991).

1. Be up to speed on how multicultural issues affect supervision
2. Be aware of and address how issues of diversity affect the supervisory relationship
3. Model cross-cultural sensitivity
4. Be willing to ask supervisees about their cultural background
5. Be open to discussing cross-cultural differences with supervisees

6. Be aware of how power and privilege may affect the supervisory relationship
7. Help supervisees see how power and privilege may affect their counseling relationships
8. Assist supervisees in being able to conceptualize clients from a multicultural perspective
9. Be able to build a strong working alliance with your supervisee
10. Have and share your knowledge and skills specific to cross-cultural issues
11. Be a model and provide examples of social advocacy
12. Be able to use models of cross-cultural supervision (e.g., Ancis & Ladany, 2001; Ober, Grannello, & Henfield, 2009).

Ethical, Professional, and Legal Issues

Ethical Issues in the Consulting Relationship

A number of authors as well as the ACA ethical code illuminate some key ethical issues specific to the consulting process (ACA, 2005; Dougherty, 2009; Kampwirth, 2006). Some of the more salient issues include the following (also, please read Section B.8 and D.2 of the ACA ethics code):

- *Agreements:* Counselors should ensure that agreements regarding consultation are obtained from all parties involved, especially in relationship to confidentiality.
- *Respect for Privacy:* Client identity should be protected and information should only be discussed for professional purposes.
- *Growth toward Self-Direction:* The consultant should have as its primary goals the ability of those involved in consultation to become increasingly independent and able to use the skills that the consultant imparts.
- *Disclosure of Confidential Information:* Information should be kept confidential and only discussed for professional purposes.
- *Multiple Relationships:* Consultation often involves multiple relationships and consultants should take steps to ensure that all involved are clear about the purpose of the consulting relationships, the limits of the relationships, and its goals.
- *Informed Consent in Consultation:* Counselors should give in writing and verbally to those involved in the consulting relationship information concerning the purpose of the consultation and should jointly decide how goals will be achieved. Those involved in consultation should give consent to the procedures.
- *Consultant Competency:* Counselors should ensure that they have the competence and the resources to conduct consultation and should refer when they do not.
- *Understanding with Consultees:* Counselors should develop a "clear understanding" with those involved in the consulting relationship of the problem, goals, and consequences of an intervention.

Ethical Issues in the Supervisory Relationship

Because supervision is technically a kind of consultation, when supervising one should be aware of the issues just highlighted. However, some ethical issues that have

specifically stood out in supervision include the following (ACA, 2005; Bernard & Goodyear, 2009; Bradley, Kottler, & Lehrman-Waterman; 2001; Fall & Sutton, 2004; Falvey, 2002):

- *Supervisor Preparation:* Supervisors should be trained and competent in supervisory methods.
- *Client Welfare:* Supervisors have a responsibility to monitor the welfare of the client and take appropriate action if the client is at risk of harming self or another person or if the supervisee cannot effectively work with a client.
- *Informed Consent:* Supervisors should obtain informed consent from their supervisees and clients should be informed that the supervisee is in supervision with a supervisor and how that might affect confidentiality.
- *Multicultural Issues:* Supervisors should be aware of and address how issues of diversity affect the supervisory relationship (see "Multicultural Supervision").
- *Relationship Boundaries:* Supervisors are aware of how power differentials play a role between themselves and their supervisees and are thus respectful of appropriate professional and social boundaries.
- *Sexual Relationships:* Supervisors do not engage in sexual relationships with supervisees.
- *Dual and Multiple Relationships:* Although dual relationships with some supervisees are inevitable (e.g., a supervisee taking a class from his or her supervisor, having a supervisor serve on a supervisee's dissertation committee), supervisors should be particularly sensitive to the potential for abuse of power in any dual relationship.
- *Responsibility to Clients:* Supervisors have a responsibility to ensure that adequate counseling is taking place between the supervisee (counselor) and the client.
- *Limitations of Supervisees:* Supervisors have a responsibility to evaluate supervisees and to find remedial assistance for them if they are not performing adequately. If supervisees are not able to function effectively, supervisors have the responsibility to recommend dismissal from their program, an agency, or not recommend them for a specific credential.
- *Evaluation and Accountability:* Supervisors have a responsibility to evaluate the supervisee's progress in supervision, to ensure ongoing feedback to the supervisee, and to document supervisory sessions.
- *Endorsement:* Supervisors do not endorse unqualified supervisees for credentialing but rather attempt to take steps to help them become qualified.

Professional Issue: Professional Association

The Association for Counselor Education and Supervision (ACES), a division of ACA, is specifically focused on issues of counselor training, including supervision. Although admittedly the association has had more involvement with educators, as compared to supervisors, it is an association that you might want to consider joining if you are interested in counselor education and in supervision. The association publishes one journal, *Counselor Education and Supervision*, and it offers regional and national workshops as well as grants in the area of counselor education and supervision.

Legal Issue: Liability in Consultation and Supervision

Because consultants and supervisors are directly or indirectly in a position to effect change in clients, they can be held responsible for any potential negative results of their consultation or supervision (Guest & Dooley, 1999). This particularly came to light during the Tarasoff decision (see Chapter 4). After learning that a client was threatening to harm his ex-girlfriend, the client's therapist, a psychologist at a campus counseling center, broke confidentiality and told campus police, who subsequently picked up the client for questioning. The psychologist's supervisor reprimanded the psychologist for breaking confidentiality. The ex-girlfriend was subsequently murdered by the client, and her parents sued everyone involved in the case, including the supervisor. The supervisor, among others, was found liable for not ensuring the safety of the client's ex-girlfriend (Falvey, 2002). Thus, we see how consultants/supervisors can be held responsible for the work they perform.

■ *The Counselor in Process: Committed to Ongoing Consultation and Supervision*

Consultation is not just something you read about in a book. It is your professional responsibility. You are responsible for consulting when you are working with a difficult client, when you are not sure of the best direction in which to move with a client, and when you think you may be working outside your area of competence. Consultation and supervision are living processes. Those who do not seek consultation are dead to the profession and are likely harmful to their clients. If we are to be the best at what we do and are committed to the growth of our clients, we must ensure that throughout our professional lives we are forever seeking out consultation and supervision.

■ *Summary*

This chapter examined two important types of helping relationships: consultation and supervision. We began the chapter by defining consultation, the consultant, and the consultee. We noted that consultation is a triadic relationship in that the consultant indirectly affects others with whom the consultant meets. We also noted that consultation is systemic; developmental (has predictable stages), and that consultants can intervene on one of three levels: primary, secondary, or tertiary.

In this chapter, we gave a brief history of consultation, noting that it first became popular during the 1940s and 1950s when it was known as a direct-service approach. Over the years, however, it became increasingly more process oriented. As we moved toward the latter part of the twentieth century, we noted that a number of consultation models evolved that could be loosely grouped into one of two categories. Consultant-centered consultation (i.e., expert, prescriptive, and trainer/educator) involves the consultant using his or her body of knowledge to offer suggestions and advice for systemic change. In contrast, system-centered consultation (i.e., collaborative, facilitative, and process-oriented) occurs when the consultant assists people in the system to use their own resources in the change process. This same time period saw the rise of a number of theoretical

approaches to consultation. Sampling some of these theories, we briefly discussed the following approaches as applied to consultation: person-centered, learning (cognitive and behavioral), Gestalt, psychoanalytic, social constructionist, and chaos theory. We noted that consultants generally have a style or model of working related to the theoretical approach to which they adhere.

As the chapter continued, we pointed out that regardless of the approach a consultant uses, there are a number of predictable stages to the consulting process. We explored one model that included the following six stages: pre-entry; entry, problem exploration, and contracting; information gathering, problem confirmation, and goal setting; solution searching and intervention selection; evaluation; and termination. Finally, we examined some of the consultation activities of college counselors, agency counselors, and school counselors. Some of the major points noted in this section included Cooper's "cube" model for consultation in colleges, inward and outward consultation including Caplan's model of consulting for agencies, and the fact that consultation is one of the more important and complex tasks for school counselors.

This chapter also examined the process of supervision. Supervision was defined as an intense interpersonally focused relationship that involves a number of systems, the most basic being that of the supervisor ↔ (supervisee/counselor) ↔ client. We described supervision as a special type of consultation and noted similarities and differences between the two. Both consultation and supervision focus on the change process, are systemic, are therapeutic but are not therapy, and involve talking with a third person(s) about another party. Noting differences, we stated that consultation, unlike supervision, is time-limited and the consultant does not have a direct evaluative responsibility to the consultee. We also noted the important role that parallel process can play in supervision.

We next offered some definitions of the supervisor and the supervisee. We identified twelve competencies of an effective supervisor and noted some of the qualities of good supervisors. We went on to discuss the fact that one role of the supervisor is to evaluate the supervisee, and that this can sometimes lead to resistance. We also pinpointed some reasons that resistance can result. In conducting supervision, we distinguished between individual, triadic, and group supervision and pointed out some of the advantages and disadvantages of each.

This chapter then examined three models of supervision that have evolved over the years. Developmental models, such as Stoltenberg's Integrated Developmental Model (IDM), speaks to predictable stages a supervisee will go through while in supervision. Psychotherapy-based models approach the supervisory process by using a specific counseling theory as its basis for the supervisory process. Integrative models are not theory specific and can be integrated within one's theoretical orientation, and we highlighted two integrative models. Bernard's discrimination model looks at the supervisor in the role of teacher, counselor, and consultant and examines domains of supervision that include interventions, conceptualization, and personalization. Interpersonal Process Recall (IPR), developed by Norm Kagan, views the supervisor's role as one in which he or she attends to the feelings and thoughts of the supervisee and, when appropriate, asks leading questions to deepen the session.

Highlighting supervision as a crucial component of graduate school training, we observed that supervision is generally provided during skills classes and fieldwork experiences. We noted the various ways that supervisors today can view the work of practicing

students (e.g., case notes, live observation, electronically). We also noted that a large percentage of practicing counselors continue to seek out supervision after graduate school through individual, group, and peer supervision, and highlighted the difficulty that some school counselors have in obtaining supervision.

As the chapter continued, we spoke of the opportunity the consultant has to effect change in systems based on the dynamics of cultural differences that exist in all systems. Relative to supervision, we made twelve suggestions for being an effective cross-cultural supervisor. As the chapter neared its conclusion, we identified a number of ethical issues critical to the consulting relationship and others that are critical to the supervisory relationship. We identified the Association for Counselor Education and Supervision (ACES) as the primary association that addresses supervision, and we discussed the responsibility that consultants and supervisors have in protecting the welfare of clients. Finally, we concluded this chapter by stressing that consultation and supervision should be an ongoing component of the counselor's job. Without consultation and supervision, we are an island unto ourselves, left only to our own resources.

References

Agnew, T., Vaught, C. C., Getz, H.G., & Fortune, J. (2000). Peer group clinical supervision program fosters confidence and professionalism. *Professional School Counseling, 4*(1), 6–12.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American School Counselor Association. (2005). *The ASCA National Model: A framework for school counseling programs* (2nd ed.). Arlington, VA: Author.

Ancis, J., & Ladany, N. (2001). A multicultural framework for counselor supervision. Ethical issues in supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 63–86). Philadelphia: Brunner-Routledge.

Association for Counselor Education and Supervision. (1990). Standards for counseling supervisors. *Journal of Counseling and Development, 69,* 30–36.

Baker, S. & Gerler, E. (2008). *School counseling for the twenty-first century* (5th ed.). Upper Saddle River, NJ: Merrill.

Bernard, J. M. (1992). The challenge of psychotherapy-based supervision: Making the pieces fit. *Counselor Education and Supervision, 31,* 232–237.

Bernard, J. M. (1997). The discrimination model. In C. E. Watkins, *Handbook of psychotherapy supervision* (pp. 310–327). New York: Wiley.

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson.

Borders, L. D., & Brown, L. L. (2005). *The new handbook of counseling supervision*. Mahwah, NJ: Erlbaum.

Brack, G., Jones, E. S., Smith, R. M., White, J., & Brack, C. J. (1993). A primer on consultation theory: Building a flexible worldview. *Journal of Counseling and Development, 71,* 619–628.

Bradley, L. J., Kottler, J. A., & Lehrman-Waterman, D. (2001). Ethical issues in supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 342–360). Philadelphia: Brunner-Routledge.

Caplan, G. (1970). *The theory and practice of mental health consultation.* New York: Basic Books.

Caplan, G., & Caplan-Moskovich, R. B. (2004). Recent advances in mental health consultation and mental health collaboration. In N. M. Lambert, I. Hylander, & J. H. Sandoval, *Consultee-*

centered consultation: Improving the quality of professional services in schools and community organizations (pp. 21–35). Mahwah, NJ: Lawrence Erlbaum.

Cashwell, C. S. (1994). *Interpersonal process recall.* Retrieved from ERIC database. (ED 372342)

Clare, M. (2009). Decolonizing consultation: Advocacy as the strategy, diversity as the context. *Journal of Educational and Psychological Consultation*, *19*(1), 8–25.

Champe, J., & Kleist, D. M. (2003). Live supervision: A review of the research. *The Family Journal*, *11*, 268–275. doi: 10.1177/1066480703252755

Chang, J. (2010). The reflecting team: A training method for family counselors. *Family Journal: Counseling and Therapy for Couples and Families*, *18*(1), 36–44.

Cobia, D. C., & Pipes, R. B. (2002). Mandated supervision: An intervention for disciplined professionals. *Journal of Counseling and Development*, *80*, 140–144.

Cooper, S. (2003). College counseling centers as internal organizational consultants to universities. *Consulting Psychology Journal: Practice and Research*, *55*(4), 230–238. doi: 10.1037/1061-4087.55.4.230

Corey, G., Haynes, R., & Moulton, P., & Muratori, M. (2010). *Clinical supervision in the helping professions: A practical guide* (2nd ed.). Alexandria, VA: American Counseling Association.

Council on the Accreditation of Counseling and Related Educational Programs. (2010). *2009 standards*. Retrieved from http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Coursol, D. (2004). *Cybersupervision: Conducting supervision on the information superhighway.* Retrieved from ERIC database. (ED 478213)

Crothers, L., Hughes, T., & Morine, K. (2008). *Theory and cases in school-based consultation: A resource for school psychologists, school counselors, special educators, and other mental health professionals.* New York: Routledge/Taylor & Francis Group.

Czander, W., & Eisold, K. (2003). Psychoanalytic perpectives on organizational consulting: Transference and counter-transference. *Human Relations*, *56*, 475-491.

Daniels, J., & D'Andrea, M. D., & Kim, B. S. K. (1999). Assessing the barriers and changes of cross-cultural supervision: A case study. *Counselor Education and Supervision*, *38*, 191–204.

Dollarhide, C., & Miller, G. (2006). Supervision for preparation and practice of school counselors: Pathways to excellence. *Counselor Education and Supervision*, *45*(4), 242–252.

Dougherty, A. M. (2009). *Psychological consultation and collaboration in school and community settings* (5th ed.). Belmont, CA: Brooks/Cole.

Dye, H. A., & Borders, L. D. (1990). Counseling supervisors: Standards for preparation and practice. *Journal of Counseling and Development*, *69*, 27–29.

Erchul, W. (2009). Gerald Caplan: A tribute to the originator of mental health consultation. *Journal of Educational and Psychological Consultation*, *19*(2), 95–105.

Fall, M. (1995). Planning for consultation: An aid for the elementary school counselor. *The School Counselor*, *43*, 151–157.

Fall, M., & Sutton, J. M. (2004). *Clinical supervision: A handbook for practitioners.* Boston: Pearson.

Falvey, J. E. (2002). *Managing clinical supervision: Ethical practice and legal risk management.* Pacific Grove, CA: Brooks/Cole.

Fong, M. L. (1994). *Multicultural issues in supervision.* Retrieved from ERIC database. (ED372346)

Gladding, S. T. (2009). *Counseling: A comprehensive profession* (5th ed.). Upper Saddle River, NJ: Pearson.

Gould, L., & Bradley, L. (2001). Evaluation in supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 271–303). New York: Brunner-Routledge.

Guest, C. L., & Dooley, K. (1999). Supervisor malpractice: Liability to the supervisee in clinical supervision. *Counselor Education and Supervision*, *38*, 269–279.

Hoffman, M., Phillips, E., Noumair, D., Shullman, S., Geisler, C., Gray, J., … Ziegler, D. (2006). Toward a feminist and multicultural model of consultation and advocacy. *Journal of Multicultural Counseling and Development*, *34*(2), 116.

Homan, M. S. (2011). *Promoting community change: Making it happen in the real world* (5th ed.) Pacific Grove, CA: Brooks/Cole.

Idol, L., Nevin, A., & Paolucci-Whitcomb, P. (2000). *Collaborative consultation* (3rd ed.). Austin, TX: Pro-Ed.

International Association of Counseling Services. (2000). *Accreditation services*. Retreived from http://www.iacsinc.org/Accreditation%20Standards.htm

Kagan, N. (1980). Influencing human interaction Eighteen years with IPR. In A. I. Hess (Ed.), *Psychotherapy supervision: Theory, research, and practice* (pp. 262–283). New York: Wiley.

Kagan, N., & Kagan, N. I. (1997). Interpersonal process recall: Influencing human interaction. In C. E. Watkins, (Ed.), *Handbook of psychotherapy supervision* (pp. 296–309). New York: Wiley.

Kampwirth, T. J. (2006). *Collaborative consultation in the schools: Effective practices for students with learning and behavior problems* (3rd ed.). Upper Saddle River, NJ: Pearson.

Kline, W. B. (Ed.) (2006). Supervision in schools [Special section]. *Counselor Education and Supervision, 45*(4), 242-303.

Komives, S. R. (2003). *Student services: A handbook for the profession* (4th ed.). San Francisco: Jossey-Bass.

Kurpius, D. J., Fuqua, D. R., & Rozecki, T. (1993). The consulting process: A multidimensional approach. *Journal of Counseling and Development, 71,* 601–606.

Kurpius, D. J., & Robinson, S. E. (1978). An overview of consultation. *Personnel and Guidance Journal, 56,* 321–323.

Ladany, N., & Friedlander, M. L. (1995). The relationship between the supervisor working alliance and trainee's experience of role conflict and role ambiguity. *Counselor Education and Supervision, 34,* 220–231.

Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education and Supervision, 40*(4), 263–275.

Lawson, G., Hein, S., & Getz, H. (2009). A model for using triadic supervision in counselor preparation programs. *Counselor Education and Supervision, 48*(4), 257–270.

Lee, R. E., Nichols, D. P., Nichols, W. C., & Odom, T. (2004). Trends in family therapy supervision: The past 25 years and into the future. *Journal of Marital and Family Therapy, 30,* 61–69.

Levinson, H. (2009). Assessing organizations. *Consulting psychology: Selected articles by Harry Levinson* (pp. 137–166). Washington, D. C.: US: American Psychological Association. doi:10.1037/11848-008

Lovell, C. (1999). Empathic-cognitive development in students of counseling. *Journal of Adult Development, 6*(4), 195–203.

McNeill, B. W., Stoltenberg, C. D., & Romans, J. S. C. (1992). The integrated developmental model of supervision: Scale development and validation procedures. *Professional Psychology: Research and Practice, 23,* 504–508.

Mendoza, D. W. (1993). A review of Gerald Caplan's theory and practice of mental health consultation. *Journal of Counseling and Development, 71,* 629–635.

Mortola, P., & Carlson, J. (2003). "Collecting an anecdote": The role of narrative in school consultation. *Family Journal: Counseling and Therapy for Couples and Families, 11*(1), 7–12.

Much, K., Wagener, A., & Hellenbrand, M. (2010). Practicing in the 21st century college counseling center. *Journal of College Student Psychotherapy, 24*(1), 32–38. doi:10.1080/87568220903400138

Muro, J. J., & Dinkmeyer, D. C. (1977). *Counseling in the elementary and middle schools: A pragmatic approach.* Dubuque, IA: William C. Brown.

Neukrug, E. (1991). Computer-assisted live supervision in counselor skills training. *Counselor Education and Supervision, 31,* 132–138.

Ober, A., Granello, D., & Henfield, M. (2009). A synergistic model to enhance multicultural competence in supervision. *Counselor Education and Supervision, 48*(3), 204–221.

Pearson, Q. M. (2001). A case in clinical supervision: A framework for putting theory into practice. *Journal of Mental Health Counseling, 23,* 174–183.

Pearson, Q. M. (2006). Psychotherapy-driven supervision: Integrating counseling theories into role-based supervision. *Journal of Mental Health Counseling, 28*(3), 241–252.

Page, B. J., Pietrzak, D. R., & Sutton, J. M. (2001). National survey of school counselor supervision. *Counselor Education and Supervision, 41,* 142–150.

Peters, T. (1989). *Thriving on chaos.* New York: Park Avenue Press.

Ray, D., & Altekruse, M. (2000). Effectiveness of group supervision versus combined group and individual supervision. *Counselor Education and Supervision, 40*(1), 19–30.

Riva, M., & Erickson Cornish, J. A. (2008). Group supervision practices at psychology predoctoral internship programs: 15 years later. *Training and Education in Professional Psychology, 2*(1), 18–25. doi:10.1037/1931-3918.2.1.18

Rubenstein, G. (1973). Towards authenticity in the consulting process. In W. L. Claiborn & R. Cohen (Eds.), *School intervention* (pp. 32–50). New York: Behavioral Publications.

Schein, R. (1969). *Process consultation: Its role in organization development.* Reading, MA: Addison-Wesley.

Schein, R. (1999). *Process consultation revisited: Building the helping relationship.* Reading, MA: Addison-Wesley.

Schmidt, J. J. (2004). *A survival guide for the elementary/middle school counselor* (2nd ed.). San Francisco: Jossey-Bass.

Sears, R., Rudisill, J., & Mason-Sears, C. (2006). *Consultation skills for mental health professionals.* Hoboken, NJ: John Wiley.

Senge, P. (2006). *The fifth discipline: The art and practice of the learning organization* (rev. ed.). New York: Doubleday.

Smith, J., Amrhein, P., Brooks, A., Carpenter, K., Levin, D., Schreiber, E., … Nunes, E. (2007). Providing live supervision via teleconferencing improves acquisition of motivational interviewing skills after workshop attendance. *The American Journal of Drug and Alcohol Abuse, 33*(1), 163–168. doi:10.1080/00952990601091150

Somody, C., Henderson, P., Cook, K., & Zambrano, E. (2008). A working system of school counselor supervision. *Professional School Counseling, 12*(1), 22–33.

Sterner, W. (2009). Influence of the supervisory working alliance on supervisee work satisfaction and work-related stress. *Journal of Mental Health Counseling, 31*(3), 249–263.

Stinchfield, T., Hill, N. R., & Kleist, D. M. (2007). The reflective model of triadic supervision: Defining an emerging modality. *Counselor Education and Supervision, 46*(3), 172–183.

Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist, 60*(8), 857–864.

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists.* San Francisco: Jossey-Bass.

Stoltenberg, C. D., McNeil, B. W., & Delworth, U. (1998). *IDM supervision.* San Francisco: Jossey-Bass.

Stone, G. L., & Archer, J. (1990). College and university counseling centers in the 1990s: Challenges and limits. *The Counseling Psychologist, 18,* 539–607.

Wachter, A. (2004). To "create a conversation that is a little bit different." In N. M. Lambert, I. Hylander, & J. H. Sandoval (Eds.), *Consultee-centered consultation: Improving the quality of professional services in schools and community organizations* (pp. 325–338). Mahwah, NJ: Lawrence Erlbaum.

Westbrook, F. D., Kandell, J. J., Kirkland, S. E., Phillips, P. E., Regan, A. M., Medvene, A., & Oslin, Y. D. (1993). University campus consultation: Opportunities and limitations. *Journal of Counseling and Development, 71,* 684–688.

The Development of the Person

Overview

*T*he common theme running through the three chapters in this section is the focus on human development. Although each chapter spotlights a specific area in the development of the person, they all offer us a manner of conceptualizing our clients and ourselves as a function of a developmental process. Chapter 9 does this by examining normal development in a number of important domains, including physical, cognitive, and moral development; lifespan development; and the development of faith. Chapter 10 identifies theories about the development of abnormal behavior and presents a way of classifying behavior, and Chapter 11 offers a view of how personality is reflected through one's career development process.

As you read through this section, you might want to consider the developmental aspects of your life. Reflect back on your childhood and the kinds of transitions through which you passed, and then consider the transitions you've experienced in your adult life. Think about the impact they had upon you and your family. As you continue through this section, reflect on how you developed your sense of self and your state of mental health. Think about how you became you! Finally, think about why you are considering a career in counseling. What kinds of developmental issues have affected this important choice in your life? Clearly, this section offers a framework for working with clients, but it also presents a number of models to help you understand who you are today.

CHAPTER **9**

Development Across the Lifespan

With each passage from one stage of human growth to the next we, too, must shed a protective structure. We are left exposed and vulnerable but also yeasty and embryonic again, capable of stretching in ways we hadn't known before. These sheddings may take several years or more. Coming out of each passage, though, we enter a longer and more stable period in which we can expect relative tranquility and a sense of equilibrium regained. (Sheehy, 1976, p. 20)

I remember going on a trip out west with my parents and my brother. I was 13, and my brother was 8. I was miserable. I sat in the back seat of the car going through the pains of having recently reached puberty. My parents, I think, just thought I was going through a miserable stage. No matter where we went or what we did, I only thought about being in love. Oh yeah, and sex, of course. Somewhere in the middle of this trip, we stopped at a small gift shop. There was a girl who worked there who I had an instant crush on. I was shy but managed to have some small talk with her. No one knew my passion for her; it was my secret. My parents took us to national parks. We visited incredible sites where they "oohed" and "aahed," and I just thought about her. I even sent her a postcard with a short note and my return address. I hoped so much that I would hear from the girl from the gift shop. I did not. Even today when thinking back on that trip, in my mind I have a hazy picture of the Grand Canyon, Mesa Verde, and Old Faithful, but I have an indelible picture of her. Puberty is a very powerful experience, and it's a part of our normal developmental patterns.

I struggled through puberty. There was no one to talk with. My parents grew up in a time when sex was not talked about. Well, there could be a few dirty jokes, but no real conversations about sex. There was no school counselor to go to. And my friends—well, those conversations were certainly limited. I was left to my own devices, struggling with my own needs, desires, and wondering if this was all normal. Like most people, I struggled through this normal phase of development.

290

*T*his chapter is about normal development across the lifespan. The chapter's goal is to provide you with an understanding of the counselor's role in helping to ease clients through what can sometimes be painful transitions through normal developmental stages. As with my struggle through puberty, we all manage to get through a series of normal and predictable developmental stages in our journey through life. No doubt, I would have struggled through puberty even if I had had Carl Rogers to talk with. However, with Carl by my side, I probably would have felt that what I was going through was normal.

We will start this chapter by briefly reviewing some of the physical and psychological developmental milestones that children, adolescents, and adults face. Next, we will explore the cognitive and moral development of childhood, or how children develop their ways of knowing the world. This discussion will be followed by an examination of adult cognitive development, or how adults develop their ways of understanding and constructing reality. We will then examine lifespan development, or the kinds of tasks and challenges that individuals face as they pass through life stages. Finally, we will explore one model of faith development. Defining faith in a very broad manner, the theory we will examine reflects elements from all of the theories considered in this chapter. We will conclude the chapter by examining multicultural, social justice, ethical, professional, and legal issues related to normal development.

A Little Background

The counseling profession has long prided itself on having a developmental focus. However, the actual practice of counseling from a developmental perspective was, until relatively recently, greatly lacking (Blocher, 1988). In fact, what in the past was called a "developmental perspective" tended to be more of a humanistic approach that included some vague notion that the individual can develop over time. Despite the fact that the 1960s saw some attempts at applying developmental models in the schools and in college settings, generally, the concept of development "seemed little more than a catchword" (Blocher, 1988, p. 14). It was not until the 1980s that the application of theory to practice became a reality.

The1980s ushered in the era of true developmental counseling. The establishment of the Council for the Accreditation of Counseling and Related Programs (CACREP) standards in 1981, which included human development as one of its core curriculum content areas, highlighted development as a crucial element in the counseling profession. Then, in 1983, the American Personnel and Guidance Association (APGA) changed its name to the American Association for Counseling and Development (AACD, now ACA). It was becoming increasingly clear that the profession wanted a name that mirrored a developmental perspective in practice.

We have come a long way in the since the 1980s. Today, we find developmental models being applied to work with clients in all settings and even to how counselors grow and change over the years. In general, this developmental model challenges us to examine clients from a wellness perspective, in the sense that change and growth is seen as a natural progression that occurs over time, as opposed to a process that is fixed early in life or determined by our temperament.

Wellness conceptualized as the paradigm for counseling provides strength-based strategies for assessing clients, conceptualizing issues developmentally, and planning interventions to remediate dysfunction and optimize growth. (Myers & Sweeney, 2008, p. 482)

Keeping this wellness notion in mind, this chapter will explore a number of theories of development and discuss how counselors can use them when working with clients.

Understanding Human Development

The development of a person is complex and occurs on many levels. Over the years, a number of models of human development have been described that can assist the counselor when working with clients. Although these models differ tremendously in how they apply developmental theory, they tend to share common elements. For instance, most hold the belief that development is continual, is orderly, implies change, is by its nature painful and growth-producing, can be applied with many differing counseling approaches, and is preventive, optimistic, and wellness-oriented. Let's explore some of these concepts.

Development Is Continual

Whereas earlier theories of development were entrenched in biological determinism, in more recent years development has been viewed as a lifelong journey in which there is *plasticity*; that is, the individual has the ability to stretch and change cognitively, physically, interpersonally, intrapsychically, morally, and spiritually (Santrock, 2008). From this perspective, development begins when we are born and ends when we die. It is nonstop and continuous, and once we step on the ride, we can't get off.

Development Is Orderly and Sequential and Builds upon Itself

Models that describe human growth have a predictable pattern of development from earlier to later stages, in which the latter stages build on what has already been experienced and integrated into our lives:

Development proceeds stage by stage in orderly sequence, and although there are individual variations, these do not basically alter the ground plan that is typical of our species. . . . (Di Leo, 1996, p. 3)

This predictable pattern of growth allows the counselor to assess the developmental level of the client and predict the next developmental hurdle the client will face. If an individual does not successfully accomplish a developmental task when it is prime for its ascendancy, then there is greater likelihood of pathological development, or at the very least, it is more likely that the individual will struggle (Crandell, Crandell, & Vander Zanden, 2008; Santrock, 2009).

Development Implies Change, but Our Core Remains More or Less the Same

As we walk down our developmental path, we encounter much that is new to our current understanding of the world. Generally, we *assimilate* this new information, which means that we take it into our existing understanding of the world. Periodically, however, we move into a state of readiness for a dramatic shift in the way we live in the world, and with support, we *accommodate* or dramatically change the way we understand the world. Our core remains the same; but, as we assimilate and accommodate to the world, we appropriately adapt. Like a piece of clay we can be molded, sometimes torn apart and then put back together, but the basic material that defines who we are remains the same.

Development Is Painful, Yet Growth-Producing

Developmental theory suggests that there are transition points from one developmental level to another. Such points are generally earmarked by *disequilibrium* as the individual accommodates to a new way of living in the world. Transitions will often be experienced as a state of confusion, anxiety, depression, fear, and/or exhilaration, and they can occur quickly or last for years.

Transition will be less disequilibrating if the individual has had success in passing through previous developmental milestones and if there is support in the environment to ease the individual through the transition. Support for change comes in many forms; it can be the nurturing needed for the infant to grow physically, the reinforcement given to an adolescent as he or she begins to think in increasingly complex ways, or the psychological support needed by the adult going through a career change. The support can be given by a parent, a friend, or a counselor. However you pass through them, transitions are a signal that you are growing toward something greater than you were previously.

Developmental Models Are Transtheoretical

Developmental theory acknowledges the importance of the interplay among our biology, the environment in which we are brought up, and unique psychological factors of the person in the growth process. Understanding this interplay helps the counselor conceptualize client difficulties in multiple ways and frees the counselor to use strategies from many disciplines and theoretical approaches when working with specific developmental issues (Santrock, 2008; 2009).

Development Is Preventive, Optimistic, and Wellness-Oriented

The nature of developmental theory lends itself to prevention and a wellness model of mental health. By knowing expected transitions, counselors can develop workshops and educational seminars to assist individuals in understanding their natural progression from one developmental level to another. It also offers counselors a framework from which to develop strategies when assisting clients who may want to revisit unfinished developmental tasks. Whereas pathological models assume that pathology is an indication of an inborn deficit that is, at best, difficult to fix, developmental models view pathology as either a normal response to a developmental transition or an indication that a past developmental task has remained unfinished (Crandell, Crandell, & Vander Zanden, 2008; Roberts, Brown, Johnson, & Reinke, 2005; Santrock, 2009).

In summary, human development is continuous, orderly, sequential, painful yet growth producing, and a natural and potentially positive part of our existence. Developmental counseling offers the counselor a unique perspective when working with clients. The developmentally astute counselor knows (1) a variety of developmental theories, (2) the types of social issues and personal problems often experienced by clients as they pass through specific developmental stages, and (3) the kinds of counseling techniques that might work with clients as they pass through the stages. Clearly, knowledge of human development can go far in assisting the counselor in his or her work with clients.

■ *A Brief Overview of Physical and Psychosocial Development in Childhood*

Hannah and Joe

The developing child undergoes major physiological, social, and cognitive changes in the first few years of life (Rice, 2001; Santrock, 2008; 2009). Of course, until puberty and usually sometime afterward, there are great gains in height and weight. Gross and fine motor skills change quickly in the first few years of life, and the nervous system is structurally complete but functionally incomplete and will not finish growing until early adolescence. For instance, the myelin sheath that covers the nerves continues to develop until the child is 2, which accounts for the jerky movements of infants, and the cerebral cortex will not be complete until approximately age 12. As the nervous system continues to develop, there are rapid increases in the child's sensory development, speech and language ability, and cognitive and intellectual functioning. Increased physical abilities promote the child's psychosocial development. For example, increased mobility allows the toddler to explore more of his or her environment, and toddlers who are reinforced for their exploratory behavior will develop higher self-esteem than those who are reprimanded.

Because the vast majority of children will develop at fairly predictable rates, a counselor or child specialist who is aware of physiological timetables normed for children can assess whether a child is on target for his or her physiological development. Milestones of normative physical and social development have been described by dozens of authors on a variety of constructs such as intelligence, moral development, memory, motor development, and math and verbal skills (Schneider & Bullock, 2009).

Although the rate of children's physical development is fairly consistent, the scope of a specific child's development is based on the genetic predisposition of the child in interaction with the environment (Brooks-Gunn, 2004; Stearns, Allal, & Mace, 2008). For instance, although most children will be able to do multiplication by the fourth grade, their rate of learning and range of ability will vary based on genetics and environment (see Figure 9.1). Along these lines, a brilliant child is at a major disadvantage if he or she is brought up in a home that has lead paint and lead in the water or raised by neglectful parents that provide a poor diet and a lack of psychological support, while a child who is less gifted can shine if placed in a stimulating and nurturing environment.

Evidence of the importance of a nurturing environment in a child's development can be seen through the success of the Head Start program. Since the 1970s, Head Start has provided disadvantaged preschool children intellectually stimulating and nurturing environments. On average, these children have done noticeably better academically and socially than children of a similar background who have not received such an opportunity (Puma et al., 2010).

FIGURE 9.1
The Bender Visual Motor Gestalt

The Bender Visual Motor Gestalt is an assessment instrument that is used to determine possible psychological, physiological, and developmental problems in children and adults. In giving the instrument, you ask the individual to reproduce nine figures which are presented to him or her in sequence (the figures are actually much larger than depicted below). For children, difficulties in reproducing some of the figures could be indications of a learning disability, developmental delay, or emotional problems. Below are reproductions of four of the figures of two children who are developmentally on target. When Hannah couldn't reproduce figure 6, she became very frustrated and drew the lines below. Look at how much easier it is for the older child to reproduce the figures.

| Bender Gestalt figures | Hannah's drawings (age 3½) | Beckett's drawings (age 5½) |
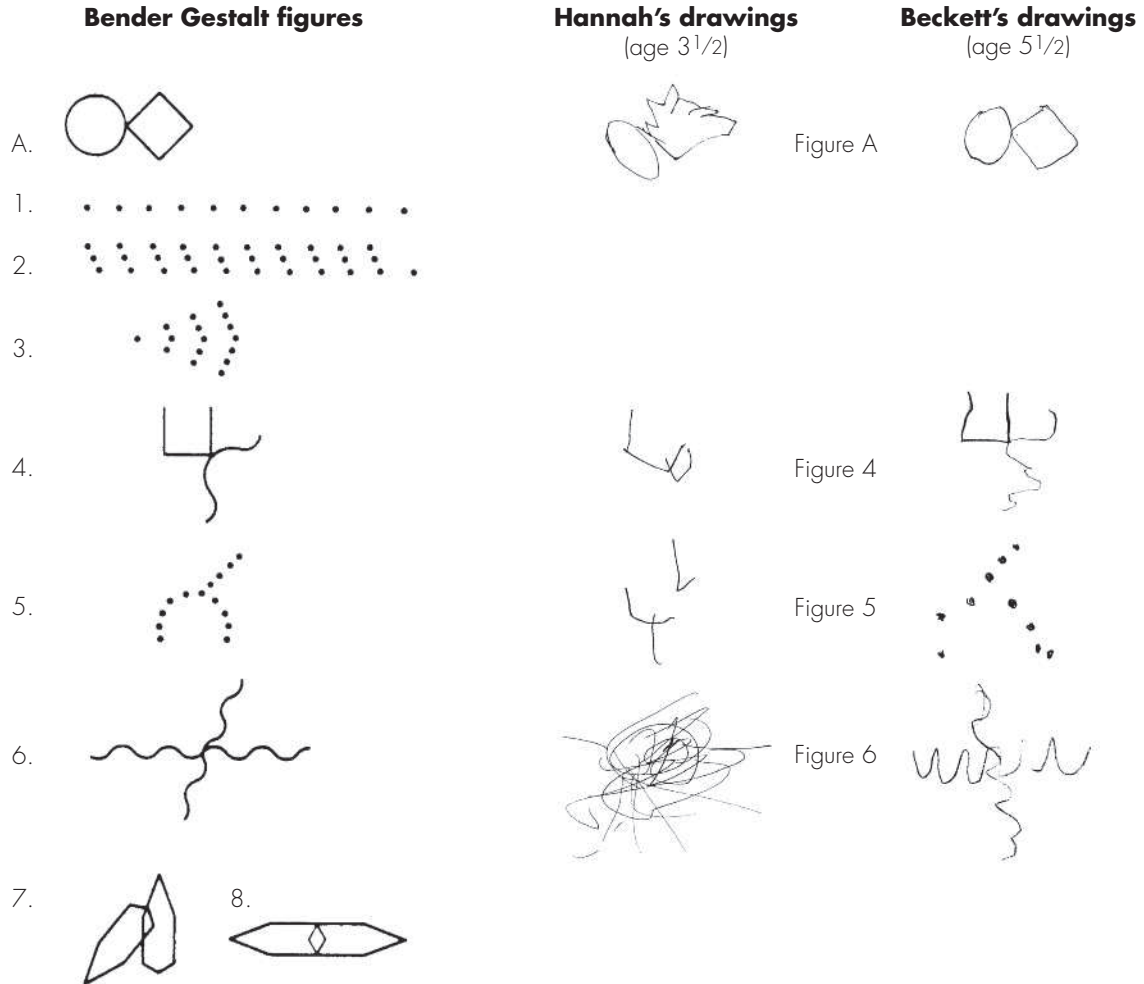
Development in Adolescence and Adulthood

As children grow into adolescence, they face the major task of dealing with the physical and psychological aspects of puberty. Of course, changes in their bodies can greatly affect how they feel about themselves. Adolescence is the time when teenagers will compare themselves to each other as they develop their identity. In adolescence, many teenagers face a myriad of social issues with which they struggle, including drug and alcohol use, crime and violence, dating, sexual identity, and sexually transmitted diseases. Late adolescence marks the time when teenagers will begin to consider their future plans. Older adolescents have to decide whether or not to go on to college or to work and consider a career and/or a college major.

Adolescence and young adulthood bring with them the blossoming of a person's sexuality. Of course, how this is dealt with can affect the individual for the rest of his or her life. Body image issues become particularly important now, especially for women who feel pressure to reflect the image portrayed in the media of what is considered beautiful (Ata, Ludden, & Lally, 2007).

Young adulthood is highlighted by making career choices and, for some, making lifelong commitments. Thus, issues of intimacy and how the young adult fits into the world of work are prominent at this time. These issues become increasingly more important as the young adult moves into what is sometimes called early adulthood. Success at having a love relationship and committing to a career is often reflected in one's psychological adjustment to the world in this time of life.

As individuals move into middle adulthood, they begin to recognize the slow decline in their physical abilities. When men and women reach their forties most will see slow weight gains and changes in vision, reaction time, strength, and motor ability. The psychological associations to death and dying are likely to increase, especially as parents and grandparents become ill and die. Women will soon face menopause and for many men and women midlife physical changes at this time in life coincide with psychological adjustments, and sometimes what's called the "mid-life crisis." Adults will begin to assess their worth in the world of work and begin to think about their entrance into late adulthood. Those who have been raising families are likely to reflect on how the family has grown, and those who have not may ponder what it is like not to leave a legacy through their children.

As we move on in life, slow physical changes continue, and in later adulthood disease and ill health increase and changes in physical abilities occur. These include changes in hearing, taste, smell, visual acuity, and memory, as well as an increasingly fragile skeletal system. As many are now living into their late eighties and nineties, additional health problems become increasingly prevalent. Psychologically, many older adults reflect on their lives and assess whether or not they are satisfied with their accomplishments.

The Development of Knowing: Cognitive and Moral Changes in Childhood

This section of the chapter will examine cognitive and moral development. Although all of the stages we will examine can be reached in adolescence or young adulthood, many individuals do not reach the higher stages at any point in their lives.

Jean Piaget and Cognitive Development
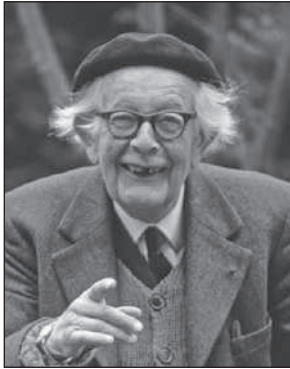
Jean Piaget

How does a child come to understand the world? This is the question that Jean Piaget asked when he first began exploring the cognitive development of children (Flavell, 1963). Piaget found that children learn through a process of *assimilation* and *accommodation*. Assimilation occurs when the child uses his or her existing way of understanding the world to make sense out of new knowledge. Accommodation, on the other hand, occurs when the child changes his or her previous ways of knowing to make sense out of this new knowledge (Piaget, 1954).

Piaget stated that in accommodating to the world, *schemata* (new cognitive structures, e.g., new ways of thinking) are formed that allow an individual to adapt and change his or her ways of thinking and understanding the world. This process of assimilation, forming new schemata, and accommodation occurs throughout the lifespan but is most obvious during childhood. Piaget showed that there were a number of concepts that a child can understand only at the age-appropriate level (see Box 9.1).

Through his research on child cognitive development, Piaget determined that children pass through predictable stages of development, each highlighted by a particular way of understanding the world (Inhelder & Piaget, 1958; Piaget, 1954). In the *sensorimotor stage* (birth through 2), the infant responds almost exclusively to his or her physical and sensory experience. At this stage, the child hasn't acquired full language ability, is not able to maintain mental images, and responds only to the here-and-now of experience. Therefore, not surprisingly, a parent attempting to have a rational conversation with a 1-year-old is pretty much wasting his or her time. However, it may be good practice for the child to hear periodically the tone of rational talk as the child readies him- or herself for the next stage of development.

The *preoperational stage* (2 through 7) is marked by the development of language ability, the ability to maintain mental images and to manipulate the meaning of objects (e.g., a doll is a baby, a block is a car) (Muro & Dinkmeyer, 1977). The child in this stage responds intuitively to the world. Not yet able to think in logical sequences or in complex ways, the child responds to what seems immediately obvious as opposed to what might be logical. Unless the child is on the verge of entering the next stage of development, trying to explain logical principles would be difficult and usually impossible. Imagine trying to explain to Hannah that the two kinds of M&M's had different amounts of mass (see Box 9.1). She just wouldn't get it!

From ages 7 through 11 the child enters the *concrete-operational stage*, in which he or she can begin to figure things out through a series of logical tasks, can begin to classify objects, and is able to understand a sequence of events. Children can now make mental comparisons and mentally manipulate images. For instance, a child in this stage could create a mental image of a map of how to get to a friend's house. Children in this stage are often adamant about

BOX 9.1

Hannah's Developmental Readiness

When my daughter, Hannah, was two years old, she loved M&M's®, which we attempted to give to her sparingly. At one point, we discovered small M&Ms (M&M Minis), which are about half the size of the regular ones. Giving her a bunch of these small candies made Hannah ecstatic. After all, now she could have more than she had been given on previous occasions. Hannah had not yet learned the concept that more in number does not necessarily mean more in volume or mass. In a relatively short amount of time, however, she came to understand the concept of differences in size, shape, and mass.

their logical way of viewing the world. For instance, when I was helping a friend's son with a math problem, he became angry when I suggested another way of finding the solution. He did not yet have the cognitive flexibility to examine other ways of knowing.

Children in the concrete-operational stage will have difficulty with metaphors or proverbs, because they haven't developed the capacity to think abstractly. However, when children or young adults move into Piaget's final stage, *formal-operational* (11 through 16), they are able to apply more complex levels of knowing to their understanding of the world. A child in this stage can understand that objects might have symbolic meaning (e.g., the Liberty Bell is more than just a bell), can test hypotheses, understand proverbs, and consider more than one aspect of a problem at a time.

Piaget's research on child development has greatly assisted us in understanding how children learn and gives us a healthy respect for age-appropriate developmental limitations. Such knowledge has greatly affected styles of teaching, ways to parent effectively, and methods of counseling children.

Kohlberg's Theory of Moral Development

© Harvard University Archives

Lawrence Kohlberg

Like Piaget, Lawrence Kohlberg wondered how children come to understand the world. However, Kohlberg was most interested in how children and adults come to understand and justify their moral behavior. Although Piaget had written about the process of moral development, by having children respond to moral dilemmas (problem situations of a moral nature with no clear-cut answer), Kohlberg greatly extended Piaget's original thoughts (Muro & Dinkmeyer, 1977) (see Box 9.2).

Kohlberg (1981, 1984) discovered that moral reasoning developed in a predictable pattern that spanned three levels of development, each containing two stages. The first level, *preconventional* (roughly ages 2 through 9), is based on the notion that children are egocentric and make moral decisions out of a concern of being punished or to be rewarded. In *Stage 1* of this level, moral decisions are made to avoid punishment or gain rewards from individuals in authority (*punishment-obedience orientation*), while in *Stage 2*, decisions are made with an egocentric/

BOX 9.2

The Heinz Dilemma

The following represents one of the more well known of Kohlberg's moral dilemmas. Presenting dilemmas such as these to adolescent boys, he developed his well-known theory of moral development. After reading the dilemma and reviewing the stages and levels, devise responses that a "typical" person might make as a function of the stage he or she is in.

In Europe, a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost him to make. He paid $200 for the radium and charged $2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about $1,000 which is half of what it cost. He told the druggist that his wife was dying and asked him to sell it cheaper or let him pay later. But the druggist said: "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and broke into the man's store to steal the drug—for his wife. Should the husband have done that? (Kohlberg, 1963, p. 19)

hedonistic desire to satisfy one's own needs (*instrumental-hedonism orientation*). Imagine two 6-year-old children vying for the same toy, both yelling, "I want it!" A parent comes over and asks the children to share, and they comply (wanting to avoid punishment from authority). Suddenly, one of the 6-year-olds gives the other a piece of candy and says, "Here, you have this and give me the toy" ("You scratch my back and I'll scratch yours"). Here the child recognizes the needs of another but is more concerned with having his or her own needs met.

In Kohlberg's *conventional level*, moral decisions are based initially on social conformity and mutualism (*good girl–nice boy orientation*) and later on rule-governed behavior (*law and order orientation*). In *Stage 3* of this level, the individual responds in a manner designed to please others and to avoid the disapproval of significant others. Most children will reach Stage 3 by age 13 (Gerrig & Zimbardo, 2010). An example of a stage 3 behavior is a 10-year-old who acts appropriately at school to gain the approval of his or her teacher. In *Stage 4* of the conventional level, adolescents and adults will emphasize a system of laws and rules as a means of maintaining a sense of order in their lives. Here, there is some recognition that if we violate rules, society will be in chaos. For example, some 10-year-olds will reason that it is not right to make fun of other kids in school because it is against the rules at school. This stage represents an important shift from externality to internality—from a need for approval to following a set of internalized rules.

Kohlberg believed that the final level of development, *postconventional morality*, requires formal-operational thinking. He found that most individuals will never reach this level because of the cognitive complexity involved. In *Stage 5* of this level, the postconventional thinker believes in the process of democratically devised social contracts (e.g., laws) that can be analyzed, interpreted, and changed, but that ultimately take precedence over individual needs (*social contract orientation*). Here, an individual would likely follow the law because there are governing moral principles that have been used in their development. However, such a person is willing to examine inconsistencies in laws and work on changing laws not seen as good for society.

In *Stage 6* of the postconventional level, moral decisions are based on a sense of universal truths, personal conscience, and principles of justice that are seen as being valid beyond current laws and social contracts (*principled conscience orientation*) (Cincotta, 2008). Here an individual would consider moral truths in his or her decision-making process and, after deep reflection, might choose to break a law, deciding that such an action is taken out of respect for the dignity of people and for the betterment of society (see Box 9.3). For instance, during the civil rights movement of the 1960s some individuals broke laws to advance the cause of civil rights for all people.

Although Kohlberg identified the lowest ages at which some individuals had reached conventional and postconventional thinking, he found that some young adults and adults have not mastered conventional thinking, while most have not reached postconventional thinking. He therefore advised that it would not be unusual to find same-aged adults at different levels of moral development.

Gilligan's Theory of Women's Moral Development

In 1982, Carol Gilligan wrote a book called *In a Different Voice*, which questioned some of Kohlberg's assumptions. Gilligan, who had been a colleague of Kohlberg's, noted that most of his research was based on a small group of boys, and after conducting research with girls and women, she proposed that moral reasoning for females might be based on a different way of knowing or understanding the world. She noted that Kohlberg's theory

BOX 9.3

Going to Jail for Reasons of Personal Conscience

For fourteen months, my brother-in-law Steve (lower left in the photo) was incarcerated because he and others broke into a naval shipyard, snuck onto an Aegis destroyer, poured their own blood onto the ship, and banged on the ship to protest against nuclear missiles. Some might say that Steve is in Kohlberg's Stage 6 because he chose to break the law for the betterment of society and out of his deeply held belief that nuclear arms can only harm people. If Steve has thoroughly reflected upon this, considered all points of view, and come to this decision in a deeply personal and thoughtful manner, he would be in Stage 6. If he did this act out of a desire for approval of his social group or because he adhered strongly to a system of rules, he would be in Stage 3 or 4. Often people can do the same acts and be at different stages. You must know the person to determine the stage.

Cover of *The Boston Globe Magazine*, July 27, 1997, as photographed by Bill Greene, courtesy of John Wirtz. Boston Globe/Landov.

stressed the notion that high-stage individuals make choices that stress autonomy and individuality, whereas her research seemed to indicate that women at high levels of development value connectedness and interdependence and view the relationship as primary when making moral decisions. In describing the differences between men and women, Gilligan notes the responses of one of Kohlberg's subjects and compares him to a woman she interviewed:

> *Thus, while Kohlberg's subject worries about people interfering with each other's rights, this woman worries about "the possibility of omission, of your not helping others when you could help them."* (Gilligan, 1982, p. 21)

Gilligan stated that in the development of moral reasoning, especially in Stages 3 and above, women will emphasize a "*standard of caring*" in moral decision making; that is, a concern for the other person will be a core ingredient when making moral decisions. She noted that women are more likely to be concerned about the impact their choices have on others, whereas men are more concerned about a sense of justice being maintained (Gerrig & Zimbardo, 2010). Noting these male and female differences, Gilligan states:

> *Given the differences in women's conceptions of self and morality, women bring to the life cycle a different point of view and order human experience in terms of different priorities.* (Gilligan, 1982, p. 22)

More specifically, the level 1 preconventional girl is not dissimilar to Kohlberg's level 1 boy in that her moral reasoning is narcissistic; she reasons from a

© Harvard University Archives

Carol Gilligan

survival-oriented, self-protective perspective. For Gilligan, the level 2 conventional woman shows a concern for others and feels responsible for others, as opposed to Kohlberg's level 2 person, who is concerned about pleasing others or following the rules. Gilligan's level 3 postconventional woman is a complex thinker who recognizes the interdependent nature of humans and that every action a person takes affects others in deeply personal ways.

Consider how an adolescent or adult woman might respond if her moral reasoning is grounded in a standard of care for others and a sense of responsibility to others as opposed to the individualistic and rule-following perspective of many men. Gilligan also found that because adolescent girls tend to be more concerned with the feelings of others, they will often lose their "voice" as they defer in decision-making. However, as women age and grow, their voice, or strong sense of self, will often return as they realize they can be concerned about others and also have a perspective on the world that they will stand up for (see Gilligan's novel, *Kyra*, 2008).

Gilligan has added a unique perspective to the concept of moral development and brings to the forefront major differences in how many men and women approach moral reasoning. Understanding such differences is crucial in helping us understand why men and women view moral reasoning in very different ways.

Comparison of Cognitive and Moral Development

There is a logical association between Piaget's stages of cognitive development and Kohlberg's and Gilligan's levels of moral development. The preoperational thinker responds intuitively and cannot think logically or in complex ways. From a perspective of moral development, this person can only be in the preconventional level, responding on a gut level to the rudimentary morality of punishment and reward and acting in a self-centered manner. Although Kohlberg and Gilligan offer different perspectives on their understanding of the conventional person, reflection on self or complex thinking concerning higher moral principles is not possible at this level. Therefore, moral reasoning from the conventional level is likely a function of concrete-operational thinking. Finally, for both Kohlberg and Gilligan it is clear that the kind of introspection and consciousness necessary for postconventional thinking can be found only by the individual who has conquered formal-operational thought (see Table 9.1).

Adult Cognitive Development

For years, tracing the development of knowing in the adult took a back seat to understanding the cognitive development of children. However, recently a number of theories have offered an explanation of how adults make sense of the world. Like their child-development counterparts, which reach upward and attempt to explain pieces of adult development, these theories extend downward and have something to say about child development. However, in practice, these theories tend to be applied to adults. Two of the theories that have gained some prominence in recent years are Kegan's constructive development theory and Perry's theory of epistemological reflection (Kegan, 1982, 1994; Perry, 1970).

T A B L E 9.1

		KOHLBERG/GILLIGAN		
PIAGET'S STAGES	PIAGET	LEVELS	KOHLBERG	GILLIGAN
Sensorimotor	Responds to physical and sensory experience.			
Preoperational	Intuitive responding. Maintenance of mental images. No logical thinking.	**Preconventional**	1. Punishment/reward. 2. Satisfy needs to gain reward (you get from me, I get from you).	Concern for survival.
Concrete-Operational	No complex thinking. Uses logical thinking sequencing, categorizing, to figure things out.	**Conventional**	1. Social conformity/ approval of others. 2. Rules and laws to maintain order.	Caring for others Sacrifice of self for others Responsible to others.
Formal-operational	Abstract thinking. Complex ways of knowing.	**Postconventional**	1. Social contract/ democratically arrived at. Rules that can be changed through a logical process. 2. Individual conscience.	Decision-making from an interdependent perspective. All that we choose affects everyone else.

NOTE: Kohlberg's levels are each divided into two stages as shown.

Kegan's Constructivist Developmental Model

Robert Kegan believes that our understanding of the world is based on how we construct reality as we pass through the lifespan. *His subject–object* theory states that there are specific developmental stages through which individuals pass that reflect their meaning-making system. Movement from a lower to higher stage necessitates a letting go of the earlier stage. This is not done easily, and Kegan suggests that movement occurs most successfully if there is challenge to one's existing view of the world within a supportive environment (Kegan, 1982).

Kegan (1982) suggests there are six stages of cognitive development (stages 0 to 5), with stages 3, 4, and 5 representing ways in which the adult views the world. Kegan states that the self-absorbed infant, being born into *the incorporative stage*, is all reflexive and has no sense of self as separate from the outside world. However, as the very young child begins to experience the world, reflexes are no longer the primary focus; instead, the young child attempts to have his or her needs met through attainment of objects outside of self. In this *impulsive stage* the child has limited control over his or her actions and acts spontaneously to have needs met. For instance, a young child might impulsively grab a toy from another child. No wonder the second year of life is often called the "terrible twos":

> *In disembedding herself from her reflexes the two-year-old comes to have reflexes rather than be them, and the new self is embedded in that which coordinates the reflexes, namely, the "perceptions" and the "impulses."* (Kegan, 1982, p. 85)

As children gain control over their impulses, they move into the *imperial stage*, where needs, interests, and wishes become primary and impulses can now be controlled (see Box 9.4). Here the child has a desire for and begins to recognize what he or she wants and has some control over how to obtain it. For instance, in this case rather than impulsively grabbing for a toy, the child might control his or her impulses and wait until the other child is not looking or trade a toy for the one he or she wants.

Although some adults are in the imperial stage of development, most are in the last three stages. During the *interpersonal stage*, the individual is embedded in relationships; that is, relationships are primary, and needs and wishes are met through them. Symbolically, the interpersonal person lives by the following statements, "I am you, and you are me. I do not exist without you. You make me who I am." As opposed to the narcissistic orientation of the imperial person, the interpersonal person begins to show glimpses of empathy. After all, if your existence is contingent on your relationships with others, you had better periodically show them understanding. However, mostly this stage is symbolized by its dependency on others. The interpersonal person's need for relationships can be seen in many of the popular songs of our era, which are often highlighted by dependency messages such as "I will die without you" or "I am no one if you are not in my life."

The individual who moves out of embeddedness with another moves into the *institutional stage*, where a sense of autonomy and self-authorship of life is acquired. Relationships in this stage are still important but no longer seem like the essential ingredient for living. In this stage, the individual's understanding of his or her values and interests become important. Here the individual may choose a partner because the other person shares similar values; however, the person in this stage does not need the partner as he or she would in the interpersonal stage. The institutional person can sometimes become quite arrogant about his or her point of view. Feeling independent and strong, this person can sometimes angrily stake out his or her position. Some of my colleagues joke that all New Yorkers are in this stage of development.

Kegan's final stage, the *interindividual stage*, highlights *mutuality* in relationships; that is, the individual can share with others and learn from others in a nondependent

BOX 9.4

Garrett: Responding from the Imperial Stage

Garrett, a 12-year-old son of a friend, wanted to spend time with a friend of his. However, after being told by his friend that he had already made plans to spend time with another boy, Garrett felt rejected and left out. If Garrett had still been in the impulsive stage, he might have thrown a temper tantrum. Instead, having passed into the imperial stage, he had control over his impulses and devised a way to get his needs met. He manipulated a way to spend time with both of them, disregarding their need to be with one another. You see, in the imperial stage one can control impulses and therefore develop plans to have one's needs met, and in this stage, there is little empathy for other people's desires. Therefore, Garrett did not yet have the ability to talk over his feelings with his friends. Hopefully, when he's a little older, he'll be able to share his feelings of being left out and understand (have empathy for) his friends' desire to be with one another.

When his father was explaining this situation to me, he said that at first he was going to try to talk with his son about the other kids' feelings but then he realized that Garrett just couldn't hear that yet. If you're in the imperial stage and not yet ready to give it up, little can be done to "make" a person move to the interpersonal stage.

way. Here there is a sharing of selves, without a giving up of self, and difference is tolerated and even encouraged at times. In an effort to be continually self-reflective, this individual encourages feedback about self. Finally, the interindividual person has respect for self and for all others, regardless of their stage. One might say that this person is the epitome of the self-actualized human.

Kegan's *constructivist model* stresses the interpersonal nature of development and the fact that we construct new ways of understanding the world and ourselves as we grow. In his eyes, growth is based on our ability to interact with others and to let go of past, less effective types of relating. Although Kegan gives some general time lines for when movement into higher levels could occur, it is usual to find older adults who have not moved out of the interpersonal and sometimes even the imperial stages. The life of Malcolm X is an extraordinary example of a person's movement through the stages (see Box 9.5).

Perry's Theory of Intellectual and Ethical Development

William Perry's theory of *epistemological reflection* (Perry, 1970) was developed to examine the cognitive development of adults, particularly college students. The *Perry scheme*, as it is known, describes movement through four stages (King, 1978). In the first stage, *dualism*, students view truth categorically, as right or wrong, and they have little tolerance for ambiguity. Dualists engage in all-or-nothing thinking and believe that experts have answers to almost all questions. Therefore, they believe that they can get the "truth" from their professor. As individuals develop, they begin to doubt some of their absolutist-type thinking and move into *multiplicity*, or, as reported by some, *transition* (Magolda & Porterfield, 1988), in which a beginning recognition of the limits of authorities occurs.

In the next stage, *relativism*, students are able to think more abstractly and become interested in differing opinions. In relativism, a student comes to understand that there may be many ways of constructing reality and defining truth; that the professor has a body

BOX 9.5

The Life of Malcolm X

The life of Malcolm X is a good example of movement through Kegan's stages (see Haley, 2001). As a young adult, Malcolm X found himself involved in a life of crime and drug addiction as he narcissistically tried to have his needs met (imperial stage). Given a ten-year jail sentence for robbery, in prison he was introduced to the Nation of Islam, a Black Muslim religion headed by Elijah Mohammad. Malcolm readily gave up his former lifestyle and became embedded in the values of the Nation of Islam. He lived, slept, and breathed *their* values, and his identity became these values (interpersonal stage). However, as he grew as a person, he realized that he did not agree with some of their ideas, and he moved from embeddedness in their values to a strong sense of his own religious, cultural, and moral values. Although still an activist, and still somewhat closed to other points of view, he had matured to the point where he was now embracing his own set of values (institutional stage).

Following a pilgrimage to Mecca, he changed his name to Al Hajj Malik al-Shabazz and again modified his views "to encompass the possibility that all white people were not evil and that progress in the black struggle could be made with the help of world organizations, other black groups, and even progressive white groups" (*Encyclopedia of Black America,* 1981, p. 544). Clearly, Al Hajj Malik al-Shabazz had evolved to Kegan's interindividual stage. He could now hear other points of view, be open to feedback, and yet have a clear sense of his own uniqueness in the world.

of knowledge, but others have knowledge as well; and that learning can be a joint sharing process between the professor and students. Individuals in this stage are often ambivalent about what values and relative truths to call their own.

Perry's last stage is called *commitment in relativism*. In this final stage, individuals have the capacity to maintain their relativistic outlook while also committing themselves to specific behaviors and values that guide them. Such individuals make a commitment to embracing specific values and beliefs (e.g., pro-life, pro-choice), are open to changing their commitments if given new facts, and can hear different points of view. For example, the committed relativist may make a specific religious or job commitment while at the same time be able to recognize the possibility that new information may modify that choice (Widick, 1977).

Perry's theory has been actively used in college settings to understand how college students think and the cognitive changes they go through while attending college (Magolda & Porterfield, 1988). However, the theory may have broader implications, because it may describe a general orientation to how individuals interact in the world, with some people reflecting the rigid, inflexible themes found by the dualists, while other people are capable of the *multiple-perspective-taking* of the relativist. Higher development on the Perry scheme, and related models of cognitive development, appear to be related to the development of many of the counselor qualities discussed in Chapter 1 as critical to effective counseling (Choate & Granello, 2006; Granello, 2002; Granello, Kindsvatter, Granello, Underfer-Babalis, & Moorhead, 2008; Neukrug & McAuliffe, 1993).

Although Perry did not set age limits for individuals who are dualistic, relativistic, or committed in relativism, it would not be too difficult to approximate the lowest ages in which you might find each. The dualist could be as young as the individual in the concrete-operational stage (around 12), while the multiple-perspective-taking of the relativist could only take place somewhat after a person has achieved Piaget's formal-operational stage and Kegan's institutional stage (perhaps a minimum of age 18, but usually much older). The individual who is committed in relativism would also have to be in the formal operational stage, and this person also seems to hold many of the same qualities as Kegan's interindividual person (minimal age of 40).

Comparison of Adult Cognitive Development Theories

Although Kegan's theory is much more broadly based than Perry's, there are many similarities. For instance, both examine how the individual constructs reality and makes meaning in his or her life. Both suggest that as individuals develop, their view of reality becomes increasingly more complex, more open, and seems to embody many of the characteristics of what we might call the self-actualized person. Finally, both theories state that adult development is likely to occur if the individual is afforded an environment that is supportive yet challenging to one's current way of making meaning.

■ Lifespan Development

Some models of understanding the development of the person have taken a lifespan perspective; that is, the individual is seen as continuing to grow over the lifespan with development not being viewed as suddenly ending in childhood or starting in adulthood. In addition, the previous models we have examined offered stages through which all people

could pass, although many will not reach the highest stages of development. Lifespan models offer stages through which every person *will* pass.

Erikson's Stages of Psychosocial Development

One of the more recognized models of lifespan development has been Erikson's stages of psychosocial development, which examines how psychosocial forces affect the development of the person. Another model, offered by Levinson, examines stages of development in a number of arenas (e.g., work, love, family) experienced by men and women over the lifespan.

Although Erik Erikson started out studying Freud's psychoanalytic approach, he later developed a model that challenged Freud's understanding of the developing ego. Contrary to psychoanalysis, he felt that the influence of instincts and the unconscious were not as great as many had posited and that *psychosocial forces*, in combination with biological and internal psychological factors, were major contributors to the development of a healthy personality. Suggesting that individuals pass through eight life stages, Erikson viewed the individual as changing throughout his or her life and placed considerably more emphasis on the influence of social factors than did any of his predecessors (see Table 9.2). In addition, Erikson's approach was more positive than traditional psychoanalysis, as he believed that when previous stages were not successfully traversed, they could be revisited at a later date (see Erikson, 1963, 1968, 1980, 1982).

Erikson suggested that as individuals pass through the eight stages they are faced with a *task*, sometimes called a *crisis*. Portrayed as a pair of opposing forces, Erikson described the first opposing task in each stage as *syntonic,* or positive emotional quality, and the second task as *dystonic,* or negative emotional quality. He suggested that individuals needed to experience both the syntonic and dystonic qualities. However, in the end, one has to find a balance between the two, with individuals leaning toward the syntonic quality. For instance, trust is a critical factor in all people's lives as we must generally trust others if we are to get along with one another. However, a certain amount of mistrust is also important. For example, if a person is walking down a dark street and sees an ominous figure, he or she should react with a fair amount of mistrust. More generally, Erikson believed that too much trust would lead to what he called *sensory distortion* while too much mistrust would lead to *withdrawal* (see Table 9.2). Similarly, too much autonomy would lead to *impulsivity* whereas too much shame and doubt would lead to *compulsion*, and so forth. Clearly, the role of significant others in the early stages had much influence over the ability to find the correct balance between the syntonic and dystonic qualities.

Erikson believed that the development of a healthy ego is contingent on the individual's ability to master these critical periods of development and is highlighted by a particular *virtue* or *strength* that is associated with successful passage through each stage (see Table 9.2). If a positive identity is created and the virtue embraced, the individual can move on to the next critical period. On the other hand, the individual who is not able to cope with age-specific developmental tasks will develop a low self-image and a bruised ego and will carry these dysfunctions forward, making it difficult to successfully complete later developmental tasks.

Erikson's eight lifespan stages are often referenced as a means of assisting the helper in understanding typical developmental tasks of the client. Such understanding can aid the helper in developing strategies for clients as they attempt to pass successfully through the stages and can sometimes help normalize problems that may feel quite unbearable in the moment.
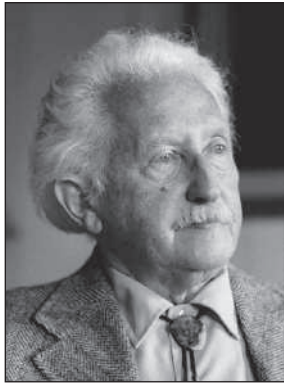
Erik Erikson

TABLE 9.2

Erikson's Psychosocial Stages of Development			
STAGE	NAME OF STAGE WITH AGES	VIRTUE OF STAGE	DESCRIPTION OF STAGE
1	Trust vs. Mistrust (Birth–1)	Hope	In this stage the infant is building a sense of trust or mistrust, which can be facilitated by significant others' ability to provide a sense of psychological safety to the infant.
2	Autonomy vs. Shame and Doubt (1–2)	Will	Here, the toddler explores the environment and is beginning to gain control over his or her body. Significant others can either promote or inhibit the child's newfound abilities and facilitate the development of autonomy or shame and doubt.
3	Initiative vs. Guilt (3–5)	Purpose	As physical and intellectual growth continues and exploration of the environment increases, a sense of initiative or guilt can be developed by significant others who are either encouraging or discouraging of the child's physical and intellectual curiosity.
4	Industry vs. Inferiority (6–11)	Competence	An increased sense of what the child is good at, especially relative to his or her peers, can either be reinforced or negated by significant others (e.g., parents, teachers, peers) leading to feeling worthwhile, or discouraged by others, which leads to feeling inferior.
5	Identity vs. Role Confusion (Adolescence)	Fidelity	Positive role models and experiences can lead to increased understanding of temperament, values, interests, and abilities that define one's sense of self. Negative role models and limited experiences will lead to role confusion.
6	Intimacy vs. Isolation (Early Adulthood)	Love	A good sense of self and self-understanding leads to the ability to form intimate relationships that are highlighted by mutually supporting relationships that encourage individuality with interdependency. Otherwise, the young adult feels isolated.
7	Generativity vs. Stagnation (Middle Adulthood)	Caring	Healthy development in this stage is highlighted by concern for others and for future generations. This individual is able to maintain a productive and responsible lifestyle and can find meaning through work, volunteerism, parenting, and/or community activities. Otherwise, the adult feels stagnant.
8	Ego Integrity vs. Despair (Later Life)	Wisdom	The older adult who examines his or her life either feels a sense of fulfillment or despair. Successfully mastering the developmental tasks from the preceding stages will lead to a sense of integrity for the individual.

Levinson's Seasons of a Man's Life/Seasons of a Woman's Life

Daniel Levinson's book, *The Seasons of a Man's Life* (1978) examined developmental changes of men through the lifespan. His research, which was the basis for the well-known bestseller *Passages* (Sheehy, 1976), examined men in a number of occupational groups. He subsequently wrote a book on the lifespan development of women that was finished posthumously by his wife, Judy Levinson (Levinson, 1996).

Levinson expected to find differences between men and women relative to the stages through which they pass in life. However, after intensive biographical interviews with men, and later with women, Levinson identified four comparable *eras* through which men and women pass, including: *pre-adulthood, early adulthood, middle adulthood,* and *late adulthood* (Newton, 1994) (see Figure 9.2). (With people living later, he also hypothesized there might be a fifth era, which he called late, late adulthood.) Eras are preceded by

FIGURE 9.2
Developmental Periods in the Eras of Early and Middle Adulthood

Source: Levinson, D. L. (1996). *Seasons of a Woman's Life.* New York: Alfred A. Knopf, p. 18.

LATE ADULT TRANSITION: *Age 60-65*

Culminating Life Structure for Middle Adulthood: 55-60

Age 50 Transition: 50-55

Entry Life Structure For Middle Adulthood: 45-50

ERA OF LATE ADULTHOOD: 60-?

MID-LIFE TRANSITION: *Age 40-45*

Culminating Life Structure for Early Adulthood: 33-40

Age 30 Transition: 28-33

Entry Life Structure for Early Adulthood: 22-28

ERA OF MIDDLE ADULTHOOD: 40-65

EARLY ADULT TRANSITION: *Age 17-22*

ERA OF EARLY ADULTHOOD: 17-45

ERA OF PRE-ADULTHOOD: 0-22

transitional periods, which are followed by *periods* that reflect unique issues or *life structures* that all individuals face in the areas of career, love relationships, marriage and family, relationships with self, uses of solitude, roles in social contexts, and relationships with individuals, groups, and institutions (see Box 9.6). Levinson believed that the eras are universal, cross-cultural, and predetermined by a complex interaction of social forces, biology, and psychological factors.

Although eras and periods were found to be the same for men and women, how they faced the issues and constructed their life structures within the periods varied dramatically. Noting the issue of "*gender splitting*," Levinson found that traditional stereotypes were the centerpoint for the struggles of men and women. For instance, in the era of early adulthood, where the individual is dealing with settling into a relationship, career focus, and life goals, women were often struggling with their decision around

BOX 9.6

Developmental Periods of Levinson

Ages 17 to 22. Early adult transition: Leaving the family and adolescent groups, going to college, military service, marrying

Ages 22 to 28. Entering the adult world: Time of choices, defining goals, establishing occupation and marriage; conflict between desire to explore and desire to commit

Age 28 to 33. Age 30 transition: Period of reworking, modifying life structure; smooth transition for some, disruptive crisis for others; growing sense of need for change before becoming locked in because of commitments

Age 33 to 40. Settling down: Accepting a few major goals, building the structure around central choices; establishing one's niche, working at advancement

Age 40 to 45. Midlife transition: Midlife crisis, link between early and middle adulthood; review and reappraise early adult period; modify unsatisfying aspects of life structure; adjust psychologically to the final half of life; intense reexamination causes emotional upset, tumultuous struggles with self, questioning every aspect of life

Age 45 to 50. Entering middle adulthood: End of reappraisal, time of choices, forming a new life structure in

relation to occupation, marriage, locale; wide variations in satisfactions and extent of fulfillment

Age 50 to 55. Age 50 transition: Work further on the tasks of midlife transition and modification of structure formed in the mid-40s; crisis if there was not enough change during midlife transition

Age 55 to 60. Culmination of middle adulthood: Building a second middle adult structure; time of fulfillment for those who can rejuvenate themselves and enrich their lives

Age 60 to 65. Late adult transition: Conclude efforts of middle adulthood, prepare for era to come; major turning point in life cycle

Age 65 and over. Late adulthood: Confrontation with self, life: need to make peace with the world

Age 80+. Late, late adulthood: Further psychosocial development or senescence

motherhood and career. The career woman could often be found feeling guilty over her decision to not be a full-time mother while the stay-at-home mom, having given up a career, often struggled with her sense of identity and with finding meaning and fulfillment in life. In contrast, men's struggles were focused on being a good husband, father, and provider for the family.

Levinson's theory is important because it identifies the ebbs and flows of the developmental process for men and women. Noting that within each era there are periods of great stability and of great fluctuation, he offers us an understanding of the normal life tasks that will be faced by most men and women.

Comparison of Lifespan Development Theories

> *If this developmental sequence does hold to some degree for the species, its origins must be found in the interaction of all these influences as they operate during a particular phase.* . . . (Levinson, 1978, p. 322)

A number of similarities exist between the lifespan theories of Erikson and Levinson. For instance, both state that there are specific developmental stages through which all individuals must pass and that each individual will be dealing with specific developmental tasks within each stage. Both theories are sequential but not hierarchical;

that is, although stages follow one another in an orderly manner, and difficulty in one stage can affect later stages, no stage is considered better than another. Finally, Erikson and Levinson suggest that developmental tasks are a function of biological, psychological, and sociological factors and are probably universal across cultures.

Fowler's Theory of Faith Development

Drawing on the work of Erikson, Piaget, and Kohlberg, James Fowler developed a theory of faith development (Fowler, 1976, 1991, 1995, 2000). Fowler believes that faith is universal and inherent in our nature and relates to how we make meaning. Faith, as defined by Fowler, is much broader than a singular examination of one's religious orientation. It has to do with core values, the images of power that drive the person, and the stories that motivate the individual consciously and unconsciously throughout life (e.g., the stories of Jesus, Martin Luther King, Jr., Muhammad, the unique stories that drive our families, and so forth):

> . . . We shape commitments to causes and centers of value. We form allegiances and alliances with images and realities of power. And we form and shape our lives in relation to master stories. In these ways we join with others in the finding and making of meaning. (Fowler, 1991, p. 22)

This broad definition of faith means that the atheist, agnostic, fundamentalist, and communist all have some faith experience, for faith is not dependent on a belief in God (Fowler, 1991). In fact, faith is deeper than one's belief system because it includes unconscious motivations.

Based on his research, Fowler (1976, 1991, 2000) identified six stages of faith development with minimal ages at which a person can enter a specific stage. Within this model, one can see pieces of each of the theories we examined in this chapter. Thus, as we read through this theory, consider how all of the developmental models examined might explain different aspects of his theory. This can act as a mini review for this chapter.

Stage 0, Primal Faith (Infancy): Based on Erikson's first psychosocial stage of trust versus mistrust, Fowler believes that infants have a predisposition toward a trusting relationship, which, if developed, will be the basis for the development of faith later in life. (Not considered one of the actual stages, although important to eventual development.)

Stage 1, Intuitive–Projective Faith (Minimal Age: 4): Based on Piaget's preoperational stage, children in this stage respond mostly to stories, feelings, and imagery. Their world is not logical; it is a symbolic mystery and can be greatly affected by adult views of faith. Symbols and stories are swallowed whole and can be used to expand a child's vision of the world; however, they can also be used to instill fear:

> My friend told me that the devil will come up out of a hole in the ground and get me if I'm not careful, so now I won't play in the backyard by myself. (Fowler, 2000, p. 42)

In this stage, children are quite malleable and will mimic those around them. This stage offers opportunity for faith development, yet it can also restrict a person's ability to develop faith if he or she is placed in a fearful environment (see Box 9.7).

BOX 9.7

A Child with Intuitive–Projective Faith

A friend of mine had twin 5-year-old boys whom she placed in a fundamentalist Christian day-care center. She was of a different faith but found this center to be the most convenient for her. One evening, about two weeks after the boys had started at that day-care center, I was having dinner at their house when one of the boys asked me, "Do you believe in God?" I began to respond by saying, "That's a difficult question," and before I could say any more he yelled out, "You're going to hell!"

My friend's son, in just a few short weeks, had taken in a powerful new belief from a newfound social force in the environment—the day-care center. He projected his newfound belief onto me. If these are values you would want to instill in your child, then leaving the child in this school would be important. My friend, however, did not want her malleable children to take on such values and removed them from this school.

Stage 2, Mythic–Literal Faith (Age 6½ to 8): Having entered Piaget's concrete-operational stage, children in this stage are particularly susceptible to literal interpretations of faith. Symbols, stories, and beliefs from one's traditions are taken one-dimensionally and literally. They are what they are. Children are logical, believe in causation, and rely on the truth held by authorities, such as one's parents. Therefore, others play a particularly powerful role in developing the child's meaning-making system. These ways of making sense out of the world are strikingly similar to what Perry calls dualistic thinking.

Stage 3, Synthetic–Conventional Faith (12 to 13): As the child moves into adolescence, he or she enters Piaget's formal-operational stage and takes on an increasingly complex and abstract view of the world. The individual is now able to reflect on his or her interactions with others and consider what is important for the development of a value system. Ultimately, the individual in this stage synthesizes many viewpoints from his or her social sphere into a unique meaning-making system. However, because the individual remains embedded within his or her social sphere, this meaning-making system is still naive because it reflects only those values within that sphere. One's faith is therefore unique to one's self, yet based on those close to him or her. This may be compared to Kegan's interpersonal stage of development, where the person is embedded in others for definition of self.

Stage 4, Individuative–Reflective Faith (18 to 19): Like the individual in Kegan's institutional stage, the individual in this stage has the ability to take responsibility for his or her own faith development. This is epitomized by being able to let go of values that are based solely on one's immediate social sphere and being able to develop a new meaning-making system through reflection and introspection. This relativistic individual now recognizes different types of faith experiences and may forcefully move toward a new ideology (e.g., the college student who grew up Baptist and becomes a Buddhist). Certainly, the beginning ability to reflect on self and see different points of view are indicative of postoperational and postconventional thinking. In addition, we can see remnants of Levinson's early adult transition stage as the individual is symbolically leaving his or her family.

Stage 5, Conjunctive Faith (30 to 32): This relativistic experience of faith happens when the individual is able to honor and affirm others who have different faith commitments while not denying his or her own faith. There is a newfound understanding of symbols and metaphors related to one's own faith tradition, as well as the

faith traditions of others. There is openness to other points of view, a commitment to one's own point of view, and a sense of humility regarding all that is known (or not known). This stage has strong leanings toward what Perry called "commitment in relativism."

Stage 6, Universalizing Faith (38 to 40): Few individuals reach this stage of faith, which involves acceptance of others, regardless of stage or faith tradition. Fowler calls this *decentration from self*, or the ability to understand fully the views of others, to be able to see the world through their eyes, a true knowing of others. The individual in this stage experiences faith as universal, beyond particular ideological beliefs, and is therefore able to embrace all others. This individual is able to integrate beliefs from many disparate viewpoints and synthesize them into a faith experience that is unique to him- or herself. This stage shares many similarities with Kegan's interindividual stage where the person may be described as self-actualized. This person has compassion for and understands all points of view:

> *From primal relationships in the immediate family we gradually widen our circle of awareness and regard to extended family and friends, to those who share our political or religious identifications, and finally beyond those to humankind or being, in an inclusive sense.…It means "knowing" the world through the eyes and experiences of persons, classes, nationalities, and faiths quite different from one's own.*
> (Fowler, 2000, p. 55)

Fowler's model can be used to help counselors and supervisees better understand the nature of their client's faith experience (Parker, 2009; Ripley, Jackson, Tatum, & Davis, 2007). Thus, when counselors understand and advance their own faith development, they in turn will have a deeper comprehension of and appreciation for the values and spiritual orientation of others.

Other Developmental Theories

Many other developmental theories exist. For instance, Loevinger (1976) developed a theory of ego development that examined how individuals develop interpersonally, cognitively, and morally over the lifespan. In studying college students, Chickering developed a theory of college student development that elaborates on Erikson's stages of identity and intimacy (Chickering & Reisser, 1993) and assists counselors and others to understand college student development (see Chapter 18). Similarly, Gould (1972, 1978) and Vaillant (1977) have both examined adult development over the lifespan and offer stages similar to those of Erikson and Levinson. Other models include Belenky's developmental model of women's ways of understanding the world (Belenky, Clinchy, Goldberger, & Tarule, 1986/1997); Stoltenberg and colleagues' supervision model (Stoltenberg, McNeil, & Delworth, 1998), which was discussed in Chapter 8; Super's (Super, Savickas, & Super, 1996) model of career development, which will be examined in Chapter 11; and D'Andrea's stages of racism, which will be explored in Chapter 14 (D'Andrea & Daniels, 1999). The theories mentioned in this chapter offer us a beginning look at some of the more popular developmental theories.

■ *Applying Knowledge of Development*

Counselors can assist people of all ages in making smooth psychological transitions as they develop. For instance, a counselor who has knowledge of normative growth in children will be alerted to developmental lags, which can be caused by abuse, poverty, lack of parenting skills, genetics, biology, and other influences. In the areas of cognitive and moral development of children, knowledge of the developmental stages can give the counselor insight into the child's way of understanding the world and help identify stage-appropriate ways to work with children (McAuliffe, 2001). Similarly, knowing the predictable psychological pitfalls of adolescence can help counselors develop appropriate counseling skills, groups, and workshops to help youth through this often difficult time, making appropriate referrals when necessary.

Adult cognitive development models can offer counselors great insight into understanding how their clients construct reality and thus help them develop treatment plans that are appropriate to the client's developmental level. Also, such models can be used by school counselors and college student development specialists when trying to help teachers understand their students. These models can then be used to develop new ways of teaching students that are developmentally appropriate. Finally, adult cognitive development models can be used by mental health professionals as a possible alternative to some of the pathological models of development.

Cognitive development models have direct application to counselor training. Research reveals a strong positive relationship between level of adult cognitive development and the helper's ability to be empathic, nondirective, flexible, cognitively complex, nondogmatic, and to have an internal locus of control (Basseches, 1984; Benack, 1984, 1988; Eriksen & McAuliffe, 2006; Granello, 2002; Lovell, 1999; Neukrug & McAuliffe, 1993). By assessing their developmental levels, graduate students can examine potential weaknesses and strengths that they may bring with them to the counseling relationship. In addition, counselor educators can adapt their training practices to the developmental level of the student (McAuliffe & Eriksen, 2010).

Through knowledge of lifespan models and the stage-specific developmental issues that clients face, counselors can better comprehend the problems of clients and be less likely to pathologize normal developmental crises. When an issue of adjustment is found to be directly related to a current developmental crisis or unresolved issues from past developmental stages, counselors can devise appropriate strategies to help the client resolve the crisis.

Finally, knowledge of faith development can help counselors understand the values, images, and stories of our clients and help us fully appreciate their uniqueness. The felon and the model citizen, the child and the older person, individuals from diverse cultures and those from mainstream culture—all have been driven by values, images, and stories. Know these and you know your client. Know your client, and you are much more likely to develop effective treatment strategies.

■ *Comparison of Developmental Models*

The varying models of development we have looked at in this chapter offer differing dimensions to our understanding of the person. Some of these models looked at cognitive functioning, others at lifespan development, and still others at moral reasoning

and the development of faith. With some of the models, individuals will pass through all of the stages; in others, they may never reach the higher stages. Although all of the models are sequential (stages build upon stages), only some of the models are hierarchical, which implies that each stage is considered better than the previous stage. Figure 9.3 offers a visual comparison of the varying models we looked at in this chapter.

FIGURE 9.3
A Comparison of Developmental Models

Piaget
Sensorimotor (0–2)
Preoperational (2–7)
Concrete-operational (7–11)
Formal-operational (11–16)

Kohlberg/ Gilligan
Preconventional (2–9)
Conventional (9–18)
Postconventional (18–23)

Fowler
Primal (0–4)
Intuitive-Projective (4–6½)
Mythic-Literal (6½–8)
Synthetic-Conventional (12–)
Individuative-Reflective (18–)
Conjunctive (30–)
Universalizing (38–)

Erikson
Trust vs. mistrust (0–1)
Autonomy vs. shame and doubt (1–2)
Initiative vs. guilt (3–5)
Industry vs. inferiority (6–11)
Identity vs. role confusion (12–17)
Intimacy vs. isolation (18–35)
Generativity vs. stagnation (36–65)
Integrity vs. despair (66–)

Levinson
Childhood and adolescence (0–17)
Early adult transition (17–22)
Entering adult world (22–28)
Age 30 transition (28–33)
Settling down (33–40)
Midlife transition (40–45)
Entering middle adulthood (45–50)
Age 50 transition (50–55)
Culmination of middle adulthood (55–60)
Late adult transition (60–65)
Late adulthood (65–80)
Late, late adulthood (80+)

Kegan
Incorporative (0–1)
Impulsive (2–7)
Imperial (7–13)
Interpersonal (14–)
Institutional (16–)
Interindividual (40–)

Perry
Dualistic (9–16)
Transtion (16–)
Relativistic (18–)
Commitment in relativism (40–)

Birth   2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50 52 54 56 58 60 62 64 66 68 70 72 74 76 78 80

Note: The onset of certain stages can vary by several months in childhood and several years in adulthood, In fact, in many of the above developmental schemes, an individual may never reach the later stages of possible development. A dashed line represents the age range in which an individual could potentially attain a particular stage. A solid line represents the age range in which an individual is more likely to attain a particular stage.

Multicultural/Social Justice Focus

Bias in Developmental Models

Most of the models you have read about in this chapter were developed by White males, and perhaps even more alarming, most of their research was based on White males who grew up in the mid to late 1900s. Models that are based on the thinking of White males a good number of years ago does not make them wrong. However, one must pause and consider what the models might look like if they had taken into account differences based on social class, ethnicity, culture, and gender. And, might they change if we were to look at them today, as moors and values have changed? There is little doubt that we can gain something from the models in this chapter. But do they apply in the same way to all? As much as they might help us understand one client, perhaps they can hinder our understanding of another client who does not neatly fit into the demographic around which the models were created.

The Development of Cultural Identity

Like many characteristics, how we identify with our cultural or ethnic group can be explained as a developmental process. Thus, we can examine how we have grown and changed as men, as women, as gay, lesbian, or heterosexual men and women, as Blacks, Whites, or Asians, and so forth (Ponterotto, Casas, Suzuki, & Alexander, 2010). Cultural identity models assume there is a predictable progression through stages of development of cultural/ethnic consciousness. In Chapter 14, we will explore some of these models in detail.

In recent years, scholarship has increasingly examined the relationship between cultural identity, cross-cultural training, and perceived and actual counselor competence (Alvarez, & Piper, 2005; Farrell, 2009). And, as you might guess, it has been hypothesized that those who have a better sense of their own cultural identity are better equipped to work with clients who are from different cultures. Thus, it is imperative that as students of counseling you assess your cultural/ethnic identity. Counseling programs can assist students in examining themselves; but, ultimately, if we are to move toward an identity that embraces and effectively works with all cultures, each of us must be willing to explore our own cultural/ethnic identity.

Ethical, Professional, and Legal Issues

The ACA Code of Ethics: A Developmental Emphasis

The counseling profession today prides itself on having a positive, growth-oriented, developmental focus. This emphasis is reflected in the ACA *code of ethics*:

> *The American Counseling Association is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the life span. . .* (ACA, 2005, Preamble)

As a counselor, there is no doubt that you will come across and work with some clients whom you might consider to be abnormal, mentally ill, or, at the very least, a little out of the mainstream. We may even diagnose and label them, but we must always have respect for our clients' dignity and honor their unique developmental journey (Hansen, 2003). Through our caring, our knowledge of development, and our effective use of skills, we can help lift some of the burdens clients feel and assist them in their journey through life.

Professional Associations

Although the entire counseling profession has a developmental foundation, two divisions of ACA particularly focus on development across the lifespan: the Association for Adult Development and Aging (AADA), which publishes the journal *Adultspan*; and the Counseling Association for Humanistic Education and Development (C-AHEAD), which publishes the *Journal of Humanistic Counseling, Education, and Development*. If you have a particular interest in the knowledge of developmental theory, you might consider joining one or both of these divisions.

Legal Issue: Missing Problems Because We Are Too Positive

Psychiatrists, and some clinical psychologists, often get a reputation for being too oriented toward psychopathology. They tend to diagnose and label and this tunnel vision can sometimes prevent client growth. Counselors sometimes have the opposite problem. By seeing only the positive side of human nature, they may sometimes miss serious pathology, suicidal or homicidal thoughts, and deeply troubling feelings. A counselor who misses a serious problem can damage the counseling process and may even have some responsibility for a client's suicide or homicide. Clearly, this is tragic for all involved and can lead to malpractice suits.

Counselors must not be fearful of seeing the dark side of people. One can help a person look at his or her shadow and yet still have an optimistic view of the person. In fact, some would say that only through looking at one's darkest side can healing and growth occur.

▨ The Counselor in Process: Understanding Your Own Development

Recently, a friend of mine was telling me about a theory of development that, unlike Levinson, suggests that we are always in transition, and we never have periods of rest. Hmm, I thought to myself, that certainly feels like my life—it's kind of a roller coaster that sometimes moves fast and smoothly, while other times it feels like chugging along an uphill climb. Maybe there are short periods of rest, but they sure do seem to last only a moment or two. I guess I can either go along for the ride or get off. I think I'll keep moving. But maybe while on this roller coaster of life, I can do my best to make sure that the ride is as smooth as possible—kind of oil the wheels, make sure that I'm in the seat snugly, and get to know the person sitting next to me.

Our lives can be unexplored and bumpy, or, as we move along our unique paths, we can check ourselves out, look at the path ahead of us, and make sure that things are as even as possible. This, I believe, means exploring our own development.

It means examining the physical, social, and psychological forces that have impinged upon us and continue to affect us. It means looking at the developmental crises in our past that may still be impinging upon us, exploring the developmental phases we are currently experiencing, and thinking about where our future development might take us.

Knowledge of our own development increases our self-knowledge and helps us understand the ways in which we interact with others. But perhaps what is most important, understanding our own development helps us understand the relationships we form with our clients.

◼ *Summary*

In this chapter, we looked at development: child development, adult development, cognitive development, moral development, lifespan development, and the development of faith. We started by noting that development is continual, orderly and sequential, builds upon itself, painful yet growth-producing, transtheoretical, and preventive, optimistic, and wellness oriented. A developmental framework allows us to understand the common characteristics of people at different ages and stages, the typical problems experienced by people as they pass through the lifespan, the causes of some problems, and therapeutic strategies for change.

The chapter began by presenting an overview of development through the lifespan and particularly focused on some of the physical and associated psychosocial changes that occur in childhood, adolescence, and adulthood. It was noted that development occurs at fairly predictable rates, and a counselor or developmental specialist who is aware of physiological and psychological timetables can assess whether or not a person is on target for his or her development.

Within the chapter, we examined a number of developmental models. We started by looking at cognitive and moral development. We noted that Piaget examined how cognitive development unravels and identified a number of stages that he called sensorimotor, preoperational, concrete-operational, and formal-operational. He found that, as children move through these stages, there is an orderly progression that begins with the child's ability to maintain mental images and language skills, leads to the child's ability to think in a logical and orderly manner, and culminates in adolescence with the child's ability to think abstractly and in complex ways.

We next examined Kohlberg's theory of moral development, in which he identifies three levels of development called preconventional, conventional, and postconventional thinking. These stages reflect Kohlberg's belief that moral reasoning goes through a series of stages that move from extreme narcissism toward concern for democratic principles and personal conscience. We also made mention of Gilligan's argument that unlike men's moral development, which tends to be individualistically oriented, women's development includes a standard of care whereby women are concerned with how their choices affect others. Gilligan also found that adolescent girls will often lose their voice, but as grown women find it again.

Looking at adult cognitive development, we examined two theories: Kegan's theory of constructive development and Perry's theory of epistemological reflection. Both Kegan and Perry believe that we continually construct reality and that this occurs in stages, with

many individuals never having the opportunity to reach the higher stages of development. Although Kegan's stages span the life cycle, his theory is mostly applied to adult development. His stages are called incorporative, impulsive, imperial, interpersonal, institutional, and interindividual. Kegan believes that in adulthood, individuals move from a narcissistic position to a position of mutuality, to a place where the individual develops a strong sense of self, to the final position where the person is a complex thinker who can perceive situations from many perspectives, have a strong sense of self, and be able to hear feedback. Perry's theory, which focuses mostly on college students, mapped the potential changes of young adults as they move from being dualistic, black-and-white thinkers toward becoming relativistic people who can see differing perspectives. The highest stage for Perry is the person who is committed in relativism, epitomized by the person who can see varying perspectives yet has a strong commitment to specific values.

Lifespan development was another frame from which we examined the development of the person. Reviewing the theories of Erikson and Levinson, we noted that both offer age-specific stages through which all people must pass. Erikson's stages include trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair. Erikson suggested that through the stages individuals are faced with a task (sometimes called a crisis), and that each task can be syntonic (positive emotionally) or dystonic (negative emotionally). Balance between the two is critical. Levinson's theory identified four eras in the lives of men and women that include: childhood and adolescence, early adulthood, middle adulthood, and late adulthood. Levinson believed that each era is marked by transition and periods of stability and has its own unique tasks to master. Although men and women pass through the same eras and periods, the tasks they address within each of them will vary dramatically as a function of gender issues.

The final theory we examined was Fowler's model of faith development. Defining faith as a person's core values, the images of power that drive that person, and the stories that motivate the individual consciously and unconsciously, we stressed that Fowler's model is much broader than a religious focus on faith. Presenting six stages of faith development, Fowler suggests that the development of faith parallels many other developmental theories and moves from a rigid adherence to a point of view, toward a relativistic understanding of varying points of view, to an acceptance of and love for many different perspectives while simultaneously having one's own faith experience.

As the chapter zeroed in on multicultural and social justice issues, we noted that most of the theories were developed by White males in the 1900s and their research samples tended to be White males. Thus, we said that one must consider the efficacy of these theories with this in mind. We also noted that like many characteristics we examined, our identity with our cultural or ethnic group can be explained as a developmental process. We stressed the fact that if we are to work effectively with all clients, we must risk looking inward and gain an understanding of our own cultural/ethnic identity.

As we neared the end of the chapter, we highlighted the notion that the foundation of our profession is developmental and noted that ACA has two divisions that focus on development (AADA and C-AHEAD). This developmental focus stresses the dignity and growth of the client while discouraging labeling and diagnosing. While on the one hand this is our strength, we warned that at times this positive, future-oriented focus may make some counselors become too lax and miss a serious client problem.

This could have devastating effects and lead to ethical complaints and lawsuits against the counselor.

Finally, we stressed that knowledge of our own development can greatly assist us in understanding ourselves, the ways in which we interact with others, and the ways in which we form relationships with our clients.

◼ *References*

Alvarez, A., & Piper, R. (2005). Integrating theory and practice: A racial-cultural counseling model. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling, Vol. 2: Training and practice* (pp. 235–248). Hoboken, NJ: John Wiley & Sons.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling .org/Resources/CodeOfEthics/TP/Home/CT2.aspx

Ata, R., Ludden, A., & Lally, M. (2007). The effects of gender and family, friend, and media influences on eating behaviors and body image during adolescence. *Journal of Youth and Adolescence*, *36*(8), 1024–1037.

Basseches, M. (1984). *Dialectical thinking and adult development*. Norwood, NJ: Ablex.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1997). *Women's ways of knowing*. New York: Basic Books. (Original work published 1986)

Benack, S. (1984). Post-formal epistemologies and the growth of empathy. In M. Commons, F. A. Richards, & C. Armon (Eds.), *Beyond formal operations* (pp. 340–356). New York: Praeger.

Benack, S. (1988). Relativistic thought: A cognitive basis for empathy in counseling. *Counselor Education and Supervision, 27*(3), 216–232.

Blocher, D. (1988). Developmental counseling revisited. In R. Hayes & R. Aubrey (Eds.), *New directions for counseling and human development* (pp. 13–21). Denver: Love Publishing Company.

Brooks-Gunn, J., (2004). Intervention and policy as change agents for young children. In P. L. Chase-Lansdale, K. Kiernan, & R. J. Friedman (Eds.), *Human development across lives and generations: The potential for change* (pp. 293–342). New York: Cambridge University Press.

Chickering, A. W., & Reisser, L. (1993). *Education and identity* (2nd ed.). San Francisco: Jossey-Bass.

Choate, L., & Granello, D. (2006). Promoting student cognitive development in counselor preparation: A proposed expanded role for faculty advisers. *Counselor Education and Supervision, 46*(2), 116–130.

Cincotta, N. F. (2008). The journey of middle childhood: Who are "latency-age children?" In S. G. Austrian (Ed.), *Developmental theories through the life cycle* (2nd ed., pp. 79–122). New York: Columbia University Press.

Crandell, T. L, Crandell, C. H., & Vander Zanden, J. M. (2008). *Human development* (9th ed.). New York: McGraw-Hill.

D'Andrea, M., & Daniels, J. (1999). Exploring the psychology of White racism through naturalistic inquiry. *Journal of Counseling and Development, 77*(1), 93–101.

Di Leo, J. H. (1996). *Child development: Analysis and synthesis. New* York: Brunner/Mazel.

Encyclopedia of Black America. (1981). New York: McGraw-Hill.

Eriksen, K. P., & McAuliffe, G. J. (2006). Constructive development and counselor competence. *Counselor Education and Supervision, 45*(3), 180–192.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

Erikson, E. H. (1980). *Identity and the life cycle*. New York: Norton.

Erikson, E. H. (1982). The *life cycle completed*. New York: Norton.

Farrell, R. (2009). Developing a diverse counseling posture. In C. M Ellis & J. Carlson (Es.), *Cross cultural awareness and social justice in counseling* (pp. 45–60). New York: Routledge/Taylor & Francis Group.

Flavell, J. H. (1963*). The developmental psychology of Jean Piaget.* New York: Van Nostrand.

Fowler, J. W. (1976). Stages in faith: The structural-developmental approach. In T. C. Hennessy (Ed.), *Values and Moral Development* (pp. 173–211). New York: Paulist Press.

Fowler, J. W. (1991). The vocation of faith developmental theory. In J. W. Fowler, K. E. Nipkow, & F. Schweitzer (Eds.), *Stages of faith and religious development: Implications for church, education, and society* (pp.19–37). New York: Crossroad Publishing.

Fowler, J. W. (1995). *Stages of faith: The psychology of human development and the quest for meaning.* New York: Harper & Row. (Original work published 1981)

Fowler, J. W. (2000). *Becoming adult, becoming Christian: Adult development and Christian faith* (rev. ed.). San Francisco: Jossey-Bass.

Gerrig, R., & Zimbardo, P. G. (2010). *Psychology and life* (19th ed.). Upper Saddle River, NJ: Pearson.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Gilligan, C. (2008). *Kyra.* New York: Random House.

Gould, R. L. (1972). The phases of adult life: A study in developmental psychology. *American Journal of Psychiatry, 129,* 521–539.

Gould, R. L. (1978). *Transformations: Growth and change in adult life.* New York: Simon & Schuster.

Granello, D. H. (2002). Assessing the cognitive development of counseling students: Changes in epistemological assumptions. *Counselor Education and Supervision, 41,* 279–293.

Granello, D., Kindsvatter, A., Granello, P., Underfer-Babalis, J., & Moorhead, H. (2008). Multiple perspectives in supervision: Using a peer consultation model to enhance supervisor development. *Counselor Education and Supervision,* 48(1), 32–47.

Haley, A. (2001). *The autobiography of Malcolm X.* London, UK: Penguin.

Hansen, J. T. (2003). Including diagnostic training in counseling curricula: Implications for professional identity development. *Counselor Education and Development, 43,* 96–107.

Inhelder, B., & Piaget, J. (1958). *The growth of logical thinking: From childhood to adolescence.* New York: Basic Books.

Kegan, R. (1982). *The evolving self.* Cambridge, MA: Harvard University Press.

Kegan, R. (1994). *In over our heads.* Cambridge, MA: Harvard University Press.

King, P. M. (1978). William Perry's theory of intellectual and ethical development. In L. Knefelkamp, C. Widick, & C. L. Parker (Eds.), *Applying new developmental findings* (pp. 34–51). San Francisco: Jossey-Bass.

Kohlberg, L. (1963). The development of children's orientations towards a moral order. I. Sequence in the developmental of moral thought. *Vita Humana,* 6, 11–33.

Kohlberg, L. (1981). The *philosophy of moral development: Moral stages and the idea of justice.* San Francisco: Harper and Row.

Kohlberg, L. (1984). *The psychology of moral development: The nature and validity of moral stages.* San Francisco: Harper & Row.

Levinson, D. (1978). *The seasons of a man's life.* New York: Alfred A. Knopf.

Levinson, D. L. (1996). *Seasons of a woman's life.* New York: Alfred A. Knopf.

Loevinger, J. (1976). *Ego development.* San Francisco: Jossey-Bass.

Lovell, C. (1999) Empathic-cognitive development in students of counseling. *Journal of Adult Development,* 6(4), 195–203.

Magolda, M. B., & Porterfield, W. D. (1988). *Assessing intellectual development: The link between theory and practice.* Alexandria, VA: American College Personnel Association.

McAuliffe, G. (Ed.). (2001). *Working with troubled youth in schools: A guide for all school staff.* Westport, CT: Bergin & Garvey.

McAuliffe, G., & Eriksen, K. (Eds.) (2010). *Handbook of Counselor Preparation*. Thousand Oaks, CA: Sage and Alexandria, VA: Association for Counselor Education and Supervision.

Muro, J. J., & Dinkmeyer, D. C. (1977). *Counseling in the elementary schools: A pragmatic approach*. Dubuque, IA: William C. Brown.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development*, 86(4), 482–493.

Neukrug, E., & McAuliffe, G. (1993). Cognitive development and human service education. *Human Service Education*, *13*(1), 13–26.

Newton, P. (1994). Daniel Levinson and his theory of adult development: A reminiscence and some clarifications. *Journal of Adult Development, 1*(3), 135–137.

Parker, S. (2009). Faith development theory as a context for supervision of spiritual and religious issues. *Counselor Education and Supervision*, 49(1), 39–53.

Perry, W. G. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. New York: Holt, Rinehart, & Winston.

Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.

Ponterotto, J. G., Casas, J. M., Suzuki, L.A., & Alexander, C. M. (Eds.) (2010). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage.

Puma, M., Bell, S., Cook, R., Heid, C., Shapiro, G., Broene, P., & Jenkins, F. (2010). *Head Start impact study. Final report*. Retrieved from ERIC database. (ED507845)

Rice, F. P. (2001). *Human development: A life-span approach* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

Ripley, J., Jackson, L., Tatum, R., & Davis, E. (2007). A developmental model of supervisee religious and spiritual development. *Journal of Psychology and Christianity*, 26(4), 298–306.

Roberts, M. C., Brown, K. J., Johnson, R. J., & Reinke, J. (2005). Positive psychology for children: Development, prevention, and promotion. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 663–675). New York: Oxford University Press.

Santrock, J. W. (2008). *Life-span development* (12th ed.). Boston: McGraw Hill.

Santrock, J. W. (2009). *A topical approach to life-span development* (5th ed.). Boston: McGraw Hill.

Schneider, W., & Bullock, M. (2009). *Human development from early childhood to early adulthood: Findings from a 20 year longitudinal study*. New York: Psychology Press.

Sheehy, G. (1976). *Passages: Predictable crises of adult life*. New York: Bantam Books.

Stearns, S. C., & Allal, N., & Mace, R. (2008). Life history theory and human development. In C. Crawford & D. Krebs (Eds.), *Foundations of evolutionary psychology* (pp. 47–70). New York: Lawrence Erlbaum, Associates.

Stoltenberg, C. D., McNeil, B. W., & Delworth, U. (1998). *IDM supervision*. San Francisco: Jossey-Bass.

Super, D. E., Savickas, M. L., & Super, C. M. (1996) Life-span, life-space approach to careers. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed., Chapter 5). San Francisco: Jossey-Bass.

Vaillant, G. E. (1977). *Adaptation to life*. Boston: Little, Brown.

Widick, C. (1977). The Perry scheme: a foundation for developmental practice. *The Counseling Psychologist, 6*(4), 35–38. doi:10.1177/001100007700600415

Abnormal Development, Diagnosis, and Psychopharmacology

My second job after obtaining my master's degree was as an outpatient therapist at a community mental health center. Suddenly, I was working closely with clinical psychologists and psychiatrists. I had a caseload that included a number of clients with serious emotional disorders, and every time I conducted an intake interview, I was required to follow up with a consultation with the psychiatrist. Invariably, the psychiatrist wanted me to talk diagnosis and clinical terms I had never considered or learned about in school or in past jobs. I had to catch up quickly. However, part of me didn't want to do it, because I really didn't believe in making a diagnosis. I had to use this book called the *Diagnostic and Statistical Manual-II* (DSM-II) that had descriptions of the various emotional disorders. It soon became my bible.

I rather quickly learned about making diagnoses, and I didn't find it half bad. It helped me categorize clients, which seemed to help organize my thinking about them. It helped me understand which medications might be appropriate for specific disorders. And it sometimes helped me in treatment planning. However, I was still doubtful. A part of me thought, "Is this real, or are we making up these categories? And maybe diagnosing these people increases the likelihood that they'll remain ill, like a self-fulfilling prophecy. We see them that way, we label them that way, and they become that way." Most of all, it bothered me when some of the other clinicians would smugly say things like, "Oh, he's borderline, he can't act any other way."

It's quite a few years later now, and I hope I've become a little more sophisticated about psychopathology and diagnosis. However, whenever I listen to someone diagnosing another, there's still a part of me that asks, "Is this real?" I believe this is a healthy part of me and is reflective of the history of our profession—a profession that has, in the past, balked at the use of diagnosis and the concept of "abnormal behavior" or psychopathology. On the other hand, maybe there is something to categorizing behavior and using diagnosis. I would hope that I could understand psychopathology, reap the possible benefits of using diagnosis, and continue to have a healthy, questioning attitude.

*I*n this chapter, we will examine abnormal development, diagnosis, and psychophar-macology. We will start by examining reasons each of them may be important and examine the close relationships among them. We will then describe the development of abnormal behavior (interchangeably called "psychopathology" in this chapter) from genetic and biological, psychodynamic, learning theory, humanistic and post-modern perspectives. This discussion will be followed by an overview of the *Diagnostic and Statistical Manual-IV-TR* (DSM-IV-TR; DSM-5 in 2013), the current diagnostic sys-tem used in the United States and throughout much of the rest of the world. We will also offer a brief overview of many of the psychotropic medications currently used in the treatment of various disorders. As usual, the chapter will offer some perspectives from a multicultural/social justice focus, discuss some relevant points related to ethi-cal, professional, and legal issues, and conclude with a comment about the "counselor in process."

Why Study Abnormal Development, Diagnosis, and Medication?

John is in fifth grade and has been assessed as having a conduct disorder and attention deficit hyperactivity disorder (ADHD). John's mother has a panic disorder and is tak-ing antianxiety medication. His father is bipolar and taking lithium. Jill is John's school counselor. It is written into John's individualized educational plan (IEP) that he should see Jill for individual counseling and for group counseling. Jill must also periodically con-sult with John's mother and father.

Tenesha is a sophomore in college. She has just broken up with her boyfriend, is severely depressed, and cannot concentrate on her schoolwork; her grades have dropped from A's to C's. She comes to the counseling center and sobs during most of her first ses-sion with her counselor. She admits having always struggled with depression but states that, "This is worse than ever; I need to get better if I am going to stay in school. Can you give me any medication to help me so I won't have to drop out?"

Eduard goes daily to the day treatment center at the local mental health center. He seems fairly coherent and generally in good spirits. He has been hospitalized for schizo-phrenia on numerous occasions and now takes Abilify to relieve his symptoms. He admits to Jordana, one of his counselors, that when he doesn't take his medication he believes that computers have consciousness and are conspiring through the World Wide Web to take over the world. His insurance company pays for his treatment. He will not receive reimbursement from his insurance company unless Jordana specifies a diagnosis on the insurance form.

With evidence that over one-fourth of Americans have a diagnosable mental dis-order within any year (Kessler, Chiu, Demler, & Walters, 2005), regardless of where you are employed, you will be working with clients who (1) have serious emotional problems that are sometimes labeled as abnormal behavior or as an emotional disorder, (2) have been given or are in need of a diagnosis for treatment purposes and/or for legal reasons, and (3) are taking or in need of medication. Although controversy exists about defining abnormality, developing a diagnosis, and using psychotropic medications

(Eriksen & Kress, 2005; Hansen, 2003; Madesen & Leech, 2007), all counselors today deal with these issues. This has not always been the case.

Counselor educators and counselors have historically had a disdain for diagnosing and labeling and have at times opposed the use of psychotropic medication (Eriksen & Kress, 2005; Hansen, 2003). In fact, within counseling programs, learning about psychopathology (the development of mental disorders) was practically unheard of until recently (Hansen, 2003). The reasons for this were many. First, the early history of the counseling profession was largely influenced by the humanistic approaches to counseling, which downplayed the notion of abnormal development, the role of diagnosis, and the use of medication. This influence also led to counseling professionals believing that training in psychopathology and diagnosis would lead counselors to stigmatize individuals unduly. In addition, many counselors and counselor educators believed that counselors should be working with "normal" individuals and in a preventive and wellness role. They felt that the role of the counselor should be to focus on normal developmental issues and the positive side of human nature, not on psychopathology. Recently, however, many counseling programs have included in their curriculum a focus on psychopathology, diagnosis, and psychopharmacology (Hansen, 2003). There are many reasons for this change:

1. Counselors in all specialty areas are increasingly working with clients who are severely disturbed.
2. In contrast to past years, when most graduates from counseling programs obtained jobs in schools where they less frequently encountered individuals with serious emotional disorders, a large portion of graduates now work in community agencies, often with individuals with mental illness.
3. Federal and state laws (e.g., PL94-142, IDEA) now require that students with severe emotional disorders be serviced in the schools. Thus, today's school counselor is more likely to be dealing with students with severe emotional problems.
4. Many licensing boards require knowledge of diagnosis and psychopathology for counselors to obtain a license.
5. Today, many counselors need to know diagnostic procedures if they are to receive reimbursement from insurance companies.
6. Society has become more tolerant of individuals with emotional problems and mental disorders, and there is less stigmatizing of individuals with diagnoses.
7. A diagnostic system offers clinicians a common language with which to discuss client issues.
8. There has been a retreat by some from the rigid adherence to a philosophy that all mental illness is a social construction.
9. Diagnosis can sometimes be helpful in the development of treatment plans, and treatment plans sometimes may include the use of medication.
10. There is a growing body of evidence that our biology contributes to, and in some cases may even determine, some forms of mental illness.
11. Some people get better with medication, and we now understand that we had best not throw out the baby with the bathwater (the concepts of abnormal behavior and diagnosis are inextricably tied to the use of medications).

You Can't Have One without the Other: Abnormal Behavior, Diagnosis, and Medication

What comes to your mind when you ponder the word "abnormal?" Most people probably think of something unnatural or out of the norm, as the word itself suggests. When applied to a clinical situation, abnormality entails an infrequent and unusual emotional, cognitive, or behavioral response:

> *Patterns of emotion, thought, and action deemed pathological for one or more of the following reasons: infrequent occurrence, violation of norms, personal distress, disability or dysfunction, and unexpectedness.* (Kring, Davison, Neale, & Johnson, 2007, Glossary, p. 1)

No doubt, at moments in our lives we have all seen or experienced what might be considered abnormal behaviors, thoughts, or feelings. If one experiences these on an ongoing basis, then they become the norm for the individual, but are deviations from what is considered usual or normal in the culture. As a species, when we observe deviations from the norm, we tend to want to understand them and classify them. This is what diagnosis does. It is a classification of thoughts, feelings, or behaviors that deviate from the norm. Classification systems, such as those found in the *Diagnostic and Statistical Manual* (APA, 2000), offer clinicians a mechanism for understanding how some individuals deviate from more typical behavior. In addition, if you can classify individuals into different categories, you can research which treatment strategies, including the use of medications, will best apply to each diagnostic category. For instance, research has shown that psychoanalytic therapy is probably not the best type of therapy for a person who has an obsessive–compulsive disorder, whereas this used to be the treatment of choice!

Today, there is less controversy about the concept of abnormality, with most clinicians believing that the development of mental disorders is the result of a complex interaction of genetic, biological, sociological, and psychological factors. We may and probably should argue about the term abnormal, but no matter what you call it, there are individuals who exhibit some types of behavior that deviate from the norm. We may and probably should argue that diagnosis is stigmatizing, but there are individuals who are helped because of adequate diagnoses and subsequent treatment plans. And we probably should argue about the overuse of medication, but it is now clear that some people are helped, and even miraculously changed, by taking medication.

Personality Development and Abnormal Behavior

A number of models of personality development offer us an understanding of "abnormal behavior," sometimes simply referred to as the development of mental disorders (psychopathology). In this section, we will examine five such models, including the genetic and biological model that assumes that there are inherited factors that, when expressed, will show certain personality traits; the psychoanalytic model that proposes a relationship between psychosexual stages of development and abnormal behavior; the learning perspective that views abnormal behavior as the result of learned dysfunctional behaviors and

faulty cognitions; the humanistic approach, which stresses the importance of the relationship with significant others in the development of personality variables; and the postmodern and social constructionist approach that views reality as a function of language used in a person's social milieu and questions the whole assumption of abnormality.

Genetic and Biological Explanations of Development

> *It is not about nature versus nurture, as that old cliché would have it. It is about nature-on-nurture-on-nature-on-nurture, round and round and round.* (Baker, 2004, p. 28)

Genetics, which is the science of hereditary characteristics, is a subset of *biology*, which is the science of life. Biology therefore includes genetic factors, but genetics does not include all biological factors. For instance, if we say that biological factors can affect the development of intelligence in children, we are referring to such things as prenatal care, nutrition, exposure to toxins, hormonal changes, genetics, and so forth. However, when we assert that genetics can affect the development of intelligence in children, we are referring to how the expression of genes, not other factors, can affect cognitive ability.

The *nature-versus-nurture* debate as it relates to personality formation has a long and turbulent history and continues today. However, the schisms among genetic determinists, environmental advocates, and intrapsychic zealots are clearly much less than ever before. This is partially because the concept of *heritability* has changed, with genes no longer being seen as deterministically causing behavior. Today's views of genetics assume that in most cases there are *complex environmental influences* on the action of genes (Neukrug, 2001; Duncan, 2005; Krueger, Johnson, & Kling, 2006). For instance, after an extensive review of the literature, Clark and Watson (2008) note that genetics and the individual's unique experiences both play an essential role in the expression of personality traits. They go on to remark that "it is largely through gene–environment interactions that each individual's unique personality develops" (p. 277).

The linking of biology, including genetics, with environmental factors in the development of personality moves the counseling profession toward an approach that is truly holistic. Understanding the intricate interaction among these variables can be very powerful in the effective use of counseling. Clinicians in today's world should no longer be shy about consulting experts familiar with genetics and biology as these efforts can help provide the most broadly based treatment for their clients.

Which emotional disorders are most likely to be biologically based? Conduct a literature review, and you'll find research that suggests that most mental disorders have some genetic basis. However, the actual expression of those disorders is complex, and for any individual a disorder only gets expressed if a number of genes are turned on by environmental influences at specific times (Krueger et al., 2006; Clark & Watson, 2008). Thus, the old idea that one gene determines a specific mental disorder is no longer believed to be true:

> *The vast majority of mental disorders are believed to be polygenic: health problems occur when disease-related alleles are inherited for many different genes. Most mental disorders also are multifactorial, which means that multiple environmental and genetic factors are operating in an intricate, epigenetic fashion to upset the stable development and functioning of cells.* (Baker, 2004, p. 63)

Finally, it would seem to make intuitive sense that if a disorder has some genetic or biological basis, one might consider using biological interventions in addition to psychotherapy. Biological interventions can be defined broadly to include such things as stress reduction, exercise, how we eat, how we sleep, the amount of light we receive, psychopharmacology, and so forth. All of these factors, in some manner, affect one or more major biological systems and can affect our mood positively or negatively. Although the use of medication to alleviate symptoms has shown efficacy across a wide range of mental disorders (National Institute of Mental Health, 2010), some still consider their use controversial, noting that most medications have side effects, some potentially devastating ones, and the relative effectiveness of some medications are still questioned (Murray, 2006).

Freud's Model of Psychosexual Development

As we remember from Chapter 4, Freud believed that we are born with sexual and aggressive instincts that unconsciously affect our behaviors throughout life. He identified a *structure of personality* that includes the *id*, the depository of all of our instincts; the *ego*, the development of the rational part of our mind; and the *superego*, which constitutes the moral part of our mind. Freud believed that infantile sexuality is an expression of instinctual body urges associated with different pleasurable bodily functions. Based on these *erogenous zones*, Freud identified stages of development through which each individual will pass. How the erogenous zones are satisfied is related to ego and superego development and the mental health of the individual (Neukrug, 2011).

Born all id, the infant is immediately thrust into the first stage of psychosexual development, the *oral stage*, in which pleasure is received through feeding. The hungry infant wants to be fed, and his or her main goals are to obtain pleasure through feeding and to reduce stress caused by hunger and lack of tactile stimulation received through the mouth. The major developmental task of this stage, which occurs between birth and 1½, is how the child becomes attached to the mother (or the major caretaker) as a function of feeding. This early relationship affects later personality characteristics, including mistrust of others, difficulty in forming close relationships, dependency needs, aggression, greediness, acquisitiveness, and sarcasm (Appignanesi & Zarate, 2006; Corey, 2009). From this perspective, one can see how abusive or neglectful parenting can lead to pathological behavior.

During the *anal stage*, the child receives pleasure from bowel movements, and the child's instinctual urges become focused on the anal erogenous zone. This stage, which occurs between ages 1½ and 3, is distinguished by a child's physiological readiness to be toilet trained. The main function of this stage is for the child to develop his or her capacity to retain or evacuate, which becomes a metaphor for the child's ability to master his or her impulses. The parents' attempts at introducing the idea that there are socially appropriate behaviors (the prototype being using the potty) are significant in the development of the child's ego and superego. However, defecating is pleasurable, and the child resists interference with this pleasurable experience. Consequently, the child becomes embroiled in a battle of control, independence, power, and doing the socially correct thing (Hall, 1954/1999). Ultimately, the child has to learn how to control his or her feelings of aggression, housed in the id, and does so by the development of the ego, which learns to deal

rationally with the world, and through the use of *defense mechanisms*, which are now being spawned in an effort to have the child restrain murderous impulses (see Chapter 4).

Parental attitudes about defecation, cleanliness, control, and responsibility have a major effect on personality development. For instance, strict parents may have children who retaliate and aggress against them and grow into adults who have little respect for authority, and are irresponsible, messy, disorderly, extreme, and controlling of others. On the other hand, some children with punitive and strict parents may assume their parents were right and become adults who are extremely neat, fastidious, compulsive about orderliness, disgusted by and fearful of dirt, and generally exhibit over-controlled behavior (Hall, 1954/1999). You might say that these individuals are constipated in their relationship to the world.

In contrast, parents who extensively praise children for their ability to go to the potty can lead them to have an exaggerated sense of self. As adults, these individuals may make things to please others or may be generous, philanthropic, charitable, and maybe even gravitate toward the helping professions! On the other hand, too much emphasis on toilet training may leave the child feeling he or she has lost something when defecating, ultimately leading toward a sense of depression and anxiety of future losses. These individuals become *fixated* upon the erotic pleasure of defecating and may become adults who have a strong desire to collect and possess things (e.g., hoarders), or, in a defensive posture, these individuals may respond in the opposite way by becoming reckless, gambling, and giving away possessions.

In the third stage of development, the *phallic stage*, which occurs from ages 3 to 5, the erogenous zone again shifts, this time to the child's genitals. Here, the child becomes aware of pleasurable feelings associated with touching his or her genitals and receives pleasure from self-stimulation. The types of permission parents give the child in this stage can greatly affect the child's attitudes and values and are crucial in the development of the individual's superego.

During this stage, an *Oedipus* or an *Electra complex* is awakened as instinctual urges emerge related to the child's wish to possess the opposite-sex parent and eliminate the same-sex parent. However, the child soon realizes this is not achievable, and the subsequent guilt as a result of the child's attempts to possess the opposite-sex parent is resolved by the child developing a sense that everything in life is not attainable, identification with the same sex parent, and an understanding that we must live responsibly in the world. Thus, this stage is crucial for the development of the nature of attachments to significant men and women in one's life, the identification with masculinity or femininity, and the development of the superego. The values learned in this stage are stored in the superego, which is reflected in who we are as parents and shapes the morality of our social system. Imagine the kinds of behaviors an adult might exhibit if his or her parents were extremely permissive or strict during this stage!

The *latency stage*, ages 5 through puberty, is a period of relative relaxation for the child where he or she replaces earlier sexual feelings with a focus on socialization. Here the child becomes more aware of peers, and there is increased attention placed on peer-related activities. Freud's final stage of development, the *genital stage*, begins at puberty and continues through the lifespan. Sexual energy, in this stage, is focused on social activities with peers and on love relationships. During this stage, we discover whether earlier stages of development were resolved adequately, as the adult's behavior will reflect unresolved

issues from the earlier stages. These issues will often be cloaked by defense mechanisms but can generally be deduced through analysis.

As reflected in the above, parenting behaviors through the developmental stages affect the formation of the ego and superego and establish the precarious balance among the id, ego, and superego:

> *Thus the ego—driven along by the id, held back by the superego, repulsed by reality—struggles to master its economic task of creating harmony among the forces and influences acting within it and upon it: and we understand why we are so often unable to stop ourselves from crying out: "Life is so difficult!"* (Freud, 1940/2003, pp. 71–72)

Ultimately, how the id, ego, and superego impinge on our lives, unconsciously and to a lesser degree consciously, determine the individual's level of health or dysfunction. Our defense mechanisms, created to ward off anxiety resulting from tension among the id, ego, and superego, give us a peek into our early development and the kinds of parenting that we received.

Conclusion

Freud was quite specific in his description of disorders and their roots, with the oral, anal, and phallic psychosexual stages holding the potential for the later development of dysfunctional behavior. However, some of these assertions have not held up under research. Despite this fact, the basic core of his theory remains tenable. For instance, the concept that development occurs as we pass through a series of erogenous zones and that early parenting can affect personality formation is considered, at the very least, to be an important factor in understanding emotional disorders. Also, the role of unconscious impulses has remained an important concept for most therapists in their understanding of behavior. Finally, the idea that we can explore our early development and examine how it has affected our personality style is important in almost all counseling approaches. Whether or not one agrees with most of what Freud conceptualized, it is clear that the lens through which counselors and others view the developing person has been greatly affected by the psychoanalytic view of development.

Learning Theory and the Development of the Person

> *The child is born empty of psychological content into a world of coherently organized content. Like a mirror, however, the child comes to reflect his environment; like an empty slate he is written upon by external stimuli; like a wax table he stores the impressions left by these stimuli; and like a machine he may be made to react in response to stimulating agents.* (Langer, 1969, p. 51)

This radical quote, reflecting early behavioral thought, shows the rigid views that many learning theorists held about the development of the person. Drastically differing with Freud's notion on instincts, B. F. Skinner and other early learning theorists believed that "the most important causes of behavior are environmental and [that] it only confuses the matter to talk about inner drives" (Nye, 2000, p. 80). However, the vast majority of

learning theorists today have a much broader view of development, with many now believing that genetic factors, cognitive structures, and even intrapsychic forces play a role in personality development (Neukrug, 2011). However, the basic core of this nonstage theory is still learning theory.

As we learned in Chapter 4, learning theorists believe that individuals learn behaviors through *operant conditioning*, *classical conditioning*, or *modeling* (*social learning*) and therefore place emphasis on how *positive or negative reinforcement*, *models*, and the pairing of an *unconditioned stimulus* with a *conditioned stimulus* affect our personality development (Bandura, Ross, & Ross; 1963; Skinner, 1971; Wolpe, 1969). Operant conditioning is generally considered to be the most common type of conditioning and occurs when behavior is reinforced, thus increasing the probability of that response occurring again. Over the years, through rigorous research, Skinner and others delineated many principles of operant conditioning, each of which is crucial to the shaping of behaviors and the development of personality. A small portion of these include:

1. *Positive reinforcement:* Any stimulus that, when presented following a response, increases the likelihood of that response.
2. *Negative reinforcement:* Any stimulus that, when removed following a response, increases the likelihood of that response.
3. *Punishment:* Applying an aversive stimulus to decrease a specific behavior. Punishment is often an ineffective method of changing behavior as it may lead to undesirable side effects (e.g., counteraggression).
4. *Schedules of reinforcement:* The numerous ways in which a stimulus can be arranged to reinforce behavior; based on elapsed time and frequency of responses.
5. *Discrimination:* The ability of a person to respond selectively to one stimulus but not respond to a similar stimulus.
6. *Generalization:* The tendency for stimuli that are similar to a conditioned stimulus to take on the power of the conditioned stimulus.
7. *Extinction:* The ceasing of a behavior because it is not reinforced.
8. *Spontaneous recovery:* The tendency for responses to recur after a brief period of time after they have been extinguished.

Skinner and other learning theorists maintain that reinforcements often occur very subtly and in ways that we may not immediately recognize (Nye, 2000; Skinner, 1971; Wolpe, 1969). Therefore, things like changes in voice intonation, subtle glances, TV shows that appeal to us, or body language could subliminally affect our personality development. They note that by examining a situation closely enough, one could attain an understanding of the types of reinforcement contingencies that were instrumental in shaping an individual's behavior.

Over the years, many learning theorists have included a cognitive framework within their conceptualization of development. Such cognitive therapists as Albert Ellis (Ellis & Harper, 1997), Michael Meichenbaum (1977), and Aaron Beck (J. Beck, 1995; 2005) believe that not only do behaviors of individuals become reinforced, but so do the ways in which people think. Therefore, thinking can dramatically affect behavior, and behavior can dramatically affect thinking in a complex interaction. Cognitive-behaviorists have challenged the beliefs of the original behavioral purists and have changed the manner in which most learning theorists conceptualize the development of the individual.

Because abnormal development is seen as a result of *reinforcement contingencies*, learning theorists believe that change can occur at any point in the life cycle. Therefore, one can identify dysfunctional behaviors and irrational thinking, determine which reinforcers continue dysfunctional ways of living in the world, and devise methods of reinforcing new behaviors and different cognitions.

Summarizing some of the major factors that can lead to healthy or abnormal development, modern-day learning theorists believe:

1. The individual is born capable of developing a multitude of personality characteristics.
2. Behaviors and cognitions are continually reinforced by significant others and by cultural influences in our environment.
3. Reinforcement of behaviors and cognitions is generally very complex and can occur in very subtle ways.
4. Abnormal development is largely the result of the kinds of behaviors and cognitions that have been reinforced (other factors such as genetics may also affect development). By carefully analyzing how behaviors and cognitions are reinforced, one can understand why an individual exhibits his or her current behavioral and cognitive repertoire.
5. Through the application of principles of learning, old dysfunctional behaviors can be extinguished and new healthy behaviors can be learned.

Conclusion

Learning theory offers a unique, objective, straightforward method of understanding personality development. Maladaptive behavior is believed to be the result of dysfunctional behaviors and faulty cognitions that are conditioned, sometimes in very subtle ways. Because maladaptive behavior is believed to be at least partly learned, it can be unlearned and new functional behaviors can be adopted. Thus, modern-day learning theorists generally have an optimistic view of the person in that they believe people can change their way of living in the world. Today's behaviorists, therefore, have an antideterministic view of human nature in that they believe people can use reinforcement contingencies and biological interventions (e.g., medication) to become better human beings.

The Humanistic Understanding of Personality Development

The humanistic approaches that have probably had the most impact on our understanding of the development of the individual have been the *person-centered approach* of Carl Rogers (1951) and Abraham Maslow's *hierarchy of needs* (1943, 1968, 1970). Rogers's and Maslow's ideas are in stark contrast to the views of psychoanalysts and the learning theorists:

> *I think it is now possible to be able to delineate this view of human nature as a total, single, comprehensive system of psychology even though much of it has arisen as a reaction against the limitations (as philosophies of human nature) of the two most comprehensive psychologies now available: behaviorism (or associationism) and classical, Freudian psychoanalysis. . . . In the past I have called it the "holistic-dynamic."* (Maslow, 1968, p. 189)

Maslow stated that people have what he called a hierarchy of needs, with lower-order needs having to be satisfied before the next need on the hierarchy can be assimilated (see Figure 10.1). This has great implications for understanding the motivations of individuals. For instance, by examining Figure 10.1 we can see that an individual who is hungry or in need of shelter probably has little ability to focus on the needs of love and belonging; the individual who feels unloved and does not have some sense of a social support will necessarily have lowered self-esteem; and so forth. The highest need to be satisfied, stated Maslow, was *self-actualization*, in which one has the desire to become self-fulfilled and to live out the person one actually is. Individuals who are self-actualized are in touch with their feelings, have high self-worth, are alive and spontaneous, and have developed a sense of their spirituality. Although Rogers's theory is not hierarchical, on many occasions he stated his support for the ideas of Maslow and implied that an individual who is given a nurturing environment would develop according to Maslow's hierarchy (Kirschenbaum, 2009).

Rogers believed that individuals are born good and have a natural tendency to actualize and obtain fulfillment if placed in a nurturing environment that includes *empathy*, *congruence*, and *unconditional positive regard*. Unlike Freud, Rogers did not emphasize the importance of instincts, the unconscious, or developmental stages in the formation of personality development. Unlike Skinner, Rogers did not place much value on reinforcement contingencies in creating the personality of the individual. In fact, during 1960s, Rogers and Skinner did a series of debates that highlighted their differences. One such difference was Rogers's strong belief that the quality of the relationship between the child

FIGURE 10.1
Maslow's Hierarchy of Needs

Self-Actualization
Self-fulfillment,
Potentiality,
True Self

Self-Esteem Needs
Respect, Recognition, Attention,
Admiration, Approval, Appreciation

The Love and Belonging Needs
Affection, Friendships, Significant Other,
Sexual Intimacy, Group Affiliation, Social Support

Safety Needs
Psychological safety,
Physical safety

Physiological Needs
Air, Hunger, Thirst,
Sex, Shelter

and his or her major caretakers is one of the most significant factors in personality development (Rogers, 1951, 1957, 1959, 1980).

Rogers believed that we all have a need to be loved. He stated that significant people in our lives often place upon us *conditions of worth* or expectations about the ways we should act if we are to receive their love. Therefore, as children we will sometimes act in ways to please others in an effort to obtain a sense of acceptance, even if the pleasing self is not our real self. In essence, the child has learned that by acting in an *incongruent* or *nongenuine* fashion, he or she will receive acceptance. This nongenuine way of living then becomes the way of relating to the world and prevents the person from becoming self-actualized, becoming one's true self. This is when our self-actualizing tendency is thwarted.

Rogers would not have used the term abnormal. He felt strongly that this term and others like it are stigmatizing and not accurate. He believed that all dysfunctional behaviors were the result of individuals having conditions of worth placed upon them that would eventually result in disengagement from self. In fact, he believed this response to conditions of worth was a natural reaction to an unhealthy environment. The story of Ellen West epitomizes this kind of response to an untenable situation, with unfortunate results (see Box 10.1).

Conclusion

The humanistic approach downplays, and in many cases challenges, the concept of abnormality. Instead, so-called abnormal behavior is seen as an attempt by reductionist and dispassionate clinicians to objectify and isolate the client. If we call the individual abnormal, we take away his or her humanness and no longer need to deal with the person. In fact, humanists would say that abnormal behavior is a healthy response to an unhealthy situation. In other words, abnormal behavior is the individual's attempt to survive in a world that places conditions of worth on the person. What is abnormal, say the humanists, is the attempt to call something abnormal that is actually natural.

BOX 10.1

The Story of Ellen West

As described by Rogers (1961), Ellen West was a client who underwent psychotherapy by a number of well-known nonhumanistically oriented therapists (a client Rogers knew about but never saw himself). Rogers noted that Ellen felt that she had to follow her father's wishes (conditions of worth) and not marry the man whom she loved. Consequently, she disengaged herself from her feelings by overeating and becoming quite obese. A few years later, she again fell in love but instead married a distant cousin due to pressure from her parents. Following this marriage, she became anorectic, taking 60 laxative pills a day, again as an apparent attempt to divorce herself from her feelings. She saw numerous doctors, who gave her differing diagnoses, treated her dispassionately, and generally denied her humanness. Eventually, disenchanted with her life, Ellen West committed suicide.

This story, Rogers noted, gives a poignant view of what it's like to lose touch with self—to be incongruent. As Ellen West felt she needed to gain the conditional love of her parents, she gave up the most valuable part of self—her "real" self. This led to a life filled with self-hate and a sense of being "out of touch." Eventually, she was viewed by therapists as mentally ill, which Rogers implied might have added to her feelings of estrangement and her eventual suicide.

Post-Modernism and Social Constructionism's View of Development

Post-modernism has sometimes been defined as the questioning of *modernism*, which states that truth could ultimately be uncovered and that underlying structures are responsible for shaping how one comes to understand the world. Post-modern therapists, such as Michael White and David Epston, suggest that much of what has been handed to us as "truth" by the modernists is only the modernist's particular "take" on reality. Therefore, counselors who act in an "objective" manner and assume there are certain inherent mechanisms that lead a person down a path toward a particular personality style have become entrenched in believing that particular truth. *Social constructionism* views knowledge and truth as something that is constructed through conversations (Gergen, 1985, 2009; Rudes & Guterman, 2007). Fitting comfortably alongside post-modernism, this philosophy suggests that language used and the discourses we have with others are key factors in the development of reality. In other words, nothing is fixed. Freedman and Combs (1996) suggest four premises that summarize post-modernism and social constructionism: *realities are socially constructed*, *realities are constituted through language*, *realities are organized and maintained through narrative*, and *there are no essential truths*.

Because language creates reality through discourse, the major responsibility of a counselor would be to recognize that the language he or she uses will likely impact the client (as will the client's language likely impact the counselor). Therefore, the counselor must carefully choose his or her words knowing the influence of language on the person. In fact, *not* saying certain things will reinforce existing ways of being for the client. Also, because reality is constantly changing and a function of language, it is assumed that one can never fully know the inner world of another, "all one can know is the verbal expressions of another's experiences" (Rudes & Guterman, 2007, p. 388). For post-modernists and social constructionists, even the idea of an "inner world" is seen as a cultural by-product, not something that necessarily exists. From this perspective it would make sense to question any counselor who states he or she knows the client's inner world as a result of understanding the functioning of some hypothesized inner structures (e.g., id, ego, super-ego; incongruent vs. congruent self, self-actualization, etc.). Hypothetically, what I say is the color blue may be someone else's red, and what I say is depression may be experienced differently by another, and what I say is happiness also may be experienced differently by another (see Box 10.2).

Conclusion

You can see that the post-modern and social constructionist approaches turn the concept of abnormality on its head. From their perspective, abnormal behavior is simply a social construction—a construct that has been developed by certain individuals within the helping professions who have tended to be in power (e.g., psychiatrists) and have subtly, but forcefully pushed their viewpoint onto the rest of the mental health field. They also believe that through dialogue and new knowledge, people can build new constructions of their sense of self.

One might wonder how the field of counseling could have been enhanced if, in the early 1950s when the DSM was first published, the American Counseling

BOX 10.2

Color Therapy

Imagine there was a counseling approach that stated color preference was an indication of mental health, and the closer a person's favorite color was to "red," the healthier he or she was. Those that liked red most were very healthy, those that liked orange were pretty healthy, those that liked yellow were somewhat healthy, and so forth down the spectrum to green, then blue, and then those who liked violet, who were really unhealthy. Now imagine that this approach became so popular that it was accepted throughout the land and most people "know" that color preference is related to mental health.

Now, imagine a client sees a counselor who is a "Color Counselor." Naturally, one of his first questions is to ask the client what her favorite color is. She says "blue." Well, immediately, the counselor assumes the client is not mentally healthy. After all, blue is way down the list toward violet. So, the counselor begins to treat her and tries to change her favorite color. He even has a systematic way of having her work up the hierarchy toward red. If she practices the system every day, she will eventually get closer to red, says the counselor. After a few months, she has worked her way up to green, and the counselor says he thinks that she might want to consider taking some medication, for medication will help her experience the red more often. And, the counselor

tells her that after a few years of experiencing more red, she can try to reduce her medication because maybe she can begin to like red on her own.

Frustrated that she is not making progress fast enough, the client decides to see a new counselor. The new counselor is clearly non-conventional and does not even believe in Color Therapy. She asks the client to tell her what her problem is. The client states "Well, everyone says that liking blue is bad, and so I must be mentally ill. What do you think?" This counselor replies by saying, "How about we don't focus on the color right now. Instead, let me ask you: What do you want your life to look like? Where do you want to take therapy? What do you want as your end goal? And, what would make you happier?"

With counselor number one, there is an external reality based on preconceived notions about colors. And, this reality has been bought into by many. In fact, a whole system of working with clients has been developed. And, almost everyone "knows" and believes in this approach. The second counselor, however, does not have these preconceived ideas, and indeed even questions the moral authority that asserts that this reality exists. This counselor does not believe there are any internal structures that mediate mental health based on color. This counselor is the post-modern, social constructionist counselor!

Association (then the American Personnel and Guidance association) had published a complementary diagnostic framework, perhaps a "Manual of Client Core Issues" (MCCI). This diagnostic guide would not have focused on symptoms of pathology but rather on psychosocial and relational formulations of client struggles that tend to be problematic. . . . (Halstead, 2007, pp. 6–7)

Comparison of Models

Table 10.1 shows a comparison of the five models we examined. Each approach offers a unique perspective on the development of the person. Today, attempts have been made to integrate many of these approaches. To view a more in-depth description of these models (with the exception of the biological model) see Chapter 4.

T A B L E 10.1

Comparison of How Different Models View Psychopathology				
	BIOLOGICAL	PSYCHOANALYTICAL	LEARNING THEORY	HUMANISTIC	POST-MODERN/ SOCIAL CONSTRUCTIONIST
DEVELOPMENTAL FOCUS	Traits exhibited at varying times based on our biological timetable; other traits we are born with.	Psychosexual stages of development are oral, anal, phallic, latency, and genital.	Learning occurs from birth and people can continue to learn throughout the lifespan.	Maslow's hierarchy may loosely be considered developmental with no age parameters. People are capable of moving toward self-actualization.	Not a developmental focus, although there is a belief that people can change over time
DEVELOPMENTAL STAGES/ MAJOR THEMES	Traits are a function of multiple genes as the person interacts with the environment over one's lifespan.	Psychosexual stages. Structure of personality: id, ego, superego. Unconscious. Instincts. Defenses.	Reinforcement contingencies. Schedules of reinforcement. Learning/relearning. Generalization. Discrimination. Recently: Intervening cognitions.	People are born with an actualizing tendency optimized by empathy, unconditional positive regard (UPR), and genuineness. Conditions of worth are sometimes placed on people. The need to be regarded can lead to an inability to actualize self.	Reality is socially constructed through language and organized and maintained through narratives. There are no essential truths.
DEVELOPMENT OF HEALTHY SELF	Traits may be a function of the draw of the cards (genes). Environment can affect biology and ultimately development of healthy self (e.g., prenatal care).	Early healthy parenting is crucial, as is ability to master psychosexual stages and suitable development of id, ego, and superego.	Reinforcement of specific behaviors and/ or thoughts will lead to a healthy sense of self.	Conditions in environment need to be conducive for the individual to expose his or her true self. Conditions include empathy, UPR, genuineness. The true self is always healthy.	The concept of a "healthy self" is a construction, as there is no "one" healthy self. Individuals define what is healthy or unhealthy for themselves.
TREATMENT	Genetic engineering, healthy environment, care of body, and medication.	Psychodynamic therapy, long-term treatment, and resolution of unresolved conflicts.	Identifying problem behaviors, setting goals, and using behavioral and cognitive change strategies.	Exposure to environment that will be conducive to development of one's true self (can be through therapy).	Help people see how they have constructed their reality and invite them to construct a new reality that works more effectively for them.

■ *Diagnosis and Mental Disorders: What Is DSM-IV-TR?*[1]

Derived from the Greek words *dia* (apart) and *gnosis* (to perceive or to know), the term diagnosis refers to the process of making an assessment of an individual from an outside, or objective, viewpoint (Segal & Coolidge, 2001). Although attempts have been made to classify mental disorders since the turn of the century, it was not until 1952 that the American Psychiatric Association (APA) published the first comprehensive diagnosis system, called the *Diagnostic and Statistical Manual* (DSM-I). Although DSM-I had many critics, and was indeed a crude effort at a diagnostic system, it did represent the first modern-day attempt at the classification of mental disorders. The DSM has been revised numerous times over the years to its current edition, the DSM-IV-TR (DSM-5 is due out in 2013). This version, which is a distant cousin of the original DSM-I, offers explicit ways of determining a diagnosis and presents a five-part multiaxial diagnostic system (APA, 2000). Although the DSM-IV-TR has its critics and supporters (see Table 10.2), it has become the most widespread and accepted diagnostic classification system of mental disorders (Eriksen & Kress, 2005; 2006; 2008; Halstead, 2007; Kress et al., 2005; Madesen & Leech, 2007; Seligman, 2004).

The DSM-IV-TR offers five axes to assist in diagnosis and treatment of mental disorders. Although many clinicians do not use all five axes, a good number will find two or more of the axes useful. Axis I describes "Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention," Axis II delineates "Personality Disorders and Mental Retardation," Axis III explains "General Medical Conditions," Axis IV describes "Psychosocial and Environmental Problems," while Axis V offers a "Global Assessment of Functional" (GAF) scale.

TABLE 10.2

Advantages and Disadvantages of DSM	
DISADVANTAGES	**ADVANTAGES**
1. Does not predict outcomes of counseling 2. Does not examine etiology 3. Use can reinforce counselor's tendency to use a medical model of treatment 4. Does not fully account for contextual and social factors 5. Can lead to labeling and stigmatization of client 6. Can be dehumanizing to client 7. Fosters an objective view of client and minimizes the counseling relationship 8. Problems with the "scientific" evidence supporting diagnostic categories	1. Can help with case conceptualization 2. Proper diagnosis can lead to good treatment planning including proper use of medication 3. Facilitates communication among professionals 4. Fosters research on diagnostic categories 5. Helps client understand their emotional problems 6. Offers a model to test hypotheses concerning treatment outcomes 7. Provides a sense of what is "normal" for most people 8. Provides a forum for professionals to discuss nomenclature and treatment

[1] Much of this section is paraphrased from DSM-IV-TR (APA, 2000). If you are reading this book after DSM-5 has been published in 2013, you may want to discuss how DSM-IV-TR differs from the new DSM-5.

The use of the five axes underscores one of the most important aspects of the DSM-IV-TR classification system: to describe and communicate with other professionals who are familiar with the system in an effort to enhance agreement and improve the sharing of information among clinicians about the client picture they are observing (Neukrug & Schwitzer, 2006). In addition, a diagnosis can help a clinician determine the primary focus of counseling. For example, a focus on a mood problem might be dealt with very differently from a focus on somatic complaints; similarly, a focus on an adjustment problem is dealt with very differently from a focus on problems related to long-term life patterns, such as with a personality disorder. Determining the focus can assist the clinician when deciding which interventions might be most useful. Although all five axes can be helpful in determining the kind of intervention, the first two axes focus specifically on the kind of disorder involved and are generally most important in determining treatment plans.

Axes I and II: The Mental Disorders

The first two axes of DSM-IV-TR offer a wealth of information on specific mental disorders, including (1) the disorder's main features, (2) subtypes and variations in client presentations, (3) the typical pattern, course, or progression of symptoms, and (4) how to differentiate the disorder from other, similar ones. DSM-IV-TR also provides findings about predisposing factors, complications, and associated medical and counseling problems, when they are known, and it does not hypothesize about etiology of a disorder when information is not known. Thus, using DSM-IV-TR categories and descriptors allows clinicians to describe clients and communicate with mental health colleagues while being able to apply their own theoretical orientation to the treatment planning process (Jongsma & Peterson, 2003; Seligman, 2004).

It should be noted that the DSM-IV-TR system is only used to share information about a very small set of human behavior or experience: those conditions that meet the "mental disorder" definition. From a diagnosis standpoint, the vast majority of human behavior does not meet the definition of "mental disorder" (APA, 2000; Schwitzer & Everett, 1997). It should also be remembered that many of those individuals that meet the definition of having a mental disorder live a rather normal life in many, if not most, ways. The following very brief overview defines the mental disorders in Axis I and II and summarizes hundreds of pages of information from Axis I and Axis II of DSM-IV-TR. For an in-depth review of the disorders, please see DSM-IV-TR (APA, 2000).

Axis I Disorders: "Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention."

This axis includes all disorders except those classified as personality disorders or as mental retardation (Axis II disorders). Generally, Axis I disorders are considered treatable in some fashion, and are often reimbursable by insurance companies as a function of mental health or related services. These disorders are described below.

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE. The disorders in this section are generally found in childhood; however, at times individuals are not diagnosed with the disorder until they are adults. Particularly important for school counselors, the disorders include learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, feeding and eating disorders of infancy or early childhood, tic disorders, elimination disorders, and other disorders of infancy, childhood, or adolescence.

DELIRIUM, DEMENTIA, AMNESTIC, AND OTHER COGNITIVE DISORDERS. Delirium, dementia, and amnestic disorders are all cognitive disorders that represent a significant change from past cognitive functioning of the client. All of these disorders are caused by a medical condition or a substance (e.g., drug abuse, medication, allergic reaction).

MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION. This diagnosis is made when a mental disorder is found to be the result of a medical condition and includes catatonic disorder, personality change, and mental disorder not otherwise specified. Other disorders that may at times be the result of a medical condition are listed under the following specific diagnostic categories: delirium, dementia, amnestic disorder, psychotic disorder, mood disorder, anxiety disorder, sexual dysfunction, and sleep disorder.

SUBSTANCE-RELATED DISORDERS. A substance-related disorder is a direct result of the use of a drug or alcohol, the effects of medication, or exposure to a toxin. These substances include alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine (PCP), sedatives, and hypnotics.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS. All disorders classified in this section share one thing in common: psychotic symptomatology as the most distinguishing feature. The disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified.

MOOD DISORDERS. The disorders in this category share a common feature: mood disturbances of the depressive, manic, or hypomanic type. The mood disorders are divided into five broad categories: depressive disorders, bipolar disorders, mood disorder due to a general medical condition, substance-induced mood disorder, and mood disorders not otherwise specified.

ANXIETY DISORDERS. There are many types of anxiety disorders, each with its own discrete characteristics. They include panic attacks, agoraphobia, panic disorder with or without agoraphobia, agoraphobia without history of panic disorder, specific phobia, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder,

generalized anxiety disorder, anxiety disorder due to a general medical condition, substance-induced anxiety disorder, and anxiety disorder not otherwise specified.

SOMATOFORM DISORDERS. Somatoform disorders are characterized by symptoms that would suggest a physical cause. However, no such cause can be found, and there is strong evidence that links the symptoms to psychological causes. Seven somatoform disorders include somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriases, body dysmorphic disorder, and somatoform disorder not otherwise specified.

FACTITIOUS DISORDERS. As opposed to somatoform disorders, which describe individuals who believe that their physical symptoms have a physiological etiology, factitious disorders describe individuals who intentionally feign physical or psychological symptoms in order to assume the sick role. Two subtypes include factitious disorder with predominantly psychological signs and symptoms and factitious disorder with predominantly physical signs and symptoms.

DISSOCIATIVE DISORDERS. Dissociative disorders occur when there is a disruption of consciousness, memory, identity, or perception of the environment. Five dissociative disorders are dissociative amnesia, dissociative fugue, dissociative identity disorder (formerly called multiple personality disorder), depersonalization disorder, and dissociative disorder not otherwise specified.

SEXUAL AND GENDER IDENTITY DISORDERS. This section includes disorders that focus on sexual problems or identity issues related to sexual issues. They include sexual dysfunctions, paraphilias, gender identity disorders, and sexual disorder not otherwise specified.

EATING DISORDERS. These disorders focus on severe problems with the amount of food intake by the individual that can potentially cause serious health problems or death. They include anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified.

SLEEP DISORDERS. These disorders have to do with severe sleep-related problems and are broken down into four subcategories: primary sleep disorders, sleep disorder related to another mental condition, sleep disorder due to a general medical condition, and substance-induced sleep disorder.

IMPULSE CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED. Impulse control disorders are highlighted by the individual's inability to stop him- or herself from exhibiting certain behaviors. They include intermittent explosive disorder, kleptomania, pyromania, pathological gambling, trichotillomania, and impulse-control disorder not otherwise specified.

ADJUSTMENT DISORDERS. Probably the most common disorders clinicians see in private practice, adjustment disorders are highlighted by emotional or behavioral symptoms that arise in response to psychosocial stressors. The subtypes of this diagnosis include adjustment disorders with depressed mood, with anxiety, with mixed anxiety and depressed mood, with disturbance of conduct, with mixed disturbance of emotions and conduct, and unspecified.

Axis II Disorders: "Personality Disorders and Mental Retardation."

Axis II diagnoses tend to be long-term disorders in which treatment almost always has little or no effect on changing the presenting symptoms of the individual. The two kinds of Axis II disorders are mental retardation and personality disorders.

MENTAL RETARDATION (NOTE: TO BE CHANGED TO "INTELLECTUAL DISABILITY" IN DSM-5). Characterized by intellectual functioning significantly below average (below the 2nd percentile) as well as problems with adaptive skills, mental retardation can have many different etiologies. There are four categories of mental retardation: mild mental retardation (IQ of 50–55 to approximately 70), moderate mental retardation (IQ of 35–40 to 50–55), severe mental retardation (IQ of 20–25 to 35–40), and profound mental retardation (IQ below 20 or 25).

PERSONALITY DISORDERS. Individuals with a personality disorder show deeply ingrained, inflexible, and enduring patterns of relating to the world that lead to distress and impairment. Such an individual may have difficulty understanding self and others, may be labile, have difficulty in relationships, and have problems with impulse control. Personality disorders are generally first recognized in adolescence or early adulthood and often remain throughout one's lifetime. There are three clusters of personality disorders, with each cluster representing a general way of relating to the world.

- *Cluster A* includes paranoid, schizoid, and schizotypal personality disorder. Individuals with these disorders all exhibit characteristics that may be considered odd or eccentric by others.
- *Cluster B* disorders include the antisocial, borderline, histrionic, and narcissistic personality disorders. Individuals suffering from these disorders are generally dramatic, emotional, overly sensitive, and erratic.
- *Cluster C* includes the avoidant, dependent, and obsessive-compulsive personality disorders. Common characteristics found within this cluster are anxious and fearful traits.

Axis III: General Medical Conditions

Axis III provides the clinician the opportunity to report relevant medical conditions of the client. If the medical condition is clearly related to the cause or worsening of a mental disorder, then the medical condition is noted on Axis I and listed on Axis III. If the medical condition is not a cause of the mental disorder but will affect overall treatment of the individual, then it is listed only on Axis III. An example of an Axis III medical condition that could be a cause of an Axis I diagnosis would be the development of hypothyroidism that causes an anxiety disorder. In this case, on Axis I the anxiety disorder due to a general medical condition is noted, and on Axis III the specific medical condition is listed. The *International Classification of Diseases*, Ninth Revision (ICD-9-CM), an abbreviated form of which is found in the DSM-IV-TR, is used to code the Axis III medical condition. Axis I uses the DSM-IV-TR classification and includes a reference to the medical condition.

Axis I: Anxiety Disorder Due to a General Medical Condition (293.84)
Axis III: Hypothyroidism, acquired (244.9)

On the other hand, if an individual has a sleep disorder and subsequently develops acute prostatitis (infection of the prostate) that worsens, but did not cause, the sleep disorder, it would be written as:

Axis I: Narcolepsy (347)
Axis III: Prostatitis (618.9)

If there is no Axis III diagnosis, then a notation of "Axis III: None" is included in the diagnosis.

Axis IV: Psychosocial and Environmental Problems

Psychosocial or environmental problems that affect the diagnosis, treatment, and prognosis of mental disorders as listed on Axes I and II are noted on Axis IV. Generally, such problems will only be listed on Axis IV, but in those cases where it is believed that such stressors may be a prime cause of the mental disorder, a reference should be made to them on Axis I or II. General categories of psychosocial and environmental problems include the following: problems with one's primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, and problems related to interaction with the legal system/crime. An example of an Axis IV diagnosis might include:

Axis IV: Job Loss.

Axis V: Global Assessment of Functioning (GAF)

Axis V is a scale used by the clinician to assess the overall functioning of the client and is based on the psychological, social, and occupational functioning of the client. The GAF *scale* describes behaviors, in 10 point increments from 0 to 100, that range from very severe dysfunction to superior functioning, and a score of 0 means there is inadequate information to make a judgment (see Table 10.3). In giving a GAF rating, the clinician can report current functioning, the highest functioning within the past year, or any other relevant GAF ratings based on the uniqueness of the situation.

Making a Diagnosis

The DSM-IV-TR offers *decision trees* to assist the clinician in differential diagnosis. Thus, if one is considering two or more diagnoses that share similar symptoms, the decision tree walks the clinician through a series of steps designed to assist in choosing the most appropriate diagnosis. This is particularly important because the eventual diagnosis chosen affects treatment planning and choices of psychotropic medication. It is possible to have more than one Axis I and Axis II diagnosis, and in those cases, the additional diagnoses should be reported. A typical multiaxial assessment may look something like the following:

Axis I: Adjustment Disorder with Depressed Mood (309.0)
Axis II: Avoidant Personality Disorder (301.82)
Axis III: No Diagnosis
Axis IV: Divorce
Axis V: GAF = 60 (current); 75 (highest in past year)

Text not available due to copyright restrictions

A diagnosis can be critical to the determination of whether one is to recommend the use of psychotropic medication. Let's take a look at this sometimes important adjunct to counseling.

Psychopharmacology

Whether or not medication should be used as an adjunct to counseling and how one broaches this possibly delicate topic with clients are increasingly important issues for the counselor and other mental health professionals (Ingersoll, 2000; Preston, O'Neal, & Talaga, 2010). If counselors are to make informed decisions about a referral for medication, they should know the pros and cons of their usage (see Table 10.4) and should have some basic knowledge about psychotropic medications (Preston et al., 2010). With a host of possible medications available (see Kalat, 2009; Schatzberg & Nemeroff, 2009), the following represents a brief overview of some of the more commonly used psychotropic drugs. Although classification systems of psychotropic drugs vary, almost all systems describe medications in most or all of the following five groups: *antipsychotics, mood-stabilizing drugs, antidepressants, antianxiety agents*, and *stimulants* (National Institute of Mental Health, 2010; Preston et al., 2010; Videbeck, 2011). Let's take a look at each of these.

Antipsychotics

During the early 1950s, the first wave of antipsychotic drugs was discovered (Nasrallah & Tandon, 2009). These were soon to dramatically change the field of mental health. For the first time, individuals with severe psychotic symptoms could be treated with some success; this became one reason for the release of hundreds of thousands of individuals from mental institutions around the country.

TABLE 10.4

Advantages and Disadvantages of Psychotropic Medications	
ADVANTAGES OF MEDICATION	*DISADVANTAGES OF MEDICATION*
- Efficacy of medication use is easily studied - If they work, medications can help quickly - The quick response of medications can instill hope - The quick response of medication can lead to more effective work in therapy - The quick response of medication can reduce the likelihood of a serious mental illness (e.g., schizophrenia) occurring again - Medication may help some people that psychotherapy won't help - Sometimes, medications are more cost effective than psychotherapy - Due to their biological basis, some mental disorders can only be treated by medication	- Only counseling can address the complexity of the human condition - Counseling leads to autonomy, drugs lead to dependence - The quick effects of medications lessen the desire for clients to work on their problems - Most psychotropic medications have some side effects - The effects of some psychotropic medications are serious and long-lasting - Research on the effects of some psychotropic medications are mixed and confusing - Psychotropic medications do not solve life's problems, only the individual can do this

TABLE 10.5

Antipsychotic Medications			
CONVENTIONAL ANTIPSYCHOTICS		**2ND GENERATION ANTIPSYCHOTICS**	
GENERIC NAME	*TRADE NAME*	*GENERIC NAME*	*TRADE NAME*
Chlorpromazine	Thorazine	Clozapine	Clozaril
Haloperidol	Haldol	Risperidone	Risperdal
Thioridazine	Mellaril	Olanzapine	Zyprexa
Trifluoperazine	Stelazine	Quetiapine	Seroquel
Fluphenazine	Prolixin	Ziprasidone	Geodon
Perphenazine	Trilafon	Aripiprazole	Abilify
Thiothixene	Navane		
Loxapine	Loxitane		
Molindone	Moban		

Antipsychotic drugs, sometimes called *neuroleptics*, are generally used for the treatment of schizophrenia, as well as schizoaffective disorders, and the manic phase of bipolar disorder (Videbeck, 2011). Less frequently, these drugs are used in the treatment of Alzheimer's disease, aggressive behavior, and anxiety and insomnia. There are three broad classes of antipsychotic drugs that include the *conventional antipsychotics*, the *atypical antipsychotics*, and the new, *2nd generation antipsychotics* (Patterson, Albala, McCahill, & Edwards, 2006; Videbeck, 2011). Some of the classic antipsychotic and 2nd generation drugs used in these disorders are listed in Table 10.5.

Antipsychotics can dramatically alter the course of an individual who is having an acute psychotic episode. This is important, because the quicker an individual can recover from a psychotic episode, the greater the likelihood of eliminating or at least decreasing the intensity of future psychotic episodes. Although antipsychotic medications can help an individual who has a long history of psychotic behavior live a more normal life, they are often not a cure. For these individuals, normal cognitive functioning is often not restored, and they are frequently left seeming somewhat stilted in their thinking and ability to respond.

Depending on the type and dosage of medication, a number of side effects may occur. For instance, some individuals may have one or more of the following side effects:

- *Anticholinergic side effects* include dry mouth, blurred vision, constipation, urinary retention, decreased memory, and a decreased libido;
- *Extrapyramidal side effects* (EPS) include muscle spasms, Parkinson-type symptoms, and motor restlessness;
- *Tardive dyskinesia*, which includes involuntary movements of the tongue, lips, and facial muscles, can occur in some individuals who have taken high dosages of antipsychotic medications over a long period of time, although it has occasionally been seen when the medications are taken for short periods in lower doses;
- *Blood disorders*, which can lead to death if not treated, have been found with some of the newer antipsychotic medications;
- *Other effects*, such as a fast heartbeat, rigidness, agitation, sedation, weight gain, and skin pigmentation.

Mood-Stabilizing Drugs

During the 1800s, an element called *lithium* was discovered that was found to have positive effects for the treatment of a number of bodily afflictions (Freeman, Wiegand, & Gelenberg, 2009). In the early 1950s, lithium was rediscovered as an effective treatment for bipolar disorder (then called manic-depression). Lithium seems to act particularly well in lessening the effects of manic symptoms in an individual with bipolar disorder. Because it does not have the same dramatic effects with the depressive end of the illness, antidepressants are often also prescribed. For individuals who take lithium, the level of drug in the system has to be assessed through a blood test, because too much lithium can cause severe side effects and too little will be ineffective in treatment. Like the antipsychotics, lithium can produce a number of side effects including gastrointestinal problems, excessive thirst, excessive urination, hand tremors, a metallic taste, fatigue, lethargy, and mild nausea; however, the side effects are generally viewed as less serious than those with the antipsychotic medications. Although lithium has been used in the treatment of other disorders (Freeman et al., 2009), generally it is often an early treatment of choice for bipolar disorder.

Lithium has been shown to be a very effective drug for the treatment of bipolar disorder, often restoring an individual to a normal lifestyle. However, some individuals do not respond to treatment with lithium. For those individuals, a number of other drugs have shown some success, including *anticonvulsant medications* such as Depakote and Tegretol (Freeman et al., 2009; Patterson et al., 2006). In addition, some *benzodiazepines* (antianxiety drugs) may also be helpful in treating manic episodes (McElroy & Keck, 2009).

Antidepressants

The use of *amphetamines* during the 1930s was one of the first attempts to treat depression psychopharmacologically (Pirodsky & Cohn, 1992). Known as "speed," this medication did little except to temporarily stimulate a person's central nervous system, which often would eventually lead to a "crash" and more serious depression. In addition, consistent use of amphetamines can lead to paranoia and health problems.

The 1950s saw a dramatic shift in the treatment of depression with the identification of two classes of antidepressants called *monoamine oxidase inhibitors* (MAOIs) and *tricyclics* (Krishnan, 2009; Nelson, 2009). Until recently, these classes of drugs were the medications of choice in the treatment of depression, with the tricyclics being used more frequently because they tended to have fewer side effects. However, the last twenty years have seen the widespread use of a new class of antidepressants called selective *serotonin reuptake inhibitors* (SSRIs) (Videbeck, 2011). The *SSRIs* have been called miracle drugs by some due to their limited side effects and often dramatic results. In fact, these drugs have been so effective that there is some evidence that they can help make an individual who already feels relatively well feel even better. For these reasons, such drugs as Prozac, Luvox, Paxil, Lexapro, Celexa, and Zoloft have very quickly become commonplace in American society. However, in recent years some have argued that these drugs increase the risk for suicide, especially in children (Fergusson et al., 2005). As a result, warnings have been given to individuals taking these medications. In addition to the treatment of depression, SSRIs also show promise in treating other disorders, including obsessive–compulsive disorder, panic disorder, some forms of schizophrenia, eating disorders, alcoholism, obesity, and some sleep disorders.

Besides the SSRIs, there are a number of what have been called *atypical anti-depressants* that also have fewer side effects than the tricyclics or the MAOIs and seem to be promising in the treatment of depression. Some of these include Serzone, Effexor, Wellbutrin, and Desyrel.

Antianxiety Medications

The use of modern-day antianxiety agents started with the discovery of Librium, which came on the market in 1960 and was soon followed by Valium. These medications and other *benzodiazepines* were better tolerated and less addictive than barbiturates (e.g., phenobarbitol), the previous treatment of choice (Sheehan & Raj, 2009). However, tolerance of and dependence on benzodiazepines can be developed, and there is a potential for overdose on these medications.

Today, benzodiazepines, such as Valium, Librium, Tranxene, Xanax, and others, are frequently used for generalized anxiety disorders as they have a calming effect on the individual (Videbeck, 2011). In conjunction with psychotherapy, these medications can be an effective agent in treating such disorders. Benzodiazepines have also been shown to be helpful in reducing stress, relieving insomnia, and managing alcohol withdrawal (Nishino, Mishima, Mignot, & Dement, 2009). In addition, they have been used in conjunction with some antidepressants for the treatment of obsessive–compulsive disorder (OCD) and in treating social phobias and post-traumatic stress disorder (Sheehan & Raj, 2009). Two other *nonbenzodiazepines*, Buspar and Gepirone, have been found to be effective for use in generalized anxiety disorders and can be an alternative to the the more popular benzodiazepines. In addition, these drugs show some efficacy in the treatment of depression, especially with those who are exhibiting anxiety disorders (Robinson, Rickels, & Yocca, 2009).

Stimulants

Probably the first modern-day stimulant used to treat emotional disorders was *cocaine*, which was first discovered in the mid-1800s. However, due to its addictive qualities, cocaine has never become a treatment of choice in this country. In 1887, *amphetamines*, which had many of the same stimulant qualities of cocaine but were less addictive, were synthesized (Ballas, Evans, & Dinges, 2009; Fawcett & Busch, 1998). Over the years, amphetamines were used, mostly unsuccessfully, as diet aids, as antidepressants, and to relieve the symptoms of sleepiness. However, during the 1950s amphetamines were found to have a *paradoxical effect* in many children diagnosed with *attention deficit disorder* (ADHD), in that they seemed to calm them down and help them focus. Today, the use of stimulants in the treatment of attention deficit disorder is widespread, with the three most common drugs being Ritalin, Cylert, and Dexedrine. In addition to treating attention deficit disorder, stimulants have also been found to be successful in the treatment of *narcolepsy* and are somewhat successful in treating residual attention deficit disorder in adults.

Psychopharmacology has come a long way since the 1950s when the first modern-day psychotropic medications were introduced. Increasingly, the medications used for a wide array of disorders are more effective and have fewer side effects than in the past. As the mechanism for psychological disorders becomes increasingly understood, new and

even more effective medications can be developed to target the underlying physiological mechanism causing the disorder.

▪ *Multicultural/Social Justice Focus*

The Misdiagnosis of Underrepresented Groups

Because people from diverse cultures may express themselves in different ways, symptomatology may differ as a function of culture (Mezzich & Caracci, 2008). Thus, some have argued that although diagnosis can be helpful in treatment planning, it can lead to the misdiagnosis of culturally oppressed groups because it does not fully take into account differences. Others have noted that DSM-IV-TR tends to diagnose from an individual perspective and does not account for the effects of the broader system on the individual.

In addition, mental health practitioners are primed by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to diagnose client problems as mental disorders that reside in the individual and largely to ignore the external forces that can produce and exacerbate psychological problems (Atkinson, 2004). An even more radical view held by some is that a diagnosis is a way of legitimizing socially unacceptable behavior, thus giving those in positions of power the ability to legally oppress the culturally different (Eriksen & Kress, 2005; 2006; 2008; Halstead, 2007; Horwitz, 2002; Kress et al., 2005; Madsen & Leech, 2007). In fact, Szasz (1970) years ago warned that the "aim of psychiatric classification [diagnosis] is to degrade and socially segregate the individual as a mental patient . . . and the creation of a class of justifiably persecuted scapegoats" (p. 239). With up to 80% of counselors being White (American Counseling Association, 2009), counselors must be trained in culturally sensitive diagnosis so they will not allow their own biases and inherent views of the world to taint how they view clients from other cultures.

DSM-IV-TR's Attempt to Address Cross-Cultural Issues

Although many of the criticisms of the current DSM are justified, it was constructed with much greater attention to issues of age, gender, socioeconomic status, and culture than were past editions. For example, age differences in symptoms are often acknowledged, such as the notation that major depression is associated with increased withdrawal in children, over-sleeping in adolescents, and cognitive problems like memory loss in older adults. Along the same lines, relevant gender-specific information about prevalence and symptoms is provided. For example, the clinician is alerted that bipolar disorders are equally common among men and women, unlike major depression, which is diagnosed more commonly among women, or obsessive-compulsive disorder, which is diagnosed more commonly among men. Similarly, differences in prevalence according to socioeconomic status are described for some diagnoses.

Other cultural differences also are highlighted in the DSM, such as the fact that clients from diverse backgrounds present depression in varying ways. For instance, somatic complaints, such as headaches among Latinos and fatigue and weakness among Asians, are symptoms that could be representative of depression more frequently in these cultural

groups than in others. In addition, the DSM-IV-TR has included a section called the *Glossary of Culture-Bound Syndromes* that includes 25 syndromes specific to some cultures that could be falsely mistaken for any of a number of diagnoses found in DSM-IV-TR. For example, nervios is included as a common type of stress disorder among Latinos, and includes symptoms of emotional distress, nervousness, tearfulness, and bodily complaints. And, consider the term *koro*, also highlighted in the DSM-IV-TR:

> A *term, probably of Malaysian origin, that refers to an episode of sudden and intense anxiety that the penis (or in females, the vulva and nipples) will recede into the body and possibly cause death*. . . . (APA, 2000, p. 900)

Finally, in DSM-IV-TR, expected reactions or culturally appropriate responses to life events are not diagnosable as mental disorders, even when they cause distress in the client's life. For instance, while counseling may focus on the grief process following the loss of a loved one, a diagnosis of major depression usually is not made even when the person experiences major depression criteria such as extreme sadness, insomnia, or poor concentration during the first two months following the loss. Or, identity confusion in adolescence, which is often associated with distress about long-term life goals, relationships, and values, is viewed as a normal, expected experience and not diagnosed as a mental disorder.

Despite the fact that DSM-IV-TR has clearly gone further than past diagnostic manuals in its attempt to address cross-cultural issues, there are many who still consider the DSM-IV-TR to be culture-bound and biased against minorities (Horwitz, 2002; Kress, Eriksen, Rayle, & Ford, 2005; Madsen & Leech, 2007; Mezzich et al., 1999). Thus, one should carefully consider the background of the client when making a diagnosis and the impact such a diagnosis would have on the client.

◾ *Ethical, Professional, and Legal Issues*

Ethical Issues

Noting the potential misuse and abuse of diagnosis, the code of ethics of the American Counseling Association (ACA) addresses a number of important issues when making a diagnosis (ACA, 2005, Standard E.5: Diagnosis of Mental Disorders), including the importance of making a proper diagnosis, being culturally sensitive, knowing the historical and social prejudices related to diagnosis, and the right to refrain from making a diagnosis:

PROPER DIAGNOSIS. "Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used." (Section E.5.a)

CULTURAL SENSITIVITY. "Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders." (Section E.5.b)

HISTORICAL AND SOCIAL PREJUDICES IN THE DIAGNOSIS OF PATHOLOGY. "Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment." (Section E.5.c)

REFRAINING FROM DIAGNOSIS. "Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others." (Section E.5.d)

Professional Issues

DSM-5. As of the writing of this text, DSM-5 is scheduled to be published in 2013. This revised classification system will have many changes from its DSM-IV-TR cousin, with the most dramatic being the likelihood that Axis I and Axis II (the mental disorders) and Axis III will be combined (American Psychiatric Association, 2010). Such a consolidation of the axes would remove the stigma that has sometimes been associated with the personality disorders located on Axes II and would imply a closer link between mental disorders and medical problems. Many other changes are also likely. The American Psychiatric Association is currently seeking feedback about potential changes and we probably won't know the outcome until the book is actually published.

CHALLENGING ABNORMALITY AND DIAGNOSING. For years, authors have argued that important distinctions can be made about the causes of emotional problems and whether using a diagnostic classification system is worthwhile (Glasser, 1961; Ivey & Ivey, 1998; Laing, 1967; Madsen & Leech, 2007; Rogers, 1961; Szasz, 1961, 1970, 1990, 1995). For instance, both Laing and Szasz viewed mental illness as a normal response to a stressful situation. In fact, Laing even encouraged people to get in touch with their own psychosis as a means of letting go of their stressors, and he would periodically allow himself to "go insane" in his own hospitals. Szasz believed psychopathology is the client's way of communicating about social and cultural forces that impinge on him or her. In a similar vein, Glasser believes that psychopathology is a client's clumsy attempt at meeting his or her needs. If you help clients understand their needs and wants, you can help them find more effective behaviors toward those ends.

Ivey and Ivey (1998) suggest that rather than assuming there is something inherently wrong with a person, we should view problems as a "logical response to developmental history" (p. 334) and natural responses to issues in the family, community, and broader culture. This approach does not suggest discontinuing the use of diagnosis but offers a humanistic and antideterministic alternative to understanding the person (see Box 10.3).

Finally, Corey and associates (2011) summarize some reasons that clinicians might want to be tentative when making a diagnosis:

1. Diagnosis is an objective process in which the person making the diagnosis is really "not in the shoes" of the person being diagnosed.
2. Diagnosis tends to rob people of their uniqueness.
3. Diagnosis can lead to a self-fulfilling prophecy for both the client and clinician (I think, therefore I am).
4. Diagnosis leads to tunnel vision where the clinician attempts to fit all problems into the specific diagnostic category.
5. Diagnosis tends to view individuals from an individual perspective and not a contextual one and thus minimizes the effect of family and social systems.

BOX 10.3

Positive Reframe of Personality Disorders (Ivey & Ivey, 1998, p. 338).						
Personality Style	**Paranoid**	**Schizoid**	**Schizotypal**	**Antisocial**	**Borderline**	**Histrionic**
Positive Frame	It is important to watch out for injustice	It is useful to be a loner or independent of others at times	Ability to see things differently than others see them	It is sometimes necessary to be impulsive and take care of our own needs	Intensity in relationships is desirable at all times	All could benefit at times with open access to emotions
Personality Style	**Narcissistic**	**Avoidant**	**Dependent**	**Obsessive-Compulsive**	**Passive-Aggressive**	
Positive Frame	A strong belief in ourselves is necessary for good mental health	It is useful to deny or avoid some things	We all need to depend on others	Maintaining order and a system is necessary for job success	All of us are entitled to procrastinate at times	

6. Diagnoses are sometimes cross-culturally biased.
7. Diagnoses tend to look at pathology at the expense of the strengths of the client.

Today, the controversy over the use of diagnosis still exists, although it has calmed down a bit. When you are called to diagnose a client (and you will be), you may want to reflect on the above issues and carefully consider how your diagnosis will be used.

The Over-Diagnosis of Mental Illness

Swenson (1997) notes that clinicians who are trained in diagnostic procedures will tend to over-diagnose. This is probably because the medical model suggests that it is better to judge a well person sick than a sick person well. Clearly, what is best is to diagnose a person accurately or, if in doubt, to consult and discuss your doubts. A dramatic case of over-diagnosis was shown in a study conducted by Rosenhan, *On Being Sane in Insane Places* (1973; cited in Swenson, 1997), in which eight healthy people were inaccurately diagnosed and placed in mental hospitals for a range of 7 to 52 days (see Box 10.4).

Because Rosenhan's study was conducted in the early 1970s, we can hope that times have changed and the same would not occur today. However, the tendency to over-diagnose by clinicians trained in DSM-IV-TR is probably still here.

Legal Issues

Confinement against One's Will

One controversial role that diagnosis has played over the years has been its importance in having a person hospitalized against his or her will. Prior to the mid 1970s, if a client was given certain diagnoses (e.g., acute schizophrenia), he or she would

BOX 10.4

On Being Sane in Insane Places (Rosenhan, 1973)

A group of eight pseudopatients presented themselves to mental hospitals. One was a psychology graduate student, three were psychologists, one a pediatrician, one a psychiatrist, one a painter, and one a housewife. These subjects presented themselves to 12 mental hospitals in five states. The only symptoms they displayed in the admissions offices were saying that they felt their lives were empty and hollow and that they heard voices saying "empty, hollow, thud." The researchers chose these symptoms because they could not find one case of "existential psychosis" in the literature. Once admitted, the pseudopatients ceased showing any symptoms at all. Mental health professionals diagnosed all but one of these people as schizophrenic, and the length of hospitalizations ranged from 7 to 52 days. The professional staffs of the hospitals never detected the fraud, although many actual patients were suspicious and questioned the fake patients. (Swenson, 1997, p. 449)

almost assuredly be placed involuntarily in a psychiatric hospital. However, as a result of the *Donaldson v. O'Connor* (1975) decision (see Chapter 2), individuals can no longer be involuntarily held in mental institutions for extended periods of time if they are not in danger of harming themselves or others. In most states, severely impaired clients can be hospitalized for short periods of time, perhaps two to three days. At that point, a certification by two or more experts or a court hearing is generally needed to continue short-term hospitalization of two or three weeks. Long-term confinement, against the patient's will, would necessitate a court hearing and is very unusual in today's world.

Insurance Fraud

Today, certain diagnoses are often not reimbursed by insurance companies. Although there may be a tendency by some to alter a client's diagnosis so that he or she would obtain reimbursement, this practice is unethical and constitutes insurance fraud. With this practice being one of the more commonly cited complaints made against Licensed Professional Counselors (Neukrug, Milliken, &Walden, 2001), counselors must learn to inform clients of what will and will not be reimbursed and work with clients when faced with certain diagnoses that are not reimbursable (Braun & Cox, 2005).

◼ *The Counselor in Process: Dismissing Impaired Graduate Students*

I have at times sat in a faculty meeting when a faculty member brought up the name of a student and suggested that the student be approached because it seemed apparent that he or she had severe emotional problems. Sometimes I have agreed with the faculty member's assessment; other times I have not. For me, this issue is similar to the old debate concerning the use of the term abnormal behavior. In terms of students, it first challenges me to define "severe emotional problem," and secondarily asks me to ponder whether or not I believe such students can be assisted to the point that they can

be effective counselors (see Foster & McAdams 2009). The ACA (2005) ethical code suggests the following:

> Counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators
>
> 1. assist students in securing remedial assistance when needed,
> 2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
> 3. ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (Section F.9.b)

If I were conceptualizing a "problem student" from a developmental and wellness perspective as presented in Chapter 9, I would assume that he or she could change. However, if I were to look at this student from an abnormal development perspective, I might think that there is something inherently wrong with him or her, and that change would be particularly difficult, if possible at all. In this latter example, I might ask the student to drop out of the program. Perhaps there is a middle point between these two extremes; however, the issue remains: Do we believe that any student can eventually overcome his or her personal limitations and be effective as a counselor, or do we think that some individuals are simply too impaired? What do you think?

▣ *Summary*

This chapter introduced the concepts of abnormal behavior, diagnosis, and psychopharmacology, noting that the three are inextricably connected. Whereas it used to be unusual for counseling programs to examine these concepts, changes in the field have made it increasingly common and important.

In attempting to explain abnormal behavior, in this chapter we looked at five models. The genetic and biological model assumes that there are inherited factors that, when expressed, will produce certain personality traits. It also asserts that some genetic factors are expressed only when a person is exposed to certain environmental factors. In addition, the biological model states that environmental factors can greatly affect the development of certain traits regardless of one's genetics. The psychoanalytic model, on the other hand, assumes that abnormal development is a function of the ability to master the psychosexual stages. Individuals who are parented poorly as they pass through the first five years of life will develop a precarious balance among their id, ego, and superego, which ultimately will lead to dysfunctional ways of being. This model is particularly deterministic, stating that personality development occurs very early in life and is difficult to change. In contrast, the learning perspective assumes that what was learned can be unlearned, and new behaviors and ways of thinking can be learned. Learning theorists believe that through operant conditioning, classical conditioning, and modeling, we learn either healthy or dysfunctional ways of living. In recent times, most learning

theorists have included a cognitive perspective stating that our cognitions are also reinforced and can lead to healthy functioning or to irrational ways of thinking. The humanistic perspective suggests there is a natural growth force in people, and, if a person is placed in a nurturing environment (e.g., empathy, genuineness, positive regard), the individual will develop a healthy personality and high self-esteem. However, if conditions of worth are continually placed upon the person, growth will be thwarted and there will be a tendency toward dysfunctional ways of living in the world. Humanists believe that the individual can change at any point in his or her life if placed in a supportive environment. Finally, post-modernists and social constructionists view reality as being socially constructed through language and organized and maintained through narratives. Therefore, they believe abnormal behavior to be socially constructed as there are no essential truths and that individuals can change through dialogue with others.

If one believes that there are deviant behaviors, then it is natural to want to classify them. This is what diagnosis achieves. The chapter therefore offered an overview of the DSM-IV-TR, the major diagnostic classification system for emotional disorders. We noted that the DSM-IV-TR is a multiaxial system used to describe and communicate mental disorders. We then highlighted each of the five axes of DSM-IV-TR, including Axis I, which describes "Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention"; Axis II, which explains "Personality Disorders and Mental Retardation"; Axis III, which encompasses "General Medical Conditions"; Axis IV, which describes "Psychosocial and Environmental Problems"; and Axis V, which offers a "Global Assessment of Functioning." We noted that the DSM-IV-TR offers a system of differential diagnosis to assist the clinician in distinguishing among similar diagnoses. This ultimately can greatly assist in treatment planning.

If an accurate diagnosis is made, then treatment planning becomes easier, one aspect of which may be the use of psychotropic medication. Therefore, we examined five classes of drugs often used in the treatment of a wide range of emotional disorders. They included the antipsychotics, mood-stabilizing drugs, antidepressants, antianxiety agents, and stimulants. A brief history of the use of various psychopharmacological agents was provided, along with descriptions of some of the major psychotropic medications currently in use.

Near the end of the chapter, we explored problems inherent in the use of diagnosis for some minority clients. For instance, due to bias and not understanding possible differential expressions of symptomatology, we noted that errors can be made in the diagnosis of clients from diverse cultures. Despite some inherent problems with the diagnosis and treatment of minorities, we noted that DSM-IV-TR was constructed with much greater attention to issues of age, gender, socioeconomic status, and culture than were past editions and that client experiences that are considered to be expected reactions or culturally appropriate responses to life events are not diagnosable as mental disorders, even when they cause distress in the client's life. We next highlighted a number of ethical issues addressed in ACA's ethical code that highlight the potential misuse and abuse of diagnosis including the importance of making a proper diagnosis, being culturally sensitive, knowing the historical and social prejudices related to diagnosis, and the right to refrain from making a diagnosis.

Going on to professional issues, we noted that DSM-5 is currently scheduled to be published in 2013. We pointed out that this revised classification system will likely consolidate Axes I, II, and III. We encouraged you to compare the DSM-IV-TR to DSM-5 if the transition to the DSM-5 has been made when you have read this book.

Another professional issue discussed was how diagnosis is viewed by some as a way to legitimatize the oppression of minorities and those who are labeled mentally ill. We reviewed the ideas of Szasz, Glasser, Rogers, and Laing and noted that they all refused to use the term mental illness, stating that it tends to depersonalize and oppress the individual. We also highlighted Ivey and Ivey's work on trying to understand diagnosis from a developmental perspective and Corey's points concerning why we all should be careful when making diagnoses. A final professional issue we noted was that research seems to indicate that clinicians who are trained in the use of diagnosis will tend to overuse it.

In this chapter, we also discussed two legal issues. First, we noted that it is no longer easy to confine a person in a mental institution against his or her will. Today, evidence that a person is in danger of harming self or others or is gravely ill must be presented if a person is to be committed for a short period of time. We also discussed the importance of making an accurate diagnosis and of being careful not to commit insurance fraud by changing a diagnosis in order to be reimbursed. Finally, we ended the chapter with a brief consideration of the impaired graduate student and whether counseling programs should view students such as this as incapable of change and therefore problematic for continuation in a program.

References

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Counseling Association. (2009, August 1). *Membership report*. Alexandria, VA: Author.

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychiatric Association. (2010). *DSM-5: The future of psychiatric diagnosis*. Retrieved from http://www.dsm5.org/Pages/Default.aspx

Appignanesi, R., & Zarate, O. (2006). *Introducing Freud*. Thriplow, England: Icon Books.

Atkinson, D. R. (2004). Addressing the mental health needs of ethnic minorities. In D. R. Atkinson (Ed.), *Counseling American minorities* (pp. 57–80). New York: McGraw-Hill.

Baker, C. (2004). *Behavioral genetics: An introduction to how genes and environments interact through development to shape differences in mood, personality, and intelligence*. New York: American Association for the Advancement of Science.

Ballas, C. A., Evans, D. L., & Dinges, D. F. (2009). Psychostimulants in psychiatry: Amphetamine, methylphenidate, and modafinil. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 843–861). Washington, DC: American Psychiatric Press.

Bandura, A. T., Ross, D., & Ross, S. A. (1963). Imitation of film-mediated aggressive models. *Journal of Abnormal and Social Psychology, 67*, 3–11. doi:10.1037/h0048687

Beck, J. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Beck, J. (2005). *Cognitive therapy for challenging problems*. New York: Guilford Press.

Braun, S., & Cox, J. (2005). Managed mental health care: Intentional misdiagnosis of mental disorders. *Journal of Counseling and Development, 83*, 425–433.

Clark, L. A., & Watson, D. (2008). Temperament: An organizing paradigm for trait psychology. In O. P. John, R. W., Robins, & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 265–287). New York: Guilford Press.

Corey, G. (2009). *Theory and practice of counseling and psychotherapy* (8th ed.). Belmont, CA: Brooks/Cole.

Corey, G., Corey, M. S., Callanan, P. (2011). *Issues and ethics in the helping professions* (8th ed.). Belmont, CA: Brooks/Cole.

Donaldson v. O'Connor, 422 U.S. 563 (U.S. Supreme Ct., 1975).

Duncan, E. (2005, October). Genes are not destiny. *Discover,* 62–63.

Ellis, A., & Harper, R. A. (1997). *A guide to rational living* (3rd ed.). North Hollywood, CA: Wilshire Book Company.

Eriksen, K., & Kress, V. (2005). *Beyond the DSM story: Ethical quandaries, challenges, and best practices.* Thousand Oaks: Sage.

Eriksen, K., & Kress, V. (2006). The *DSM* and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28,* 202–217.

Eriksen, K., & Kress, V. (2008). Gender and diagnosis: Struggles and suggestions for counselors. *Journal of Counseling and Development, 86,* 152–162.

Fawcett, J., & Busch, K. A. (1998). Stimulants in psychiatry. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (2nd ed., pp. 503–522). Washington, DC: American Psychiatric Press.

Fergusson, D., Doucette, S., Glass, K. C., Shapiro, D. H., Healy, D., Hebert, P. & Hutton, B. (2005). Association between suicide attempts and selective serotonin reuptake inhibitors: Systematic review of randomized controlled trials. *BMJ, 330,* 396–399. doi:10.1136/bmj.330.7488.396

Foster, V., & McAdams, C. (2009). A framework for creating a climate of transparency for professional performance assessment: Fostering student investment in gatekeeping. *Counselor Education and Supervision, 48*(4), 271–284.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities.* New York: W. W. Norton and Company.

Freeman, M. P., Wiegand, C., Gelenberg, A. J. (2009). Lithium. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 697–718). Washington, DC: American McElroy & Keck.

Freud, S. (2003). *An outline of psychoanalysis* (rev. ed.) (J. H. Ragg-Kirby, trans.). New York: Penguin Group. (Original work published 1940)

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40,* 266–275. doi:10.1037/0003-066X.40.3.266

Gergen, K. M. (2009). *An invitation to social construction* (2nd ed.). Thousand Oaks, CA: Sage.

Glasser, W. (1961). *Mental health or mental illness?* New York: Harper & Row.

Hall, C. S. (1999). *A primer of Freudian psychology.* New York: Meridian. (Original work published 1954)

Halstead, R. W. (2007). *Assessment of client core issues.* Alexandria, VA: American Counseling Association.

Hansen, J. (2003). Including diagnostic training in counseling curricula: Implications for professional identity development. *Counselor Education and Supervision, 43,* 96–107.

Ingersoll, R. (2000). Teaching a psychopharmacology course to counselors: Justification, structure, and methods. *Counselor Education and Supervision, 40,* 58–69.

Ivey, A., E. & Ivey, M. (1998). Reframing *DSM-IV:* Positive strategies from developmental counseling and therapy. *Journal of Counseling and Development, 76*(3), 334–350.

Jongsma, A. E., Jr., & Peterson, L. M. (2003). *The complete adult psychotherapy treatment planner* (3rd ed.). New York: Wiley.

Kalat, J. W. (2009). *Biological psychology* (10th ed.). Belmont, CA: Wadsworth.

Kessler, R., Chiu, W., Demler, O., & Walters, E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 617–627. doi:10.1001/archpsyc.62.6.617

Kirschenbaum, H. (2009). *The life and work of Carl Rogers.* Alexandria, VA: American Counseling Association.

Horwitz, A. V. (2002). *The social control of mental illness.* Clinton Corners, NY: Percheron Press.

Kress, V., Eriksen, K., Rayle, A., & Ford, S. (2005). The DSM-IV-TR and culture: Considerations for counselors. *Journal of Counseling and Development, 83*(1), 97–104.

Kring, A. M., Davison, G. C., & Neale, J. M., & Johnson, S. L. (2007). *Abnormal psychology* (10th ed.). New York: Wiley.

Krishnan, K. R. R. (2009). Monoamine oxidase inhibitors. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 389–403). Washington, DC: American Psychiatric Press.

Krueger, R. F., Johnson, W., & Kling, K. C. (2006). Behavior genetics and personality development. In D. K. Mroczek & T. D. Little (Eds.), *Handbook of personality development* (pp. 81–108). Mahwah, NJ: Lawrence Erlbaum Associates.

Laing, R. D. (1967). *The politics of experience.* New York: Ballantine.

Langer, J. (1969). *Theories of development.* New York: Holt, Rinehart, & Winston.

Madesen, K., & Leech, P. (2007). *The ethics of labeling in mental health.* Jefferson, NC: MacFarland & Company.

Maslow, A. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. doi:10.1037/h0054346

Maslow, A. (1968). *Toward a psychology of being* (2nd ed.). Princeton, NJ: Van Nostrand.

Maslow, A. (1970). *Motivation and personality* (rev. ed.). New York: Harper & Row.

McElroy, S. L., & Keck, P. E. (2009). Topirmate. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 795–810). Washington, DC: American Psychiatric Press.

Meichenbaum, D. (1977). *Cognitive behavior modification: An integrative approach.* New York: Basic Books.

Mezzich, J. E., & Caracci, G. (Eds.) (2008). *Cultural formation: A reader for psychiatric diagnosis.* Lanham, MD: Jason Aronson.

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., Fabrega, H., Parron, D. L., Good, B. J., Lin, K., & Manson, S. M. (1999). The place of culture in DSM-IV. *The Journal of Nervous and Mental Disease, 187*, 457–464. doi:10.1097/00005053-199908000-00001

Murray, T. (2006). The other side of psychopharmacology: A Review of the literature. *Journal of Mental Health Counseling, 28*(4), 309–317.

Nasrallah, H. A., & Tandon, F. (2009). Classic antipsychotic medications. In A. F. Schatzberg and C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 533–554). Washington, DC: American Psychiatric Press.

National Institute of Mental Health. (2010). *Mental health medications: Complete index.* Retrieved from http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml#pub1

Nelson, J. C. (2009). Tricyclic and tetracyclic drugs. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 263–288). Washington, DC: American Psychiatric Press.

Neukrug, E. (2001). Medical breakthroughs: Genetic research and genetic counseling, psychotropic medications, and the mind–body connection. In T. McClam & M. Woodside (Eds.), *Human service challenges in the twenty-first century* (pp. 115–132). Birmingham, AL: Ebsco Media.

Neukrug, E. (2011). *Counseling theory and practice.* Belmont, CA: Brooks/Cole.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*(1), 57–70.

Neukrug, E. & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional counseling.* Pacific Grove, CA: Brooks/Cole.

Nishino, S., Mishima, K., Mignot, E., & Dement, W. C. (2009). Sedative-hypnotics. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 821–842). Washington, DC: American Psychiatric Press.

Nye, R. D. (2000). *Three psychologies: Perspectives from Freud, Skinner, and Rogers* (6th ed.). Belmont, CA: Brooks/Cole.

Patterson, J., Albala, A. A., McCahill, M. E., & Edwards, T. M. (2006). *The therapist's guide to psychopharmacology: Working with patients, families, and physicians to optimize care.* New York: The Guilford Press.

Pirodsky, D. M., & Cohn, J. S. (1992). *Clinical primer of psychopharmacology* (2nd ed.). New York: McGraw-Hill.

Preston, J. D., O'Neal, J. H., & Talaga, M. C. (2010). *Handbook of clinical psychopharmacology for therapists* (6th ed.). Oakland, CA: New Harbinger Publications.

Robinson, D. S., Rickels, K., & Yocca, F. D. (2009). Buspirone and gepirone. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 487–502). Washington, DC: American Psychiatric Press.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory.* Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103. doi:10.1037/h0045357

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science, Vol. 3, Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.

Rogers, C. R. (1961). Ellen West and loneliness. In H. Kirschenbaum & V. L. Henderson (Eds.), *The Carl Rogers reader* (pp. 157–167). Boston: Houghton Mifflin.

Rogers, C. R. (1980). *A way of being.* Boston: Houghton Mifflin.

Rosenhan, T. (1973). On being sane in insane places. *Science, 179*(19), 250–258. doi:10.1126/science.179.4070.250

Rudes, J., & Guterman, J. T. (2007). The value of social constructionism for the counseling profession: A reply to Hansen. *Journal of Counseling and Development, 85*, 387–392.

Schatzberg, A. F., & Nemeroff, C. B. (Eds.). (2009). *Textbook of psychopharmacology* (4th ed.). Washington, DC: American Psychiatric Press.

Schwitzer, A. M., & Everett, A. (1997). Reintroducing the *DSM-IV*: Responses to ten counselor reservations about diagnosis. *The Virginia Counselors Journal, 25*, 54–64.

Segal, D. L., & Coolidge, F. L. (2001). Diagnosis and classification. In M. Hersen & V. B. Van Hasselt (Eds.), *Advanced abnormal psychology* (2nd ed., pp. 5–22). New York: Kluwer Academic/Plenum Publishers.

Seligman, L. (2004). *Diagnosis and treatment planning in counseling* (3rd ed.). New York: Kluwer Academic/Plenum Press.

Sheehan, D., & Raj, B. A. (2009). Benzodiazepines. In A. F. Schatzberg & C. B. Nemeroff (Eds.), *Textbook of psychopharmacology* (4th ed., pp. 465–486). Washington, DC: American Psychiatric Press.

Skinner, B. F. (1971). *Beyond freedom and dignity.* New York: Knopf.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Szasz, T. (1961). *The myth of mental illness.* New York: Paul B. Hoeber.

Szasz, T. (1970). *Ideology and insanity: Essays on the psychiatric dehumanization of man.* New York: Anchor Books.

Szasz, T. (Speaker). (1990). *A conversation with an officially documented schizophrenic patient* (Cassette Recording No. PC289-W9AD). Phoenix, AZ: The Milton H. Erickson Foundation.

Szasz, T. (1995). The healing word: Its past, present, and future. In J. K. Zeig (Ed.), *The evolution of psychotherapy: The third conference.* New York: Brunner/Mazel.

Videbeck, S. L. (2011). *Psychiatric mental health nursing* (5th ed.). New York: Lippincott, Williams, & Wilkins. Washington, DC: American Psychiatric Press.

Wolpe, J. (1969). *The practice of behavior therapy.* New York: Pergamon Press.

Career Development: The Counselor and the World of Work

My father was a building contractor. When I was young he used to take me to various construction sites, and I would watch buildings slowly being built. As a teenager, during the summers, I assisted a carpenter or laborer at the sites. I remember getting picked up at five-thirty in the morning, cramped half-asleep in the cab of a well-seasoned truck, to be taken on a bumpy ride to work. I would think to myself, "Is this what I want to do for the rest of my life?" Luckily, because I did well in school, I knew I'd be going on to college; but to do what?

Majoring in biology and thinking I would not be accepted to medical school, I chose dentistry as my eventual occupational choice. My mind was made up, I thought. But something did not feel right. Although a part of me said, "Go to dental school," another distant voice said, "This is not for you, you have other things to do in your life, other things that involve helping people in other ways." These divergent feelings and thoughts were certainly an outgrowth of many things, including my family values, placement in my family, my interests, my own emerging values, and my abilities.

Although it was a tough decision, I eventually chose to listen to my inner voice, and I switched my major to psychology. Eventually, through selected trial and occasional error, I ended up in the field of counseling. No doubt my life would have been made somewhat easier if I had had the benefit of a career counselor who could have helped me assess my likes and dislikes, my values, and my abilities; helped me understand my personality; facilitated self-knowledge and self-reflection; and assisted me in applying all of this knowledge to my career development journey.

As I proceeded in my career, I continued to be faced with a number of choices. Should I go on for a doctoral degree? Should I go toward clinical work or academia? Should I change career paths totally? Again, my choices often seemed to be a product of trial and error. I would try something out to see if I liked it and if I was good at it, and would then make a decision about my future career direction. However, as I gained more awareness and began more fully to understand the career development process, I saw that

I could choose my own direction in life if I had adequate knowledge of myself and knowledge of the world of work. No longer would my career decision making be an accident. I began to choose my future!

Despite the fact that I have been pretty satisfied with my chosen occupation, there were times when my life did not feel complete. Therefore, other activities began to fill in some of the empty spaces. In my mid-twenties, I began to jog. As the years continued, running and other workout routines became a focal point in my life. They offered an outlet for my stress, a place for me to meet other people, and an activity that took me away from my work. In my early forties I married, and soon after, I was a father. As new life roles emerged, I found that I had to balance my roles of professor, clinician, exerciser, and writer with those of husband and father.

My story, with its twists and turns, is fairly common. People tend to haphazardly go through life without the benefit of guidance, sometimes intuitively moving in the direction that serves them best. However, many times people are unhappy with their jobs and other life roles. If afforded the opportunity for career counseling, many would have an easier time in their journey through life. They would be able to make smart occupational and life choices. That is why this chapter is so important. It explains the career development process, its importance to life satisfaction, and the role of the counselor in facilitating career development.

This chapter will survey the career development process and specifically examine how individuals make career choices, the meaning of work in people's lives, the major theories of career development, and some of the career information systems available. In addition, we will conclude the chapter by examining multicultural and social justice issues related to career development, and ethical, professional, and legal issues in the realm of career development.

Some Definitions

The career development process is perhaps the most misunderstood counseling-related subject. Therefore, it is particularly important to start out with some basic definitions. The following definitions, synthesized from some prominent authors, are terms related to the career development process (Brown, 2007; Greenhaus & Callanan, 2006; Herr, Cramer, & Niles, 2004; Sharf, 2010). Keep in mind that some of these definitions may not be the same as our common, lay definitions.

- *Avocation.* A chosen activity that is pursued by an individual because it gives satisfaction and fulfills an important aspect of the person's life. It may or may not be income generating.
- *Career.* The totality of work and life roles through which an individual expresses him- or herself. It may include work, leisure, and avocational activities.

- *Career awareness.* One's consciousness about career-related decisions, which can be facilitated through self-examination of one's values, abilities, preferences, knowledge of occupations and life roles, and interests.
- *Career development.* All of the psychological, sociological, educational, physical, economic, and other factors that are at play in shaping one's career over the life span.
- *Career counseling.* Individual or group counseling with a focus on increasing career awareness and fostering decision making relative to career goals.
- *Career guidance.* A program, designed by counselors, that offers information concerning career development and facilitates career awareness for individuals.
- *Career path.* The sequence of positions and/or jobs that typically signifies potential advancement.
- *Job.* Positions that use similar skills within the same work environment.
- *Leisure.* Time taken from required effort (e.g., job or occupation) in order to pursue self-chosen activities that express one's abilities and/or interests.
- *Occupation.* Jobs of a similar nature that can be found within several work environments and connote the kinds of work a person is pursuing.
- *Work.* Effort expended at a job, occupation, or avocation in order to produce or accomplish something.

Is Career Development Developmental?

You might be wondering why a chapter on career development is included in a section on human development. In fact, career development is developmental because it examines the career decision-making process of an individual as it unfolds through distinct stages. Unfortunately, I find that when most people think about career development, they often think that it is just a process of finding a job. In actuality, it is much more than that. In fact, career development includes all of the following:

- The 3-year-old who plays house or hammers a peg into a hole
- The 5-year-old who joins a T-ball league
- The 10-year-old inner city youth who has few positive role models
- The 12-year-old who begins to examine his or her abilities and likes and dislikes
- The 14-year-old who suddenly discovers that her parents are getting divorced
- The 17-year-old who considers what college to go to and the 17-year-old who ponders what job to take after high school
- The 25-year-old who takes a new job and also leads an aerobics class
- The 30-year-old who gives up a full-time job to do childcare
- The 37-year-old who is promoted and is vice-president of the local PTA
- The 45-year-old who hates her job but continues to work at it to make money while maintaining an exciting hobby on the side
- The 50-year-old who wonders, "Is this all there is?"
- The 60-year-old who ponders whether or not he should retire in a couple of years
- The 70-year-old who never worked, has raised a family, and has become a fairly good tournament bridge player
- The 85-year-old who reflects back on his or her various life roles

Our career development is expressed through the jobs, occupations, leisure activities, and avocations we have chosen throughout our lifespan (Ethridge, Burnhill, & Dong, 2009; Super & Hall, 1978). Most important, it is how we experience ourselves in all of our life roles. It is affected by the kinds of messages we received from our parents, from our community, from our religious affiliation, and from society. It is ongoing, ever transforming, and doesn't end until we die.

Why Career Development and Career Counseling?

I hope by now you see that career development is not just the process of finding a job, but the development of all of our various life roles and the factors that go into shaping them. It is reflected in how each of us expresses our identity through the roles we choose. Career counseling helps an individual navigate the career development process. Thus, career counseling is helping the 3-year-old develop a sense of self, assisting the 12-year-old in understanding what she is good at and what she likes, helping the 17-year-old choose a college or a job, helping a client weigh the relative importance of being a parent and working at a job, assisting a person through a midlife crisis, helping an individual as she readies for retirement, and reminiscing with an older person about his life. Career counseling helps to raise a person's awareness about the choices he or she is making in life.

Adequate career counseling can assist us in making smart choices around our work and other life roles. The work we choose is a large part of our career development process and serves a number of important economic, social, and psychological needs for the individual (see Table 11.1). Numerous studies show that career planning and career counseling are related to job satisfaction and positive mental health (Fritzsche, & Parrish, 2005; Spokane, Meir, & Catalano, 2000; Ton & Hansen, 2001; Verbruggen & Sels, 2010; Verquer, Behr, & Wagner, 2003). It is not a big leap to realize that adequate career planning and career counseling can help us feel better about our lives. This is why career counseling is so vital to facilitating a client's career development.

Text not available due to copyright restrictions

■ *A Little Bit of History*

The counseling profession owes its existence to *vocational guidance*. At the turn of the twentieth century, on the heels of the industrial revolution, there came many demographic changes throughout the United States. Almost overnight, there was a large influx of people who moved from rural areas to the cities, an increased number of immigrants who settled mostly in urban areas, and, with this, a large increase in the number of children in city schools. Shifts in the types of available jobs were evident as was the need to assist these new city dwellers and students in their vocational development.

One of the first persons credited with developing a systematic approach to vocational guidance was Frank Parsons (Briddick, 2009a; McDaniels & Watts, 1994). As noted in Chapter 2, Parsons envisioned systematic vocational guidance in the schools, a national vocational guidance movement, and the importance of counseling to assist individuals in their vocational development (Briddick, 2009b; Jones, 1994). Parsons, a humanitarian and social justice advocate, later became known as the founder of vocational guidance and suggested that vocational guidance involved a three-step process that included knowing oneself, knowing job characteristics, and making a match between the two through *true reasoning* (Parsons, 1909/1989, Pope & Sveinsdottir, 2005). Realizing the importance of vocational guidance, others jumped on the bandwagon. Individuals like Jesse Davis in Grand Rapids, Michigan; Eli Weaver in New York City; and Anna Reed in Seattle established guidance services in their respective school systems (Aubrey, 1977).

In 1932, during the midst of the Depression, the *Wagner O'Day Act* was passed establishing the U.S. Employment Service, which provided vocational guidance for the unemployed. Also around this time, the testing movement began to spread. The merging of vocational guidance with testing formed a natural partnership because assessment offered a relatively quick and reliable means of determining individual traits. It was also during this time frame that the U.S. Department of Labor published the *Dictionary of Occupational Titles*, which represented one of the first attempts at organizing career information. Now, individuals could assess their traits and match them to existing jobs.

The 1950s was the beginning of an explosion of career development theories. For instance, it was at this time that Ann Roe developed her classification system of career counseling, which promoted the idea that early childhood experiences were responsible for later career choice. Other theories began to broaden the concept of career to include such things as leisure activities, avocations, occupations, and post-vocational patterns related to retiring. One theory, proposed by a team composed of an economist, a sociologist, a psychiatrist, and a psychologist (Ginzberg, Ginsburg, Axelrad, & Herma, 1951; Ginzberg, 1972), and a second theory, developed by Donald Super (Super, 1953, 1957), were instrumental in transforming the static vocational guidance model, that viewed career choice as a moment in time decision, into a model that viewed career development as a lifelong process (Hershenson, 2009).

With the emergence of humanistic approaches to counseling as well as government initiatives such as the *National Defense Education Act* (NDEA), which stressed career guidance in the schools, new comprehensive models of career guidance were developed in the 1960s and 1970s. These models viewed career guidance broadly and included (1) focusing on lifelong patterns of career development; (2) assisting individuals in making choices that reflected their sense of self; (3) examining leisure and avocational

activities when working with clients; (4) viewing career development as a flexible and changeable process as compared to the rigid, irreversible process of earlier times; and (5) emphasizing the individual, not the counselor, as the career decision-maker (Herr et al., 2004). During the 1970s, we also saw the emergence of John Holland's personality theory of career counseling, which examined the importance of how an individual's personality "fit" into differing work environments.

The 1980s and 1990s expanded the notion that career development was a lifespan process in which counselors could assist individuals in defining their life roles. As the 1990s unfolded, the computer age took firm hold and brought about a wealth of accessible information that allowed for quick exploration of the world of work. The evolution of career development models in conjunction with this new technology made career exploration an exciting and in-depth process. In recent years, we saw the expansion of some of the earlier models of career development as well as the addition of some newer models, including *social cognitive career theory* and *constructivist theory*, which increasingly looked at how an individual develops a sense of self relative to his or her career. Recently, we have seen authors attempt to integrate many of these various career development models.

Today, career guidance and career counseling are important components of what all counselors do. This is one of the reasons career and lifespan development has been selected by CACREP as one of the eight content areas all counseling students must learn in graduate school.

Theories of Career Development

Today, there are many theories of career development that help counselors understand how the client has come to approach the world of work and provide a framework for devising strategies to assist clients in their career search (see Sharf, 2010). Although this text cannot go into all of the theories, we will explore some of those that have been highlighted in the literature, including modern-day *trait-and-factor theory*, Ann Roe's *psychodynamic theory*, John Holland's *personality theory of occupational choice*, Super's *lifespan development theory*, *social cognitive career theory*, and *constructivist career counseling*. The next section, "Integatrating Models of Career Development," will demonstrate how these theories can be combined when conducting career counseling.

Trait-and-Factor Approach

The *trait-and-factor approach*, which grew out of the early work of Frank Parsons, was the major career development theory for many years, maintaining its popularity until the 1950s (Blustein, 2006; Gysbers, Heppner, & Johnston, 2009). Originally, this approach was a straightforward process that involved the counselor assisting the client in assessing his or her strengths, examining the availability of jobs, and using a rational process to make career decisions. Largely focusing on assessment of ability and interests, this approach tended to be didactic and directive.

Although trait-and-factor theory has maintained its emphasis on the importance of a fit between the individual and the environment, the application of current-day trait-and-factor theory looks very different than it did years ago. The following summarizes

some of the important principles held by current-day trait-and-factor theorists (Brown, 2002; Herr et al., 2004; Sharf, 2010):

1. Individuals have unique traits that can be measured, discussed, and examined. Some of these include aptitudes, needs and interests, values, stereotypes and expectations, psychological adjustment, the propensity to take risks, and aspirations.
2. Occupations necessitate that individuals have certain traits if they are to be successful in that occupation.
3. The better the ability of the individual to match his or her traits to occupations, the greater the likelihood the individual will have success and feel satisfied.
4. The interaction between client and therapist is a dynamic process that includes both affective and cognitive components.
5. The ability of an individual to match his or her traits with occupations is a conscious process that can occur in a deliberate fashion. However, such matching can only be effective if a person has insight into self and knowledge of his or her unique traits and the sociological factors that may affect potential decisions.
6. Cultural values are important when conducting career counseling (e.g., interaction between client and counselor) and affect the success of the individual on the job (how the person sees self and is viewed by others at work).

Today's trait-and-factor counselor does not simply match abilities and interests with jobs but uses a variety of techniques to examine how the vast array of the client's skills, interests, and personality variables might affect eventual career choices. This is done in a dynamic manner in which the counselor, through the use of modern-day counseling techniques, facilitates client understanding of self and assists the client in making decisive career choices.

Ann Roe's Psychodynamic Theory

In 1956, Ann Roe developed a rather elaborate theory that based career choice on the kinds of early parenting received (Roe, 1956). Roe hypothesized that parents can be classified as either *warm* or *cold* and that these two styles result in one of three types of *emotional climates: emotional concentration on the child, acceptance of the child,* or *avoidance of the child* (see Figure 11.1). The type of emotional climate in the home will result in one of six types of parent–child relationships, which, often unconsciously, influences the kinds of occupational choices the child will eventually make (Roe & Siegelman, 1964). Parenting style, said Roe, ultimately results in the individual having one of the following eight orientations toward the world of work: *service* (I), *business* (II), *organization* (III), *technology* (IV), *outdoor* (V), *science* (VI), *general culture* (VII), and *arts and entertainment* (VIII) (see Figure 11.1).

Peterson, Sampson, and Reardon (1991) describe Roe's different parenting styles and the possible influence they have on occupational choice:

1. *Protective.* The parents are indulgent and demonstratively affectionate and give the child special privileges. The home may be described as child-centered. Children from such homes tend to gravitate to the service, arts, or entertainment fields.
2. *Demanding.* The parents set forth high expectations for accomplishment and impose strict regulation and obedience. Children growing up in this type of environment may be oriented to general culture (lawyers, teachers, scholars, librarians) or to the arts and entertainment fields.

FIGURE 11.1
Roe's Circular Model

SOURCE: "The Origins of Interests,"
by A. Roe and M. Siegelman in
APGA Inquiry Studies No. 1.
Copyright © 1964 ACA. Reprinted
with permission. No further
reproduction authorized without
written permission.
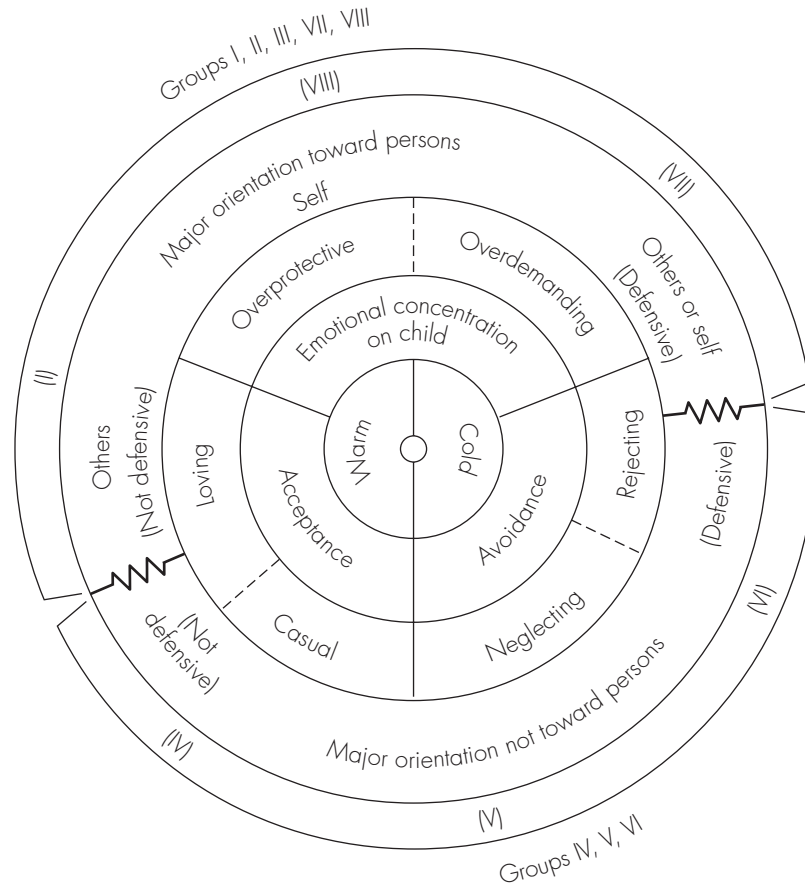
3. *Rejecting*. The parents do not accept the child as a child, perhaps not even as an individual. They are often cold, hostile, and derogatory, making the child feel inferior and unaccepted. Rejected children tend to pursue science occupations.

4. *Neglecting*. The parents simply ignore the child; they give little attention, either positive or negative. They provide minimum physical care and less emotional sustenance. Neglected children tend to develop science and outdoor interests.

5. *Casual*. The parents give emotional and physical attention to the child, but only after higher-priority issues in their own lives have been attended to. Children treated casually tend to gravitate to technological occupations (engineers, aviators, applied scientists) or organizational occupations (bankers, accountants, clerks).

6. *Loving*. The parents are warm, helpful, and affectionate. They set limits and guide behavior through rational problem solving. They help the child with activities but are not intrusive. Children whose parents are loving, tend to gravitate to service or business-contact occupations (promoters, salespersons). (pp. 55–56)

Although Roe believed that early parenting styles were instrumental in shaping occupational choice, she also believed that such factors as gender, the economy, physical appearance, chance factors, family background, temperament, and one's genetic makeup could all affect one's interests and abilities and ultimately, one's career choice. She believed that these factors interacted in complex ways. Although research on Roe's model has produced mixed results (Herr et al., 2004; Brown, Lum, & Voyle, 1997), she has contributed much by being one of the first theorists to relate occupational choice to personality style. Such a focus has dramatically changed the way that counselors work with clients as it suggests the importance of looking at early family dynamics when practicing career counseling.

John Holland's Personality Theory of Occupational Choice

John Holland's (1919–2008) theory of occupational choice proposes that people express their personality through their career choices (Holland, 1973; Holland & Gottfredson, 1976). Considered both a personality theory and a trait-and-factor theory (Dawis, 2005; Spokane, Luchetta, & Richwine, 2004), Holland's theory suggests that genetic and environmental influences lead people to develop "a hierarchy of habitual or preferred methods for dealing with social and environmental tasks" (Herr et al., 2004, p. 211). In essence, Holland suggested that if individuals could identify their unique personality styles, they could find a job that best fits their personality and ultimately find satisfaction in their careers. Identifying six personality types, Holland stated that each type represents a way a person relates to the world and assigned each type a name that reflected its general personality style, including *realistic, investigative, artistic, social, enterprising*, and *conventional* (see Box 11.1). Holland believed there were numerous occupations that could fit each individual's personality type and ability level.

Although one can be a pure type (i.e., their personality is almost exclusively one type), it is more usual for an individual to have two or more types that dominate. By listing an individual's top three types in order of preference, we can find what is called one's occupational code, often referred to as one's *Holland Code*. Holland conducted research that supported the notion that the six personality types could be viewed on a hexagon, with adjacent types sharing more common elements than nonadjacent ones (see Figure 11.2). Generally, an individual's predominant type and secondary types are close to one another on the hexagon. For instance, if an individual was highest in the social type, then it would not be surprising if the artistic and enterprising types were also high because they are next to the social type on the hexagon.

Holland also asserted that jobs could be classified by type. Thus, he hypothesized that if you accurately matched an individual's code to a job that has the same code, you increase your chances of having a person who is satisfied at the job and ultimately in his or her career. For instance, the individual with the SAE code could be matched with the occupation "counselor," which has the same corresponding code. Research on the Holland codes has been plentiful and has shown that accurate matches do indeed increase the chances for job satisfaction (Rottinghaus, Hees, & Conrath, 2009; Spokane, Meir, & Catalano, 2000). Keep in mind, however, that there are many other SAE choices besides counselor.

Holland and others have worked hard to identify the codes that would best fit in various jobs. For instance, Gottfredson, Holland, and Ogawa (1996) identified the occupational codes for more than 12,000 jobs and published these codes in the book *The Dictionary of Holland Occupational Codes*. By taking one or more of a number of assessment instruments such as the *Strong Interest Inventory* (CPP, 2004, 2009a) or the *Self-Directed*

BOX 11.1

Holland's Personality and Work Types

Realistic: Realistic persons like to work with equipment, machines, or tools, often prefer to work outdoors, and are good at manipulating concrete physical objects. These individuals prefer to avoid social situations, artistic endeavors, or intellectual tasks. Some settings in which you might find realistic individuals include filling stations, farms, machine shops, construction sites, and power plants.

Investigative: Investigative persons like to think abstractly, problem solve, and investigate. These individuals feel comfortable pursuing knowledge and manipulating ideas and symbols. Investigative individuals prefer to avoid social situations and see themselves as introverted. Some settings in which you might find investigative individuals include research laboratories, hospitals, universities, and government-sponsored research agencies.

Artistic: Artistic individuals like to express themselves creatively, usually through artistic forms such as drama, art, music, and writing. They prefer unstructured activities in which they can use their imagination and creative side. Some settings in which you might find artistic individuals include the theater, concert halls, libraries, art or music studios, dance studios, orchestras, photography studios, newspapers, and restaurants.

Social: Social people are nurturers, helpers, and caregivers and have high concern for others. They are introspective and insightful and prefer work environments in which they can use their intuitive and caregiving skills. Some settings in which you might find social people are government social service agencies, counseling offices, churches, schools, mental hospitals, recreation centers, personnel offices, and hospitals.

Enterprising: Enterprising individuals are self-confident, adventurous, bold, and sociable. They have good persuasive skills and prefer positions of leadership. They tend to dominate conversations and enjoy work environments in which they can satisfy their need for recognition, power, and expression. Some settings in which you might find enterprising individuals include life insurance agencies, advertising agencies, political offices, real estate offices, new and used car lots, sales offices, and management positions.

Conventional: Individuals of the conventional orientation are stable, controlled, conservative, and sociable. They prefer working on concrete tasks and like to follow instructions. They value the business world and clerical tasks and tend to be good at computational skills. Some settings in which you might find conventional people include banks, business offices, accounting firms, and medical records offices.

FIGURE 11.2
Holland's Hexagon Model
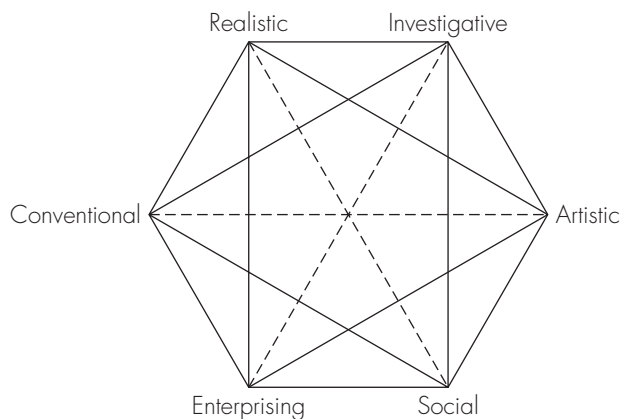
Search (Psychological Assessment Resources [PAR], 2009), an individual can determine his or her Holland code and then match it with occupational codes. You might want to do the exercise in Figure 11.3 if you would like a crude yet quick way of obtaining your Holland code.

Holland's theory has been used extensively by career counselors, and it is to his credit that numerous assessment instruments to determine one's code have been developed. In addition, research has consistently shown the importance of the Holland theory when working with clients to achieve job satisfaction. John Holland has certainly added much to career counseling.

Super's Lifespan Development Approach to Career Counseling

During the 1950s Donald Super drew from a number of developmental models to come up with his lifespan approach to career choice. This approach, which quickly gained in popularity, involves an individual passing through a series of sequential and predictable

---

FIGURE 11.3
Finding Your Holland Code

Realistic: People who are practical, robust, have good physical skills, like the outdoors, and who avoid social situations, intellectual pursuits, and artistic endeavors.

Investigative: People who like to investigate, think abstractly, and do problem solving, but avoid social situations and tend to be introverted.

Conventional: People who are concrete, like to work with data, and prefer routine problem solving. They prefer clerical tasks and tend to be neat, follow instructions, and look for social approval.

Artistic: People who express themselves through art, are creative and imaginative, like unstructured activities, and tend to be sensitive, introspective, and independent.

Enterprising: People who are persuasive, self-confident, like to lead, and see themselves as stable, sociable, adventurous, bold, and self-confident.

Social: People who are concerned for others, nurturers, introspective, and responsible; who like social situations and are verbally skilled.

Take the first letter of the group for each of the first three groups that you picked, in the order that you picked them; this is your code. For instance, I picked the social group first, the artistic group second, and the enterprising group third. Therefore, my Holland code would be SAE.

stages. Initially known as a *developmental self-concept theory*, Super's theory (1953, 1957, 1976, 1990; Super & Hall, 1978; Super, Savickas, & Super, 1996) contended that:

1. Career development is an ongoing, continuous, and orderly process starting in early childhood and ending with death.
2. People's abilities, personality traits, and self-concepts differ, and individuals are qualified for a number of different types of occupations based on their characteristics.
3. Occupations tend to be specifically appropriate for people with certain kinds of qualities, although there is enough variability in occupations to allow for some differences in the kinds of people who will be drawn to them.
4. Self-concept is both a function and result of one's career development process and can change as one passes through developmental stages.
5. Movement from one occupational level to another is influenced by a number of factors, including parental socioeconomic level, status needs, values, interests, skill in interpersonal relationships, economic conditions, and intelligence.
6. Starting in early childhood and continuing into late adulthood, career development can be assisted by helping individuals understand and develop their abilities and interests and by assisting them in understanding their strengths and weaknesses.
7. By understanding the developmental level of the individual, counselors can make appropriate interventions that can assist individuals in learning about themselves and their career development process, thus making occupational choices more likely to lead to satisfaction at work and a high self-concept.
8. Career development is generally irreversible, although some people who face important developmental crises may recycle through the stages at any point in their career.

Super saw career development as a five-stage process, with each stage having substages distinguished by unique developmental tasks (see Figure 11.4). During the *growth stage* (ages birth through 14), children identify with others, gain an awareness of interests and abilities, and begin to develop a career self-concept. Included in this stage is the very young child's beginning awareness of the world of work and the middle school youth who compares his or her abilities and interests to those of peers. In the *exploration stage* (ages 14 to 25), adolescents and young adults begin to tentatively test out their occupational fantasies through work, school, and leisure activities. Later in this stage, individuals begin to *crystallize* their vocational preferences by choosing an occupation or further professional training. The *establishment stage* (ages 25 to 45) involves stabilizing career choices and advancing in chosen fields, while the *maintenance stage* (ages 45 to 60) encompasses the preservation of one's current status in the choices made and avoidance of stagnation. During the *decline stage* (ages 60 and over), people begin to disengage from their chosen fields and increasingly focus on retirement, leisure, and/or avocational activities.

If counselors are going to design effective strategies that will work with clients, they should be familiar with each stage and substage so they can tailor their techniques to the particular tasks unique to that developmental milestone. For instance, an elementary school counselor would be foolish to assist a child in making specific career choices, and a college counselor would be remiss to encourage a college student to become established quickly in a career.

FIGURE 11.4

Super's Stages and Substages

Source: Donald E. Super, *New Dimension in Adult Vocational and Career Counseling* (Columbus, Ohio: The Center on Education and Training for Employment [formerly NCRVE], The Ohio State University). Copyright 1985. Used with permission.
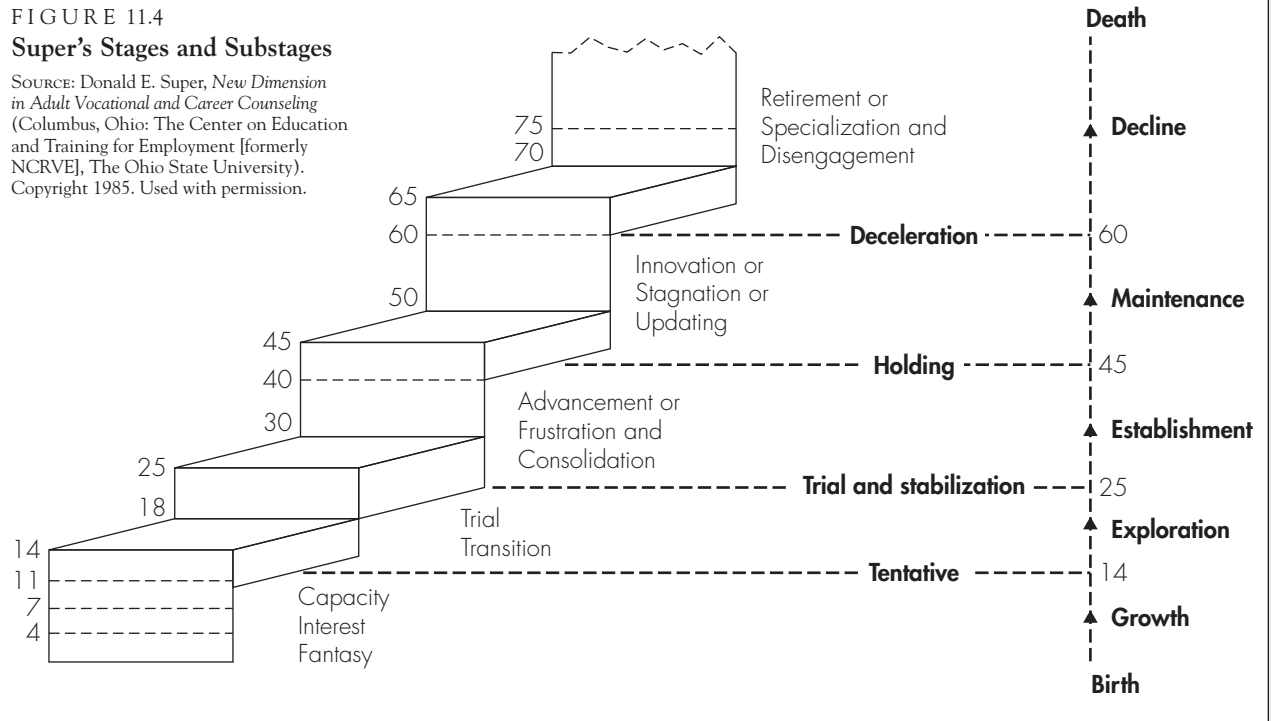
Super's developmental approach has added an important dimension to the understanding of the career development process by making us aware of the universal developmental tasks that people face throughout their lifetimes.

Social Cognitive Career Theory

. . . SCCT highlights people's capacity to direct their own vocational behavior (human agency)—to assemble their own puzzle, so to speak—yet it also acknowledges the many personal and environmental influences (e.g., sociostructural barriers and supports, culture, disability status) that serve to strengthen, weaken, or in some cases, even override human agency in career development. (Lent, 2005, p. 102)

In recent years, *Social Cognitive Career Theory* (SCCT) has become one of the more popular theories of career development (Lent, 2005; Patton & McIlveen, 2009). SCCT pulls together ideas from a number of career development concepts. Anchored in self-efficacy theory (Sharf, 2010), SCCT states that the types of choices we make are based on our current beliefs about whether or not we can perform certain behaviors (Albert & Luzzo, 1999; Bandura, 1997). However, SCCT suggests that self-efficacy is related to our family experiences (e.g., what we're told we're good at), sociological influences (e.g., discrimination, mobility, sexism, and the economy), our abilities and aptitudes, our interests, our sense of our personality style (e.g., the kinds of work environments we most comfortably seem to fit in), and the goals we have in life.

SCCT suggests that individuals are affected by *objective factors* and *perceived environmental factors* (Lent, Brown, & Hackett, 1994, 2000, 2002). For instance, economic hardship, educational experiences, and societal factors (e.g., societal values around gender, culture, disability status, etc.) can all affect the kinds of choices available to a person. However, an individual's perceptions of environmental factors can also affect career decisions. For instance, discrimination may legitimately affect the ability of an individual to obtain a certain job. However, perceived discrimination (as opposed to discrimination that actually exists) may prevent one person from obtaining a job whereas it may not affect another person from the same minority group from acquiring the same job. SCCT therefore examines how objective and perceived factors shape an individual's self-efficacy. The example of quite different responses by two individuals faced with the same objective factors suggests the important role a phenomenological perspective (understanding the unique world view of the client) plays in SCCT (Lent et al., 2000).

SCCT has particular implications for the counselor's role in working with clients. Counselors can have a great impact on the lives of their clients by affecting their environment while simultaneously working on the client's belief system. For instance, high school counselors can work with teachers to help them understand that their beliefs about their students, and how those beliefs become translated behaviorally (whom they pick on in class, nonverbal messages sent to students, and so on), can affect how students view themselves. Embedded, often unconscious racist beliefs about the inability of some minority groups to achieve can be counteracted by counselors doing workshops for teachers and helping them see how they have held such beliefs and the importance of believing and behaving in ways that give all students the message that they can achieve. In this age of No Child Left Behind, and the accountability being asked of teachers to have all children achieve, this has become a critical task for counselors. Simultaneously, counselors can work with students to effect a change in their beliefs about themselves. Students who have not been supported by significant others in their academic pursuits often need such direct support. Girls and boys who have been reinforced for gender and social stereotypes that might negatively affect their career choices can have their horizons broadened.

Like school counselors, counselors working in agencies or college settings can influence the ways in which young adults and adults view themselves and direct them toward a broader understanding of the world of work. In addition, they can advocate for social change by working to break down societal barriers that some clients might face (e.g., discrimination). SCCT theory has wide implications for the greater society, as it potentially can break many of the stereotypes and beliefs that individuals hold about themselves and the beliefs we all hold about one another relative to the world of work.

Constructivist Career Counseling: A Post-Modern Approach

The counselor's tasks are to assess clients' implicit meaning-making stances and challenge and support clients to face dilemmas and become open to new possibilities.
(McAuliffe, 1993, p. 1)

Another, relatively recent addition to career development theory has been promulgated by *constructivist theorists*, who believe that career decision making is related to how clients "construct" or make meaning of their career process (Gysbers et al., 2009; Hutchison & Niles, 2009; Schultheiss, 2007). In the *post-modern* tradition, these theorists do not

believe that reality is fixed or that there is one "correct" path for any individual (Sharf, 2010). Instead, they believe that knowing about self in relationship to career is an ongoing and active process that can change as the individual interacts with others and sees new aspects of self. They believe that reality shifts based on conversations people have with others. They also suggest that narratives in society, disseminated by people in positions of power (usually the "majority"), become part of the reality of society and often result in the oppression of minorities and women.

One method that constructivists often rely on in an effort to unravel the client's meaning making system is the narrative, or life story (Bujold, 2002). By hearing the client's narrative one can obtain a sense of where the client has come from, where he or she is now, and how the client is thinking about the future. *Dominant narratives* often drive how a person acts in the world and can be destructive. "I can't do statistics because I could never do it and because girls are not good at statistics" can be related to narratives in the client's life, stories in society about women doing math, and may have nothing to do with the "reality" of an individual's ability at statistics. Such narratives can be deconstructed and new stories can be constructed through dialogue with the counselor and others.

Constructivists argue that most career development theories do not explain changes in an individual's cognitive functioning over the lifespan. They suggest that an individual's unique meaning making—or ways in which an individual comes to "know" the world—changes as each client experiences the world. By meeting with clients and hearing their narratives, counselors can both understand clients' unique meaning-making systems and develop conversations with them to foster new possibilities for the decisions a person makes relative to his or her career. When meeting with clients, counselors will often ask questions and show respectful curiosity in trying to understand the narratives that drive a person and the other narratives in a person's life that they may not have been particularly aware of.

Some of the basic goals of the counselor when applying this approach include:

1. Trying to understand the client's sense of his or her career self by listening to his or her narratives, or life stories.
2. Helping clients, through conversation, understand the dominant narratives that drive their lives and push them to certain career-related decisions.
3. Helping clients identify career-related dominant narratives that are detrimental to their lives.
4. Helping clients deconstruct negative career-related dominant narratives and develop new, positive narratives that can offer better career choices.
5. Understanding that there are barriers in society, created through language, that affect a large number of people, particularly oppressed groups, and influence how these individuals come to understand the world and the choices they have in the world of work.
6. Focusing on changing dominant societal language and the resulting barriers that they create, which differentially affect minorities and women.

Constructivist career development theory is an exciting new approach in which client growth is possible if the counselor is able to understand the unique ways that clients view the world, identify their dominant narratives, and help them develop new narratives that can expand client choices.

Integrating Models of Career Development

After examining the theories of career development in this chapter, you can see how varied they are in their approach to working with clients. In an attempt to pull positive components from all the approaches, many counselors integrate the various theories. Look at Angela (Box 11.2), and then let's examine how each theory discussed could offer a different and important perspective on her situation.

Trait-and-Factor Theory and Holland's Personality Theory

By using a modern day trait-and-factor approach a counselor can have Angela take some interest inventories, personality measures, and/or ability tests which will help her to explore her traits, including her interests, aptitudes, values, and personality qualities. In addition, by using the trait-and-factor approach the counselor can help Angela explore the stereotypes she holds about specific occupations, as well as her beliefs about the kinds of occupations she thinks she can do (e.g., self-efficacy). This approach can also help Angela examine the world of work and give her a better understanding of all the occupations that might fit her personality type (e.g., Holland) as well as the sociological factors that could affect her choices.

Developmental Theory

Angela is in the exploration stage of her career development process. A person in this stage usually wonders about the choices he or she has made and considers other options. Knowing this, when a counselor uses this approach he or she might want to assure Angela that it is usual for young adults to be questioning their decisions. At the same time, it would be important for the counselor to understand the nature of the doubts Angela has about her decision to be a counselor and help her explore these doubts. Ultimately, the goal of the career counselor who uses developmental theory would be to help Angela move toward a more stable position relative to whatever career-related decisions she makes.

BOX 11.2

Integrating Career Development Theories: Angela

Angela is a 24-year-old African American in her first year of graduate school in counseling. Her mother, who is a school counselor, and her father, who is a head nurse, have both encouraged her to go into the counseling profession. Angela has a brother, John, who is two years older and going to medical school. She describes her relationship with her parents as loving but sometimes a little overwhelming and claustrophobic. Angela lives at home and is beginning to feel frustrated because her parents continue to want to know where she is most of the time. Angela has done particularly well in school, especially in the sciences and math. In fact, while working toward her bachelor's degree, she switched majors her junior year from psychology to chemistry with the distant thought that, like her brother, maybe she too would go to medical school. Although Angela is doing well in her courses, she continues to have a "funny feeling" about being a counselor. Deep inside, she thinks that maybe she should be doing something else.

Psychodynamic Theory (e.g., Roe)

The career counselor who employs a psychodynamic approach would assume that, in unconscious ways, Angela's parents have strongly influenced the kinds of career choices she has made. Having had loving parents who were somewhat overprotective and who are both in service occupations could push Angela toward a service occupation such as counseling (see Figure 11.1). However, one would not want to rule out many other service occupations. In addition, examining the kinds of early modeling and messages she received from her parents, as well as the general parenting style and how that may have affected her personality development (e.g., dependency needs), can offer the counselor a wealth of information about Angela. Also, the counselor would want to examine Angela's position in her family and understand what it was like being the youngest in the family, the only daughter in the family, and the younger sister of a successful older brother.

Social Cognitive Career Theory

The career counselor who uses a social cognitive career approach is concerned about objective factors and perceived factors in building Angela's self-efficacy. This is especially important in that Angela seems to be interested in sciences, and yet is pursuing a field that she has a "funny feeling" about. In particular, the counselor might want to examine the kinds of messages Angela has received from her parents and from society relative to her career choices. Sometimes, despite the fact that one does well in school, reinforcement for certain jobs may not occur due to stereotypes that teachers and others hold of African American students. For Angela, these stereotypes might have affected her perceived notions of what she can (and cannot) do in the world of work. The counselor might also want to look at blocks that have been put in Angela's way toward achieving in the medical field. For instance, have there been opportunities that have been missed because of her cultural background (e.g., not being chosen in class for special projects, not being told about certain "paths" to medical school, etc.)? Both perceived and objective factors have built Angela's self-efficacy—or belief in what she can and should do, all of which affects the choices she makes for her future.

Constructive Development Theory

From the constructivist perspective, the counselor wants to understand how Angela makes meaning out of her career decisions. Ultimately, the counselor wants to listen to the narratives, or stories, Angela tells herself relative to her career path. What dominant stories are driving her current decision to be a counselor, and are there other, non-dominant stories, that present a different scenario for Angela? Whether these others stories can and should take on a more dominant role in Angela's life might be something for her to consider. Being respectfully curious, the counselor might ask such questions as:

- Tell me how you ended up pursuing a counseling degree?
- What factors affected your choices to go into counseling?
- What stories do you tell yourself about being a counselor?
- Are there specific memories you have about being a counselor? What are those?
- Are there other careers that you have fantasized about?

- Are there memories you have about pursuing a career in the medical field? What are those?
- What prevented you from pursuing these other careers?
- Do you think the stories you have about other careers would be important for you to explore?
- What do you think about focusing on the "other" stories rather than the dominant story of being a counselor?

Ultimately, Angela will want to look at her narratives and make a decision about which stories have dominated her life and which stories she wants to have dominating her life.

Bringing it all Together

As you can see, each theory offers us a unique perspective about Angela; when used together, they can provide Angela the best opportunity to understand herself and make choices that would work best for her. As you can imagine, to fully assist Angela would take some time and would involve understanding that Angela is working through expected developmental struggles, exploring her past and the influences it has had on her, assessing her lifespan developmental level, taking time to understand her present ways of making sense out of the world, assessing her traits, helping her examine opportunities that are available to her, understanding her self-efficacy, exploring stereotypes that may have influenced her, exploring her dominant and non-dominant narratives, and assisting her in making a transition to a new way of perceiving the world. Indeed, we are not simply talking about finding Angela a job or changing her major but helping Angela gain deep knowledge about herself so she can make the wisest decisions for her life.

■ The Use of Career-Related Information

An extensive amount of occupational information is available in the field of career counseling and career development, which can assist clients in understanding the nature of work, increase client self-understanding, and help counselors understand their clients. This section will examine some of the more prevalent informational resources available. Keep in mind that these represent just a few of the many ways of obtaining information about the world of work.

Occupational Classification Systems

O*NET OnLine and O*NET Dictionary of Occupational Titles

The *Occupational Information Network* (O*NET, www.onetcenter.org), is an online database developed by the Department of Labor that provides a large array of worker attributes and job characteristics for approximately 1,000 occupations.

O*NET OnLine and O*NET DOT (Farr & Shatkin, 2004), a hardbound version of O*NET OnLine, replace the *Dictionary of Occupational Titles* (DOT), which for years was the major occupational classification system of the Department of Labor and gave descriptions of approximately 13,000 occupations. Although far fewer occupations are listed in O*NET OnLine and O*NET DOT, "Many old DOT jobs were highly specialized

or employed few people, and their descriptions were not included in the O*NET. The result is a list of O*NET occupations that is smaller and far more useful for many purposes" (Farr & Shatkin, 2004, p. 1).

O*NET OnLine and O*NET DOT provide a large array of occupational information, much of which can be cross-referenced, examined from different perspectives, and provide illumination in occupational searches. Figure 11.5 is the content model from which O*NET is based. Each of the occupations listed in O*NET describes the different kinds of information listed in this model (for a detailed discussion, see: http://www.onetcenter.org/content.html).

Box 11.3 shows two items from the content model for school counselors and mental health counselors: "Job Tasks" and "Wages and Employment" (Labor Market Information) and offers a glimpse of the extensive information that O*Net offers.

The Guide for Occupational Exploration (GOE)

Originally published in 1979 as a companion volume to the DOT, the *Guide for Occupational Exploration* (GOE) recently underwent a major revision and now includes 16 *interest areas* (see Box 11.4) and 100 *work groups* (Farr & Shatkin, 2006). The GOE lists approximately 900 occupations that are cross-referenced with the interest areas and work groups. Based on the O*NET system, the GOE includes such information as job descriptions, projected growth rate, education and/or training needed, values, skills, and working conditions. In addition, the GOE provides a mechanism to cross-reference interests, skills, values, and so forth to potential occupations.

FIGURE 11.5
The O*NET Content Model
Source: O*NET (2010). *The O*NET content model*. Retrieved from http://www.onetcenter.org/content.html
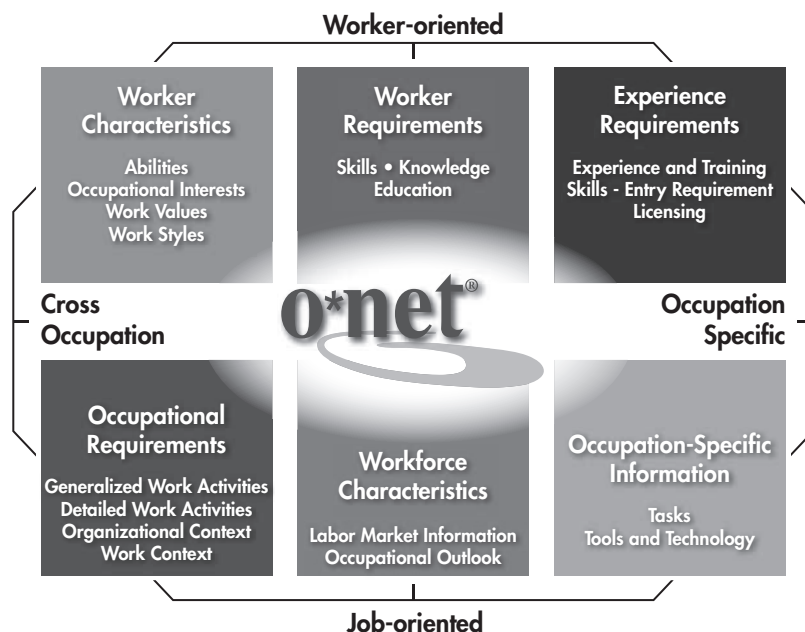
BOX 11.3

Tasks and Wages and Employment for School and Mental Health Counselors from O*Net Online

Tasks (School Counselor)

- Counsel students regarding educational issues such as course and program selection, class scheduling, school adjustment, truancy, study habits, and career planning.

- Counsel individuals to help them understand and overcome personal, social, or behavioral problems affecting their educational or vocational situations.

- Maintain accurate and complete student records as required by laws, district policies, and administrative regulations.

- Confer with parents or guardians, teachers, other counselors, and administrators to resolve students' behavioral, academic, and other problems.

- Provide crisis intervention to students when difficult situations occur at schools.

- Identify cases involving domestic abuse or other family problems affecting students' development.

- Meet with parents and guardians to discuss their children's progress and to determine their priorities for their children and their resource needs.

- Prepare students for later educational experiences by encouraging them to explore learning opportunities and to persevere with challenging tasks.

- Encourage students or parents to seek additional assistance from mental health professionals when necessary.

- Observe and evaluate students' performance, behavior, social development, and physical health.

Wages and Employment Trends (School Counselor)
Median wages (2009): $25.27 hourly, $52,550 annual
Employment (2008): 276,000 employees
Projected growth (2008–2018): Faster than average (14% to 19%)
Projected job openings (2008–2018): 94,400

Tasks (Mental Health Counselor)

- Maintain confidentiality of records relating to clients' treatment.

- Assess patients for risk of suicide attempts.

- Encourage clients to express their feelings and discuss what is happening in their lives, and help them to develop insight into themselves and their relationships.

- Collect information about clients through interviews, observation, and tests.

- Counsel clients and patients, individually and in group sessions, to assist in overcoming dependencies, adjusting to life, and making changes.

- Guide clients in the development of skills and strategies for dealing with their problems.

- Develop and implement treatment plans based on clinical experience and knowledge.

- Fill out and maintain client-related paperwork, including federal- and state-mandated forms, client diagnostic records, and progress notes.

- Prepare and maintain all required treatment records and reports.

- Evaluate clients' physical or mental condition based on review of client information.

Wages and Employment Trends (Mental Health Counselor)
Median wages (2009): 18.28 hourly, $38,010 annual
Employment (2008): 113,000 employees
Projected growth (2008–2018): Much faster than average (20% or higher)
Projected job openings (2008–2018): 50,100

Retrieved June 9, 2010, from O*NET Online from "School Counselors" and "Mental Health Counselors."

BOX 11.4

GOE's Sixteen Interest Areas

1. Agriculture and Natural Resources	9. Hospitality, Tourism, and Recreation
2. Architecture and Construction	10. Human Service
3. Arts and Communication	11. Information Technology
4. Business and Administration	12. Law and Public Safety
5. Education and Training	13. Manufacturing
6. Finance and Insurance	14. Retail and Wholesale Sales and Service
7. Government and Public Administration	15. Scientific Research, Engineering, and Mathematics
8. Health Science	16. Transportation, Distribution, and Logistics

The Occupational Outlook Handbook (OOH)

The Occupational Outlook Handbook (OOH) (United States Department of Labor, 2010) is an online "handbook" that includes information on the nature of work of an occupation; training, other qualifications, and advancement; employment statistics; job outlook; projections; earnings; wages; related occupations; and sources of additional information. Although the handbook focuses on a few hundred major job categories, information about sub-categories are found after one goes to the main page of the major category. Thus, if one goes to the statistics for "counselor" (see: www.bls.gov/oco/ocos067.htm), information would be found about school counselors, rehabilitation counselors, vocational counselors, mental health counselors, substance abuse counselors, and marriage and family counselors.

Assessment Instruments

Interest Inventories

Over the years, a number of assessment instruments have been developed to assist individuals in their career exploration process. Probably the most important of these have been the *interest inventories*, such as the *Strong Interest Inventory* (CPP, 2004, 2009a), the *Career Decision-Making System* (CDM) (PsychCorp, 2009a), and the *Career Assessment Inventory* (CAI) (PsychCorp, 2009b). Interest inventories examine a client's interests in such areas as school subjects, types of people, types of occupations, amusements, and/or personal characteristics. Some interest inventories, like the *Self-Directed Search* (PAR, 2009), and the *Strong* (again) use the Holland Codes to examine an individual's personality orientation toward the world of work and usually provide occupations in which the client might find a good fit.

Assessment of Aptitude

Aptitude testing allows an individual to examine whether or not occupational preferences match his or her ability. For instance, an individual who has interest in becoming a researcher but has little math ability may have a difficult time achieving his or her occupational goals, and a person who is found to have high mechanical ability might consider various jobs that relate to this aptitude. Two of the popular aptitude tests include

the Differential Aptitude Test (DAT) (Pearson, 2009), and the *Armed Services Vocational Aptitude Battery* (ASVAB) (Military.com, 2010), which was developed for the military and is sometimes given in high schools for free.

Personality Assessment

Numerous personality tests have been used in conjunction with career counseling. Tests such as the *Myers-Briggs Type Indicator* (CPP, 2009b) and the *California Psychological Inventory* (CPI) (CPP, 2009c). can help a client focus on basic personality dimensions and examine whether or not his or her personality profile might fit with certain jobs (see Box 11.5).

Computer-Assisted Career Guidance

The expansion in the use of personal computers has made career information systems available to a vast array of individuals. Today, there are numerous software programs that allow individuals to assess abilities, interests, values, and skills and other related information. For instance, self-directed comprehensive computer-based career guidance programs that help individuals explore their interests, personality, and skills can now be found on the web or purchased as stand-alone software programs. Two common programs include *Discover* (ACT, 2010) and the *System of Interactive Guidance and Information-Plus* (SIGI-Plus) (Valpar, 2010), which can often be accessed at college career counseling centers and other settings where career guidance is offered. Of course, today, a host of interest inventories and personality tests related to career choice can be accessed directly on the web. In addition, other career information is also available, from sites like O*NET, OOH, and other government and non-government sources.

Other Sources of Occupational Information

The amount of occupational information available is enormous, and much of it is free! For instance, printed materials can be obtained from a number of government agencies, commercial publishers, professional associations, and educational institutions. In addition, many colleges and trade schools have career centers available for use by their students and even sometimes for the general public. In addition to free materials, numerous books offer career information materials. Today, there are even best-selling paperbacks that assist us in our career development [e.g., *What Color Is Your Parachute?* (Bolles, 2010)]. Finding information about occupations is relatively easy if one spends just a little bit of time.

BOX 11.5

Shayna's Personality Profile

Shayna had definitely decided that she was interested in an occupation that would provide her with an opportunity to help people. A personality inventory indicated that she was very reserved and nonassertive and deferred to others. She agreed with the results of the personality inventory and further agreed that these characteristics would make it difficult for her to accomplish her occupational goal. Shayna became convinced that she would have to modify these personality characteristics through a variety of programs, including self-discovery groups and assertiveness training. (Zunker, 2002, pp. 222–223)

■ *The Clinical Interview: The Lost Child in Career Development*

The field of career counseling is so replete with theories, career information, and career assessment instruments that sometimes it seems like our most precious counseling tool, the clinical interview, is forgotten. A good clinical interview can help the counselor gain an enormous amount of information about a client, information that can be effectively used in helping the client make career choices. The clinical interview is our way of operationalizing our career development theories. It can be used to assess family-of-origin issues that have had an impact on the client's career development, the meaning-making system of the client, client desires and wants, how the client tends to present him- or herself, and emotional problems that might interfere with seeking out or maintaining certain jobs.

The clinical interview is a major part of the total assessment process for the client, and the counseling skills learned in a graduate program are the vehicle for that assessment. If career counseling meant only assessing traits and matching those traits with jobs, we would be operating out of a turn-of-the-last-century paradigm and would hardly need an advanced degree to work with clients.

■ *Integrating Theory, Career Information, and Career Assessment*

Between the numerous theories of career counseling and the enormous amount of occupational information available to counselors, you may be asking, "Where do I start when doing career counseling?" The following offers general guidelines for what you might want to cover when doing comprehensive career counseling.

1. Conduct a thorough clinical interview. Assess factors crucial to the client's career development process, including the following:

   - How early childhood issues may have affected the client's propensity toward certain careers (e.g., placement in family, parenting styles, traumatic events, etc.)
   - How socioeconomic status of the family of origin may impact the client's aspirations (affordability of continuing one's education)
   - How parents' career development may impact the client's aspirations (e.g., stories we are told about our parents' work life and how that translates into stories about our career path)
   - How emotional problems may interfere with career decision making (e.g., depression, anxiety disorder, etc.)
   - How sociological issues may impact career decision making (stereotyping, discrimination, economic issues, and so forth)
   - How certain dominant stories drive the client's career decision-making process
   - An assessment of the tasks to be completed based on the client's career development level (e.g., Super)
   - How perceived factors and client's self-efficacy affect the choices the client makes
   - How past, current, and future barriers might deleteriously affect the client's career decision-making process

2. Assess the client's abilities, interests, and personality characteristics through the use of appropriate assessment instruments (e.g., Holland code, the CPI, the Strong).
3. Devise treatment strategies in collaboration with your client that are congruent with his or her developmental readiness and the information gathered about your client.
4. Make available appropriate informational resources that can be used in conjunction with your treatment plan.
5. Assist the client in understanding the world of work and factors that may potentially affect career choice (such as economic conditions or market saturation).
6. Help the client examine issues related to self-efficacy, dominant narratives, and perceived factors that prevent the client from taking his or her best career path.
7. Examine barriers to career choices and what can be done to eliminate them (e.g., racism, economic hardship, lack of educational opportunities, etc.).
8. Have the client make tentative career decisions.
9. Explore the practicality of the career decisions chosen and begin to crystallize a choice.
10. Have the client take preliminary steps toward choosing a career path by doing such things as informational interviews with individuals who have taken a similar path, shadowing people at a job, and reading literature about the career path.
11. Follow up with the client to ensure satisfaction and closure of the career development process.
12. Recycle if necessary. If the client is unsatisfied with his or her progress, start the process over and reexamine all the issues.

As you can imagine from the above, a thorough career assessment can be a rather lengthy process. However, the use of such a process creates career choice and not career happenstance.

Multicultural/Social Justice Focus

Multicultural Theory of Career Development

Although no one method of conducting career counseling for individuals from diverse backgrounds has been developed, a number of unique issues have been highlighted for counselors to consider when working with culturally diverse clients. Some of these include the following (Arthur & McMahon, 2005; Byars-Winston & Fouad, 2006; Gysbers et al., 2009; Subich, 2005):

1. Cultural values and practices may make full access to the workplace more difficult for some people (e.g., certain religious practices, such as praying every day and taking time off for certain holidays, may be frowned upon at the workplace).
2. Whereas mainstream America has lived a life of upward mobility, some cultures and classes have not lived this dream and approach career development with different goals and aspirations.
3. Acknowledgement that there is a wide range of influences on a person (e.g., geography, family, media, workplace, etc.) and that they differentially affect people of color.

4. The expression of self and the development of self-concept is central to the career development process, regardless of cultural background.

5. The person environment (personality workplace) fit, regardless of cultural background, is crucial for satisfaction at work.

6. The better the client understands his or her cultural identity development (see Chapter 14), the easier it will be for the client to find a fit between self and environment.

7. Discrimination in attaining jobs and at the workplace is a reality and needs to be addressed and acknowledged by career counselors.

8. Discrimination and racism have resulted in some people having serious doubts about their ability to obtain jobs and be upwardly mobile.

9. There are probably more differences within a cultural group than between cultural groups. Avoid uniformity of assumptions or thinking that all clients from one culture are the same.

10. Know that assessment procedures, so prevalent in career counseling, may have inherent biases and may not predict as well for some culturally diverse groups and women.

11. Knowing one's own biases and stereotypes and how to address them while counseling clients from nondominant groups is critical.

12. Have the knowledge and skills necessary to be able to work effectively with a wide range of clients (see multicultural career counseling and development competencies in the next section).

Multicultural Career Counseling and Development Competencies

In 2009, the National Career Development Association (NCDA) developed a set of *Minimum Competencies for Multicultural Career Counseling and Development* (see NCDA, 2009). These competencies speak to the ability of the career counseling professional to "promote the career development and functioning of individuals of all backgrounds" (para. 1). The competencies touch on multicultural competence in a wide variety of areas including career development theory, counseling skills, assessment, information technology, program development, coaching and consultation, supervision, ethical and legal issues, and research and evaluation.

Social Justice Focus: Reshaping Clients' Stories

Yet is it possible to prepare students [and clients] for the vagaries of an uncertain world without ensuring that they have a critical understanding of how social, political and economic discourses impact on constructions of 'career', 'opportunity', 'self', and 'justice'? (Irving, 2010, p. 51)

Recent approaches to the understanding of career counseling and career education have increasingly focused on how a client's sense of their "career" is affected by the kinds of relationships and discourse he or she has with others. This relational cultural constructivist approach assumes that in interaction with the world around us, there are forces that shape one's view of how people make sense of who they are relative to their occupational

choices and career path (Schultheiss, 2007). This approach assumes that change does not reside "within" the person, but is a function of interactions with people. And, it assumes that individuals can understand these interactional forces and see how biases, racism, discrimination, and so forth have affected their development and meaning making system. Taking this perspective, counselors are increasingly called to have a new discourse with clients and help them see how their stories or narratives have been shaped by those around them. In the case of career counseling, this means helping clients understand how relationships have embedded certain belief systems within their understanding of their world of work (I am not capable, people will prevent me from making it, I cannot achieve in _____, etc.). Today, the dual role for the career counselor includes being a listener to clients' stories and helping them hear how they have developed their stories and being an advocate for oppressed groups to lessen the negative impact that social factors have on them (Marchand, 2010; McMahon, Arthur, & Collins, 2008).

Ethical, Professional, and Legal Issues

Ethical Issues

Ethical Standards for Career Counseling and Consultation

In 1982, the National Board for Certified Counselors (NBCC) developed its own set of ethical standards, which was adopted by the National Career Development Association (NCDA) in 1987 and revised in 2003 (NCDA, 2003). Because NCDA is a division of ACA, these ethical guidelines should be read in conjunction with the overarching ethical guidelines of ACA. The guidelines contain six sections: general ethical concerns, the counseling relationship, measurement and evaluation, research and publication, consulting, and private practice. In addition, the guidelines contain a statement on how to make an ethical complaint against a career counselor.

Competency Guidelines for Career Development

In addition to the *Multicultural Career Counseling and Development Competencies* already mentioned, NCDA offers a broad-based description of competencies needed for all counselors who practice vocational and career counseling (NCDA, 1997). These competencies include general counseling skills, information, individual/group assessment, management/administration, implementation, and consultation. Recognizing the complexity of career development over the lifespan, the NCDA has also developed specific competencies for those who work with elementary, middle/junior, or high school students, and/or with adults. These competencies address the skills, knowledge, behaviors, and attitudes necessary to be an effective career counselor at the various levels of development.

Professional Issues

Professional Associations

The NCDA and the National Employment Counselors Association (NECA), both divisions of ACA, are two associations oriented toward career development. (You can reach these divisions through the ACA Web site: www.counseling.org.) The *Career Development*

Quarterly, published by NCDA, and the *Journal of Employment Counseling*, published by NECA, are circulated quarterly and are two of the many benefits to those who join the associations.

Optimizing Career Development

Recently, when teaching a class, I asked my students to share why they had decided to enter the helping professions. An African American student told me about her school counselor, who had treated most African American students in her high school in a manner that would discourage them from pursuing jobs in professional fields. She said, "This is why I have decided to become a school counselor—so I could assist African Americans in reaching their potential." Unfortunately, this is not the first time I have heard a story such as this.

Career counselors should be optimizing choices for clients, whether they are school counselors working with disadvantaged youth, college counselors assisting college students in job choices, agency counselors working with middle-aged adults who are seeking a job change, vocational rehabilitation counselors working with individuals who recently became paraplegic, or graduate students considering their options concerning doctoral work. Counselors should never say, "I don't think you can make it, you don't have the ability, you don't have the skills, or you won't be able to take the pressure." Instead, they should be encouraging clients, increasing options, and helping clients reach their potential. Be realistic, but don't be discouraging. At best, discouraging clients in the pursuit of career dreams is incompetent; at worst, it is racist, sexist, ageist, and discriminatory toward individuals with disabilities.

Legal Issues: Important Laws

Carl Perkins Act

Passed in 1984, this act authorized grants for the expansion of career guidance programs for students who had vocational education needs, as well as adults, single parents, displaced homemakers, ex-offenders, incarcerated persons, and individuals with disabilities who have needs for vocational education (Herr et al., 2004).

Americans with Disabilities Act

This law, passed in 1992, ensures that qualified individuals with disabilities cannot be discriminated against in job application procedures, hiring, firing, advancement, compensation, fringe benefits, job training, and other terms, conditions, and privileges (see http://www.ada.gov).

PL94-142 (The Education of All Handicapped Children Act)

Concerning career guidance, this law, along with the *Carl Perkins Act*, requires that students in occupational education programs must be given vocational assessment to assist them in their career development.

PL93-112

This law requires colleges to provide career services to persons with disabilities. For instance, students who are visually impaired might be given materials in Braille to assist them in career guidance activities.

Rehabilitation Act of 1973

The *Rehabilitation Act of 1973* ensured access to vocational rehabilitation services for adults if they are severely physically or mentally disabled, if they have a disability that interferes with their ability to obtain or maintain a job, and if assessment has shown that employment with their disability is feasible.

School-to-Work Opportunities Act

Passed in 1994 by Congress, this act provides incentives to help schools and community colleges develop programs that integrate academic learning with on-the-job experiences.

Title VII and Title IX

Title VII of the *1964 Civil Rights Act* and Title IX of the *Education Amendments of 1972* prohibit discrimination against women and minorities in all aspects of employment. In addition, Title VII and subsequent amendments set standards for the use of tests to ensure they do not discriminate against culturally diverse populations.

The Counselor in Process: Career Development as a Lifespan Process

Career development is a lifelong process. It starts at birth and continues until we die. It is not just the process of finding a job, but how we actualize all our life roles. An astute counselor understands this process. He or she views it much like navigating a flowing river—a river that has twists and turns; parts that seem shallow, dangerous, and scary; and parts that are deep, still, and stable. This counselor understands that the river starts to flow in infancy when the child first begins to imitate adult behaviors and continues into young childhood when the youngster wonders about the world of work. Such a counselor sees this river pick up speed in adolescence with the teenager who begins to explore his or her interests, values, and abilities, and watches it move more rapidly and dangerously in young adulthood when the individual tentatively chooses a career. This river soon deepens and slows in mid-adulthood with the person who feels established, or suddenly takes sharp twists and turns with the middle-aged person who decides to take a fresh look at his or her career choices. The river begins to slow in later life with the individual who moves out of work and into leisure activities, or the person who decreases the amount of work he or she is doing. The committed and wise career counselor is willing to flow, for a short while, along this river with his or her client; and, perhaps, if the helper is a good navigator, he or she can assist in guiding the client down the river along the most direct and stable route.

◼ *Summary*

This chapter examined the counselor and the world of work. We began by defining a number of terms relevant to understanding career development. We then examined some sociological, psychological, and economic reasons why work and adequate career planning are so crucial for job satisfaction and positive mental health.

We noted that career development, formerly called vocational guidance, is the origin of the counseling profession and can be traced back to the early 1900s with the work of Frank Parsons. We noted that vocational guidance started out as a concrete and somewhat directive trait-and-factor approach. However, with the advent of new theories by Donald Super and others, it became a more humanistically oriented, developmental approach and has since been called career development.

We next went on to describe some of the more popular and researched theories on career development, although we noted a number of other theories also are used. Starting with trait-and-factor theory, we talked about how it has expanded over the years and today users of this approach assess how a wide range of client skills, interests, and personality variables might affect eventual career choices. We then examined the psychodynamic theory of Ann Roe, who advanced the idea that early parenting styles were instrumental in shaping occupational choice. We looked at John Holland's theory, which states that people express their personality through the types of career choices they make, and we examined Donald Super's developmental theory, which suggests a person's self-concept is both a function and result of one's career development process. Moving on to a more recent approach, we highlighted Social Cognitive Career Theory and noted that this theory suggests that objective factors, such as environmental factors (e.g., social influences) and perceived factors, both affect the kinds of decisions one makes about career choice. Lastly, we reviewed constructive developmental theory, which stresses the importance of understanding how the client makes meaning of his or her career development process. We noted that narratives are often used to assess meaning and to help identify a client's meaning-making system. We concluded by noting that most career counselors today attempt to integrate many of these approaches when doing career counseling.

The next part of this chapter examined some of the prevalent kinds of career-related information that is available. We first presented an overview of occupational classification systems. We started by describing the Occupational Information Network (O*NET), which is an online database developed by the Department of Labor that provides a large array of worker attributes and job characteristics for about 1000 occupations. Next we discussed the Guide for Occupational Exploration, which lists approximately 900 occupations that are cross-referenced with 14 interest areas and 83 work groups. The last system we examined was the Occupational Outlook Handbook (OOH), which includes a wide range of information on the nature of work for a select group of a few hundred occupations. We then learned about how the assessment of interest inventories, aptitudes, and personality is important in career counseling.

We next went on to discuss the growing use of computers in career guidance and noted that comprehensive computer-based programs, computer-assisted assessment, and career resources on the Internet are becoming increasingly popular.

Having discussed theories, occupational information, and assessment techniques, we highlighted the point that the clinical interview is one of the most important tools the counselor has when working with clients. We then presented an outline for the

integration of career development theories, occupational information, assessment techniques, and the clinical interview when doing career counseling.

Although we noted that there was no theory of multicultural career development, we stated that some general guidelines should be considered when working with diverse clients. In addition, we elucidated a number of steps to use when counseling clients from nondominant groups on career issues.

Near the end of the chapter, we mentioned the two major associations in the field of career development: the NCDA and the NECA. We also noted that the NCDA offers ethical guidelines and suggests general competencies in the training of career counselors as well as Minimum Competencies for Multicultural Career Counseling and Development. We discussed the fact that counselors should be optimizing choices for clients, not limiting them, and we noted some important laws related to career counseling and career guidance.

Lastly, we emphasized that career counseling is a lifelong process that has twists and turns and that an effective career counselor helps to guide the client toward making this ride a little more satisfying.

References

ACT. (2010). DISCOVER career planning program. Retrieved from http://www.act.org/discover/

Albert, K. A., & Luzzo, D. A. (1999). The role of perceived barriers in career development: A social cognitive perspective. *Journal of Counseling and Development, 77*(4), 431–436.

Arthur, N., & McMahon, M. (2005). Multicultural career counseling: Theoretical applications of the systems theory framework. *Career Development Quarterly*, 53(3), 208–222.

Aubrey, R. F. (1977). Historical development of guidance and counseling and implications for the future. *Personnel and Guidance Journal, 55*, 288–295.

Bandura, A. T. (1997). *Self-efficacy: The exercise of control.* New York: W. H. Freeman.

Blustein, D. L. (2006). *The psychology of work: A new perspective for career development counseling, and public policy.* Mahwah, NJ: Lawrence Erlbaum Associates.

Bolles, R. N. (2010). *What color is your parachute? 2010: A practical manual for job-hunters and career changes.* New York: Ten Speed Press.

Bujold, C. (2002). Constructing career through narrative. *Journal of Vocational Behavior, 64*, 470–484.

Briddick, W. (2009a). Frank findings: Frank Parsons and the Parson family. *Career Development Quarterly*, 57(3), 207–214.

Briddick, W. C. (2009b). Frank Parsons on interests. *Journal of Vocational Behavior, 74*(2), 230–233.

Brown, D. (2002).The role of work values and cultural values in occupational choice, satisfaction, and success: A theoretical statement. In D. Brown (Ed.), *Career choice and development* (4th ed., pp. 465–509). San Francisco: Jossey-Bass.

Brown, D. (2007). *Career information, career counseling, and career development* (9th ed.). Boston, MA: Pearson.

Brown, M., Lum, J., & Voyle, K. (1997). Roe revisited: A call for the reappraisal of the theory of personality development and career choice. *Journal of Vocational Behavior*, 51(2), 283–94.

Byars-Winston, A., & Fouad, N. (2006). Metacognition and multicultural competence: expanding the culturally appropriate career counseling model. *Career Development Quarterly*, 54(3), 187–201.

CPP. (2004). *Technical brief for the newly revised Strong Interest Inventory assessment: Content, reliability, and validity.* Retrieved from http://www.cpp.com/products/strong/StrongTechnicalBrief.pdf

CPP. (2009a). *Strong Interest Inventory*. Retrieved from https://www.cpp.com/products/strong/index
.aspx

CPP. (2009b). *Myers-Briggs Type Indicator*. Retrieved from https://www.cpp.com/products/mbti/
index.aspx

CPP. (2009c). *The CPI Assessments*. Retrieved from https://www.cpp.com/products/cpi/index.aspx

Dawis, R. V. (2005). The Minnesota theory of work adjustment. In S. D. Brown & R. W. Lent
(Eds.), *Career development and counseling: Putting theory and research to work* (pp. 3–23). Hobo-
ken, NJ: Wiley.

Ethridge, G., Burnshill, D., & Dong, S. (2009). Career counseling across the life span. In I. Marini, &
M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 443–465). New York:
Springer Publishing Company.

Farr, J. M., & Shatkin, L. (2004). *O*NET Dictionary of occupational titles* (3rd ed.). Indianapolis, IN:
Jist Works.

Farr, J. M. & Shatkin, L. (2006). *Guide for occupational exploration* (4th ed.). St. Paul, MN: JIST
Publishing.

Fritzsche, B., & Parrish, T. (2005). Theories and research on job satisfaction. In S. D. Brown
& R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work*
(pp. 180–202). Hoboken, NJ: John Wiley & Sons.

Ginzberg, E. (1972). Toward a theory of occupational choice: A restatement. *Vocational Guidance
Quarterly, 20,* 169–176.

Ginzberg, E., Ginsburg, S. W., Axelrad, S., & Herma, J. (1951). *Occupational choice: An approach to
a general theory*. New York: Columbia University Press.

Gottfredson, G. D., Holland, J. L., & Ogawa, D. K. (1996). *Dictionary of Holland occupational codes*.
Odessa, FL: Psychological Assessment Resources.

Greenhaus, J. H., & Callanan, G. A. (Eds.). (2006). *Encyclopedia of career development*. Thousand
Oaks, CA: Sage.

Gysbers, N. C., Heppner, M. J., & Johnston, J. A. (2009). *Career counseling: Contexts, processes, and
techniques* (3rd ed.). Alexandria, VA: American Counseling Association.

Herr, E. L., Cramer, S. H., & Niles, S G. (2004). *Career guidance and counseling through the life span:
Systematic approaches* (6th ed.). Boston: Pearson/Allyn & Bacon.

Hershenson, D. B. (2009). Historical perspectives in career development theory. In I. Marini, &
M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 411–420). New York:
Springer Publishing Company.

Holland, J. L. (1973). *Making vocational choices: A theory of career*. Englewood Cliffs, NJ: Prentice Hall.

Holland, J. L., & Gottfredson, G. D. (1976). Using a topology of persons and environments to ex-
plain careers: Some extensions and clarifications. *Counseling Psychologist, 6,* 20–29.

Hutchison, B., & Niles, S. G. (2009). Career development theories. In I. Marini, & M. A. Steb-
nicki (Eds.), *The professional counselor's desk reference* (pp. 467–476). New York: Springer Pub-
lishing Company.

Irving, B. A. (2010). (Re)constructing career education as a socially just practice: an antipodean
reflection. *International Journal for Educational and Vocational Guidance, 10,* 49–63. doi: 10.1007/
s10775-009-9172-1

Jones, L. K. (1994). Frank Parsons' contribution to career counseling. *Journal of Career Develop-
ment, 20*(4), 287–294. doi: 10.1007/s10775-009-9172-1

Lent, R. W. (2005). A social cognitive view of career development and counseling. In S. D. Brown &
R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp.
101–127). New York: John Wiley.

Lent, R. W., Brown, S. D. & Hackett, G. (1994). Toward a unifying social cognitive theory of
career and academic interest, choice, and performance. *Journal of Vocational Behavior, 45,*
79–122.

Lent, R. W., Brown, S. D., & Hackett, G. (2000). Contextual supports and barriers to career choice: A social cognitive analysis. *Journal of Counseling Psychology, 47*, 36–49.

Lent, R. W., Brown, S. D., & Hackett, G. (2002). Social cognitive career theory. In D. Brown and Associates, *Career choice and development* (4th ed., pp. 255–311). San Francisco: Jossey-Bass.

Marchand, M. M. (2010). Application of Paulo Freire's *Pedagogy of the Oppressed* to human services education. *Journal of Human Services, 30*(1), 43-53.

McAuliffe, G. (1993). Constructive development and career transition. Implications for counseling. *Journal of Counseling and Development, 72*, 29–36.

McDaniels, C., & Watts, G. A. (Eds.). (1994). Frank Parsons: Light, information, inspiration, co-operation [Special issue]. *Journal of Career Development, 20*(4).

McMahon, M., Arthur, N., & Collins, S. (2008). Social justice and career development: Looking back, looking forward. *Australian Journal of Career Development, 17*(2), 21–29.

Military.com. (2010). *Common ASVAB questions*. Retrieved from http://www.military.com/ ASVAB/0,,ASVAB_Explained2.html

National Career Development Association. (1997). *Career counseling competencies*. Retrieved from www.ncda.org/pdf/counselingcompetencies.pdf

National Career Development Association. (2003). *Ethical standards*. Retrieved from http://www .ncda.org/pdf/EthicalStandards.pdf.

National Career Development Association. (2009). *Minimum competencies of multicultural career counseling and development*. Retrieved from http://www.associationdatabase.com/aws/NCDA/ asset_manager/get_file/9914/minimum_competencies_for_multi-cultural_career_counseling.pdf

Parsons, F. (1989). *Choosing a vocation*. Garrett Park, MD: Garrett Park. (Original work published 1909)

Patton, W., & McIlveen, P. (2009). Practice and research in career counseling and development—2008. *The Career Development Quarterly, 58*(2), 118–161.

Pearson. (2009). *Differential Aptitude Tests-Fifth Edition*. Retrieved from http://www. pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=015-4060-47X

Peterson, G. W., Sampson, J. P., & Reardon, R. C. (1991). *Career development and services: A cognitive approach*. Pacific Grove, CA: Brooks/Cole.

Pope, M., & Sveinsdottir, M. (2005). Frank, we hardly knew ye: The very personal side of Frank Parsons. *Journal of Counseling and Development, 83*, 105–115.

PsychCorp. (2000a). Harrington-O-Shea Career Decision-Making System Revised. Retrieved from http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm? Pid=PAa12633&Mode=summary

PsychCorp. (2009b). Career Assessment Inventory – The Enhanced Version. Retrieved from http:// www.pearsonassessments.com/tests/cai_e.htm

Psychological Assessment Resources. (2009). *Self-Directed Search*. Retrieved from http://www.self-directed-search.com/default.aspx

Roe, A. (1956). *The psychology of occupations*. New York: Wiley.

Roe, A., & Siegelman, M. (1964). *The origin of interests*. APGA Inquiry Studies No. 1. Washington, DC: American Personnel and Guidance Association.

Rottinghaus, P. J., Hees, C. K., & Conrath, J. A. (2009). Enhancing job satisfaction perspectives: Combining Holland themes and basic interests. *Journal of Vocational Behavior, 75*, 139–151.

Schultheiss, D. E. P. (2007). The emergence of a relational cultural paradigm for vocational psychology. *International Journal for Educational and Vocational Guidance, 7*, 191–201. doi: 10.1007/ s10775-007-9123-7

Sharf, R. S. (2010). *Applying career development theory to counseling* (5th ed.). Belmont, CA: Brooks/ Cole.

Spokane, A. R., Luchetta, E. J., & Richwine, M. H. (2004). Holland's theory of personalities in work environments. In D. Brown (Ed.), *Career choice and development* (4th ed., Chapter 9). San Francisco: Jossey-Bass.

Spokane, A. R., Meir, E., & Catalano, M. (2000). Person-environment congruence and Holland's theory: A review and reconsideration. *Journal of Vocational Behavior, 57*, 137–187.

Subich, L. M. (2005). Career assessment with culturally diverse individuals. In W. B. Walsh & M. L. Savickas (Eds.), *Handbook of vocational psychology: Theory, research, and pratice* (pp. 397–422). Malwah, NJ: Erlbaum.

Super, D. E. (1953). A theory of vocational development. *American Psychologist, 8*(2), 185–190. doi:10.1037/h0056046

Super, D. E. (1957). *The psychology of careers.* New York: Harper & Row.

Super, D. E. (1976). *Career education and the meaning of work.* Monographs on career education. Washington, DC: Office of Career Education, U.S. Dept. of Education.

Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey-Bass.

Super, D. E., & Hall, D. T. (1978). Career development: Person, position, and process. *Counseling Psychologist, 1*, 2–9.

Super, D. E., Savickas, M. L., & Super, C. M. (1996) Life-span, life-space approach to careers. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed., Chapter 5). San Francisco: Jossey-Bass.

Ton, M., & Hansen, J. (2001). Using a person-environment fit framework to predict satisfaction and motivation in work and marital roles. *Journal of Career Assessment, 9*(4), 315–331.

United States Department of Labor. (2010). *Occupational Outlook Handbook, 2010–2011 Edition.* Retrieved from http://www.bls.gov/oco/

Valpar. (2010). *Sigi³.* Retrieved from http://www.valparint.com/sigi3.htm

Verbruggen, M., & Sels, L. (2010). Social-cognitive factors affecting clients' career and life satisfaction after counseling. *Journal of Career Assessment, 18*(1), 3–15.

Verquer, M. L., Behr, T. A., & Wagner, S. H. (2003). A meta-analysis of relations between person-organization fit and work attitudes. *Journal of Vocational Behavior, 63*, 473–489.

This page intentionally left blank

Research, Program Evaluation, and Assessment

CHAPTER **12** *Testing and Assessment*

CHAPTER **13** *Research and Evaluation*

Overview

Research, program evaluation, and assessment have much in common, and it is therefore natural to find them together in Section V of this text. For instance, some form of quantification is involved with the application of research, program evaluation, and assessment. Program evaluation can be loosely seen as a kind of research, in that you are researching the value and worth of a program. Research often will use assessment techniques to examine the research question at hand. Finally, research, program evaluation, and assessment all involve close scrutiny of people. In research, you are examining people in reference to a hypothesis or research question; in program evaluation, you are examining how people respond to a program being offered; and in assessment you are trying to determine a person's typical or habitual ways of responding. As you read through these chapters, consider the common factors you find in these important content areas and think about ways in which you might apply research, program evaluation, and assessment in your role as a counselor.

Testing and Assessment

Ohe day while living in Cincinnati and working on my doctorate, I was walking on a downtown street when a person came up to me and said, "Do you want to take a personality test?" I said, "Sure!" I was led into a storefront and proceeded to spend about 30 minutes completing an inventory. When I finished, I was asked to wait a few minutes while they scored it. Then, a person came into the room and said, "Well, you have a pretty good personality, and you're fairly bright, but if you complete Ron Hubbard's book on *Dianetics* (the basis of "Scientology") you will have a better personality and be even brighter."

Ten years later, I was walking down a street in Minneapolis when I passed a store that was again selling books by Ron Hubbard. I walked in. Someone approached me and said, "Would you like to take a test?" I responded by noting that a number of years back I had taken such a test and was not convinced it was well made. We bantered back and forth, and finally the Scientology devotee and I came to an agreement. The deal was that I would purchase the book, *Dianetics*, and after the devotee sent me information on the reliability and validity of the test he wanted me to take (thus showing me if it was a well-made test), I would read the book. I gave him my home address. I never heard from him again.

You will be tested on this chapter! Just kidding; well, at least *I* won't be testing you on it. Tests create anxiety! Tests! Some of the most interesting, feared, misused, disliked, and potentially valuable tools we have as counselors are tests. What are they all about? This chapter will examine tests, as well as other assessment techniques.

We will begin this chapter by defining testing and assessment and then exploring why assessment is important. Then we will give a brief overview of the history of tests and assessment. We will survey some of the many different kinds of tests and review the use of basic test statistics in the development and the interpretation of assessment instruments. We will discuss the concepts of reliability, validity, cross-cultural fairness, and practicality and relate these concepts to how worthwhile a test is. Also, we will suggest ways of finding good tests, discuss the importance of writing assessment reports, and review how the use of computers has affected the administration, scoring, and interpretation of tests. Finally, we will discuss multicultural/social justice, ethical, legal, and professional issues related to testing.

Defining Testing and Assessment

*There is much ignorance about very basic measurement, evaluation,
and research topics among the practitioners . . . and among those who
are ignorant, there is, on occasion, a fair amount of hostility toward
some useful data.* (Mehrens, 1992, p. 439)

Unfortunately, although written close to twenty years ago, the above quote continues to be true today. In fact, after teaching testing and assessment for close to thirty years, I find that students initially know little about this CACREP content area. Perhaps worse, they often don't think it's an important part of what a counselor does. So, let's start with some basic definitions, and let me see if by the end of the chapter I can convince you (if you're not already a believer) of the worth of testing and assessment.

Today, the word assessment includes a broad array of evaluative procedures that yield information about a person. Assessment includes a number of techniques, such as conducting a clinical interview to establish the overall functioning of a person; using personality tests to assess temperament, affect, and habits; administering ability tests to assess learning and cognitive functioning; and utilizing informal assessment techniques to assess a wide range of a person's behaviors (Figure 12.1).

Tests are considered a subset of a broad pool of assessment techniques and yield scores based on the gathering of collective data (e.g., adding a number of correct answers on a multiple-choice exam). Tests and other assessment procedures can be formal, where the procedure is scientifically shown to be sound (or valid and reliable); or informal, which implies that such rigor has not been demonstrated, although the procedure might still yield valuable information. But why assess a person at all?

Why Testing and Assessment?

As a counselor, you will be involved with testing and assessment (Naugle, 2010). You may be administering assessment instruments. You are likely to interpret assessment instruments. You may be a consultant to others on the proper use of assessment techniques or supervise others who interpret tests and assess clients. You may use assessment procedures in research and evaluation, and you will read about assessment techniques in the professional literature. Assessment techniques have permeated many aspects of our society, but there are only a handful of professionals who know them well enough to use them properly. As a counselor, you will be one of those few.

In most schools, counselors are the only individuals who have expertise in testing and assessment (Baker & Gerler, 2008). Although school psychologists have particular expertise in assessment (Agresta, 2004), they generally float from school to school, and school administrators and teachers may be grossly undertrained in assessment (Behuniak, 2003; Elmore & Elkstrom, 2003). Special education teachers and learning disability specialists, who generally have a strong background in diagnostic testing, have a limited focus (Neukrug & Fawcett, 2010). It is not surprising, then, that elementary, middle, and secondary school counselors all report that assessment is a critical part of their job role (Elmore & Ekstrom, 2003).

FIGURE 12.1
Assessment Procedures
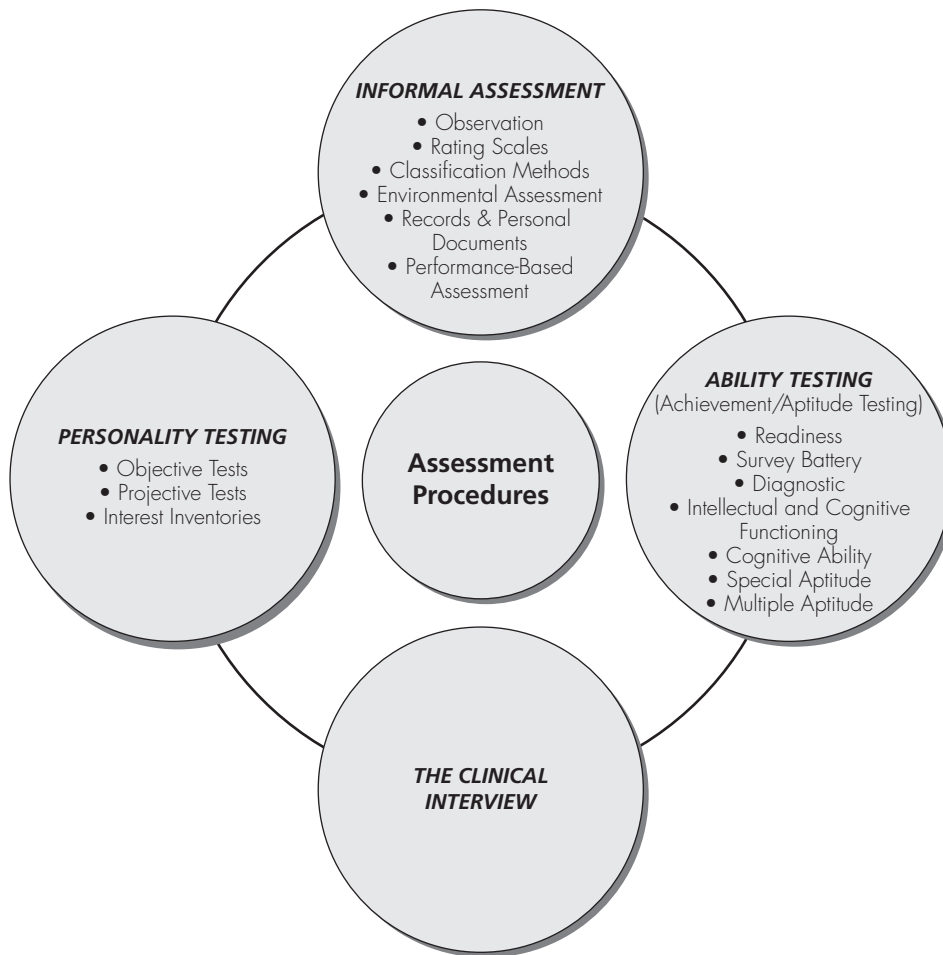
The role of school counselors in assessment varies and may include communicating test results to students and parents, assisting teachers and administrators in understanding assessment results, using assessment techniques in program evaluation and research, providing workshops and individual consultation for teachers on test use and test interpretation, and using test results and other assessment techniques to assist in the development of educational plans for children with learning disabilities (Elmore & Ekstrom, 2003; Neukrug & Fawcett, 2010). In addition, school counselors will periodically receive and need to understand test reports from agency counselors who are working with students.

In settings other than in the schools, such as in agencies and higher education, there is a greater likelihood that related mental health professionals (e.g., psychologists) will have expertise in testing and assessment. However, there is still the possibility that in some settings the counselor will be the only individual with such expertise.

But whether or not the counselor is the expert, in most settings counselors will find themselves periodically administering and interpreting educational and psychological tests for their clients (Naugle, 2010; Neukrug & Fawcett, 2010). In addition, counselors in almost all settings are asked to understand assessment reports completed by other clinicians, and many counselors will be reviewing the test records of the children with whom they work. Finally, in these days of accountability, counselors are often asked to evaluate the efficacy of clinical programs, and assessment instruments are crucial for this process. It is clear that in agency and higher education settings testing has become a core component of the counselor's work.

Although tests have been criticized over the years for being poorly made and/or having bias, with advances in statistical analysis and improvement of test quality, tests today can offer one additional way of exploring the inner world of our clients (Fremer & Wall, 2003). Today, the professional counselor should be engaged in a cycle of formulating a hypothesis about a client, gathering information from the client, and reformulating the hypothesis. And, to increase the accuracy of results of one's hypothesis, it is often suggested to increase the number of assessment procedures given. Generally, the greater the number of procedures used, the greater the likelihood that they will yield a clearer snapshot of the client (Joint Committee on Testing Practices [JCTP], 2004; Meyer et al., 2001).

Why testing? Why not testing? Tests offer an additional venue for helping us understand the ability and personality of our clients. They can be useful in diagnosis. They can help in goal setting and treatment planning, and assessment procedures are often critical aspects of research and evaluation. Because of past experiences with tests or personal biases about tests, some have made assumptions that testing is not useful. However, such assumptions should not and cannot lead one to dismiss a potentially powerful aspect of the counseling process. Let's see how testing and assessment can be an important part of what the counselor does.

A Little Background

Broadly speaking, assessment takes place whenever a person is asked to show the existence or amount of a particular trait or ability. In this sense, Abraham's faith was assessed when he was asked by God to kill his first-born son Isaac. And early Olympians were assessed as they compared their performances to one another. One of the earliest assessment techniques, used for purposes with which we're more familiar, was developed in 2200 B.C.E. by the Chinese, who gave an essay-type test for the selection of what today would be called civil service employees (DuBois, 1970; Higgins & Sun, 2002). However, it was not until the 1800s that psychological and educational assessment turned into a more formal process.

Modern-day assessment was formed out of two distinct processes occurring in the late 1800s. On the one hand, this period saw increased acceptance of Charles Darwin's theory that differences within a species and between species held the key to natural selection. Soon psychologists picked up the call to examine individual differences in people (Juve, 2008; Kerr, 2008). Individuals like Wilhem Wundt and Gustav Fechner become particularly interested in *experimental psychology* and developed some of the first *psychology labs*. It was this impetus that led to an understanding that rigorous experimental control

was crucial to scientific inquiry regarding individual differences and that tests were often critical to this process (Kaplan & Saccuzzo, 2009).

One of the first tests was developed by Alfred Binet at the end of the nineteenth century. Hired by the Ministry of Public Education in Paris, Binet was asked to develop an instrument that could differentiate those who could function in a classroom from those who could not (Ryan, 2008; Watson, 1968). This scale, which was later revised by Lewis Terman at Stanford University, became known as the *Stanford-Binet* intelligence test, a revised version of which is still in use today.

A number of developments at the beginning of the twentieth century saw the spread of assessment instruments in other realms. For instance, the popularity of psychoanalysis and its emphasis on personality development influenced the beginning of objective and projective personality assessment. In addition, on the heels of the industrial revolution, there was an influx of people to large cities, and this resulted in a need for objective tests of achievement and of vocational aptitudes in the schools. Finally, World War I saw a sudden need for the widespread use of personality and ability tests to help in the placement of recruits in the military. The assessment movement had taken hold in the United States.

With advancements in statistical knowledge and its application to test construction, assessment instruments began to take on a modern look in the 1940s and 1950s. As we moved into the 1960s and the 1970s, the advent of the computer made it easier to examine the statistical properties of tests and improve their quality. The 1980s saw the proliferation of personal computers, which increased the ability of researchers to examine the quality of tests (Sampson, 1995), and the 1990s saw a revolution in the ways that many tests were administered, scored, and interpreted. This revolution continued as we moved into the twenty-first century.

Today, assessment instruments are pervasive throughout our society. There are long tests, short tests, extremely long tests, and very short tests; instruments to measure knowledge and instruments to measure passion; procedures to properly diagnose, and others that can tell if you're self-actualized; tests for admission into graduate school and assessment procedures to finish graduate school. Tests are everywhere. Let's take a look at some of the different kinds of assessment instruments in existence today.

Types of Assessment Techniques

Although assessment techniques today are appreciably better than their ancestors from the turn of the twentieth century, the basic assessment categories have pretty much stayed the same. The following discussion offers an overview of ability tests, personality tests, informal assessment techniques, and the clinical interview (see Figures 12.1 and 12.2–12.4).

Assessment of Ability

Ability tests measure a range of cognitive abilities and include *achievement tests*, or tests that measure all of what one has learned; and *aptitude tests*, or tests that measure all that one is capable of learning. Achievement tests include *survey battery*, *diagnostic*, and *readiness tests*. Aptitude tests include *cognitive ability tests, individual intelligence tests, neuropsychological testing, special aptitude tests*, and *multiple aptitude tests* (see Figure 12.2).

FIGURE 12.2
Tests in the Cognitive Domain

Assessment of Ability (What One Can Do)

Achievement Testing (What One Has Learned)

Aptitude Testing (What One Is Capable of Learning)

Survey Battery

Diagnostic

Readiness

Cognitive Ability

Intellectual and Cognitive Functioning

Special Aptitude

Multiple Aptitude

Intelligence Testing

Neuropsychological Assessment
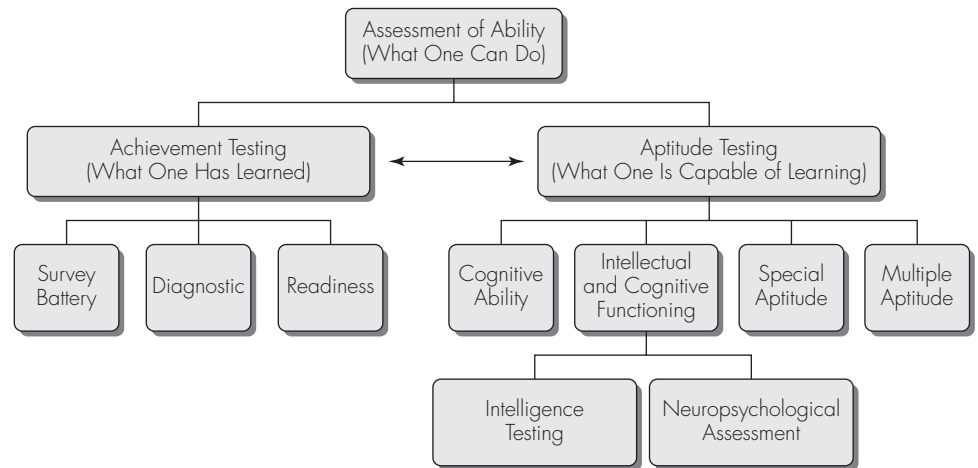
FIGURE 12.3
Assessment in the Affective Domain

PERSONALITY ASSESSMENT (Temperament, Habits, Likes, Disposition, Nature)

Objective ("Paper and Pencil")

Projective (Unstructured Responses)

Interests (Likes and Dislikes)
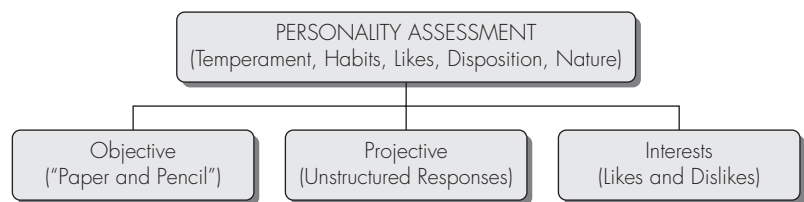
FIGURE 12.4
Informal Assessment Procedures

INFORMAL ASSESSMENT INSTRUMENTS

Observation

Rating Scales

Classification Methods

Environmental Assessment

Records and Personal Documents

Performance-Based Assessment
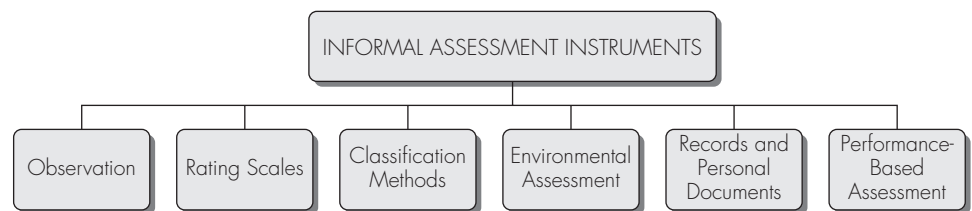
Achievement Tests (Survey Battery, Diagnostic, and Readiness)

Achievement tests include survey battery tests, diagnostic tests, and readiness tests (see Figure 12.2). Usually given in the schools to assess progress, *survey battery tests* measure content areas (e.g., 5th grade math) and are generally administered to large groups of students. Probably you are familiar with these types of tests through your own education.

BOX 12.1

PL 94-142 and the IDEA

With the passage of *Public Law 94-142* (PL94-142) in 1975 (Federal Register, 1977) as well as the more recent *Individuals with Disabilities Education Act* (IDEA), millions of children and young adults between the ages of 3 and 21 who were found to have a learning disability were assured the right to an education within the least restrictive environment. These laws also asserted that any individual who was suspected of having one of many disabilities that interfere with learning had the right to be tested, at the school system's expense, for the disability. Thus, diagnostic testing, usually administered by the school psychologist or learning disability specialist, became one of the main ways of determining who might be learning disabled. These laws also stated that a school team would review the testing, and other assessment information obtained, and that the learning disabled student would be given an Individual Education Plan that states which services would be offered to assist the student with his or her learning problem.

The *Iowa Test of Basic Skills* and the *Stanford Achievement Test* are two examples of survey battery achievement tests. The uses of survey battery achievement tests are many and include assessment of a student's ability level, determination of teaching effectiveness, and examination of the general level of students' ability throughout a school or school system.

Diagnostic achievement tests, which are used to delve more deeply into areas where there are suspected learning problems, are often given one-to-one by an experienced examiner, usually a school psychologist or learning disabilities specialist. Often these tests are recommended following the results of a survey battery achievement test and when, in consultation with parents and teachers, it seems probable that a student may have a learning disability. This means that it is suspected that the student's ability is much lower in one or more specified areas than his or her average ability in other areas. Today, if an individual is found to have a learning disability, laws protect the child's right to an education (see Box 12.1).

Readiness tests are used to assess an individual's ability to move on to the next educational level. These days, readiness tests are mostly used to determine if a child is developmentally ready to move on to first grade. However, it should be emphasized that any differences found at these young ages may not be found at later ages as children's ability at very young ages is much more variable and more affected by environment than at later ages (Hoekstra, Bartels, & Boomsma, 2007).

Aptitude Tests

The five major kinds of aptitude tests include cognitive ability tests, individual intelligence tests, neuropsychological assessments, special aptitude tests, and multiple aptitude tests (see Figure 12.2). *Cognitive ability tests* generally require true/false or multiple choice responses in an effort to measure the cognitive skills necessary to be successful in school. Often given in groups, these tests are frequently used to determine a student's overall potential in school. These tests can also aid in identifying those who are learning disabled and gifted. For instance, it is common for students who have a learning disability to score significantly higher on a cognitive ability test, which measures capability, as compared to a survey battery achievement test, which measures what one has learned in specific content areas. Other cognitive ability tests are used for placement and as predictors of ability in

college (e.g., ACTs, SATs), graduate school (e.g., MATs, GREs), and professional schools (Kobrin, Patterson, Shaw, Mattern, & Barbuti, 2008; Kuncel & Hezlett, 2007).

Individual intelligence tests, which are given one-to-one to measure general intellectual ability, are administered by highly trained examiners, most often psychologists. These tests have a broad range of uses, such as helping to identify individuals who are learning disabled, developmentally delayed, intellectually disabled (formerly called "mentally retarded"), or gifted, and can even be used as an indicator of personality characteristics. Usually, when a comprehensive assessment of an individual is requested, an individual intelligence test is included.

Neuropsychological assessment measures a broad range of behaviors related to brain functioning. It is used to identify brain damage, to measure change in one's overall cognitive functioning, to compare changes in cognitive functioning to one's norm group, to provide rehabilitation treatment and planning guidelines, and to provide specific guidelines for educational planning in the schools (Kolb & Whishaw, 2009; Lezak, Howieson, & Loring, 2004).

Special aptitude tests focus on measuring specific segments of ability (e.g., spatial ability, eye-hand coordination, mechanical ability) and are often used to predict the potential for success at specific jobs or training programs. For instance, one's aptitude on an eye-hand coordination test may be used to predict success at operating complex machinery in a factory. Or a drawing test may be used to predict success in art school.

Multiple aptitude tests, which measure a series of specific segments of ability, are used to understand an individual's aptitude on a broad range of abilities. Results of these tests can be used in occupational decision making. Some examples of multiple aptitude tests include the *Differential Aptitude Test* (DAT), which is frequently used by high school counselors, and the *Armed Services Vocational Aptitude Battery* (ASVAB), which was developed by the military and generally administered for free in the schools.

Although achievement testing measures what a person has learned and aptitude testing measures one's potential for learning, in point of fact there is often much overlap between the two. This is why there is a two-headed arrow connecting these categories in Figure 12.2. For instance, one would be naive to assume that the SATs or the GREs are not measuring what one has learned. However, because they are both used to predict future performance, they are considered aptitude tests.

Personality Assessment

The assessment of personality includes measuring one's temperament, attitudes, values, likes and dislikes, emotions, motivation, interpersonal skills, and/or level of adjustment (Neukrug & Fawcett, 2010). The three types of personality assessment that are most commonly used today are *objective tests*, *projective techniques*, and *interest inventories* (see Figure 12.3).

Objective Personality Tests

Objective personality tests are questionnaires or inventories that require true/false; yes/no, multiple choice, or related responses in an effort to measure some aspect of personality. Thus, we might find tests measuring anxiety, depression, psychosis, suicidal tendencies, eating disorders, extroversion-introversion tendencies, marital satisfaction, and so on. Some of these tests, like the *Minnesota Multiphasic Personality Inventory-2* (MMPI-2),

measure psychopathology and assess some aspects of one's temperament, or deeply embedded personality style, while others, like the *Myers-Briggs Type Indicator* (MBTI), measure common personality styles that are likely not to be related to temperament. A few uses of objective personality tests are: to deepen client insight, to help in the determination of clinical diagnosis, to make predictions about future behaviors, to determine personality characteristics for the court (e.g., child custody, child molestation accusations), and to screen applicants for sensitive jobs (e.g., working with children or nuclear arms).

Projective Techniques

Projective techniques attempt to assess personality characteristics by having an individual respond to *unstructured stimuli* (e.g., an inkblot). Stimuli presented allow for a broad range of responses that are representative of conscious and unconscious needs, desires, likes, drives, and personal struggles. For instance, the *Rorschach*, one of the most widely used projective tests, uses inkblots as stimuli to which the individual responds. After all the responses are collected, the examiner interprets their meaning. Other types of projective techniques include *sentence completion tests*, where a client completes a stem of sentence with the first thing that comes to mind; *drawings*, where the client is asked to make a specific drawing that is later interpreted (e.g., a drawing of the client's family all doing something together); and techniques in which the individual is asked to develop stories from pictures that are presented.

Interest Inventories

Although strictly speaking they are a type of objective personality test, *interest inventories* are generally classified separately because of their popularity and very specific focus. Used to determine the likes and dislikes of a person, as well as an individual's personality orientation toward the world of work, interest inventories are almost exclusively used in the career counseling process. These instruments can moderately predict job satisfaction based on occupational fit. For instance, if, a person chooses a job that seems to match his or her personality type based on the results of an interest inventory, then that person is more likely to be satisfied in that occupation than a person who does not have an occupational fit (Fritzsche, & Parrish, 2005; Verquer, Behr, & Wagner, 2003; Verbruggen & Sels, 2010). With a variety of interest inventories having been developed and with millions of individuals taking one or more each year, these assessment instruments have become big business in career counseling. Two of the more popular include the *Strong Interest Inventory* and the *Self-Directed Search*.

Informal Assessment Procedures

Informal assessment instruments are generally developed by the individual who is going to be giving the procedure (e.g., counselor, teacher) (Neukrug & Fawcett, 2010). Although they are often less valid than other kinds of instruments, they offer us an important and relatively easy method of examining a slice of behavior of an individual. There are many kinds of informal assessment instruments, with some of the more common ones being *observation, rating scales, classification methods, environmental assessment, records and personal documents,* and *performance-based assessment* (see Figure 12.4).

Observation

Conducted by the professional who wishes to observe the individual (e.g., school counselors observing students in the classroom), by significant others who have the opportunity to observe the individual in natural settings (e.g., parents observing a child at home), and even by the client, who when in counseling is asked to observe specific targeted behaviors he or she is working on changing (e.g., eating habits), *observation* can be an easy and important tool for understanding the individual. When observing, observers often conduct an *event sample*, which is when a specific event is observed without regard for time (e.g., observing empathic responses on a video-recording), or a *time sample*, when observation occurs over a specific amount of time without zeroing in on an event (e.g., observing two, five-minute segments of all counseling responses on a video recording). Sometimes, time and event sampling are combined, such as in the case when one might only listen for empathic responses on two 5-minute segments of recordings.

Rating Scales

Rating scales allow an individual to give a subjective rating of a behavior on a scale to obtain a quantity of an attitude or characteristic. Rating scales come in many different forms, with a few of the more popular kinds of rating scales being *Likert-type scales*, *semantic differential scales*, *rank order scales*, and *numerical scales* (see Box 12.2).

Classification Methods

In contrast to rating scales that tend to assess a quantity of specific attributes or characteristics, *classification methods* provide information about whether an individual has, or does not have, certain attributes or characteristics. Some of the more common classification methods include *behavior* or *feeling word checklists* (see Box 12.3). The kinds of classification methods that one can create are innumerable and are only limited by one's imagination. For instance, classification methods can be developed that asks clients to examine and choose items that represent their "irrational thoughts." Or, an elderly person might be asked to pick from a long list of physical barriers to living fully (difficulty getting out of the bath, problems seeing, etc.).

Environmental Assessment

Environmental assessment includes collecting information from a client's home, school, or workplace usually through observation or self-reports. This form of appraisal is more systems oriented and naturalistic and can be eye-opening because even when clients do not intentionally mislead their therapists, they will often present a distorted view based on their own inaccurate perceptions or because they are embarrassed about revealing some aspect of their lives (e.g., a person living in poverty might not want to reveal an unpleasant home situation). Some of the more common environmental assessments include using *direct observation* by the counselor; applying *sociometric procedures* to identify the relative position of an individual within a group (e.g., asking pre-school children which students in class they like best and mapping all of their responses), conducting a *situational assessment* where a person's responses to a contrived but natural situation is assessed (e.g., when, as part of a doctoral admissions process, a potential doctoral student counsels a role-play

BOX 12.2

Rating Scales

Below are examples of four rating scales. Consider how you might use them as a counselor.

Numerical Scale:
With "0" being equal to the worst depression you ever had and a 10 being equal to the best you could possibly feel, can you tell me where on a scale of 0–10 your depression is today?

1   2   3   4   5   6   7   8   9   10
Worst Depression   Best I Could Feel
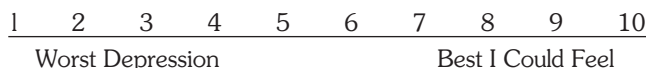
Semantic Differential Scale
Place an "X" on the line to represent how much of each quality you possess:

sadness_____happiness
1   2   3   4   5   6   7   8

introverted_____extroverted
1   2   3   4   5   6   7   8

anxious_____calm
1   2   3   4   5   6   7   8
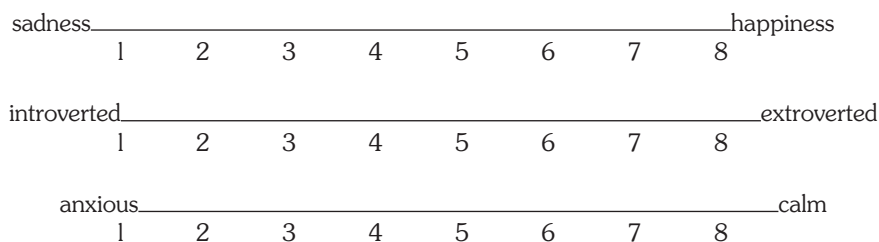
Rank Order Scale
Please rank order your preferred method of doing counseling. Place a 1 next to the item that you most prefer, a 2 next to the item you second most prefer, and so on down to a 5 next to the item you prefer least.

____ I prefer listening to clients and then reflecting back what I hear from them in order to facilitate client self-growth.
____ I prefer advising clients and suggesting mechanisms for change.
____ I prefer interpreting client behaviors in the hope that they will gain insight into themselves.
____ I prefer helping clients identify which behaviors they would like to change.
____ I prefer helping clients identify which thoughts are causing problematic behaviors and helping them to develop new ways of thinking about the world.

Likert-Type Scale
Please indicate how strongly you agree or disagree with each of the following statements:

	Strongly disagree	Somewhat disagree	Neither Agree nor disagree	Somewhat agree	Strongly agree
It is fine to view a client's personal Web page (e.g., MySpace, Facebook) without informing the client.	1	2	3	4	5
It is okay to tell your client you are attracted to him or her.	1	2	3	4	5
There is no problem in counseling a terminally ill client about end-of-life decisions including suicide.	1	2	3	4	5

BOX 12.3

Behavior Checklist of Abusive Behaviors

Check those behaviors you have exhibited toward your partner and your partner has exhibited toward you.

	Exhibited by You to Your Partner	Exhibited by Partner to You
1. Hitting	____	____
2. Pulling hair	____	____
3. Throwing objects	____	____
4. Burning	____	____
5. Pinching	____	____
6. Choking	____	____
7. Slapping	____	____
8. Biting	____	____
9. Tying up	____	____
10. Hitting walls or other inanimate objects	____	____
11. Throwing objects with intent to break them	____	____
12. Restraining or preventing from leaving	____	____

client and his or her responses are assessed), and completing an *environmental assessment instrument* that uses rating scales and checklists to assess a client's environment.

Records and Personal Documents

A number of common forms of *records and personal documents* are used to inquire about the client, including: asking the client to write an *autobiography*, collecting *anecdotal information* (e.g., typical or atypical work behaviors in a personnel file), completing a *biographical inventory* (detailed picture of client from birth created by conducting an involved interview or by having the client answer a series of questions on a checklist), examining *cumulative records* (e.g., school records), completing a *genogram* (see Figure 1 in Chapter 6), or having the client keep *diaries* or write *journals* (e.g., sleep journal, where one writes down his or her dreams and explores patterns among the dreams).

Performance-Based Assessment

This kind of assessment evaluates an individual using a variety of informal assessment procedures that are based on real-world responsibilities which are not highly loaded for cognitive skills. *Performance-based assessment* is seen as an alternative to traditional standardized testing, and is often used when individuals from nondominant groups have performed lower on traditional tests and when other procedures can be shown to predict as well as traditional tests. Thus, rather than giving a highly loaded cognitive test that may predict well for Whites who want to become firefighters, but not predict well for some minority groups, individuals can be given a series of alternative procedures such as assessing how quickly they can respond to realistic, yet contrived situations that they might actually face on the job as firefighters.

The Clinical Interview

Another assessment technique, the *clinical interview*, allows the counselor to obtain an in-depth understanding of the client through an unstructured or structured interview process. The *structured interview* allows the examinee to respond to a set of pre-established items verbally or in writing. This kind of interview generally allows for a broad assessment of client issues but sometimes does not allow for in-depth follow-up in one area. The *unstructured interview*, on the other hand, does not have a pre-established list of items or questions, and client responses to examiner inquiries establish the direction for follow-up questioning. Some counselors prefer using a *semi-structured interview*, which is a cross between the two kinds of interviewing techniques. The clinical interview serves a number of purposes (Neukrug & Fawcett, 2010). For instance, the interview:

1. Sets a tone for the types of information that will be covered during the assessment process
2. Allows the client to become desensitized to information that can be very intimate and personal
3. Allows the examiner to assess the nonverbal signals of the client while he or she is talking about sensitive information, thus giving the examiner a sense of what might be important to focus upon
4. Allows the examiner to learn firsthand the problem areas of the client and place them in perspective
5. Gives the client and examiner the opportunity to study each other's personality style to ensure that they can work together

◾ Norm-Referenced, Criterion-Referenced, Standardized, and Non-Standardized Assessment

Generally, assessment techniques are either *norm-referenced* or *criterion-referenced*. In norm-referenced assessment, the individual can compare his or her score to the conglomerate scores of a peer or norm group. Usually, norm groups consist of a national representative sample of individuals. Many tests that are sold by national publishing companies are norm-referenced. In contrast, criterion-referenced assessment techniques are designed to assess specific learning goals of an individual. Achievement of these goals, as measured by a criterion-referenced procedure, shows mastery of the subject matter at hand. Oftentimes, criterion-referenced procedures are used with individuals who are learning disabled, because goals can be individualized for the student based on his or her specific learning problem.

Standardized assessment procedures are administered in the same manner and under the same conditions each time they are given. In contrast, *nonstandardized assessment procedures* are not necessarily given under the same conditions and in the same manner at each administration. Often, informal assessment procedures are nonstandardized. However, this is not a hard-and-fast rule (see Table 12.1).

T A B L E 12.1

Comparison of Standardized, Nonstandardized, Norm-Referenced, and Criterion-Referenced Assessment		
	Standardized	*Nonstandardized*
Norm-Referenced	These assessment instruments must be given in the same manner and under the same conditions each time they're given. Often, they are highly researched objective instruments that are developed by publishing companies. Usually, large norm groups are available with which the individual can compare his or her results.	These assessment instruments may vary in how they are administered and generally are not as rigidly researched as the standardized tests. However, because of their informal nature, they may be more practical for the purpose for which they are being used. Scores that are later compared to a norm group should be viewed more tentatively than standardized tests.
Criterion-Referenced	These instruments are given in a standard manner and have preset learning goals that are based on an individual's personal educational objectives. Often created by large publishing companies, individuals who take these tests generally have the ability to tackle their individualized learning goals and have their results compared to national norm groups.	These instruments are informally made, often by teachers, and are based on the teacher's knowledge of his or her students and the content area being tested. The teacher can develop an individualized test that has preset learning goals for each student. The informal nature of these instruments means that norm groups are rarely available for comparisons.

An example of a standardized, norm-referenced test is an individual intelligence test. This kind of appraisal instrument is given the exact same way across the country and an individual's score is then compared to national norm group scores (e.g., the individual's age group scores). A second example of a standardized test is the *Counselor Preparation Comprehensive Exam* (CPCE) administered by the Center for Credentialing and Education (CCE) (see http://www.cce-global.org/cpce). In this case, all schools that use this exam have the choice of comparing their school's scores to a national sample (the norm group) or deciding on a criterion cut-off (e.g., number of correct responses needed to obtain a "passing" score).

Examples of standardized, criterion-referenced assessment procedures include nationally made individual achievement tests, which are often given to students with learning disabilities. These tests are administered the same way each time, but a student takes only those parts of the test relevant to his or her individual learning goals as defined by a special education teacher. This test could additionally be norm-referenced if a comparison to a national norm group is desired and available.

Using a checklist to measure self-concept while observing a child in a class and then comparing the child's scores to those of a local norm group (e.g., students in the school) might be an example of a nonstandardized and norm-referenced test.

Finally, a counselor-made assessment procedure that has targeted learning goals for students might be an example of a nonstandardized, criterion-referenced assessment procedure. For instance, a counselor who is working with children with behavioral problems might develop a set of nonstandardized procedures (e.g., counting child specific behaviors related to problem behaviors of each child). After counting the behaviors, the counselor would determine whether they have reached their targeted goals (the criterion).

Basic Test Statistics

Relativity and Meaningfulness of Test Scores

If Jeremiah receives a score of 47 on a test, and Elise receives a score of 95 on a different test, how well have they done? If Jeremiah's score was 47 out of 52, one might assume he has done fairly well. But if 1,000 people had taken this test and all others received a higher score than Jeremiah, we might view his score somewhat differently. And to make things even more complicated, what if a high score represents an undesirable trait (e.g., cynicism, depression, schizophrenia)? Then clearly the lower his score compared with his norm group, the comparatively better he has done, and vice versa.

What about Elise's score? Is a score of 95 good? What if it is out of a possible score of 200, or 550, or 992? If 1,000 people take the test and Elise's score is the highest, and if a higher score is desirable, we might say that she did well compared with her norm group. But if her score is on the lower end of the group of scores, then comparatively she did not do well.

By comparing Jeremiah and Elise's scores to the scores of their peer or norm group, we can put meaning to their scores. This is because *norm group comparisons*:

1. Allow individuals to compare themselves with their peer group. For instance, Jeremiah and Elise can compare their scores with those of people who took the same test and are like them in some important way (e.g., similar age, same grade).
2. Allow test takers who took the same test but are in different norm groups to compare their results. For instance, a parent who has two children who are two grades apart could determine which one is doing better in reading (e.g., one might score at the 50th percentile and the other at the 76th relative to the peer groups). Or a school counselor might be interested in the self-esteem scores of all fifth graders as compared to all third graders.
3. Allow an individual to compare his or her results on two different tests. For instance, as noted earlier, it is sometimes valuable to know an individual's score on an achievement test as well as on a scholastic aptitude test, because a discrepancy between the two tests might indicate a learning disability. Or, when doing personality assessment, it is not unusual to give a number of different tests with an effort made to finding similar themes (e.g., high indications of anxiety on a number of different tests).

Finally, let's not forget that Jeremiah and Elise will have their own opinions about how they think they should do on a test. Thus, a high score to one person would be a low score to another. The individual who consistently scores at the highest percentiles on a math test may feel upset about a score in the average range, while an individual who consistently scores low may feel good about that same score. Similarly, an individual who has struggled with lifelong depression may feel good about a moderate depression score on the *Beck Depression Inventory*, while another person might be concerned about such a score.

Measures of Central Tendency

Measures of central tendency tell us what is occurring in the midrange of a group of scores. Thus, if you know a person's score, you can compare that score to one of three scores that represent the midrange of the group. Three measures of central tendency include the *mode*, or the most frequent score; the *median*, or the middle score (50% of the scores

fall below and above that score); and the *mean*, or the average of all of the scores. Although measures of central tendency do not tell you a lot about general trends in the whole group, they do a give you a sense of whether a known score is higher or lower than the mean, median, or mode.

Measures of Variability

Measures of variability tell us how much scores vary in a distribution. Three measures of variability include the *range*, or the number of scores between the highest and lowest scores on a distribution; the *interquartile range*, which measures how 50% of the scores vary around the median; and the *standard deviation*, or the manner in which scores deviate around the mean in a standard fashion. Although all three measures of variability are important for the interpretation of test scores, in normally distributed curves the standard deviation takes on particular importance.

To better illustrate the concept of standard deviation, let me tell a quick story. A number of years ago while visiting the Boston Museum of Science I saw a device, called a *quincunx* (also known as *Galton's Board*), through which hundreds of balls would be dropped onto a series of protruding points (see Figure 12.5 and www.odu.edu/~eneukrug/galton.htm). Each ball had a 50/50 chance of falling left or right every time it would hit one of the protruding objects. After all the balls were dropped, they would be collected and automatically dropped again. All day long this machine would drop those balls over and over again. Now, this in and of itself was not so amazing. However, what did seem extraordinary was the fact that each and every time those balls were dropped, they would distribute themselves in the shape of a *normal curve* (also called the *bell-shaped curve*). Mind you, they were not distributing themselves in that manner because they were being sent in that direction. In point of fact, the resulting bell-shaped curve is a product of the natural laws of the universe and is explained through the laws of probability. So perfect are these natural laws that minds as

FIGURE 12.5
A Quincunx
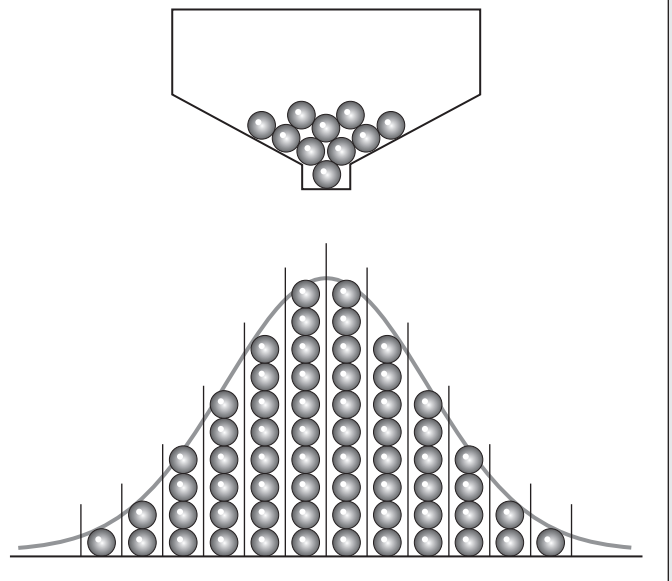
great as Einstein have given religious connotations to them (Isaacson, 2007). However, no matter what label is used to describe it, it is amazing that such a predictable pattern occurs over and over again. What does this have to with testing? Like the balls dropping in this device, when we measure most traits and abilities of people, the scores often approximate a bell-shaped distribution. This is very convenient, for the symmetry of this curve allows us to understand the most important measure of variability, standard deviation.

Let's take a look at one trait, depression, to help us understand how standard deviation works. If we examine scores of American adults on a test to measure depression, we might find something like the hypothetical curve in Figure 12.6. In this case, as in all normally distributed curves, the mean or average score always represents the 50th percentile and splits the distribution in half. In addition, the standard deviation distributes itself in a consistent manner. For instance, in all normally distributed curves, approximately 34% of the scores will fall between the mean and what is called "+1 standard deviation," and another 34% between the mean and "−1 standard deviation." Similarly, 14% will fall between +1 and +2 standard deviations and 14% will fall between −1 and −2 standard deviations. Finally, about 2% will fall between +2 and +3 standard deviations and another 2% between −2 and −3 standard deviations.

Furthermore, in the normally distributed curve in Figure 12.6, as in all scores that have a distribution that approximates a bell-shaped curve, certain assumptions can be made about how scores deviate around the mean. For instance, if an individual scores above the mean, we immediately know that he or she has scored better than at least 50% of the population who took the test. If the individual scores at about the point of one standard deviation, he or she has scored at approximately the 84th percentile, and so forth (see Figure 12.6).

Consider, for a moment, that a test has a mean of 52 and the standard deviation of 20. For this test, most of the scores (about 68%) would range between 32 and 72 (plus and minus one standard deviation; see Test 1, Figure 12.7). On the other hand, a second test that had a mean of 52 and a standard deviation of 5 would include 68% of its scores between 47 and 57 (again, plus and minus one standard deviation; see Test 2, Figure 12.7). Clearly, even though the two tests have the same mean, the range of scores around the mean varies considerably. An individual's score of 40 would be in the average

FIGURE 12.6
Normal Distribution of Scores on a Test of Depression

FIGURE 12.7
Comparison of the Variability of Two Different Normal Curve Distributions

			Test 1								Test 2			
	2%	14%	34%	34%	14%	2%		2%	14%	34%	34%	14%	2%	
−3SD	−2SD	−1SD	Mean	+1SD	+2SD	+3SD	−3SD	−2SD	−1SD	Mean	+1SD	+2SD	+3SD
−8	12	32	52	72	92	112	37	42	47	52	57	62	67
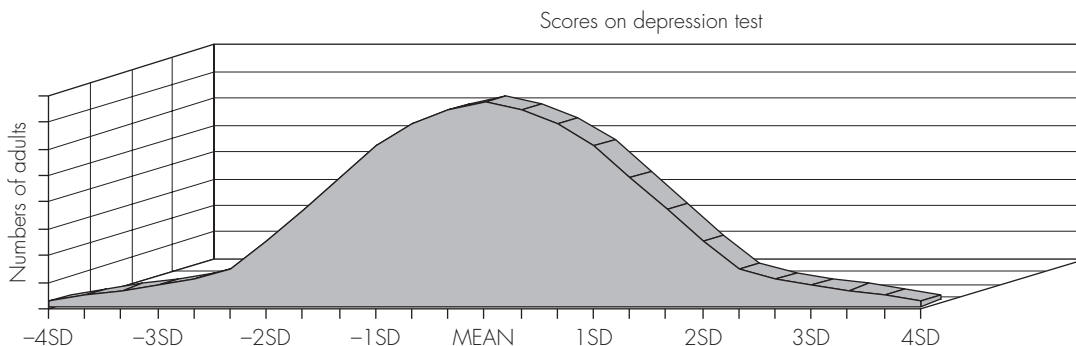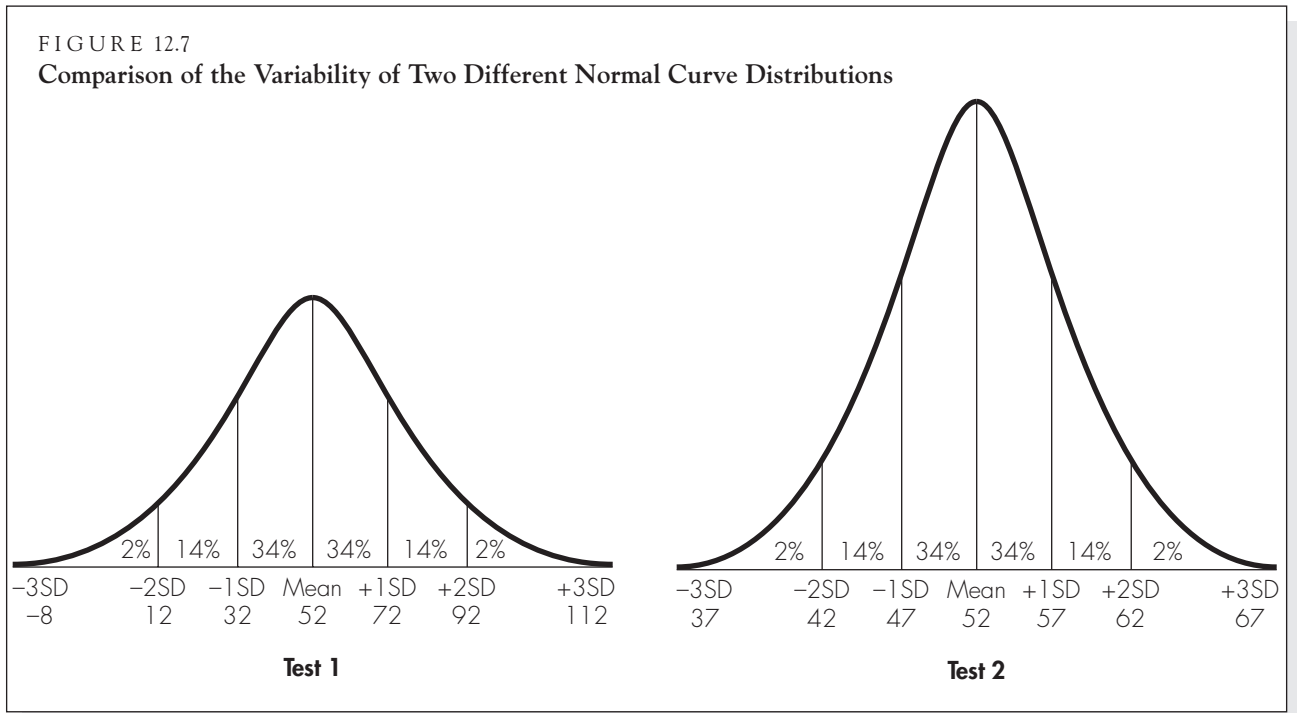
range on the first test but well below average on the second test. This example shows why measures of central tendency and measures of variability are both important in understanding test scores.

Derived Scores

Usually, when a large group of individuals takes an assessment instrument, each person's reported score is not the actual raw score obtained by that person. Similarly, the mean is generally not the actual mean of all the raw scores. Instead, to make scores easier to interpret, the raw scores are converted by publishing companies to what are called *derived scores*. You are probably already aware of a number of derived scores such as *percentiles, stanines, SAT-type scores*, and *ACT-type scores*. If scores were not converted in this fashion, every individual who wanted to interpret his or her score would need knowledge of standard deviation and how it varies from test to test. In addition, converting scores to derived scores makes it easier to compare scores on different tests because their units of measurement are made comparable (e.g., percentiles on one test can be compared to percentiles on another).

Although the means and standard deviations of tests can vary dramatically, normal (bell-shaped) curves will always have the same percentage of scores distributing between the mean and one standard deviation above the mean (approximately 34%) or below the mean (another 34%). Similarly, all normally distributed curves will have the same percentage of scores between the mean and two standard deviations above the mean

(approximately 48%) or below the mean (another 48%) and, of course, between the mean and three standard deviations above the mean (approximately 50%) or below the mean (another 50%). This property allows us to convert scores from any test that is normally distributed to a derived score of our choice. For instance, imagine two persons taking the same test: One obtains a raw score of 32 and the other a raw score of 92. When we discover that the mean is 52 and the standard deviation is 20 points, we immediately know that the first person scored at about the 16th percentile (one standard deviation below the mean, or 52 minus 20) while the second person scored at about the 98th percentile (two standard deviations above the mean, or 52 plus 20, and plus 20 again) (see Figure 12.7, Test 1). Now we know that on this test one person scored at the 16th percentile while another scored at the 98th percentile; these are derived scores. They are derived from the original raw scores. However, there are also other types of derived scores. For instance, if this was a test to measure depression, we might use a derived score called a *T-score* (*Transformed-score*). Having a mean of 50 and standard deviation of 10, T-scores are often used with personality assessment. Therefore, for the two individuals noted above, the first would have obtained a T-score of 40 (one standard deviation below the mean), while the second would have obtained a T-score of 70 (two standard deviations above the mean).

In addition to comparing two individuals on the same test, derived scores allow us to compare the same individual on different tests or on different subtests of the same test. For instance, a person might receive a T-score of 56 on a test of depression and a T-score of 32 on a test that measures trait anxiety. Thus, on the first test that person scored above the mean (mean of T-scores is 50), and the same person obtained a score quite a bit below the mean (almost two standard deviations; e.g., 50 minus 10 and minus 10 again would be a derived score of 30). Below are some of the more typical derived scores that are used.

> *Percentile rank.* A derived score that describes the percentage of scores that fall at or below a given score. Percentiles are used with many different types of tests.
>
> *T-scores.* A derived score having a mean of 50 and a standard deviation of 10 and generally used with personality tests.
>
> *Deviation IQ.* A derived score having a mean of 100 and a standard deviation of 15 and generally used with intelligence tests.
>
> *SAT/GRE-type scores.* A derived score having a mean of 500 and a standard deviation of 100. Used mostly to report SAT and GRE scores.
>
> *ACT Scores.* A derived score having a mean of 21 and standard deviation of 5. Used with the ACT, the most widely used college entrance exam.
>
> *Normal Curve Equivalents (NCE) Scores.* A derived score having a mean of 50 and standard deviation of 21.06. Often used with educational testing. Ranges from 1 to 99.
>
> *Stanines.* A derived score having a mean of 5 and standard deviation of 2. Generally used with achievement tests. Ranges from 1 to 9.
>
> *Sten Scores.* A derived score having a mean of 5.5 and standard deviation of 2. Generally used with personality inventories and questionnaires. Ranges from 1 to 10.
>
> *Grade equivalent scores.* A derived score generally used with achievement tests to determine an individual's position relative to his or her grade level. The grade

level of the student represents the mean of the grade equivalent. Probably the most misunderstood of derived scores, grade equivalents above current grade level do not mean that the individual can thrive at that grade level. Instead, it means that the student is doing much better than most students within his or her own grade level.

Idiosyncratic publisher-derived scores (scaled scores). On some tests, particularly survey battery achievement tests, publishers create a derived score, sometimes called a *scaled score*, unique for that test. Therefore, a specific achievement test might have a mean of 150 and a standard deviation of 20, or a mean of 200 and a standard deviation of 25, and so forth—whatever specific mean and standard deviation that publisher decides to use. Usually, test publishers pick numbers that allow test takers to interpret their scores relatively easily.

Correlation Coefficient

A basic statistic that is not directly related to the interpretation of tests but is crucial in test construction is *correlation coefficient*. Correlation coefficients show the relationship between two sets of scores, range from +1 to −1, and generally are reported in decimals of one-hundredths (see Figure 12.8). A *positive correlation* shows a tendency for two sets of scores to be related in the same direction. For instance, if a group of individuals took two tests, a positive correlation would show a tendency for those who obtained high scores on the first test to obtain high scores on the second test and for those who obtained low scores on the first test to obtain low scores on the second test.

A *negative correlation* shows an inverse relationship between two sets of scores; for instance, individuals who obtain high scores on the first test would be likely to obtain low scores on the second test. A correlation that approaches +1 or −1 shows a particularly strong relationship, while a correlation that approaches 0 shows little or no relationship between two factors. For instance, if I wanted to show that the GREs predict performance in graduate school, I would have to show that the correlation coefficient does not approach zero and is significant enough to warrant its use (Burton & Wang, 2005).

Similarly, if I wanted to show that my newly made test of depression was worthwhile, I could correlate scores on my new test with an established test of depression. In this case, I would hope to find a relatively high correlation coefficient as evidenced by the fact that individuals who scored high on my test would have a tendency to score high on the established test and individuals who scored low on my test would have a tendency to score low on the established test. Knowledge of correlation coefficient is particularly important in assessing some aspects of the worthiness of a test.

FIGURE 12.8
The Range and Strength of Correlation Coefficients

−1, −.99,... −.80........... −.51.... −.25... −.10... −.02, −.01,0, +.01, +.02... +.10... +.25.... +.51,........... +.80... +.99, +1
      strong   **moderate**   **low**   **none**   **low**   **moderate**   **strong**

■ *Test Worthiness*

> *The challenge to specialists in test theory is to continually broaden their methodology, to extend the toolkit of data-gathering and interpretation methods available to deal with increasingly richer sources of evidence, and more complex arguments for making sense of that evidence.* (Mislevy, 2004, p. 243)

Good tests are well-researched tests that can show evidence for the establishment of four qualities that are particularly important to *test worthiness*: (1) *validity*, whether or not a test measures what it is supposed to measure; (2) *reliability*, the ability of a test to accurately measure a trait or ability; (3) *cross-cultural fairness*, whether or not the test measures what it is supposed to measure in a consistent manner for all subgroups to whom the test is given, and (4) *practicality*, the ease of administration and interpretation of the test. Let's take a closer look at these qualities.

Validity

How well does a test measure what it's supposed to measure? That is the primary question that *validity* attempts to answer. Over the years, a number of methods have been developed to determine the validity of a test. Logically, it makes sense that the more methods one can use to provide evidence that a test is valid, the stronger the case one can make that the interpretation of test scores is accurate for its purposes (American Educational Research Association [AERA], 1999). Various types of validity that help to provide the evidence needed to demonstrate the worthiness of a test include *content validity; criterion-related validity*, which includes *concurrent validity* and *predictive validity*; and *construct validity*, which includes methods of *experimental design*, *factor analysis*, *discriminant validity*, and *convergent validity*. But first let's describe a type of validity that is really not validity—*face validity*.

Face Validity

Often said not to be a real type of validity, a test can have *face validity*, yet not be valid or not have face validity and be valid. Face validity has to do with how the test superficially looks. If you were examining the test, would it appear to be measuring what it is supposed to measure? Although most tests should have face validity, some tests could be valid yet not have it. For instance, there might be some items on a personality test that, on the surface, do not seem to be measuring the quality that the test is attempting to assess. Look, for example, at the hypothetical item below that is assessing whether or not an individual may have a panic disorder:

1. *In the past week, check the following symptoms that you have experienced:*

    _____ a. chills   _____ c. hot flashes   _____ e. depersonalization
    _____ b. choking   _____ d. abdominal distress   _____ f. unsteady feelings

Even though the symptoms listed above might not seem obvious to a person unfamiliar with panic disorder, they are often associated with the disorder, as noted in the *Diagnostic and Statistical Manual-IV-TR* (American Psychiatric Association, 2000). On the surface, this item might not seem to be measuring the construct, but individuals with

panic disorder often have some or all of these symptoms, and thus such a question might be an important indicator for test validity.

Content Validity

Content validity has to do with whether test items are constructed in a manner that show they represent the defined body of knowledge being tested. Content validity is most important in ability testing, especially achievement testing, in which items picked to be included in the instrument need to be representative of the content area being tested. Content validity is generally achieved by surveying well-known texts, the professional literature, and experts in the test content area and then developing items based on the knowledge gained.

Criterion-Related Validity

Criterion-related validity exists when an assessment instrument is shown to be related to some external criterion or reference. Two types of criterion-related validity are concurrent validity and predictive validity. *Concurrent validity* occurs when a test shows sizable correlation to a criterion in the present. For instance, using a correlation coefficient, a newly made test of depression can be correlated with experts' clinical judgments of clients' depression. A high correlation would show criterion-related validity. A low correlation would mean the test's validity is questionable. *Predictive validity* takes place when a test is shown to be predictive of a future criterion. For instance, again using a correlation coefficient, ACT or SAT scores can be correlated with students' GPAs in college. A high correlation would show that the ACT or SAT can, to some degree, predict college grades. However, a low correlation would leave us questioning the ability of the test to predict college grades and the usefulness of the test for college admissions.

Construct Validity

Construct validity is used to support a theoretical assumption that the construct being measured by a test exists (Goodwin, 2002; Neukrug & Fawcett, 2010). Construct validity is much more important for more ambiguous constructs such as depression, empathy, or intelligence and less important for something like geometry, or botany. As an example, let's say that I created a new test of depression. I would certainly expect that my test would be able to support my hypothesis that those who are depressed (e.g., psychiatric admissions for depression) would score higher on my test compared to those who are not depressed (e.g., a group of identified nondepressed individuals). If my test can distinguish these two groups, I have shown *experimental validity*, a type of construct validity that uses validation of a research hypothesis to support the construct. A second type of construct validity, *convergent validity*, examines if my test is related to an already existing, valid test (correlating my test with the existing Beck Depression Inventory). *Discriminant validity*, a third way to show construct validity, demonstrates that a test is not related to another test (e.g., there would be no relationship between scores on my depression tests and scores on an established test that measures anxiety). Finally, if my test had subscales that were supposed to be unique from one another (e.g., hopelessness, suicidal ideation, sadness), then when correlating the subscales with one another, we should find only a negligible relationship among them (*factor analysis validity*). This type of construct validity supports the notion that subscales on a test are separate and unique, although they all might be related to the larger construct (in this case, depression).

Reliability

The second quality examined in determining the adequacy of an assessment instrument is *reliability*. Whereas validity is used to show that a test is measuring what it's supposed to measure, reliability examines the accuracy of test scores. Or, put another way, reliability measures the amount of *error* in a test—the less error, the better the test. As with validity, reliability is measuring the adequacy of the test and is not making a statement about the people taking the test. There are a number of ways of examining such accuracy, including *test-retest*, *alternate forms*, *split-half*, and *internal consistency reliability*.

Test–Retest Reliability

One of the most common types of reliability, *test–retest reliability* examines the relationship between scores on one administration of a test with scores on a second administration of the same test to the same group of people. For instance, if I wished to show that my test was accurate, I might administer the instrument to a large group of individuals and, after a short time has passed, perhaps one week, administer it a second time. I would then correlate the scores from the first administration with the scores from the second administration of the test. A test that is poorly made (has a fair amount of error) will result in many individuals having large deviations between the first and second administrations of the test. One problem with this kind of reliability is in sorting out whether deviations between the first and second administration of a test are the result of changes in individuals or because of error in the test (remember, we are measuring error in the test, not changes in the person). For instance, if individuals are given a test to measure depression, then seek out therapy, and one month later are given the same test, it would be difficult to determine if changes in test scores are a result of therapy or reflective of a poorly made test. This is why other types of reliability that do not rely on a second administration of the test are often used in addition to or in lieu of test–retest reliability.

Alternative Forms Reliability

Also called *parallel forms* or *equivalent forms reliability*, *alternative forms reliability* measures accuracy in a test by correlating one form of a test with a second form that is considered to be a close mirror of the first form. Because the two forms are generally given at the same time, the possibility that the correlation is a result of changes in the individual between the first and second administrations of the test is eliminated. One problem with this kind of reliability is the difficulty of making a second form that is a true mirror of the first. Also, for many tests, it is not practical to devise a second, equivalent form of the test.

Split-Half Reliability

Sometimes called *odd-even reliability*, *split-half reliability* eliminates the problem of having to create a second form of the test. In this kind of reliability, the instrument is split in half in some rational manner that assumes that scores on the first half of the test should be equivalent to scores on the second half. The two halves are then correlated to show the accuracy of the test. A major problem with this kind of reliability revolves around the fact that two halves of a test are generally not perfectly equivalent to one another, and thus does not assess as accurately for error within the test.

Internal Consistency

Like split-half reliability, *internal consistency reliability* gives an estimate of consistency based on a single administration of a test. The reliability estimate found reflects the average of all split-half reliabilities. With the advent of computers, this kind of reliability has become quite popular. Two popular types of internal consistency reliabilities include *Cronbach's Coefficient Alpha* and *Kuder-Richardson* (see Table 12.2 for a summary of validity and reliability).

Cross-Cultural Fairness of Tests

> . . . *Information gained and decisions made about the client or student are valid only to the degree that the test accurately and fairly assesses the client's or student's characteristics. Test selection and interpretation are done with an awareness of the degree to which items may be culturally biased or the norming sample not reflective or inclusive of the client's or student's diversity* . . . (ACA, 2003, Standard 6)

Cross-cultural fairness is critical in determining whether an assessment instrument is fair for all individuals who may be taking a test or assessment instrument. Although it is impossible to eliminate all bias from tests and other assessment instruments, one should expect that the bias is small enough to allow for justifiable interpretations of any individual's responses. When examining cultural bias, test publishers should have exhaustively reviewed the extent to which the content of a test has cultural bias. For instruments used to predict future behavior, the test should be shown to be predictive for minority groups. This does not mean that it will predict in the same manner for all groups, but that the predictive validity of each subgroup was examined and the test was shown to predict accurately for each subgroup (Aiken & Groth-Marnta, 2006). In fact, the U.S. Supreme Court case of *Griggs v. Duke Power Company* (1971) asserted that tests used for hiring and advancement at work must show that they can predict job performance for all groups.

T A B L E 12.2

Summary of Types of Validity and Reliability	
VALIDITY	RELIABILITY
Content: Content analysis; experts contribute test questions and are consulted, and items are created from well-known sources.	*Test–retest:* The ability of a test to show consistency in scores from one testing to a second testing.
Concurrent: A kind of criterion-related validity that evaluates the relationship between the test and a criterion in the present (e.g., another test, expert judges' ratings).	*Alternate forms:* The correlation of one form of a test with a second equivalent form of the test. Also called equivalent or parallel form reliability.
Predictive: A kind of criterion-related validity that evaluates the relationship between the test and a future criterion.	*Split-half:* The relationship between items on one half of a test with items on the second half of the test. Also called odd-even reliability.
Construct: The ability of a test to show that a certain construct exists and can support a theoretical assumption of the test. Four types: experimental design, factor analysis, discriminant validity, and convergent validity.	*Internal consistency:* The average of all possible split-half reliabilities. Two types are Cronbach's Coefficient Alpha and Kuder-Richardson.

Cross-cultural bias in testing is an important issue when assessment instruments are used with individuals from diverse cultures. Examiners need to be aware of bias in testing, ethical issues related to assessment and multiculturalism, and state and national laws concerning the use of tests with minorities. Some related issues will be discussed later in this chapter.

Practicality

Suppose I have a test that can accurately assess mental health problems, but each administration costs $1,000. This test may be good at what it does, but the cost may be prohibitive for most people. Or, suppose we have an instrument than can accurately measure learning disabilities but takes a school psychologist two days to administer. These are some of the questions with which we must struggle when deciding whether or not a test is practical.

Practicality examines whether or not the test is realistic to give. It includes issues related to the cost of testing, the time it takes to administer the test, the ease of administration, the format of the test, the readability of the test, and the ease of interpretation. A test can have good validity and good reliability and be cross-culturally fair, and yet not be a practical test to give.

Where to Find Tests and Assessment Techniques

Today, there are well over 3,500 tests available for a wide variety of assessment procedures (Buros Institute, 2007). Because there are so many options, finding a test or assessment technique that meets one's specific needs is not always an easy task. However, a number of sources are available to assist us in the proper selection of tests for use with a desired population:

1. *Publisher resource catalogs.* Publishing companies freely distribute catalogs that describe the tests and assessment procedures they sell.
2. *Journals in the field.* Professional journals, especially those associated with measurement, will often describe assessment procedures they have used in research or give reviews of new instruments in the field.
3. *Source books and on-line source information on testing and assessment procedures.* There are a few comprehensive books that provide the names of the test author(s), the publication date, the purpose of the test, critical reviews, bibliographical information, information on test construction, the name and address of the test publishing company, the costs of the test, and other basic information. Two of the most important source books are the *Buros Mental Measurement Yearbook*, which can now be accessed online, and its companion volume, *Tests in Print* (Murphy, Spies, & Plake, 2006).
4. *Books on testing and assessment.* Textbooks that present an overview of testing and assessment techniques are usually fairly good at highlighting a number of the better-known procedures that are in use today.
5. *Experts.* School psychologists, learning disability specialists, experts at a school system's central testing office, psychologists at agencies, and professors are some of the people who can be called upon for assistance with information on assessment procedures.

6. *The Internet.* Today, publishing companies have home pages that offer information about assessment procedures they sell. In addition, the Internet has become an increasingly important place to search for information about a variety of assessment procedures. Of course, one needs to be careful to ensure that any information from the Internet is accurate.

Writing Assessment Reports

In-depth information on the writing of assessment reports is not within the purview of this text. However, because some counselors will write such reports, and all counselors will read the assessment reports of others, it is crucial that they understand the basics of report writing. Although the content of a report will vary based on the purpose of the assessment, a report will generally include the following categories: demographic information, reason for referral, family background, other relevant information (e.g., legal, medical, vocational), behavioral observations of the client, a mental status, test results, a diagnosis, recommendations, and summary (Drummond & Jones, 2010; Neukrug & Fawcett, 2010).

As with clinical case reports, assessment reports should not be longer than a few pages, and the examiner should use language that most professionals can understand—even ones who have little or no background in testing and assessment. Some common problems that have been identified in the writing of assessment reports include the overuse of jargon, focusing on the assessment procedures and downplaying the person, focusing on the person and de-emphasizing the assessment results, poor organization, poor writing skills, and failing to take a position about the person who was assessed (e.g., not making specific recommendations) (Goldfinger, & Pomerantz, 2010; Neukrug & Fawcett, 2010). Ideally, as you proceed through your training program, you will obtain many opportunities to practice writing assessment and case reports.

Multicultural/Social Justice Focus

Caution in Using Assessment Procedures

As noted earlier, so important are cross-cultural issues in testing today that they are included as one of the four aspects in determining the worthiness of an assessment instrument (Neukrug & Fawcett, 2010). Because bias in testing has been a problem since the beginning of assessment procedures, a number of standards have been developed to address this important issue. For instance, the Association for Assessment in Counseling and Education (AACE), a division of ACA, has developed *Standards for Multicultural Assessment* that provides 68 standards across four areas, including: content and purpose in test selection; norming, reliability, and validity; administration and scoring; and interpretation and application (AACE, 2003a). In addition to the standards, the ACA *Code of Ethics* speaks to the importance of the careful use of testing with minorities:

> *Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color,*

> *culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors.*
> (ACA, 2005, Standard E.8)

Also, the *Code of Fair Testing Practices in Education* has been developed, with its intent being to ensure that testing is "fair to all test takers regardless of age, gender, disability, race, ethnicity, national origin, religion, sexual orientation, linguistic background, or other personal characteristics" (JCTP, 2004, p. 1). Finally, there are many other standards and guidelines for the proper use of tests, and all address this important issue in some manner (see the section in Ethical, Professional, and Legal Issues: "Guidelines for the Use of Assessment Procedures").

Take A Stand—Do Something!

All too often I have seen counselors idly stand by and do nothing when they know that:

1. Tests have been administered improperly
2. A learning disabled student should have been removed from testing because he or she was not at his or her optimum (e.g., an ADHD child did not take medication, was hyper, and could not focus on the test questions)
3. Tests were used that were culturally biased
4. Tests were used that had limited validity or reliability
5. Cheating has taken place

It is our duty, our moral responsibility, and our ethical obligation to speak out. When you do nothing for fear of losing your job, when you do nothing for fear of being a rebel, when you do nothing for fear of reprisal, and when you do nothing because you simply do not care, you are part of the problem, not the solution. Do not make excuses for not responding—speak out.

■ Ethical, Professional, and Legal Issues

Ethical Issues

Guidelines for the Use of Assessment Procedures

To guide practitioners and the public, a number of codes and standards address a myriad of assessment issues. If you are interested in becoming more involved in assessment, you may want to take the time to examine some of the following standards:

a. *ACA's ethical code* (ACA, 2005)

b. *The Code of Fair Testing Practices in Education* (JCTP, 2004)

c. *Standards for Multicultural Assessment* (AACE, 2003a)

d. *The Standards for the Qualifications of Test Users* (ACA, 2003)

e. *Responsibilities of Users of Standardized Tests* (RUST) (AACE, 2003b)

f. *Rights and Responsibilities of Test Takers: Guidelines and Expectations* (JCTP, 2000)

g. *Standards for Educational and Psychological Testing* (AERA, 1999)

h. *Competencies in Assessment and Evaluation for School Counselors* (American School Counselor Association/Association for Assessment in Counseling and Education, 1998)

Informed Consent

Informed consent implies that each person who is to be assessed has given his or her consent after having been "informed about the nature and purpose of the evaluation, as well as information concerning confidentiality limits and how the security of tests will be maintained . . ." (Drummond & Jones, 2010, p. 132). Generally, individuals have the right to refuse testing or other assessment procedures; however, in some cases, such as court-ordered testing to assess fitness of a parent in a child custody case, a client may not have such a right.

Invasion of Privacy and Confidentiality

Assessments invade one's privacy. However, concerns about invasion of privacy are lessened if the client has given informed consent, has some real choice in whether or not he or she can refuse an assessment, and knows the limits of confidentiality, such as when testing is court ordered.

Competence in the Use of Tests

To properly administer, score, and interpret test results, test givers must have adequate knowledge about testing and familiarity with any test they may use. To establish who is qualified to give specific tests, during the 1950s the American Psychological Association (APA) adopted a three-tier system for test user qualifications. Although APA reevaluated this system and currently provides rather extensive guidelines for test user qualifications (see Turner, Demers, Fox, & Reed, 2001), many test publishers continue to use the original three-tier system:

> *Level A tests are those that can be administered, scored, and interpreted by responsible nonpsychologists who have carefully read the test manual and are familiar with the overall purpose of testing. Educational achievement tests fall into this category.*
>
> *Level B tests require technical knowledge of test construction and use and appropriate advanced coursework in psychology and related courses (e.g., statistics, individual differences, and counseling).*
>
> *Level C tests require an advanced degree in psychology or licensure as a psychologist and advanced training/supervised experience in the particular test.* (APA, 1954, pp. 146–148)

To highlight some examples based on the above categories: teachers can administer most Level A survey battery achievement tests while master's level counselors can administer Level B tests (e.g., interest inventories and many objective personality tests). Level C

tests are reserved for those who have a minimum of a master's degree, a basic testing course, and advanced training in the specialized tests they may be giving (e.g., school psychologists, learning disabilities specialists, clinical and counseling psychologists, and master's-level therapists who have gained additional training).

Technology and Assessment

The ethical use of computer-generated assessment procedures has become an important issue as individuals now have on-line access to many assessment instruments, often without the benefits of a counselor interpreting the results. To address these concerns, ACAs ethical code now includes a separate subsection under the "The Counseling Relationship" that specifically focuses upon technological applications (see ACA, 2005, Section A.12). A few of the important considerations related to technology and assessment include: helping clients understand the benefits and drawbacks of technological applications, informing clients of the limits of confidentiality, helping clients know the validity and reliability of information obtained, being aware of laws that might impact the use of on-line technology, and having adequate training and support in using technology.

The next decade will undoubtedly bring with it an ever-increasing reliance on technology in the assessment realm, and counselors will need to be ever vigilant about the proper use of assessment instruments as new technological advances are made (Kaplan et al., 2009).

Other Ethical Issues

In addition to the ethical issues already noted, other ethical issues should be considered when administering and interpreting test results and you are encouraged to read carefully the ACA ethical standards to familiarize yourself with them. Briefly, they include knowing how to (1) properly release test results; (2) select tests; (3) administer, score, and interpret tests; (4) keep tests secure; (5) pick tests that are current and up-to-date; and (6) assess whether tests are properly constructed.

Professional Issues

Computer-Driven Assessment Reports

Today, computers can generate sophisticated test reports, and oftentimes pieces of these reports can be moved directly into the examiner's written assessment report (Berger, 2006; Michaels, 2006). However, whether it is a computer generated report that resulted from a client interview or a report that includes aspects of computer-generated test reports, it is still up to the examiner to make sure that the correct questions are being asked of the client, the correct assessment procedures are being used, and that the material used in the development of the examiner's assessment report is chosen wisely by the examiner:

> While the computer may administer these [tests] and even prepare a report, what the test looks like, how it responds, what it achieves and any reports generated, are predetermined by the author, and it is a person who puts it all together to make the interpretation. (Berger, 2006, p. 70)

Professional Association

Originally called the Association for Measurement and Evaluation in Guidance (AMEG), AMEG changed its name to the Association for Assessment in Counseling and Education (AACE; see www.theaaceonline.com) in order to reflect a broader definition of assessment that includes the use of diagnosis, testing, interviewing, and other activities designed to understand the individual. Consider joining AACE if you are interested in testing, assessment, diagnosis, and the training and supervision of those who do assessment and/or if you are interested in developing and validating assessment products and procedures. AACE, a division of ACA, publishes *Measurement and Evaluation in Counseling and Development.*

Legal Issues: Laws That Have Had an Impact on Testing

A number of laws have been passed that impinge on the use of tests. Some of the more important ones include:

AMERICANS WITH DISABILITIES ACT.   This law states that accommodations must be made for individuals who are taking tests for employment and that testing must be shown to be relevant to the job in question.

THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT (FERPA).   This law affirms the right of all individuals to their school records, including test records.

CARL PERKINS ACT (PL 98-524).   This law ensures that individuals with disabilities, or who are disadvantaged, have access to vocational assessment, counseling, and placement.

CIVIL RIGHTS ACTS (1964 AND AMENDMENTS).   This series of laws asserts that any test used for employment or promotion must be shown to be suitable and valid for the job in question. If not, alternative means of assessment must be provided. Differential test cutoffs are not allowed.

THE FREEDOM OF INFORMATION ACT.   This law ensures the right of individuals to access their federal records, including test records. Most states have expanded this law so that it also applies to state records.

PL 94-142 AND THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA).   These legislative acts ensure the right of students to be tested, at a school system's expense, if they are suspected of having a disability that interferes with learning. The law asserts that schools must make accommodations, within the *least restrictive environment,* for students with learning disabilities.

SECTION 504 OF THE REHABILITATION ACT.   Relative to assessment, any instrument used to measure appropriateness for a program or service must be measuring the individual's ability, not be a reflection of his or her disability.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).   HIPAA ensures the privacy of client records, including testing records, and the sharing of such information (Zuckerman, 2008). In general, HIPAA restricts the amount of information that

can be shared without client consent and allows clients to have access to their records, except for process notes used in counseling (APA Practice Organization, 2009).

The Counselor in Process: Assessment as Holistic and Ongoing

Assessment of clients is much broader than simply giving an individual a test. In fact, one should generally "avoid using a single test score as the sole determinant of decisions . . ." And one should, "interpret test scores in conjunction with other information about individuals" (Joint Committee on Testing Practices, 2004, Section C-5). Thus, a thorough assessment will involve a number of different kinds of assessment procedures, such as formal tests, informal assessment instruments, diagnosis, and a clinical interview. This holistic process can help us obtain a broader and more accurate view of the client than if we were to rely on just one test (Mislevy, 2004; Moss, 2004).

Assessment is also an ongoing process that begins the first moment the counselor and client meet. As the helping relationship continues and deepens, the assessment process tends to move from being counselor-centered, in the sense that the counselor provides the tools to assist the client in his or her own self-assessment process, to being client-centered, wherein the client has learned how to assess self. Although the counseling relationship will eventually reach an end, it is hoped that seeds have been planted for the client to continue with an ongoing and deepening self-assessment process throughout his or her life.

Summary

We started this chapter by defining assessment and noted that testing was a subset of assessment. We noted that assessment includes such things as personality testing, ability testing, informal assessment, and the clinical interview. We examined why testing and assessment are important and noted that assessment is one additional way that counselors can come to understand the inner world of the client. We discussed how assessment can aid counselors in understanding the client's abilities and personality and can be useful in diagnosis, goal setting, treatment planning, program evaluation, and research. We also found that testing and assessment are an important function of counselors in all settings, noting that counselors provide a wide range of testing and assessment activities.

Within this chapter, we saw that throughout history people have always been assessed. We stated that the modern-day origins of assessment can be traced back to the mid-1800s when the assessment of individual differences and the use of the scientific method became popular. With changing demographics and the impact of the industrial revolution during the turn of the twentieth century, we saw the first need for the widespread use of tests, particularly vocational assessment. With the advent of World War I, the importance of assessment increased as ability and personality tests were developed to help with the placement of recruits. Soon, tests and assessment procedures of all kinds were used in many different settings. We noted that tests have been refined over the years and that new statistical models and computers have particularly improved the quality of tests.

Today, there are many different kinds of tests and assessment techniques, including ability tests, which comprise achievement and aptitude tests. Three kinds of achievement tests we noted include survey battery, diagnostic, and readiness. Some of the different kinds of aptitude tests we highlighted were cognitive ability tests, intelligence tests, neuropsychological assessment, special aptitude, and multiple aptitude tests. We noted that personality tests measure temperament, habits, likes, disposition, and nature and identified three types: objective, projective, and interest inventories. We also identified a number of different kinds of informal types of assessment, such as observation, rating scales, classification methods, environmental assessment, records and personal documents, and performance-based assessment. We also pointed out that the clinical interview is a type of assessment.

We noted that assessment procedures can be standardized and either norm-referenced or criterion-referenced; or nonstandardized and either norm-referenced or criterion-referenced. In putting meaning to test scores, we noted that it is important to examine an individual's score relative to his or her norm group and to understand what the score means to the individual taking the test. We highlighted the fact that measures of central tendency (mean, median, and mode) and measures of variability (range, interquartile range, and standard deviation) can assist us in making comparisons between individuals who take the same test, or when comparing individuals who have taken different tests.

In examining basic test statistics, we explained how the standard deviation, one measure of variability, is particularly important in understanding norm-referenced tests. We also noted that the standard deviation helps us convert raw scores to derived scores. We discussed the fact that derived scores, such as percentiles, T-scores, deviation IQ scores, ACT scores, SAT/GRE-type scores, NCEs, stanines, sten scores, grade equivalents, and idiosyncratic publisher test scores (scaled scores) are used because they are easier to interpret than raw scores.

We next discussed the statistical concept of correlation coefficient and showed how it is important when examining some issues of test worthiness. We then went on to discuss four qualities of test worthiness. The first quality we highlighted was validity, or whether or not a test measures what it is supposed to measure. We noted that face validity is not a real type of validity and then discussed three types of validity: content validity, criterion-related validity (concurrent and predictive) and construct validity (experimental, convergent, discriminant, and factor analysis). Then we defined reliability, or the ability of a test to accurately measure a trait or ability. Four types of reliability included: test-retest, alternate forms (a.k.a., parallel or equivalent forms), split-half (a.k.a, odd-even), and internal consistency (Coefficient Alpha and Kuder-Richardson). The other two qualities we discussed were cross-cultural fairness: whether or not the test measures what it's supposed to measure in a consistent manner for all groups, and practicality: the ease of administration and interpretation of the test.

We noted that today there are many sources that can help us find tests that have good reliability and validity, are practical, and have limited cultural bias. Some of these include publishers' resource manuals; professional journals; source books on testing, such as the *Buros Mental Measurement Yearbook* and *Tests in Print*; textbooks on testing; experts in schools and agencies; and the Internet. We also discussed the importance of writing a good assessment report and highlighted some potential problems in the writing of such reports.

Relative to multicultural and social justice issues, we pointed out that over the years there have been problems with bias in assessment instruments and that in recent years a number of standards have been developed to address these biases, such as AACE's Standards for Multicultural Assessment. We also pointed out the moral and ethical responsibility for counselors to address issues of bias and problems in testing.

We next highlighted a number of ethical issues in the area of assessment including identifying a number of guidelines for the ethical and professional use of assessment procedures, informed consent, invasion of privacy and confidentiality, competence in the use of tests (e.g., APAs "A, B, and C" system), technology and assessment, and "others." Professional issues we noted included the proper use of computer-driven assessment reports and identifying the ACA assessment division: the Association for Assessment in Counseling and Education.

We next went on to briefly discuss a number of legislative actions and their impact on testing, including the *Americans with Disabilities Act*, FERPA, the *Carl Perkins Act*, *Civil Rights Acts*, the *Freedom of Information Act*, PL94-142 and the IDEA, Section 504 of the *Rehabilitation Act*, and HIPAA.

Finally, we concluded the chapter by highlighting the fact that assessment is an ongoing, holistic process that includes a number of components and that when a successful counseling relationship terminates, the client ideally will be able to continue the self-assessment process on his or her own.

▇ *References*

Agresta, J. (2004). Professional role perceptions of school social workers, psychologists, and counselors. *Children and Schools*, *26*(3), 151–163.

Aiken, L. R., & Groth-Marnat, G. (2006). *Psychological testing and assessment* (12th ed.). Upper Saddle River, NJ: Pearson.

American Counseling Association. (2003). *Standards for qualifications of test users*. Alexandria, VA: Author.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Educational Research Association. (1999). *Standards for educational and psychological testing*. Washington, DC: AERA.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychological Association Practice Organization. (2009). *HIPAA: What you need to know*. Retrieved from http://www.apapracticecentral.org/business/hipaa/2009-privacy.pdf

American School Counselors Association/Association for Assessment in Counseling and Education. (1998). *Competencies in assessment and evaluation for school counselors*. Alexandria, VA: Author.

Association for Assessment in Counseling and Education. (2003a). *Standards for multicultural assessment*. Alexandria, VA: Author.

Association for Assessment in Counseling and Education. (2003b). *Responsibilities of users of standardized tests* (RUST). Alexandria, VA: Author.

Baker, S. B. & Gerler, E. R. (2008). *School counseling for the twenty-first century* (5th ed.). Upper Saddle River, NJ: Pearson.

Behuniak, P. (2003). Educational assessment in an era of accountability. In J. Wall & G. Waltz (Eds.), *Measuring up: Assessment issues for teachers, counselors, and administrators* (pp. 335–348). Retrieved from ERIC database. (ED 380066)

Berger, M. (2006). Computer assisted clinical assessment. *Child and Adolescent Mental Health, 11*(2), 64–75. doi:10.1111/j.1475-3588.2006.00394.x

Buros Institute of Mental Measurements. (2007). *Tests reviewed in the Seventeenth Mental Measurements Yearbook.* Retrieved from http://www.unl.edu/buros/bimm/html/17tests.html

Burton, N. W., & Wang, M. (2005). *Predicting long-term success in graduate school: A collaborative validity study.* Princeton, NJ: Educational Testing Service.

Drummond, R. J., & Jones, K. D. (2010). *Appraisal procedures for counselors and helping professionals* (7th ed.). Upper Saddle River, NJ: Merrill.

DuBois, P. (1970). *A history of psychological testing.* Boston: Allyn and Bacon.

Elmore, P. & EIkstrom, R. B. (2003). Assessment competencies for school counselors. In J. Wall & G. Waltz (Eds.), *Measuring up: Assessment issues for teachers, counselors, and administrators* (pp. 343–352). Retrieved from ERIC database. (ED 380066)

Fremer, J., & Wall, J. (2003). Why use tests and assessment? In J. Wall & G. Waltz (Eds.), *Measuring up: Assessment issues for teachers, counselors, and administrators* (pp. 2–19). Retrieved from ERIC database. (ED 380066)

Fritzsche, B., & Parrish, T. (2005). Theories and research on job satisfaction. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 180–202). Hoboken, NJ: John Wiley & Sons.

Goldfinger, K., & Pomerantz, A. (2010). *Psychological assessment and report writing.* Thousand Oaks, CA US: Sage Publications.

Goodwin, L. (2002). The meaning of validity. *Journal of Pediatric Gastroenterology and Nutrition, 35,* 6–7. doi:10.1097/00005176-200207000-00003

Griggs v. Duke Power Company, 401 U. S. 424 (1971).

Higgins, L. T., & Sun, C. H. (2002). The development of psychological testing in China. *International Journal of Psychology, 37*(4), 246–254. doi:10.1080/00207590244000025

Hoekstra, R., Bartels, M., & Boomsma, D. (2007). Longitudinal genetic study of verbal and non-verbal IQ from early childhood to young adulthood. *Learning and Individual Differences, 17*(2), 97–114. doi:10.1016/j.lindif.2007.05.005

Isaacson, W. (2007). *Einstein: His life and universe.* New York: Simon & Schuster.

Joint Committee on Testing Practices. (JCTP). (2000). *Rights and responsibilities of test takers: Guidelines and expectations.* Washington, DC: American Psychological Association.

Joint Committee on Testing Practices. (JCTP). (2004). *Code of fair testing practices in education.* Washington, DC: American Psychological Association.

Juve, J. (2008). Testing and assessment. In S. F. Davis, & W. Buskit (Eds.), *21st century psychology: A reference handbook* (vol. 1, pp. 383–391). Thousand Oaks, CA: Sage Publications.

Kaplan, D. M., Kocet, M., Cottone, R., Glosoff, H., Miranti, J., Moll, E., …Tarvydas, V. M. (2009). New mandates and imperatives in the revised "ACA Code of Ethics." *Journal of Counseling and Development, 87*(2), 241-256.

Kaplan, R. M., & Saccuzzo, D. P. (2009). *Psychological testing: Principles, applications, and issues* (7th ed). Belmont, CA: Brooks/Cole.

Kerr, M. S. (2008). Psychometrics. In S. F. Davis, & W. Buskit (Eds.), *21st century psychology: A reference handbook* (vol. 1, pp. 374–382). Thousand Oaks, CA: Sage Publications.

Kobrin, J. L., Patterson, B. F., Shaw, E. J., Mattern, K D., & Barbuti, S. (2008). *Validity of the SAT for predicting first-year college grade point average. Research Report No. 2008-5.* Retrieved from http://professionals.collegeboard.com/profdownload/Validity_of_the_SAT_for_Predicting_First_Year_College_Grade_Point_Average.pdf

Kolb, B. & Whishaw, I. (2009). *Fundamentals of human neuropsychology* (6th ed.) New York, NY: Worth Publishers.

Kuncel, N. R., & Hezlett, S. A. (2007). Standardized tests predict graduate students' success. *Science, 315*(5815), 1080-1081. doi:10.1126/science.1136618

Lezak, M., Howieson, D., & Loring, D. (2004). *Neuropsychological Assessment* (4th ed.). New York Oxford University Press.

Mehrens, W. A. (1992). Leadership to researchers and practitioners. *Journal of Counseling and Development, 70,* 439–440.

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., … Reed, G. F. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist, 56,* 128–165. doi:10.1037/0003-066X.56.2.128

Michaels, M. H. (2006). Ethical considerations in writing psychological assessment reports. *Journal of Clinical Psychology, 62*(1), 47–58.

Mislevy, R. J. (2004). Can there be reliability without "reliability?" *Journal of Educational and Behavioral Statistics, 29*(2), 241–244. doi:10.3102/10769986029002241

Moss, P. (2004). The meaning and consequences of reliability. *Journal of Educational and Behavioral Statistics, 29*(2), 245–249. doi:10.3102/10769986029002245

Murphy, L. L., Spies, R. A., & Plake, B. S. (Eds.). (2006). *Tests in Print VII.* Lincoln, NE: Buros Institute of Mental Measurements.

Naugle, K. A. (2010). Counseling and testing: What counselors need to know about state laws on assessment and testing. *Measurement and Evaluation in Counseling and Development, 42*(1), 31–45. doi:10.1177/0748175609333561

Neukrug, E. S., & Fawcett, R. C. (2010). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (2nd ed.). Belmont, Ca: Brooks/Cole.

Ryan, J. J. (2008). Intelligence. In S. F. Davis, & W. Buskit (Eds.), *21st century psychology: A reference handbook* (vol. 1, pp. 413–421). Thousand Oaks, CA: Sage Publications.

Sampson, J. P. (1995). *Computer-assisted testing in counseling and therapy.* Retrieved from ERIC database. (ED 391983)

Turner, S. M., DeMers, S. T., Fox, H. R., & Reed. G. M. (2001). APA's guidelines for test user qualifications: An executive summary. *American Psychologist, 56*(12), 1099–1113. doi:10.1037/0003-066X.56.12.1099

Verbruggen, M., & Sels, L. (2010). Social-cognitive factors affecting clients' career and life satisfaction after counseling. *Journal of Career Assessment, 18*(1), 3–15. doi:10.1177/1069072709340516

Verquer, M. L., Behr, T. A., & Wagner, S. H. (2003). A meta-analysis of relations between person-organization fit and work attitudes. *Journal of Vocational Behavior, 63,* 473–489. doi:10.1016/S0001-8791(02)00036-2

Watson, R. (1968). *The great psychologists from Aristotle to Freud.* Philadelphia: Lippincott.

Zuckerman, E. L. (2008). *The paper office: Forms, guidelines, and resources to make your practice work ethically, legally, and profitably.* (4th ed.). New York: Guilford Press.

CHAPTER *13*
Research and Evaluation

Research has been maligned. Some criticize it, students fear it, and others approach it as if it were a virus, never coming too close to it. Unfortunately, many lose sight, or perhaps never gain the insight, that research "can be an exhilarating experience, analogous to adding pieces to a jigsaw puzzle." (Whiston, 1996, p. 622)

I remember a graduate student coming to me one day, bewildered after not finding significant results on a study she was conducting for her thesis. She had hypothesized that there would be a relationship between the number of years that one meditated and self-actualizing values; that is, the more you meditated, the more self-actualized you would be. She went to an ashram (a yoga retreat center) and had a number of meditators complete an instrument that measured their level of self-actualization, and then she collected information from these same individuals concerning how long they had been meditating. After collecting her data and performing a statistical analysis, she found no significant relationship. As she herself had meditated for years and was an ardent believer in meditation, she was convinced that she would find such a relationship; clearly, she was personally invested in the research. Upon finding no significant relationship, she said to me, "There must be something wrong with this research, because people who have meditated for years are more self-actualized than those who have just started meditating." I suggested there was nothing wrong with the research, but that perhaps she had a bias because of her own experiences with meditation. I explained that this does not mean that meditation does not affect people, but that for this population, using this instrument, the evidence showed that no significant relationship existed. I went on to remind her that research is not how you feel something is, but what the results show. When she was able to see her own biases, she realized that perhaps I had a point.

A number of years ago I was conducting research on the relationship between dogmatism, internal locus of control, and attitudes toward learning in graduate students. I dutifully collected my data and was soon hoping to do my statistical analysis when a colleague of mine suggested it might also be interesting to look at how students make

meaning in their lives. He suggested a process by which he would interview a number of students who had participated in my study and attempt to find patterns and themes in their responses. He eventually hoped to distinguish students from one another based on their ways of making meaning and suggested that we could relate meaning making to the other attributes I was examining. I suggested that his research seemed kind of soft. "How do you quantify interviews?" I asked. He was soon to teach me an important lesson about research: that research can be more than simply looking at numbers and that research comes in many different forms. He was suggesting integrating a qualitative approach with my quantitative analysis, two very different ways of doing research.

The federal government audited me once. A colleague and I had received a $70,000 grant to train helping professionals in the schools about substance abuse interventions. We ran a series of workshops and subsequently used a number of evaluation techniques to determine whether the training program had been worthwhile. These evaluation procedures served a number of purposes, including helping us examine what had been beneficial during the earlier workshops, assisting us in fine-tuning later workshops, helping us know the overall satisfaction of the participants with the total program, designing future training programs, and perhaps most significantly in this instance, producing evidence to show our funding source—the federal government, that we were accomplishing our stated goals and that we were accountable.

Why should anyone do research and evaluation? Well, as you can see by the above examples, research and evaluation help us find answers to the questions we ponder, move us forward in our understanding of the world, help us show that what we are doing is worthwhile, are ways of expressing our creativity, and can even be interesting and fun!

This chapter will examine some of the more common research and evaluation techniques and, I hope, present them in a manner that is appealing and exciting. We will begin by defining the purpose of research and distinguishing between two major forms of research, quantitative and qualitative. We will also compare the value of different kinds of research. After surveying various research methods, we will offer an overview of evaluation methods and examine the relationship of evaluation to research. Finally, we will examine multicultural, social justice, ethical, professional, and legal issues related to research and evaluation.

◼ *Research*

The Purpose of Research

The inquiry of truth, which is the love-making, or wooing of it; the knowledge of truth, which is the presence of it; and the belief of truth, which is the enjoying of it; is the sovereign good of human nature.

(Sir Francis Bacon, 1997/1597, p. 6)

Best and Kahn (2006) describe research as "the systematic and objective analysis and recording of controlled observations that may lead to the development of generalizations, principles or theories, resulting in prediction and possibly ultimate control of events" (p. 25). In other words, research analyzes information in order to give us knowledge about the present—knowledge that may help us to make predictions about the future. Research comes in many forms and can be as varied as counting the number of times a child acts out during the day, surveying opinions of counselors, using intensive interviews to understand how moral development is established, or performing complex statistical analyses to determine which counseling skills are most effective.

Without research, knowledge remains stagnant, and new paradigms are unlikely to evolve (Kuhn, 1962). While our theories are interesting and are generally the basis for our research, theories hold little weight if they are not eventually grounded in research. Research validates what the counselor is doing and can suggest new avenues for approaching client change (Houser, 2009). Research is the basis for evaluation that enables us to know if the programs and workshops we are conducting are effective. Without research, we are an ethereal profession with our heads in the air and little or no means of showing that what we do is meaningful.

Who is the researcher? It's you, and me, and all individuals who rely on evidence to make sure that what we are doing is working. In fact, some have argued that all master's level counselors are researchers in the sense that they are *practitioner–scientists*; they work with and collect information from clients (e.g., clinical interviews) and use the information gathered, as well as information from science (e.g., information from journal articles) to make informed decisions about their clients (Houser, 2009).

Literature Reviews and the Statement of the Problem

Research offers us a mechanism to satisfy our innate curiosity about human nature. For instance, you have undoubtedly pondered the nature of emotional disorders and have wondered about effective ways to treat such problems. The researcher uses systematic methods to gather information in an effort to seek out plausible answers to these questions (Sommer & Sommer, 2002), and the practitioner uses the researcher's results.

So, where does the researcher start? At the beginning, of course, with a hunch or an educated guess about a topic of interest that the researcher would like to explore. Usually, the next step is for the researcher to examine prior research to see what has gone before (some *qualitative researchers* argue against conducting a literature review first—but more about this later). The examination of prior research is called the *review of the literature* and is generally begun by conducting a computerized search of abstracts in the fields of counseling, education, psychology, and other disciplines that might be relevant to the research. Although there are many electronic databases that are searchable, often through one's library, two particularly popular ones include *Educational Resources Information Center* (ERIC) and *PsycINFO*.

Emerging from a review of the literature is the *statement of the problem*, which places the research within its historical context, determines what research already exists on the topic, discusses why the issue at hand is important, limits the scope of what one is researching, explains how the research departs from past research, and points one in the direction of developing research questions, statements, and/or hypotheses that delimit the type of research that be will conducted (McMillan & Schumacher, 2010; Mertler & Charles, 2008). For example, examine the statement of the problem on the importance of

BOX 13.1

Statement of the Problem

What is ethical counselor behavior one year may not be ethical the next, especially in light of the fact that ethical codes change as a function of changing values in society, new evidenced-based research, and the changing nature of professional associations (Ponton & Duba, 2009; Walden, Herlihy, & Ashton, 2003). The most recent ethics code of the American Counseling Association (ACA, 2005) demonstrates how much a code can change by including a number of revisions that challenge counselors to work in new ways. For instance, the code replaces the term "serious and foreseeable harm" with "clear and eminent danger," increases the restrictions on romantic and sexual relationships, softens the admissibility of dual relationships, includes a statement on end-of-life care for terminally ill clients, increases attention to social and cultural issues, allows counselors to refrain from making a diagnosis, highlights the importance of having a scientific basis for treatment modalities, requires counselors to have a transfer plan for clients, adds guidelines for how and when to use technology, and includes a statement about the right to confidentiality for deceased clients (ACA, 2005; Kaplan et al., 2009).

Making good ethical decisions is dependent upon knowledge of one's code, familiarity with models of ethical decision-making, the cognitive complexity of the counselor, and knowledge of problematic ethical situations (Corey, Corey, & Callanan, 2011; Hill, 2004; Neukrug, Lovell, & Parker, 1996). Helping current and future counselors become more knowledgeable about and skilled at responding to difficult ethical issues can be accomplished

in a number of ways. For instance, some have surveyed credentialing boards to assess the kinds of complaints and violations made against counselors (Neukrug, Milliken, & Walden, 2001; Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007). Secondly, ethics committees of professional associations have often provided extensive information regarding ethical concerns currently facing professionals (e.g. see Glosoff & Freeman, 2007; American Psychological Association, 2008; National Association of Social Workers, 2008). These committees tend to field questions about ethical dilemmas and respond to ethical complaints from their membership and from the public (Welfel, 2010). Finally, some have surveyed counselors directly to identify those areas in which they may need additional training. For example, Gibson and Pope (1993) conducted a random sample of National Certified Counselors, asking them to rate 88 counselor behaviors. From their responses, they identified behaviors that seemed to cause the most confusion or difficulty for counselors.

This research sought to update and expand Gibson and Pope's (1993) work by administering a revised scale to counseling professionals. It is hoped that the results can guide educators in the training of students and counselors by highlighting which ethical situations are most distressing and confusing and also help guide the revision of future ethical codes of the American Counseling Association (ACA, 2005). Hopefully, this research can aid in reducing ethical complaints and violations by providing important preventive information for students, counselors, and counselor educators (Chauvin & Remley, 1996).

examining which ethical situations are most distressing and confusing for counselors (see Box 13.1).

Once the statement of the problem is developed, the research design can be formulated. Generally, one's research design is based on a number of factors, including whether the researcher believes it is best to use quantitative research, qualitative research, or a mixed methods approach, and the kind of research that has previously been conducted, as evidenced in the literature review and statement of the problem.

Distinguishing Between Quantitative and Qualitative Research

Quantitative research assumes that there is an objective reality within which research questions can be formulated and scientific methods used to measure the probability that certain behaviors, values, or beliefs either cause or are related to other behaviors, values,

TABLE 13.1

Distinctions between Quantitative and Qualitative Research		
	QUANTITATIVE	QUALITATIVE
Assumptions about knowledge	"Truth" is sought through research. Knowledge is used to develop hypotheses.	Reality is socially constructed and there are multiple realities. Knowledge emerges through research.
Research methods used	Mathematical, statistical, and logical. Hypothesis testing and attempt to find answer to research questions. Deductive Process.	Philosophical and sociological. Multiple methods to understand research question. Immersion in task with goal to have knowledge emerge. Inductive process.
Biases and validity	Bias is problematic. Increased control of study to increase validity to reduce bias.	Bias is acknowledged. Reduced through the use of multiple methods of attaining data and examining results.
Goals and generalizability	To discover evidence and "truth" and generalize to larger audience.	To uncover information and describe findings in order to enlighten.
Researcher role	Detached, objective scientist.	Researcher is immersed in social situation and describes and interprets findings.

or beliefs. *Qualitative research*, on the other hand, holds that there are multiple ways of viewing knowledge and that one can make sense of the world by immersing oneself in the research situation in an attempt to provide possible explanations for the problem being examined (Heppner, Wampold, & Kivlighan, 2008). Table 13.1 gives a summary of distinguishing features of qualitative and quantitative research.

Qualitative and quantitative research approach the analysis of research problems differently. Thus, it is not surprising that their designs vary dramatically. Whereas quantitative research attempts to reduce the problem to a few very specific variables that can be experimentally manipulated, the aim of qualitative research is to make sense out of the problem by analyzing it broadly within its naturally occurring context. Therefore, we will separately examine the types of research designs offered by the quantitative and qualitative researcher, while keeping in mind that some researchers attempt to combine these two approaches, and use a *mixed methods* approach (Gall, Gall, & Borg, 2007).

Quantitative Research Designs

As stated earlier, quantitative research assumes there is an objective reality that can be revealed through the use of research design and statistical analysis of data. Quantitative research uses the scientific method to show the plausibility that a hypothesis is valid or to find possible answers to the research question being asked. Two main types of quantitative research are *experimental* and *nonexperimental* research.

Although both experimental and nonexperimental research use the scientific method and a reductionistic approach to understanding the research problem, there are some crucial differences between these two types of designs. In experimental research, the researcher is manipulating the experience of the participants (the treatment) in some manner to show a cause-and-effect relationship between it and specific outcome measures (Orcher, 2004). Nonexperimental designs, on the other hand, tend to either look at relationships between variables or describe the attitudes, beliefs, and behaviors of a group being surveyed.

Experimental Research

TRUE EXPERIMENTAL RESEARCH   In the realm of quantitative research, *true experimental research* designs are considered la crème de la crème, as they test, in a very controlled manner, for causal relationships between the variables being studied. In this type of research, the *independent variable*, or the variable being manipulated, is examined to determine if it has a direct effect on the *dependent variable*(s) or outcome measure(s).

In *true experimental research*, there is *random assignment* of subjects to treatment groups, which means that every subject has an equal chance of being in any of the treatment groups. There is a false belief by some that all true experimental research must have a control group. This is not the case; if the researcher is confident as a result of past research that any treatment is significantly different from no treatment, then he or she is not obligated to have a control group and may instead wish to compare different types of treatment.

One example of true experimental research would be a study of the effects of aerobic exercise (the independent variable) on traits such as depression, anxiety, and stress (the dependent variables). Because aerobic exercise is the variable being manipulated, various types of treatment (aerobic exercise) must be offered; and, because this is true experimental research, there must be random assignment. Therefore, one design would be to assign 100 individuals randomly to four treatment groups: a control group that does no aerobic exercise, a group that participates in eight weeks of mild aerobic exercise, a group that participates in eight weeks of moderate aerobic exercise, and a group that does eight weeks of intense aerobic exercise. In addition, having multiple aerobics exercise instructors, each trained in the different forms of aerobic exercise and each of whom leads one class in each of the treatment groups, would help ensure that the personality of the aerobics leader is not a factor in the results.

Starting with the assumption that there would be no differences between these four groups, I would develop a *null hypothesis* that states, "There will be no difference on measures of anxiety, depression, and stress among individuals who participate in different types of aerobic exercise." When researchers use the null hypothesis, they hope to show that it is false; that is, the researcher wants to show that the treatment has caused differences between groups, thus demonstrating treatment effects. For instance, using the aerobic exercise example, if I randomly assign 100 individuals to four groups, the assumption is that prior to exercise (the treatment) these groups would look the same if I measured them on our three characteristics. Therefore, following aerobic exercise (the treatment), any differences that I find between the groups would likely be due to the effect of the treatment and not due to other factors (see Figure 13.1). Sometimes, to ensure that this assumption is correct, pre-measures are taken. If the groups vary significantly, this can be statistically controlled for later.

Now, even if a treatment was completely ineffective, when measuring four groups of people on almost any characteristic you are likely to find some differences between groups just due to chance variables or fluctuations in scores. Therefore, in demonstrating that a treatment is effective, we are actually measuring the probability that these differences are due to the treatment and not due to chance or minor fluctuations. In fact, even in studies that showed that the probability was 999 out of 1,000 that the results were due to the treatment, it could be that the results are spurious because you happened to hit that 1 in 1,000 time that variations were due to chance alone. It's kind of like playing the lottery.

FIGURE 13.1
Pre and Post Variability of Aerobic Treatment Groups

Variability of treatment groups prior to treatment

Low High	Low High	Low High	Low High
No aerobics	Low-impact	High– and low-impact	High-impact

Low High	Low High	Low High	Low High
Group 1 (control)	Group 2	Group 3	Group 4

Variability of treatment groups following treatment
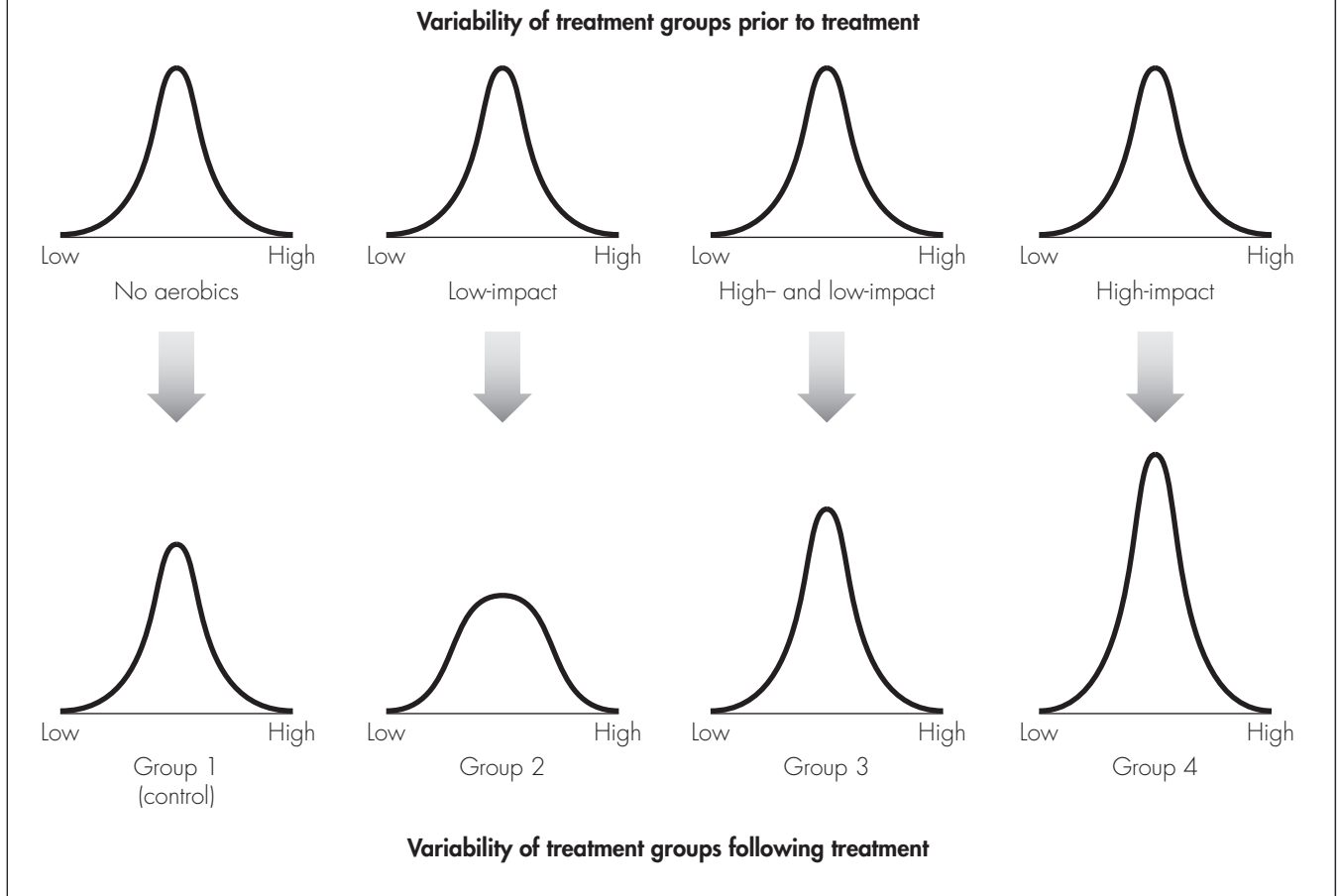
You know that you're not going to win, but once in a while, someone happens to win! In research, you can be pretty darn sure that if the probability is 1 in 100, and your results are significant, the treatment has shown effects. However, it could be that you hit the lottery, but in this case, the lottery is not lucky, and you have found results that are not real. This is why researchers never speak of proving something but instead talk in terms of the probability that the treatment was effective (Leary, 2007).

In some ways, the null hypothesis is used in our jurisprudence system. Criminal juries are operating from the null hypothesis, thus showing the probability that the criminal is guilty or not guilty. For instance, in a murder trial the defendant goes to court with the presumption of innocence, which is really the null hypothesis: "The defendant did not commit murder." The prosecution attempts to disprove the null hypothesis by showing the probability that the defendant committed the crime. If there is evidence beyond a reasonable doubt, you have disproved the null hypothesis, which

results in a finding of "guilty." On the other hand, if you have not convinced the jury of that probability, the defendant is found "not guilty," as opposed to innocent. We are not working with proof, but with probabilities. This is why a certain number of people who are innocent will always go to jail and a certain number of people will always be set free even though they are guilty. Science never gets to absolute truth, but perhaps, on occasion, comes pretty close.

In doing true experimental research, there are a number of different kinds of design possibilities when deciding how to manipulate the independent variable and measure the dependent variable. You'll probably learn about those designs in a research class. However, regardless of the research design in use, in true experimental research we are examining whether or not the groups look the same after treatment as they did before treatment (see Figure 13.1).

QUASI-EXPERIMENTAL RESEARCH   As with true experimental research, in conducting *quasi-experimental research*, the researcher is attempting to determine cause and effect, and there is manipulation of the independent variable; however, there is no random assignment (Heppner et al., 2008). Unlike true experimental research, instead of random assignment, quasi-experimental research examines already existing intact groups, giving one or more groups the treatment, while not giving the other groups the treatment. For instance, if I wanted to see the effects of classroom guidance on bullying behaviors in 5th graders, I could randomly choose six of twelve 5th and 6th grade classes to have classroom guidance activities related to bullying. Then, I would compare the groups that received the treatment (classroom guidance) with the non-treatment groups.

Unfortunately, the lack of random assignment in quasi-experimental research often results in less credibility in determining whether or not differences are due to the effects of the treatment. As you might imagine, many factors could have differentially affected the treatment groups from the non-treatment groups, thus resulting in differences being found. For instance, just the fact that we did not have random assignment means the groups may have differed initially, and what we are finding are differences based on selection rather than on treatment. Called *internal validity*, differences based on selection and other factors are listed in Box 13.2. However, because the real world often does not provide us with opportunities to randomly assign individuals to treatment groups, quasi-experimental research and its use of intact groups is often used as an alternative to true experimental research (see Box 13.3).

ONE SHOT CASE STUDY AND ONE GROUP PRETEST/POST-TEST DESIGN   When a researcher wants to examine changes in a person or group after treatment, he or she can apply the *one shot case study* or *one group pretest/posttest design* (Kline, 2009). Such designs are particularly useful in practice settings, where a subject or group is about to undergo a treatment (Lundervold & Belwood, 2000). However, there are obvious problems with internal validity (see Box 13.3) with this kind of design (Houser, 2009).

In these designs, as in quasi-experimental research, there is no random assignment to treatment groups, but there is manipulation of the independent variable, and such studies imply cause and effect. For instance, returning to our aerobic exercise example, if I were working with a client who was struggling with anxiety and stress, I might design a study that examined the effects of aerobic exercise, the treatment, on anxiety and stress as measured by a short anxiety scale and the client's resting heart rate. Using what is commonly

BOX 13.2

Threats to Internal Validity

In all types of experimental research, there are many threats to internal validity that can result in researchers coming to false conclusions about their study if certain factors are not controlled. The following are very brief descriptions of nine of these threats. A fuller understanding of them can be gained through a research course, a research text, and/or reading some of the classic texts that address these issues (e.g., Campbell & Stanley, 1963; Cook & Campbell, 1979). The nine threats include (Shadish, Cook, & Campbell, 2002):

1. *Ambiguous Temporal Precedence,* in which it is not clear which variable came first, thus yielding confusion about which was the cause and which was the effect.

2. *Selection,* which includes the ways in which subjects are selected and assigned to treatment groups, causes differences in those groups, thus clouding whether differences found are the result of the treatment *or of selection.*

3. *History,* in which external events occur during the research that affect the treatment and result in invalid conclusions.

4. *Maturation,* in which maturational changes in subjects, such as growing older or more tired or becoming hungry, affect the results.

5. *Regression,* where there is a statistical tendency for extreme scores to move closer to the mean if tested a second time. Therefore, regardless of the effect of the treatment, treatment groups with particularly high or low pretest scores may have scores move toward the mean during posttesting, thus leading to false readings concerning the effect of the treatment.

6. *Attrition,* as when participants differentially drop out of treatment, thus leaving only the "better" or "worse" participants and results that are falsely attributed to the treatment.

7. *Testing,* in which exposure to a test can affect the results, such as when knowledge of the pretest affects the results of the posttesting.

8. *Instrumentation,* where changes in the instrument(s) can affect the results, such as when a more difficult pretest is used, thus leading to the false conclusion that there were gains in posttesting.

9. *Additive and Interactive Effects of Threats to Internal Validity,* when two or more threats to internal validity are operating simultaneously and their joint or combined threats affect the results differently or more powerfully than each threat on its own.

BOX 13.3

A Failed Attempt at True Experimental Research

When I was living in New Hampshire, a colleague and I decided to conduct research on the effects of aerobic exercise on personality variables. After reviewing the literature, we found possible links between such exercise and the personality variables of self-actualization, depression, and anxiety. We approached our local YMCA, which was running a rather extensive aerobic exercise program. They agreed to let us talk with individuals who were about to start exercise for the first time. They also agreed to let these people have eight free weeks of membership at the Y if half of them (randomly chosen) would not start their exercise program for eight weeks. We found three instruments to measure anxiety, depression, and self-actualizing

values with the intent of comparing, at the end of eight weeks, the group that started aerobic exercise with the group that waited for eight weeks. We excitedly met with approximately 50 new exercisers. We told them our plans, and they looked at us and said, "Are you kidding? We want to start our exercise program now!"

Our good intentions obviously were not going to sway these individuals who were ready to get going with their exercise. Unfortunately for us, we were not able to implement our true experimental study. Instead, we had to consider using either a quasi-experimental or an ex post facto design, both of which would not be as powerful in showing treatment effects.

called an *ABA design*, I would first obtain a baseline of my outcome measures (A), in this case anxiety and stress as measured on the anxiety scale and resting heart rate.

Over a few weeks, I would take a number of *baseline* measurements and then introduce the treatment, aerobic exercise (B). I would continue to measure stress and resting heart rate over the next few weeks as the client participated in aerobic exercise. Finally, I would remove the treatment and again take baseline measures over the next few weeks (A again). Evidence that the treatment is working should be indicated by a reduction in anxiety and stress levels during the treatment and a return to higher levels after the treatment. Often, to show additional efficacy of the treatment, the design is extended and made into an ABAB design, where the study finishes during a treatment phase with the expectation that the outcome measures should again produce change (Heppner et al., 2008). Clearly, a study like this could also be done with a number of individuals (one group pretest/posttest design). Figure 13.2 shows an example of an ABAB design for aerobic exercise and its effect on anxiety and on stress.

Nonexperimental Research

CORRELATIONAL RESEARCH   *Correlational research* examines the relationship between two or more sets of scores, and generally uses correlation coefficients in examining results. If you remember from Chapter 12, a correlation ("r") between variables can range

FIGURE 13.2
ABAB Design Showing Effects of Aerobic Exercise on Heart Rate and Anxiety
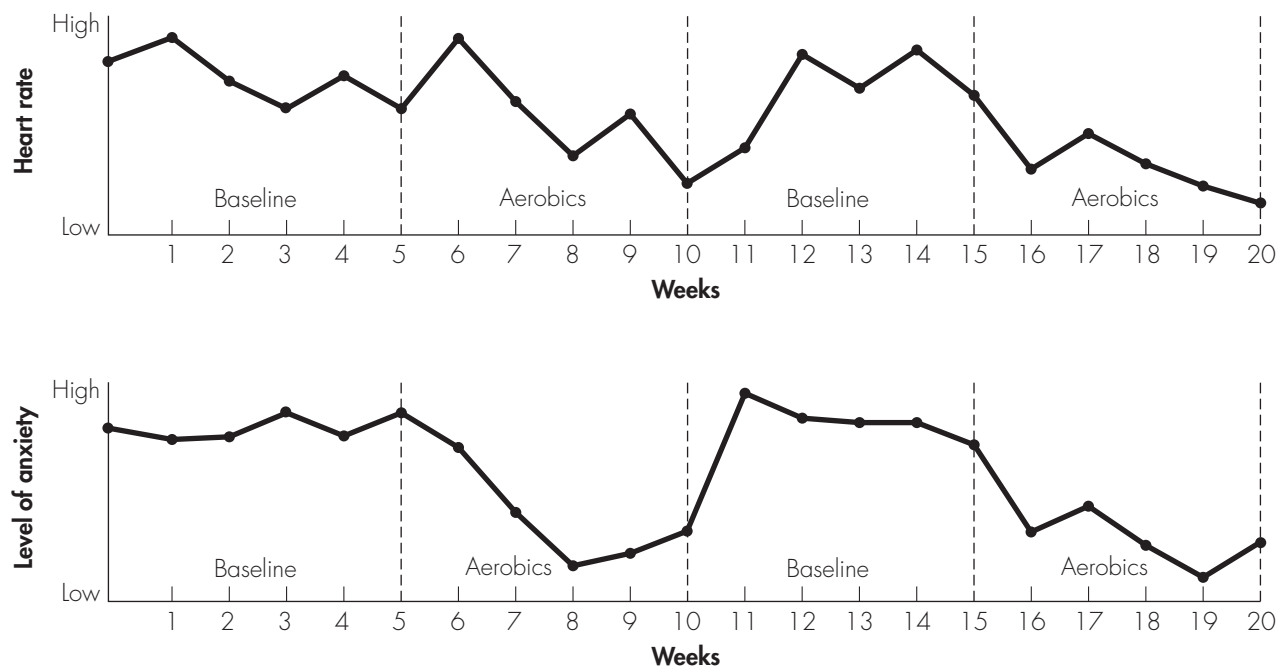
between -1 to $+1$ and tells you the strength of the relationships between variables. A *positive correlation* shows a tendency for one set of scores to be related to a second set of scores in the same direction. A *negative correlation* shows a relationship in opposite directions, and a correlation coefficient of 0 shows no relationship between variables. For instance, if I found a correlation coefficient of .89 between height and weight, I would say $r = .89$. Or, if I found that grades in graduate school had a mild negative correlation of $-.24$ with number of hours per week pursuing leisure activities, I would present the correlation as $r = -.24$. Because correlational research does not show cause and effect and does not require random assignment, such research is generally easier to implement than experimental designs and is often used as preliminary research in an effort to check out a researcher's hunches. Two of the more frequently used types of correlation research include *bivariate correlational* studies that explore the relationship between two variables, and *multivariate correlational* studies that examine the relationship among more than two variables (Gall, Gall, & Borg, 2010; Mertler & Charles, 2008).

Bivariate correlational studies examine selected variables that theory or past research suggests may be related to one another. Two types of bivariate correlation are *simple correlational research* and *predictive correlational research*. In simple correlational research, you are examining the correlation between variables in the "here and now." For example, let's say I was interested in examining the relationship between empathy and the ability to build a relationship with my client. If I could find an instrument to measure empathic responses and a second to measure the strength of the relationship between the counselor and client, I could be on my way to examining this simple correlational relationship. Hypothetically, I could find hundreds of counselors, measure their empathic ability with clients using my instrument, and then ask clients to complete an instrument that measures the strength of their perceived relationship with their counselor. I could then correlate scores on empathic ability with perceived strength of the relationship (see Figure 13.3). Figure 13.3 shows a hypothetical correlation of approximately .30, which reflects a moderate and significant relationship

FIGURE 13.3

Correlation between Empathic Ability and Strength of Counseling Relationship
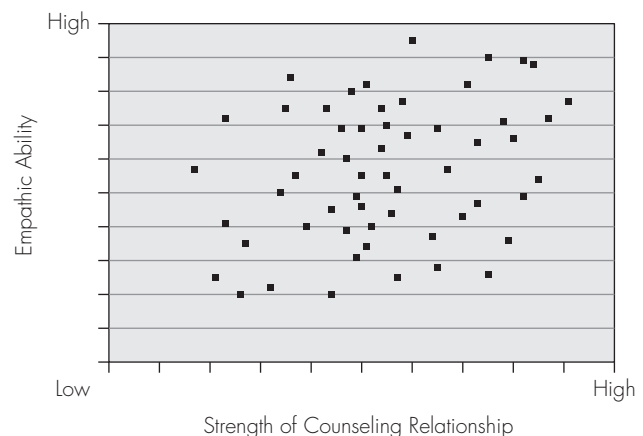
between the two measures. Does empathy cause the strength of the relationship—no, but it is one factor that is related to it. Thus, such a study might be important in the training of counselors.

In contrast to simple correlational studies that examine the relationship between variables in the here and now, predictive correlational studies look at how one variable might be able to predict one or more other variables. It must be made clear, however, that although one variable can fairly accurately predict another, a cause-and-effect relationship has not been established. For instance, scores on the GREs should be predictive of GPA in graduate school, or they would not be useful for this purpose. Indeed, such scores have been shown to be moderately predictive of graduate school GPA in most subjects (Burton & Wang, 2005). However, GRE scores certainly do not cause a certain GPA in graduate school. Similarly, numerous studies have shown that the better the *congruence* or "fit" there is between personality type and job environment (e.g., "social type" individuals fit better in helping professions), the higher the correlation there is with subsequent job satisfaction (Fritzsche, & Parrish, 2005; Ton & Hansen, 2001). This research suggests that using an interest inventory to identify personality type and matching those personality types to specific job environments can lead to greater job satisfaction. Remember, however, that a study such as this does not show causation. For instance, it could be that individuals who have higher congruence scores are more mentally stable, or brighter, or more skilled, thus leading to higher job satisfaction. Although we cannot assume a causal relationship, implications such as these can be critical. For instance, knowing that such a prediction exists for job satisfaction, if you were looking for a job, wouldn't you want to know if your personality type "fit" a specific occupational choice?

Multivariate correlational research is useful when you have more than two variables that you suspect are somehow related to one another. *Multiple regression*, one of the most commonly used types of multivariate correlational statistics, can tell you how a combination of scores predicts an outcome. For example, consider the relationship among empathic ability, being nondogmatic, and the ability to build an alliance, with client success in counseling. Hypothetically, one would hope that empathy, having a nonjudgmental attitude, and building an alliance with one's client, would each be related to client success. By measuring these different variables, we can see the strength of the relationship of each variable with client success, and we can see how the combination of these three factors is related to client success. For example, empathy, being nonjudgmental, and building an alliance might have respective correlations of .32, .25, and .28 with success with clients. However, their combined relationship with success with clients might only be .41. In addition to multiple regression, a number of other types of multivariate correlation are available, most of which use advanced statistics to determine their results. These include *discriminant analysis*, *factor analysis*, and *differential analysis*, as well as two that are considered causal: *canonical correlation* and *path analysis*. But I'll let you learn about these in your research course!

SURVEY RESEARCH   In *survey research*, a questionnaire is developed or an interview designed with the purpose of gathering specific information from a target population. Surveys can gather interesting information about the values, behaviors, demographics, and opinions of a specific population and are used in a myriad of business, educational, and

social science arenas. In describing the data obtained, survey research uses basic *descriptive statistics* such as *frequency distributions, percentages, measures of central tendency,* and *measures of variability* (see Chapter 12). Often, charts and graphs are used to illustrate some of the data obtained.

There are a number of steps that are usually followed when conducting survey research (McMillan & Schumacher, 2010; Schonlau, Fricker, & Elliot, 2002), some of which include:

1. Defining the purpose and objectives of the survey
2. Determining the target population
3. Determining the response mode (snail mail, Internet, live interviews, phone)
4. Determining the resources needed (e.g., stamps, Web-based survey maker, etc.)
5. Developing the cover letter and instrument
6. Conducting a pilot study and making revisions
7. Completing a follow-up of nonrespondents
8. Collecting the data
9. Organizing the results
10. Distributing the results (e.g., journal article)

Although survey research can be quite interesting, it is not able to tell us the underlying reasons why we found what we found and often leaves gaps in our knowledge. For instance, in research I and others have conducted on counselors' attendance in their own therapy, it was discovered that close to 80% of counselors had attended their own therapy. However, this information does not tell us the underlying reasons why they attended counseling. Do counselors attend therapy because they are more open to the experience, healthier, more dysfunctional, because they're required to in their programs, or other reasons? Therefore, survey research can be quite limiting although sometimes quite intriguing.

EX POST FACTO (CAUSAL-COMPARATIVE) RESEARCH   Whereas experimental research involves random assignment and the manipulation of variables, *ex post facto research*, sometimes called *causal-comparative research*, examines the relationship of already existing intact groups. Ex post facto research is used when it is either impractical or impossible to manipulate the independent variable, such as when one might be examining the differential effects of gender, personality type, race, or when random assignment cannot be used (Heppner et al., 2008).

For instance, let's say we wanted to compare the scores on the National Counselor Exam (NCE) of students who graduated from CACREP-accredited counseling programs with the scores of those who graduated from non-CACREP-accredited programs. Obviously, we could not randomly assign students to graduate programs, and we cannot manipulate the independent variable, which is the type of graduate program attended. However, it would be relatively easy to obtain data from students who already had attended these schools and who subsequently took the NCE. It would then be a simple process to run a statistical analysis of which students scored higher on the exam. And, in point of fact, the National Board for Certified Counselors does have this data available, and although they do not run comparative analyses, students from CACREP-accredited programs consistently do score higher on the certification exam.

Although ex post facto research is often more convenient than some experimental designs, there are inherent problems with this kind of research. For instance, because there is no manipulation of the independent variable and no random assignment, we cannot be sure exactly what is causing any differences that are found. For example, in our NCE example just discussed, there can be many, many explanations of why these differences are found. To name just a few that hypothetically could be true:

1. Students who don't get into CACREP programs go to non-CACREP programs and are less prepared academically.
2. Students who don't get into CACREP programs are more creative, and care less about academics.
3. CACREP programs are stuck in a curriculum that allows for no creativity. Non-CACREP programs teach "other" counseling related topics not covered on the NCE.
4. Faculty in CACREP-accredited programs are better teachers.
5. Faculty in non-CACREP programs are more creative teachers and don't need to focus on a specific curriculum.
6. Faculty in CACREP-accredited programs teach to the test.
7. Students in CACREP programs can take the test sooner, thus their retention is better.
8. On and on—you get the idea.

In an effort to control for such rival hypotheses as those identified above, researchers will sometimes attempt to match treatment groups on variables that may be confounding the results. For instance, in our fictitious study above, students can be matched on GRE scores and graduate GPA to ensure that ability in both groups is similar. Also, students can be selected in a manner that ensures that both groups of students have taken the exam within the same amount of time since graduation. On the other hand, it might be more difficult to control whether or not faculty are teaching to the test. Therefore, this rival hypothesis, along with any others that might be identified, should be noted as possible *confounding variables* in any discussion of results. In addition, other rival hypotheses, not identified by the researcher, could be affecting the results. This is why researchers need to be very tentative when stating any conclusions in ex post facto research.

Qualitative Research Methods

Naturalistic–phenomenological philosophy is the basis of qualitative research (McMillan & Schumacher, 2010). This approach assumes that there are many ways in which reality can be interpreted and experienced by individuals. Rather than using the scientific method, as in quantitative research, qualitative research relies on the researcher to carefully observe, describe, and interpret phenomena within a social context. For these reasons, qualitative research allows one to examine phenomena that quantitative research cannot explore, like our understanding of abstract concepts such as empathy and the meaning we ascribe to God (Hanna & Shank, 1995). As a result, the findings of qualitative research offer us rich ways to apply research paradigms to clinical settings (Haverkamp, Morrow, & Ponterotto, 2005). Also, qualitative research can add important missing pieces of information that cannot be discovered through the reductionistic methods of quantitative research (Gall et al., 2007).

Whereas quantitative research relies on the deductive method of identifying variables, isolating them, and measuring them, qualitative research relies on the *case study method*, which focuses upon and deeply probes and analyzes events or phenomena. This approach uses a number of methods, often simultaneously, in an effort to allow *themes* and the meaning about the phenomenon being studied to emerge.

Qualitative research generally uses research questions as opposed to hypotheses in providing direction for the research. Although qualitative research can take many forms, four types often identified include *grounded theory, phenomenological approach, ethnographic research,* and *historical research* (Houser, 2009).

Grounded Theory

Developed by sociologists' Glaser and Strass during the 1960s (Buckley, 2010; Houser, 2009), *grounded theory* can be described as a process, as opposed to an examination of a moment in time. In this process, a broad research question based on a concern of a population is examined in a multitude of ways. This exploration can eventually lead to the emergence of a theory that is somewhat based on the original research question. This contrasts with quantitative research that uses statistics to determine the validity of a hypothesis or research question that has emerged from a literature review. In fact, grounded theorists often suggest not initially going to the literature for fear that it might cause bias in the interpretation of results.

For instance, let's say I was interested in the research question: "How do counselors develop a theoretical orientation toward their careers?" I first would come up with a series of related questions that could be asked to counselors which would be the catalyst for exploring this subject, such as:

- When did you first consider a theoretical orientation?
- What experiences affected your choice of a theory?
- What's most important to you in picking a theory?
- How has your theoretical orientation changed over time?

After coming up with questions, I would prepare to interview counselors. For instance, I might come up with "focus groups" of counselors who had been in the field for a determined amount of time (e.g., 10 years) and begin to seek their responses to the questions as well as additional questions that might emerge as the discussion unfolds. This process would happen through a series of steps, that includes: *preparing, data collection, note taking, coding,* and *writing.*

PREPARING   This phase of research means that you reflect on your own biases and prepare to collect information from your participants. You are aware that meeting with individuals in and of itself will affect how they respond and you attempt to be respectful, nonjudgmental, and a good listener.

DATA COLLECTION   This phase has to do with the process you use to obtain your information. As noted, focus groups are often a common method of collecting data, although other methods can be used (e.g., examining writings of individuals; observing in naturalistic settings, etc.). When interviewing others, it is here that I would use my list of questions.

NOTE-TAKING   Many grounded theorists do not take notes at all, and instead, rely on their memories to write down the most important elements after having collected data. However, others find no problem with note taking or even recording the interviews. In either case, this process should be as nonintrusive as possible and should allow for participants to express their opinions.

CODING   Coding has to do with finding identifying common themes among the various conversations being listened to and giving them a code (discussed later under "statistical and data analysis"). This helps to organize the data you have collected. As individuals code, "core" categories will emerge that begin to point to broad themes evident in the data collection. In addition, *saturation* of a theme will occur when you realize that many individuals are referring to the same core themes. It is then that the process is nearing its end.

WRITING   During the note-taking and coding process, the researcher is often *memoing*, which means he or she is making a memo to oneself about important themes that may be emerging. Also, during this process, the researcher begins to *sort* out the different themes into major categories. As the final themes emerge, the researcher is ready to write up his or her findings. For instance, in examining how counselors come up with their theoretical orientation, my eventual theory might involve a series of stages that were uncovered through my interviews in the focus groups. These stages, I would then identify and suggest in my eventual write-up.

Grounded theory is a comfortable fit for counselors as they are natural listeners and observers. However, the process is painstaking and should not be considered a simple process of listening to different points of view. Instead, it is a systematic process that attempts to uncover underlying themes and theory relevant to an important research question.

Phenomenological Designs

In many ways similar to the grounded theory approach, *phenomenological designs* are less involved with eventual theory, and more interested in simply understanding the experience of a population in question (Christensen & Brumfield, 2010). For instance, let's say I was interested in understanding possible posttraumatic stress disorders experienced by individuals who had escaped the Twin Towers during 9/11. In this case, I would have a *purposeful sample* of individuals that could be defined as any individuals who were in the Twin Towers on 9/11 and survived. Next, I might conduct focus group interviews with as many individuals that I could find who fit this purposeful sample. Then, I would meet with these individuals and ask them to describe what it has been like for them subsequent to 9/11 regarding any negative psychological affects. I would observe the individuals carefully, be respectful of them, and ask follow-up questions if I thought that such questions would deepen the stories of the members and give me *richer*, sometimes referred to as *thicker*, descriptions of what it has been like for them. I would be constantly aware that my very presence is in some way affecting their responses, and would carefully try to *bracket* any biases I might have that might influence the data I am collecting. I might tape the interviews and transcribe them later. I would also be interested in collecting other sources of information that might enlighten me further about the experiences of these individuals (e.g., diaries, personal journals, etc.).

Data collection in the phenomenological approach is similar to the grounded-theory approach in the sense that I would be identifying and coding themes and trying to find common elements that many of the individuals have experienced.

Ethnographic Research

Ethnography refers to the description (graphy) of human cultures (ethno). Sometimes called cultural anthropology, ethnographic research was made popular by Margaret Mead, who studied aboriginal youth in Samoa by immersing herself with the people and their culture as she attempted to understand their lifestyle (Mead, 1961). Ethnographic research assumes that phenomena, or events, can best be understood within their cultural context. Take an event out of its context, and its meaning is likely to be interpreted from the context of the researcher as opposed to its original social context. Reality, therefore, is a social construction that, in order to be understood, needs to be examined from the phenomenological perspective within which it occurred. Thus, ethnographers seek to understand events by understanding the meanings that people place on them from within their natural context.

The first step in conducting ethnographic research is to identify the group to be studied and to identify a general problem to be researched. Conducting a literature review can help the researcher gain a better understanding of the culture or group being studied and assists the researcher in defining the purpose of the research and in developing hypotheses or research questions. Next, the researcher decides on what method he or she wishes to use to immerse him- or herself in the culture of the population. Prior to entering the culture, the researcher should develop a plan for implementing his or her data collection methods. Three common methods used in ethnographic research include *observation*, *ethnographic interviews*, and *collection of documents and artifacts*.

OBSERVATION   Ethnographers will often observe a situation or phenomenon, and using extensive notes, describe what they view. Although sometimes qualitative researchers may take a disengaged role when observing, more often they become *participant observers*. In this kind of observation, the researcher immerses him- or herself in the group and may even live with the group (Gall et al., 2007; Houser, 2009). However, it is important not to interfere with the natural process of the group and to listen and take scrupulous notes so that the observer understands the unique perspective of the group. It is only in this manner that the observer can obtain a rich appreciation for the ways in which the group constructs reality. It is particularly important that the observer record what role and what effect observing the group may have had on the group (see Box 13.4).

ETHNOGRAPHIC INTERVIEWS   Ethnographic interviews are a second popular qualitative method of collecting data from a culture or group. Such interviews involve open-ended questions in an effort to understand how the interviewees construct meaning. Interviews may be informal, where a general topic is explored but without specific guidelines; guided, in which questions are outlined in advance; or standardized, in which the exact questions are determined prior to the interview but the responses remain open-ended. Counselors are adept at doing ethnographic interviews because of their training in open-ended questioning. As with participant observation, it is important that the interviewer take scrupulous notes or record the interviews in order to obtain verbatim accounts of the conversation.

BOX 13.4

Disruptive Observation of a Third-Grade Class

While working in New Hampshire, I was once asked to "debrief" a third-grade class that had just finished a trial period in which a young boy who was paraplegic and severely mentally retarded had been mainstreamed into their classroom. During this trial period, these third graders had a stream of observers from a local university come into their classroom to assess their progress. Because this was not participant observation, the observers would sit in the back of the classroom and take notes about the interactions between the students. This information was supposed to be used at a later date to decide whether it was beneficial to all involved to have the disabled student mainstreamed.

When I met with the students, they clearly had adapted well to the presence of this young boy who was disabled. Although the students seemed to have difficulty forming deep relationships with him, his presence seemed in no way to detract from their studies or from their other relationships in the classroom. However, almost without exception, the students noted that the constant stream of observers interfering with their daily schedule was quite annoying. Perhaps if participant observation were employed, where an observer interacted and was seen as part of the classroom, the students would have responded differently.

DOCUMENTS AND ARTIFACT COLLECTION   Artifacts are the symbols of a culture or group and can help the ethnographer understand the beliefs, values, and behaviors of the group. In this process it is helpful if the researcher knows how the artifact was produced, where the artifact came from, the age of the artifact, how the artifact was used, and who used it. Interpretation of the meaning of artifacts should be corroborated from observations and through interviews.

McMillan and Schumacher (2010) suggest the following major categories of artifacts: personal documents, such as diaries, personal letters, and anecdotal records; official documents, such as internal and external papers and communications, records and personnel files, and statistical data; and objects that hold symbolic meaning of the culture (e.g., Native American headdresses).

Historical Research

The purpose of historical research is to describe and analyze conditions and events from the past in an effort to answer a research question. Historical research relies on the systematic collection of information in an effort to examine and understand past events from a contextual framework. When doing historical research, the researcher generally has a viewpoint in mind and needs to go to the literature to support this viewpoint. Then the researcher will begin to collect data to show that his or her viewpoint has validity. At any point in this process, the researcher's point of view might change as he or she is influenced by the literature or by the sources of data obtained.

In collecting data for historical research, a number of sources can be used. Whenever possible, researchers attempt to use *primary sources*, or the original record, as opposed to *secondary sources*, which are documents or verbal information from sources that did not actually experience the event. Examples of primary sources include the following (Gay, Mills, & Airasian, 2009; McMillan & Schumacher, 2010):

1. *Oral Histories.* Oral histories are gathered when researchers directly interview an individual who had participated in or observed the event in question.

2. *Documents*. Documents are records of events that are generally housed in libraries or archival centers. Examples include letters, diaries, autobiographies, journals and magazines, films, recordings, paintings, and institutional records.
3. *Relics*. Relics are any of a variety of objects that can provide evidence about the past event in question. Such things as books, maps, buildings, artifacts, and other objects are some examples of relics.

Statistics and Data Analysis in Quantitative and Qualitative Research

Although a text such as this cannot go into detail about the various kinds of statistical analyses that can be used, suffice it to say that the proper use of statistical procedures is critical to the eventual interpretation of research studies (Fong & Malone, 1994; Thompson, 1995). Whereas quantitative research uses statistics to analyze results, qualitative research uses a process called *inductive analysis*.

Quantitative Research

The general goal of quantitative research is to apply statistical procedures to a set of controlled variables in order to test out research questions and hypotheses. Which statistics are applied in quantitative research varies depending on the type of study you are conducting, but more or less falls into two broad categories: *descriptive statistics* that are used to summarize and describe results; and *inferential statistics* that are mathematical procedures used to make inferences about a larger population from the sample you are studying. The following discusses a few of the more commonly used descriptive and inferential techniques.

Largely discussed in Chapter 12, descriptive statistics include measures of central tendency, such as the mean, median, and mode; measures of variability, such as the range, variance, and standard deviation; derived scores, such as percentiles, stanines, T-scores, and DIQ scores; and measures of relationship, such as the correlation coefficient. Descriptive statistics are often used with survey research.

Inferential statistics are used to examine whether the differences or strengths of the relationships between treatment groups are likely to be found by chance alone. Some of the more common types of analyses include the *t-test* to measure differences between two means; the *analysis of variance* (ANOVA), to measure differences between two means or among more than two means; *factorial analysis of variance*, used when there is more than one independent variable and the researcher is interested in examining each independent variable and how they might interact; *multivariate analysis of variance* (MANOVA), used when two or more dependent variables are being examined; *significance of correlation coefficient*, used when examining whether the relationship between two variables is statistically significant; and *chi square*, which is used to compare whether the observed frequency of scores differs from the expected frequency of scores. Generally, experimental research and ex post facto research use inferential statistics that measure differences between means, while correlational research examines the degree of relationship between variables.

In recent years, the *effect size* of a study has become increasingly important in understanding the results of quantitative research. Effect size refers to the practical significance of one's finding. For instance, in recent research I conducted (Neukrug & Milliken, 2011),

significant differences were found between male and female counselors' views of whether certain counselor behaviors were ethical. For instance, males were more likely than females to try to persuade their clients not to have an abortion even though they want to. However, when you looked at the actual figures, the vast majority of males and females believed this to be unethical, despite this statistical significance. Today, effect size is shown using a number of varied statistical procedures and should usually be referred to in published studies.

Qualitative Research

In contrast to quantitative research, which applies statistical procedures to controlled variables, qualitative data collection relies on a process called *inductive analysis*, which means that *themes* and categories emerge from data (McMillan & Schumacher, 2010). Thus, the researcher who is examining the data collected through the various methods mentioned earlier looks through the information for themes, ways of categorizing information, and ways of selecting important pieces of information. As this process continues, the researcher begins to see particular points emerge.

Often, qualitative researchers classify their data by a process called *coding*. This process breaks down large amounts of data into smaller parts that seem to hold some meaning to the research question. For instance, if I were involved in a study to determine what problems at-risk high school students might have in a specific school, I might observe the youths; interview them; interview their teachers, school counselors, parents, and peers; and collect school records. I would then go through all of these pieces of information and identify and code themes that seem to emerge from the data. For instance, Box 13.5 shows pieces of interviews with (1) an at-risk student ("John"), (2) one of his teachers, and (3) his school counselor, as well as (4) a summary of his student records. Each of these four segments of information is broken down into themes. Similar themes are coded with the same superscript number.

My next step would be to place all similar themes (same coded numbers) together in a category that has a logical name (see Box 13.6). You can see in Box 13.6 that a number of categories have emerged from this process. Then I would continue this same process with a number of the identified at-risk students. Finally, I would look at all the categories that emerged from all of the students interviewed and begin to look for similarities among students. It may be that some of the categories will merge with one another while other, new themes might emerge. For instance, if we consistently see youths-at-risk using humor to avoid issues (item 9 in Box 13.6), it may end up as a subtopic of defensiveness (item 13 in Box 13.6). Eventually, I would come up with a list of categories that represented the most relevant issues for at-risk students.

Grounded theory, phenomenological design, and ethnographic research often rely on coding and theme identification, as noted above. However, this process can also be important in historical research when comparing different types of documents, relics, and possible interviews. In either case, this process is laborious, yet fruitful in finding out significant patterns and themes in qualitative research.

Issues of Quality in Research Studies

McMillan and Schumacher (2010) refer to validity as "the degree to which scientific explanations of phenomena match reality. It refers to the truthfulness of findings and conclusions" (p. 104). Thus, the degree to which our research design can come close to

BOX 13.5

Emerging Themes through Data Analysis for an At-Risk Student

Segment of Verbatim Interview with John

I don't like school.[1] It's a waste of time.[1] The only thing it's good for is hanging out with my friends.[2] My dad never went to school, so why should I?[3] You don't learn nothing here anyway, nothing that's good for me. I don't care how I do on tests,[4] I just want to get some money[5] so I could buy some neat clothes. Then I could show off[6] to my friends and they would think I'm cool.[2] School sucks, I cut a lot [7]—I wish I could get out of here and get a job and make some money.[5] Can you get me a job?

Segment of Verbatim Interview with One of John's Teachers

John seems to be thinking of other things while in school and not interested in what's going on in class.[1] He is always talking to his friends in class, and seems to be in a clique,[2] that is, when he comes to school. He seems absent much.[7] He rarely does well on tests,[4] but I have noticed that he seems to do a little better if I let his mom know[8] that a test is coming up and when he's attending school consistently.[7] He always dresses very well and seems a little bit like a show-off.[6] He has a funny sense of humor,[9] although I would never laugh at his jokes in class because I don't want to reinforce his joking around. I think his scores in school are not reflective of how well he can do.[10] It's a shame. It's a wasted life.[11] I'm kind of sick of seeing this same pattern over and over again.

Documents and Records

a. Achievement test scores are low.[4]

b. Aptitude test scores are average.[10]

c. Records show that student seems to miss a lot of classes.[7]

d. An autobiography that he wrote for his counseling group seemed to show a number of painful events,[12] like his parents' divorce, that he may be covering up.[13]

e. He's gotten a number of detentions for "cutting up" in class.[9]

f. Poems he wrote in English were funny,[9] yet morbid about his future.[11]

g. A sentence-completion test he took with his counselor seemed to show an obsession with money.[5]

Segment of Verbatim Interview with John's School Counselor

John was in a group of students with high absenteeism, low grades, and an apathetic attitude toward school.[7,4,1] He was the jokester in the group.[9] He always had excuses for why he was absent.[6,13] On the one hand, he used his father as a role model for not having to finish school;[3] however, it seemed that his father is absent from his life and that he's hurt over this.[12] In general, I think his jokes are a way for him to gain attention [6,9] and cover up some inner hurts.[12] He's likable in many ways, but he's hard to reach.[13] He seems to have a wall around him.[13] His mother seems a source of comfort,[8] but his peer group is increasingly having more influence on him.[2] I'm concerned about his future.[11]

representing objective reality is a mark that a study has good validity. Two types of validity are *internal validity* and *external validity*.

Internal Validity

Internal validity represents the degree to which extraneous variables have been accounted for when drawing your conclusions. Briefly discussed earlier (see Box 13.3), studies that are more tightly controlled will have fewer threats to internal validity and therefore fewer rival hypotheses that may explain the data found. Clearly, quantitative studies are generally more tightly controlled than qualitative studies.

BOX 13.6

Emerging Themes from Data Analysis

1. Dislike of school: I don't like school. It's a waste of time. . . . Not interested in what's going on in class. . . . In a group of students with . . . an apathetic attitude toward school.

2. Peer relationships: The only thing school is good for is hanging out with my friends . . . [If I wore neat clothes, my friends would think] I'm cool. . . . He is always talking to his friends in class . . . seems to be in a clique. . . . His peer group is increasingly having more influence on him.

3. Dad as role model: My dad never went to school, so why should I? . . . Uses his father as a role model for not having to finish school. . . . Father is absent from his life.

4. Test performance: I don't care how I do on tests. . . . He rarely does well on tests. . . . Achievement tests scores are low. . . . In a group of students with . . . low grades.

5. Importance of money: I just want to get some money. . . . I wish I could get out of here and get a job and make some money. . . . An obsession with money.

6. Narcissism: [If I had the neat clothes], I could show off. . . . He always dresses very well and seems a little bit like a show-off. . . . Jokes are a way for him to gain attention.

7. Absenteeism: School sucks, I cut a lot. . . . He seems absent much. . . . [Does] better . . . when he's attending school consistently. . . . Records show that student seems to miss a lot of classes. . . . In a group of students with high absenteeism. . . . He always had excuses for why he was absent.

8. Relationship with mom:. . . [Does] better [if his mom knows] a test is coming up. . . . His mother seems a source of comfort.

9. Use of humor: He has a funny sense of humor. [He cuts up] in class. Poems he wrote in English were funny. . . . His jokes are a way for him to gain attention.

10. Underachiever: His scores in school are not reflective of how well he can do. . . . Aptitude scores are average. [Achievement scores and grades are low.]

11. Sense of future: It's a shame. It's a wasted life. . . . Poems . . . were funny yet morbid about his future. . . . I'm concerned about his future.

12. Emotional pain: An autobiography . . . seemed to show a number of painful events. . . . His father is absent from his life and [he] hurts over this. . . . Jokes . . . cover up some inner hurts.

13. Defensiveness: An autobiography . . . seemed to show a number of painful events. . . . He may be covering up. . . . He always had excuses for why he was absent. . . . He's hard to reach. He seems to have a wall around him.

External Validity

External validity, on the other hand, refers to the *generalizability* of the results, or whether or not conclusions of the research can be applied to the larger population from the sample being investigated. The tight controls, small populations sometimes used, and reductionist methods of quantitative research sometimes make it difficult to generalize to the larger population. In qualitative research, external validity has to do with the ability of the researcher to describe the research in ways that will be helpful to other researchers working with other populations. If reliable methods of obtaining information are used, and if the information is useful and based on sound theoretical underpinnings, then the implications of the research will be helpful to other researchers. Put more simply, can we learn something about our culture from studying the aborigines in Samoa?

BOX 13.7

Revisionist History and Multiple Perspective Taking

How is it that two intellectuals can have different takes on the same event? Lancy (1993) suggests that neither may be wrong, but that multiple perspectives on the same event may all be correct. For example, could it be that Thomas Jefferson could have owned slaves and have been both a racist and a champion for the rights of enslaved Africans?

Look at how Lancy (1993) suggests that different perspectives can both hold truth in justifying the different conclusions of two well-known historians concerning the motivations of turn-of-the-last-century reformers such as Jane Addams:

Who is right? That is a difficult question. Both accounts have elements of the "truth." Cremin is undoubtedly right in characterizing many progressive educators as human and compassionate reformers. On the other hand, Karier is probably correct in arguing that the effect of many policies they supported was to exacerbate existing inequalities, and preserve the advantages enjoyed by corporate elites then assuming control of American society. In other words, it is possible for both interpretations to be compatible, provided they do not directly contradict one another in interpreting a specific event or person's role in history. Remember that historical explanations [and inferences from ethnography] need only be sufficient, not conclusive. (p. 258)

Is Validity Valid in Qualitative Research?

Relative to qualitative research, some suggest that rather than using the term validity, qualitative research should examine the *credibility* and *trustworthiness* of the study (Christensen & Brumfield, 2010; Buckley, 2010). In qualitative research the attempt to describe events in a reliable and valid (or credible and trustworthy) manner is difficult, as, by their very nature, events can hold multiple meanings depending on the frame of reference from which one is examining them (see Box 13.7).

The ability to show trustworthy and credible results in qualitative research is based on how well the researcher is able to accurately record information and analyze results. The following suggests some ways to ensure the credibility of qualitative research (Best & Kahn, 2006; Christensen & Brumfield, 2010; McMillan & Schumacher, 2010):

1. Conduct prolonged and persistent field work when gathering information
2. Use *triangulation*, or the use of multiple methods in obtaining information (e.g., observation, interviewing, document collection)
3. Use language that participants understand
4. Describe information obtained in concrete terms
5. Use multiple researchers to lessen bias
6. Attempt to "bracket off" one's own biases so they don't interfere with data gathering
7. Mechanically record data, if possible, to ensure accuracy
8. Use an "informant" or a researcher who is a participant observer to corroborate evidence obtained
9. Have an "outside auditor" check for biases in the research process
10. Conduct *member checks* that ask individuals who are interviewed to review transcripts for accuracy

11. Actively search for discrepant data or information that does not support a particular point of view, as such information offers a differing view of the "truth" of the situation

After data have been obtained and authenticated, the researcher must go through a rigorous process of reviewing the data, synthesizing results, and drawing conclusions and generalizations. The researcher's original research question(s) may have been changed by this point as he or she has gone through the involved process of reviewing the literature and analyzing sources of information. The final results of the research involve a logical analysis of the materials obtained as opposed to a statistical analysis as we find in quantitative research. Also, the researcher needs to be careful not to get caught up in his or her point of view and should be open to offering opinions that both support and contradict the ultimate findings. See Box 13.8 to consider what methods were used in this hypothetical example that examines the development of a counselor's theoretical orientation.

BOX 13.8

The Development of One's Theoretical Orientation

Below is a hypothetical example of qualitative research that examines the development of a counselor's theoretical orientation. Read it though and answer the questions that follow.

In conducting my research, I started by placing an ad in *Counseling Today*. The ad requested volunteers who had counseled for more than ten years and were going to the American Counseling Association's annual convention to meet with me and other volunteers in a focus group to discuss how they developed their theoretical orientation. At the conference, I ended with a purposeful sample that included 6 to 8 counselors in each of four groups. I asked them a series of questions related to my main research question: "How did you develop your theoretical orientation?"

As they talked, I listened and tried to bracket any of my biases. Mostly, I was respectful and would periodically ask questions to encourage the conversation. I believe I rarely, if ever, gave my opinion, but I did actively encourage discussion. Although many qualitative researchers do not record their sessions, I decided for accuracy, that I would. From these recordings, I summarized what I believe to be the more salient points in each group. I asked for volunteers (member checkers) from each group to review my summary to check for accuracy. I then took my summaries and coded the responses into logical groupings. I asked a colleague to do the same, separately. After we separately coded the data, I met with my colleague

and together, we came up with a number of themes that seemed to run through all the groups. The themes showed a progression relative to how the counselors tended to develop their theoretical orientation.

1. *Ignorance:* Not realizing the importance of a theory
2. *Learning:* Realizing that theories drive the way that one does counseling
3. *Adherence:* Taking on one theoretical approach
4. *Being willing to experiment:* Desiring to incorporate other theoretical perspectives within the one main approach
5. *Becoming an expert:* Being willing to develop one's own personal theory based on a number of theoretical constructs

I asked an expert in counseling theory to review my work for biases, and then I decided to write up what I had found and submit it for publication.

Questions to Ponder:

1. What types of evidence of credibility and trustworthiness can you find in this study?
2. What additionally could have been done to increase the credibility and trustworthiness of this study?
3. How could biases have affected the results?
4. How generalizable is a study such as this?

Reading and Writing Research

It is likely that some readers of this book will be actively involved in doing research, while all of you will be reading research. Certainly, if you are to remain professionally astute, it is your obligation to read the professional journals that offer the most current research in our field. Although qualitative and quantitative research studies approach the attainment of knowledge differently, the manner in which results of the research are presented is similar. Here are some of the major headings that are often used when writing research manuscripts:

Abstract. The abstract is a short summary of the article, generally fewer than 100 words.

Review of the Literature. The review of the literature examines past research that has been completed in the area being studied and elaborates on the statement of the problem. The review can be as short as one page or as long as ten and should justify the research hypothesis or research question.

Research Hypothesis or Research Question. Generally found at the end of the review of the literature, the hypothesis or research question defines the variables or what is being examined and defines the population to be studied.

Methodology. The methodology or procedures section is a description of how the study was conducted and is based on the type of research that was conducted. It may include one or more of the following: a description of the participants; statements about instruments used, including their reliability and validity (or credibility and trustworthiness); the sources of data; procedures employed in conducting the study; and procedures used in collecting the data. An individual who reads this section should be able to replicate the study being presented.

Results. Results describe the types of statistical analysis or data synthesis that were used as well as an objective description in writing or through the use of charts, tables, and figures of results found.

Discussion, Implications, and Conclusions. This section describes how the results are related to the research question or hypothesis. Results should be related to past research, and possible reasons why the results were found should be discussed. Any methodological problems should be described in this section. Although authors have some liberty in this section to speculate about the results, they should do so tentatively. Often the author concludes this section by suggesting how the research might be applied to future studies.

References. Almost all educational and psychological publications require that manuscripts use the style of the *Publication Manual of the American Psychological Association* (APA, 2009). If you learned referencing using a different style, this approach will initially seem foreign to you. Generally, the publication manual encourages simplicity in its approach, and you will quickly become used to its streamlined manner of citing and referencing. Without going into detail on how to reference, throughout all manuscripts citations should be listed whenever a statement needs to be supported by past research, and all citations are referenced at the end of the manuscript.

Evaluation

The Purpose of Evaluation

Although many research concepts are used in evaluation, the purpose of evaluation is generally different from the purposes of research (Leary, 2007). Whereas research tends to examine new paradigms to expand understanding and knowledge and how such knowledge can be applied to practice, program evaluation has to do with whether or not a program has achieved its goals and objectives and has been shown to have worth and value (Houser, 2009; Leary, 2007; Royse, Thyer, & Padgett, 2010).

As a counselor, you will be asked to evaluate the progress of your clients and the effectiveness of programs you will conduct. For instance, you may be asked to show evidence that clients have improved through counseling or to demonstrate the efficacy of a self-esteem program, a classroom guidance program, a career development program, a parenting effectiveness program, or simply a program that explains the services of your agency to your clients. Program evaluation also has an important place in examining the effectiveness of job-related behaviors at your school or agency. The use of evaluation techniques is also an important step in the accountability process and assures the public and funding agencies that a counseling setting is performing essential and effective services for its clients (Leary, 2007; Royse et al., 2010). In order to improve the program while it is occurring, or to improve it for the next time that it might be given, formative and summative evaluation measures should be undertaken.

Formative and Summative Evaluation

Sometimes called *process and outcome evaluation*, *formative* and *summative evaluation* have different purposes. Formative evaluation is concerned with the assessment of a program during its implementation in order to gain feedback about its effectiveness and to allow for change in the program as needed. On the other hand, summative evaluation involves assessment of the total training program in order to decide whether or not the program should be offered again, and if so, what changes might be made to make it more effective.

Probably the most basic way to conduct formative evaluation is to ask for verbal feedback from your audience. In this case, the presenter needs to be open to feedback, especially any negative criticism, and be willing to change his or her program midway. A less threatening and sometimes more revealing method of formative evaluation is to have participants write down reactions to the program while it is occurring. Doing this anonymously allows for participants to express their feelings openly, without fear of repercussion. Along these same lines, participants can be asked to complete rating forms during the program in order to offer ongoing feedback to the program facilitator. Data from rating forms can be easily collated and offer a quick and yet somewhat structured mechanism to obtain immediate feedback. The disadvantage of rating forms is that they do not allow for feedback outside of the questions being asked. Of course, rating forms could be created that include room for written feedback.

Often used to show accountability to funding agencies and agency administrators, summative evaluation is generally an involved and formal process that often assesses a large segment of the people who have been involved with a program. For instance, a few years back I received a federally funded grant to administer a program at a local school

BOX 13.9

Outcome Evaluation of a Drug and Alcohol Training Program: Program Evaluation (N = 202)

Describe your reaction to each of the following statements in terms of this scale:

1. Never | 3. Sometimes | 5. Always
2. Seldom | 4. Usually | 6. Not applicable

Program presenters:	Mean	Standard Deviation
1. were well prepared.	4.7	.3
2. delivered material in a clear, organized manner.	4.7	.2
3. stimulated intellectual curiosity.	3.9	.5
4. showed respect for questions and opinions of participants.	4.6	.3
5. allowed for relevant discussion when appropriate.	4.7	.3
6. were concerned that participants understood them.	4.6	.2
7. were accessible for individual and group concerns.	4.6	.1
8. offered information applicable to one's field.	4.0	.5
9. presented in a comfortable, conducive environment.	4.4	.2
10. provided a beneficial, educational experience.	4.1	.6

system that would identify, assess, and intervene with students at risk for drug and alcohol abuse. In measuring its effectiveness, a couple of measures were employed. First, an objective test to measure knowledge obtained by the participants was developed and administered. Second, rating scales were used at the conclusion of the program to assess total program effectiveness (see Box 13.9).

In some cases, you might expect training programs to have some far-reaching effects, and this too can be an aspect of summative evaluation. For instance, in the drug and alcohol program just discussed, some of the long-term outcome measures that we hoped to see from this training included reduced use of alcohol and drugs by students, a decrease in the dropout rate (as chemical abuse has been shown to be related to dropout rate), and an increase in the age of first use of drugs or alcohol. To obtain information like this would be a major undertaking and would involve large-scale assessment of students. Though it would not be an easy project, these behaviors are measurable and could be an indication that our program was effective.

Summative evaluation will sometimes involve the use of specific research designs. For instance, in employing survey research, a graduate counseling program might desire to survey all students who have graduated within the past five years, as well as their employers, in an effort to assess how effective they believe the counseling program was in preparing them to become counselors. Even experimental designs can be employed in summative research. For example, one might develop a true experimental design to compare the effectiveness of two videotape programs that focus on the attainment of empathy skills among counselor trainees. Forty students could be randomly assigned to each

videotape program. Each student could then view the videotape and be asked to respond empathically to a role-played client. A statistical comparison on the empathy scores can then be completed using a *t*-test. Whatever technique is used in summative evaluation, you can see that it is often more involved than formative evaluation.

Although formative and summative evaluation procedures share some similar goals and purposes, there are major differences, as noted above.

Summarizing Quantitative Research, Qualitative Research, and Evaluation

Quantitative research, qualitative research, and evaluation all offer us different ways of expanding our knowledge base and help us understand what works and what needs to be improved. Table 13.2 summarizes some of the major points of quantitative and qualitative research and of evaluation.

Multicultural/Social Justice Focus

Bias in Research and Evaluation

If the computer package did not ask you your values prior to its analysis, it could not have considered your value system in calculating p's [probabilities], and so p's cannot be blithely used to infer the value of research results. Like it or not, empirical science is inescapably a subjective business. (Thompson, 1993, p. 365)

Researchers choose to study specific issues because of their preferences and biases (Eaves, 2010; Parham, 1993). They design studies based on their values. They include or exclude certain participants based on their biases, and they make conclusions that are at least somewhat a function of the prism through which they view the world. There is little getting around the fact that all research, to some degree, is biased as a result of the preferences of the researcher (Chang, Hays, & Gray, 2010).

Although quantitative research has brought us many advances, its so-called "purity" must be called into question when we realize that every decision a quantitative researcher makes in designing, implementing, analyzing, and interpreting a study is a reflection of his or her personal biases. The subject matter that is chosen, the population to be examined, the kinds of designs that are chosen, even the statistical analysis used, can lead a researcher to certain conclusions. On the other hand, qualitative research offers us a unique opportunity to conduct research that focuses on the worldview of the participants. Such research seems like a natural fit for counselors who are used to taking on a phenomenological perspective when working with clients (Merchant & Dupuy, 1996).

Qualitative research allows us to peek inside the world of other groups and cultures in an effort to understand how individuals within that group or culture understand reality. For instance, examine Box 13.10, which discusses female genital mutilation, and ask yourself whether you could approach this subject in an unbiased fashion. Then consider the challenges a qualitative researcher has when studying such a topic.

BOX 13.10

Female Genital Mutilation from a Qualitative Research Perspective

In recent years there has been an uproar in many countries concerning the act of female genital mutilation (FGM), which occurs mostly in some parts of Africa, the Middle East, and Far East ("Female....," 2008). The practice generally includes anything from a partial clitoridectomy to excision of the clitoris, the inner labia, and the skin of the outer labia. In some cases the remaining skin is stitched, leaving a tiny opening that makes it difficult to urinate, leaves the women prone to infections, and acts as a kind of chastity belt (World Health Organization, 2010). The procedure, which typically occurs at around age 7, symbolizes the induction into adulthood, reduces or eliminates sexual pleasure, and often results in painful sexual intercourse. Despite laws against such FGM in the United States, in some cases, it is still practiced:

Some immigrant populations remain steadfast in their belief that it is their right and duty to cut and

mutilate the genitals of their daughters and granddaughters regardless of the laws of the land. (Raya, 2010, p. 305)

If one were to examine this procedure from our Western perspective, undoubtedly we would find this procedure distasteful, sexist, without purpose, oppressive, and abusive. The qualitative researcher, however, would ask the following questions:

1. When does the event occur in the culture?
2. Who is involved in carrying out this event?
3. What does this event symbolize for the culture?
4. How do the participants in this event view it?
5. Are the meanings to the event viewed in the same manner by all of the participants?

By bracketing his or her biases, an effective qualitative researcher can add much to our understanding of a culture or practice. For instance, reading a qualitative researcher's study on female genital mutilation could offer a counselor a broad understanding of the issues involved, why such practices have been important in particular cultures, and help the counselor have empathy for women who have undergone such a procedure. Although few if any of us would ever approve of such a procedure, qualitative research can help us understand the circumstances around the procedure and its meaning for the individuals within the culture.

Although qualitative research can offer a unique perspective on events, let us not be misled into thinking that such research does not have its share of biases. It is the unique researcher who can enter a group or culture and truly leave his or her self behind (Chang et al., 2010). For this reason, qualitative research can surely be criticized as too subjective. Therefore, when conducting or reading quantitative or qualitative research, we must always keep in mind that even the seemingly purest of research studies will be biased by the researcher. We must both learn from research and question it.

White Researchers Conducting Multicultural Research: An Unnatural Fit?

From 1932 to 1972, the United States Public Health Services examined the effects of untreated syphilis on African American men in Tuskegee, Alabama. This appalling research, known as "the Tuskegee Experiment," was one of a number of abuses against minorities and women that have taken place in the name of research. Thus, it is not surprising that some researchers have questioned whether White researchers should even perform multicultural research (Atkinson, 1993; Mio & Iwamasa, 1993; Parham, 1993;

Table 13.2

Summary of Quantitative Research, Qualitative Research, and Evaluation										
	QUANTITATIVE				QUALITATIVE				EVALUATION	
	EXPERI-MENTAL:	NON-EXPERIMENTAL								
	TRUE, QUASI, ONE-SHOT/ONE GROUP PRE-POST	CORRELA-TIONAL: BIVARIATE (SIMPLE/ PREDICTIVE) MULTIVARIATE	SURVEY	EX POST FACTO (CAUSAL-COMPARATIVE)	GROUNDED THEORY	PHENOMENO-LOGICAL	ETHNO-GRAPHIC	HISTORICAL	FORMATIVE (PROCESS)	SUMMATIVE (OUTCOME)
Focus	Cause and effect	Co-relationships among variables	Survey a population	Cause and effect	Understand experience of others to develop theory	Understanding the experience of individuals or group	Behavior of selected population	Conditions and events of past	"Here and Now"	Outcome of a program
Purpose	Show that X causes Y	Describes relationship; predict one variable from another	Assess opinions, beliefs, and attitudes	Suggest that X causes Y	To explore research question with individuals and examine subsequent emerging theory	To develop a rich understanding of others that may be helpful when working with them	To use multiple methods of under-standing a culture or way of being in the world	To describe and analyze conditions and events from the past	To determine the value of a program as it is occurring	To determine the value of a program after it has ended
Hypotheses/ Questions	Hypothesis	Hypothesis and Questions	Research Question	Ex Post Facto (Causal-Comparative)	Questions that will lead to formulation of tentative theory	Questions that will lead to deeper understanding of population	Questions that will examine multiple aspects of a culture	Questions that will explore historical accuracy	Hypothesis or questions. Usually questions	
Population	Individuals or groups chosen for study	Groups being correlated	Population being surveyed	Intact Groups	Population chosen based on questions being asked	Population chosen based on questions being asked	Culture that is to be understood in deeper ways	Event or group from past	Group obtaining services (e.g., workshop, guidance group, conference attendees)	
Design/ Statistics	Usually groups. Manipulate treatment (X) to test for outcome (Y). Inferential statistics	Mostly groups. Examine relationship being correlated Descriptive statistics	Define population, administer survey, analyze data. Descriptive statistics	Groups. Examine differences of intact groups. Inferential statistics (weak)	Gather information from individuals/ groups. Code, develop themes, etc.	Gather data by interviewing individuals. Code, develop themes, etc.	Gather data from ethnographic interviews, artifacts, observation, etc. Code, develop themes, etc.	Gather data from: oral histories, documents, relics, etc. Code, develop themes, etc.	Usually: • Informal • Descriptive statistics	• Can be: • Descriptive statistics • Experimental design • Ex post facto design
Validity/ Credibility/ Trustwor-thiness	Internal Validity/External Validity				Credibility and trustworthiness through multiple methods: prolonged field work, triangulation, bracketing, outside auditor, member checks, informant, etc.				Internal Validity/ External Validity	

Petersen, 2008). In an effort to reduce biases Chang et al. (2010) suggest that researchers do the following:

    a. obtain a skill for exploring each individual cultural perspective;

    b. be aware of their own cultural biases and be able to articulate, explore, and challenge the validity of their worldview;

    c. always remain aware of cultural differences without making them the major focus; and

    d. be considerate of participants' ethnic, racial, and cultural views when developing methodology. (p. 271)

Ethical, Professional, and Legal Issues

Ethical Issue: Code of Conduct

The American Counseling Association's (ACA) ethical code (ACA, 2005) has a separate section on research and publication that emphasizes many important research issues (see Standard G of ethics code at http://www.counseling.org/Resources/; then click "Ethics"). Summarizing a few of these, we find the following.

Research Responsibilities: Research must be conducted in a manner that respects individuals from all cultures and takes reasonable precautions to avoid psychological, physical, or social injury to subjects.

Informed Consent: Prior to consenting to participate in research, subjects must be told the purpose of the research, procedures, any potential risks involved, the potential benefits, alternative procedures to the research, any limits to confidentiality, and the fact that they can withdraw from the study at any point.

Deception: Deception in research can be used only if it can be shown that an alternative method is not available and the value of the research justifies the deception. If deception is involved, there must be extremely low risk, if any, of harm to subjects.

Confidentiality: All information obtained from research must be kept confidential, and the plans for keeping the research confidential must be explained to the subjects.

Professional Issue: Standards in Research

ACA and the American Psychological Association (APA) have both set standards in conducting research through statements in their ethical codes (ACA, 2005; APA, 2003). In addition, research and program evaluation is one of the eight core content areas designated by the Counselor for Accreditation of Counseling and Related Educational Programs (CACREP) for counselor training programs. Thus, in order for programs to obtain accreditation, they must teach the specific areas identified by CACREP. Finally, although no one division of ACA specifically addresses research, all divisions are committed to research, as is reflected in each of their publications.

Legal Issues

Exclusion of Females and Minorities in Research

The National Institute of Mental Health (2005) and other agencies now require that females and minorities be included in all research unless there is a compelling reason not to include them.

Institutional Review Boards

Federal legislation now requires that all organizations that conduct research supported by federal funds have a human subjects committee or institutional review board whose purpose is to ensure that there is little or no risk to research participants. Today, many institutions have adopted human subjects committees even if they do not receive federal funds.

The Counselor in Process: Discovering New Paradigms

Whiston (1996) challenges all practitioners to come forth and risk leaping into the black hole called research. It's scary to dive in, but one comes out a scholar and a better counselor. Counselors must see themselves as conductors of research, readers of research, and publishers of research. We cannot afford to be bound by our fears of research, because this keeps us stuck in our inert, former ways of understanding the profession of counseling. We must move forward toward new paradigms. Research and evaluation allow us to examine what we are doing, change what we have done, and adopt new and better ways of working with clients. We need to stop being fearful of conducting research; we need to embrace the reading of research; and we need to realize that research is not a virus to avoid but a living process that offers us new directions for the future and new ways of defining who we are and how we work. Learn various ways of doing research and evaluation, apply them, and publish them. Become a true scholar in the helping professions. Give to both your clients and your peers, and make a contribution to knowledge.

Summary

This chapter examined research and evaluation. Relative to research, we noted that it analyzes information in order to give us knowledge about the present—knowledge that may help us to make predictions about the future. We noted that research and evaluation help us find answers to the questions we ponder, move us forward in our understanding of the world, help to show us that what we are doing is working, and offer us new ways of approaching our work. We pointed out that some have used the term practitioner–scientist to describe the fact that all counselors use research in some fashion.

We pointed out that usually, researchers examine a subject by conducting a literature review, which is an examination of prior research. Two databases often used in this process, we noted, are ERIC and PsycInfo. Out of the literature review comes the statement of the problem, which helps to orient the research to its historical context, its scope, and to research questions, statements, and hypotheses.

We noted that qualitative and quantitative research approach the process of attaining new knowledge differently, with each offering an important perspective. We explained that although evaluation is not research, it will often employ research designs to complete its task.

Explaining the differences between quantitative and qualitative research, we noted that quantitative research assumes that there is an objective reality within which research questions can be formulated and reductionist, scientific methods used in the pursuit of knowledge, while qualitative research holds that there are multiple ways of viewing knowledge and that the role of the researcher is to carefully observe and describe phenomena and to interpret them within a social context.

In examining quantitative research, we distinguished between experimental and nonexperimental research. Experimental research includes true experimental, quasi-experimental, and one shot case study and one group pretest/post-test designs, all of which attempt to show cause and effect and manipulate the independent variable. Non-experimental research includes correlation research (bivariate and multivariate), survey research, and ex post facto (causal-comparative) research. Nonexperimental research generally does not imply cause and effect; there is no manipulation of the independent variable.

In looking at qualitative research, we distinguished the following kinds of research: grounded theory, phenomenological designs, ethnographic research, and historical research. Noting that each employs the case study method of probing or analyzing an event, we highlighted some of the differences. We noted that grounded theory attempts to develop theory from the exploration of a particular population or event being examined. This process unfolds through a series of steps: preparing, data collection, note taking, coding, and writing. Phenomenological designs attempt to understand the experience of a population, but are less interested in theory development. Ethnographic research, we noted, examines a phenomenon or event within its social context by having the researcher immerse him- or herself in the culture using observation, ethnographic interviews, and document and artifact collection. Historical research relies on the systematic collection of information from oral histories, documents, and relics in an effort to examine and understand past events within a contextual framework.

In discussing some of the statistics that are used with quantitative research, we noted that descriptive statistics are often employed with survey research, while inferential statistics are mathematical procedures used to make inferences about a larger population from the sample one is studying. Such statistics are generally used when one is examining group differences or relationships among treatment groups. We pointed out the importance of effects size, or the practical significance of research findings.

When organizing results from qualitative research, we noted that one generally relies on a process called inductive analysis, which means looking for patterns and categories that emerge from data. Thus, the researcher examines data from observation, interviews, artifacts, records, relics, and other sources and looks through the information for salient patterns and ways of categorizing information. Often, coding is used in this process.

In examining issues of quality when conducting research, we noted that quantitative research relies on an examination of a study's internal validity to show potential confounding variables and its external validity to show whether the research can be generalized to other populations. Whereas quantitative research examines the kinds of strict control one has over internal and external validity, qualitative research is more concerned

with whether or not there is congruence between the researcher's understanding of events and the actual events that have taken place. Here, we often look at the credibility and trustworthiness of the information we obtained from our study. We pointed out a number of ways to show trustworthiness of our research (e.g., prolonged research, triangulation, bracketing, using an informant, using an outside auditor, member checks, etc.)

Although qualitative and quantitative research differ in their approach to understanding knowledge, they both start with a problem statement, a review of the literature, and a hypothesis or research question. After a study is complete, researchers generally respond to the hypothesis or research question by publishing their results. Generally, a publication includes an abstract; a literature review; the hypothesis or research question; the methodology; the results; the discussion, implications, and conclusions; and the references.

The last part of the chapter reviewed evaluation. We noted that unlike research that examines new paradigms, program evaluation examines the value and worth of a program and the extent to which a program has achieved its goals and objectives. Whereas formative (process) evaluation is concerned with the assessment of a program during its implementation, summative (outcome) evaluation involves assessment of the total training program in order to decide whether or not the program was worthwhile and/or whether it should be offered again. Formative evaluation can include informal assessment procedures such as asking for verbal feedback and is an ongoing process as long as a program is being conducted. Summative evaluation, on the other hand, may involve more formal assessment procedures and may use research designs to show the efficacy of a program. Both formative and summative evaluation techniques are becoming increasingly important in being accountable to administrators and funding agencies.

In this chapter, we stated that all research is biased. The subject matter that is chosen, the population to be examined, the kinds of design that are picked, and even the statistical analysis used can lead a researcher to certain conclusions. However, that does not mean that research is not important. On the contrary, research can enhance our understanding of the world, but we need to know its limits. The strict controls of quantitative research provide us with answers to many questions, but its extremely focused results often limit its generalizability. On the other hand, the less rigid structure of qualitative research offers us a way of understanding how others come to define themselves and the culture in which they are embedded, but it can be criticized for being too subjective and easily subject to the researcher's bias.

As we neared the end of the chapter, we noted that a recent controversy has questioned whether White researchers should even perform multicultural research. We stated that researchers should obtain skills for working with people from cultures different from their own, be aware of their own cultural biases, remain aware of cultural differences, and be considerate of participants' cultural views when developing methodology.

We next highlighted a number of ethical, professional, and legal issues related to research and program evaluation. We noted that researchers must respect all research participants and ensure that no harm will occur to any person, ensure that research participants give informed consent, avoid deception in research, and keep all information gained from research participants confidential. In speaking to standards in the profession, we noted that in addition to the ethical guidelines requiring adherence to high standards in research, CACREP requires that counseling programs address specific content issues in the area of research and program evaluation. Two legal issues we discussed were the

importance of including minorities and women in research and the necessity of institutional review boards to ensure that no harm occurs to research participants. Finally, we ended this chapter by noting the importance of diving into research and the benefits of becoming a conductor of research, a reader of research, and a publisher of research. We must be active researchers if we are to remain alive and forward thinking in our profession and if we are going to be helpful to our clients and add knowledge to the world.

◼ *References*

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling. org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Psychological Association. (2003). *Ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code2002.html

American Psychological Association. (2009). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Atkinson, D. R. (1993). Who speaks for cross-cultural counseling research? *The Counseling Psychologist, 21*(2), 218–224.

Bacon, F. (1997). *Francis Bacon essays*. Hertfordshire, England: Wordsworth. (Original work published 1597)

Best, J. W., & Kahn, J. V. (2006). *Research in education* (10th ed.). Boston: Allyn & Bacon.

Buckley, M. R. (2010). Grounded theory methodology. In C. J. Sheperis, J. C. Young, & M. H. Daniels (Eds.), *Counseling research: Quantitative, qualitative, and mixed methods* (pp. 115–150). Upper Saddle River, NJ: Pearson.

Burton, N. W., & Wang, M. (2005). *Predicting long-term success in graduate school: A collaborative validity study*. Princeton, NJ: Educational Testing Service.

Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally.

Chang, C. Y., Hays, D. G., & Gray, G. (2010). Multicultural issues in research. In C. J. Sheperis, J. C. Young, & M. H. Daniels (Eds.), *Counseling research: Quantitative, qualitative, and mixed methods* (pp. 262–273). Upper Saddle River, NJ: Pearson.

Christensen, T. M., & Brumfield, K. A. (2010). Phenomenological designs: The philosophy of phenomenological research. In C. J. Sheperis, J. C. Young, & M. H. Daniels (Eds.), *Counseling research: Quantitative, qualitative, and mixed methods* (pp. 135–149). Upper Saddle River, NJ: Pearson.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Chicago: Rand McNally.

Eaves, S. H. (2010). Methodological issues. In C. J. Sheperis, J. C. Young, & M. H. Daniels (Eds.), *Counseling research: Quantitative, qualitative, and mixed methods* (pp. 32–45). Upper Saddle River, NJ: Pearson.

Female genital mutilation (FGM) in Africa, the Middle East, and the Far East. *Religious Tolerance*. Retrieved from http://www.religioustolerance.org/fem_cirm1.htm

Fong, M., & Malone, C. M. (1994). Defeating ourselves: Common errors in counseling research. *Counselor Education and Supervision, 33*, 356–362.

Fritzsche, B., & Parrish, T. (2005). Theories and research on job satisfaction. In S. D. Brown & R. W. Lent (Eds.), *Career development and counseling: Putting theory and research to work* (pp. 180–202). Hoboken, NJ: John Wiley & Sons.

Gall, M. D. Gall, J. P., & Borg, W. R. (2007). *Educational research: An introduction* (8th ed.). Boston: Allyn & Bacon.

Gall, M. D. Gall, J. P., & Borg, W. R. (2010). *Applying educational research: How to read, do, and use research to solve problems* (6th ed.). Boston: Pearson.

Gay, L. R., Mills, G. E., & Airasian, P. (2009). *Educational research: Competencies for analysis and application* (9th ed.). Upper Saddle River, NJ: Pearson.

Hanna, F. J., & Shank, G. (1995). The specter of metaphysics in counseling research and practice: The qualitative challenge. *Journal of Counseling and Development, 74,* 53–59.

Haverkamp, B. E., Morrow, S. L., & Ponterotto, G. E. (Eds). (2005). Knowledge in context: Qualitative methods in counseling psychology research [Special issue]. *Journal of Counseling Psychology, 52.*

Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2008). *Research design in counseling* (3rd ed.). Belmont, CA: Wadsworth.

Houser, R. (2009). *Counseling and educational research: Evaluation and application* (2nd ed.). Thousand Oaks, CA: Sage.

Kline, R. B. (2009). *Becoming a behavioral science researcher: Producing research that matters.* New York: Guilford Press.

Kuhn, T. S. (1962). *The structure of scientific revolutions.* Chicago: University of Chicago Press.

Lancy, D. F (1993). *Qualitative research in education: An introduction to the major traditions.* New York: Longman.

Leary, M. R. (2007). *Introduction to behavioral research methods* (5th ed.). Boston: Allyn & Bacon.

Lundervold, D. A., & Belwood, M. F. (2000). The best kept secret in counseling: Single-case (N=1) experimental designs. *Journal of Counseling and Development, 78,* 92–102.

McMillan, J. H., & Schumacher, S. (2010). *Research in education: Evidence-based inquiry* (7th ed.). Boston: Allyn & Bacon.

Mead, M. (1961). *Coming of age in Samoa: A psychological study of primitive youth for western civilization.* New York: Morrow.

Merchant, N., & Dupuy, P. (1996). Multicultural counseling and qualitative research: Shared worldview and skills. *Journal of Counseling and Development, 74,* 537–541.

Mertler, C. A., & Charles, C. M (2008). *Introduction to educational research* (6th ed.). Boston: Allyn & Bacon.

Mio, J. S., & Iwamasa, G. (1993). To do, or not to do: That is the question for white cross-cultural researchers. *The Counseling Psychologist, 21*(2), 197–212. doi: 10.1177/0011000093212001

National Institute of Mental Health. (2005). *Terms and conditions for recruitment of participants in clinical research.* Retrieved from http://www.mentalhealth.gov/research-funding/grants/terms-and-conditions-for-recruitment-of-participants-in-clinical-research.shtml

Neukrug, E., & Milliken, T. (2011). Counselors' perceptions of ethical behaviors. *Journal of Counseling and Development.* Accepted for publication.

Orcher, L. T. (2004). *Conducting research: Social and behavioral sciences methods.* Glandale, CA: Pyrczak Publishing.

Parham, T. A. (1993). White researchers conducting multicultural counseling research: Can their efforts be "Mo Betta"? *The Counseling Psychologist, 21*(2), 250–256. doi:10.1177/0011000093212009

Petersen, J. (2008). The intersection of oral history and the role of white researchers in cross-cultural contexts. *Educational Foundations, 22*(3–4), 33–52.

Raya, P. (2010). Female genital mutilation and the perpetuation of multigenerational trauma. *The Journal of Psychohistory, 37*(4), 297–325.

Royse, D., Thyer, B. A., & Padgett, D. K., (2006). *Program evaluation: An introduction* (5th ed.) Belmont, CA: Brooks/Cole.

Schonlau, M., Fricker, R. D., & Elliot, M. N. (2002). *Conducting research surveys via e-mail and the web.* Santa Monica, CA: Rand.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference.* Boston: Houghton Mifflin.

Sommer, B., & Sommer, R. (2002). A *practical guide to behavioral research: Tools and techniques* (5th ed.). New York: Oxford University Press.

Thompson, B. (1993). The use of statistical significance in research: Bootstrap and other alternatives. *Journal of Experimental Education, 61*(4), 361–367.

Thompson, B. (1995). *Inappropriate statistical practices in counseling research: Three pointers for readers of research literature.* Retrieved from ERIC database (ED 392990)

Ton, M., & Hansen, J. C. (2001). Using a person-environment fit framework to predict satisfaction and motivation in work and marital roles. *Journal of Career Assessment, 9*(4), 315–331. doi: 10.1177/106907270100900401

Whiston, S. C. (1996). Accountability through action research: Research methods for practitioners. *Journal of Counseling and Development, 74,* 616–623.

World Health Organization. (2010). *Female genital mutilation and other harmful practices.* Retrieved from http://www.who.int/reproductivehealth/topics/fgm/overview/en/index.html

This page intentionally left blank

Social and Cultural Foundations in Counseling

CHAPTER **14** *Theory and Concepts of Multicultural Counseling*

CHAPTER **15** *Knowledge and Skills of Multicultural Counseling*

Overview

*T*he tragedy of 9-11 makes it clear that issues of class, race, ethnicity, religion, and culture are some of the most pressing concerns of the twenty-first century. These issues weigh heavily on the counselor and the counseling profession and they must be addressed. Thus, this section of the text offers two chapters that will examine the ever-important area of multicultural counseling.

The two chapters in this section are a natural complement to one another. Chapter 14 focuses on theory and concepts of multicultural counseling and is foundational to the understanding of this important area. With this basic grounding in place, you are ready to move on to Chapter 15, which zeroes in on the knowledge and skills necessary when working with diverse populations. Although the chapters differ in their general thrust, throughout both you will be presented with statistics on diversity, learn how discrimination and prejudice affect us all, be given the opportunity to examine your own cultural identity, and of course, gain some of the knowledge, skills, and attitudes you will need to be an effective cross-cultural counselor.

Both chapters will present multicultural counseling as one of the most pressing issues in the mental health profession. Called by some a "fourth force" in the helping professions, multicultural counseling represents a major thrust for the counseling profession. As you read through these chapters, consider the importance that sensitivity and understanding toward different cultural groups can have for you, our profession, our country, and the world.

Theory and Concepts of Multicultural Counseling

There is an old story. We are each of us told in its tale. A child went to a rabbi and asked why God started with just Adam and just Eve. The child asked why God had not made everyone at once. The rabbi answered that God had made only Adam and only Eve so that no one of us could ever turn to another person and say, "Your father is not my father, your mother is not my mother, and we are neither brother nor sister." So this can never be said. By any of us. To any of us.
(Author Unknown)

When I was growing up in New York, the city was a world unto itself: the ethnic foods, the multicultured music, the people—oh, how I loved to watch the people. Walk down a Manhattan street and you can watch an endless sea of people, a sea that seems to change color as it flows by you, a sea whose shape transforms constantly; and, if you flow with it long enough, you can visit every part of the world. There is no question that New York gave me a multicultural perspective that many people don't have an opportunity to obtain. However, despite this exposure to a variety of cultures and ethnic groups, I never really got below the surface. I could taste the foods, I could see the people, and I could listen to the music, but that experience alone was still from a detached perspective. Even though I might see the brightly colored clothes of the Nigerian, I still didn't know that person. Even though I could taste the sushi, I didn't understand the world of the Japanese. And even though I could listen to the Latin music, I didn't really understand the people.

This chapter is about differences, similarities, and understanding one another. We will begin the chapter by suggesting a number of reasons why issues related to multicultural counseling must take a prominent place in the counseling profession today. We will review important definitions in the field and examine continued patterns of discrimination and prejudice that exist in America. By exploring models of racial and cultural identity

development, as well as White identity development, we will try to understand how each of us has developed our own cultural identity and how that might impact the way we view the world and work with clients. The chapter will highlight the importance of counselors understanding their own attitudes and beliefs, having basic knowledge of many cultures, and of knowing cross-cultural counseling skills if they are to work effectively with culturally different clients. Near the conclusion of the chapter, we will stress the importance of multicultural counseling training standards and examine some important ethical, professional, and legal issues.

■ *What Is Multicultural Counseling?*

Do counselors have the ability to understand a client who is from a different culture than their own? Can anyone, ever, 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 a counselor learn if he or she is to work effectively with clients from nondominant groups? These are some of the important questions that must be asked when defining multicultural counseling. And, as you might expect, based on how people respond to these questions, their definition of multicultural counseling will vary. For instance, McAuliffe (2008) offers a rather broad definition of multicultural counseling: "a consistent readiness to identify the cultural dimensions of clients' lives and a subsequent integration of culture into counseling work (p. 5)." Sue and Torino (2005) offer a bit more specificity, which is listed below and shown diagrammatically in Figure 14.1:

> *Multicultural counseling and therapy can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, utilizes universal and culture-specific helping strategies and roles, recognizes client identities to include individual, group, and universal dimensions, and balances the importance of individualism and collectivism in the assessment diagnosis and treatment of client and client systems. (p. 6)*

FIGURE 14.1
One Way of Understanding Multicultural Counseling
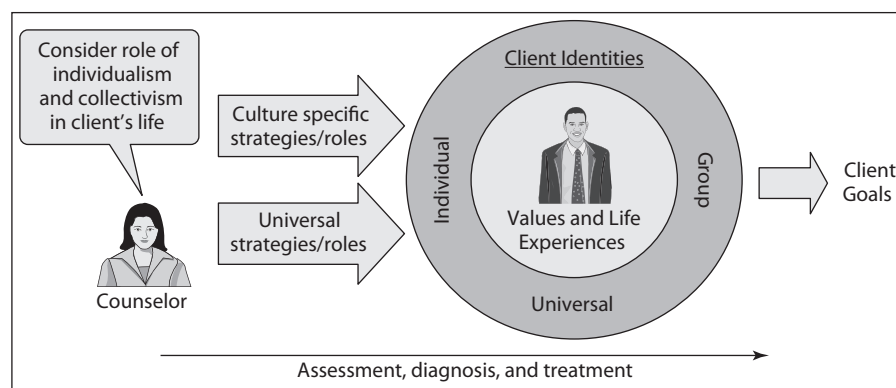
In addition to definitions of multicultural counseling, *Multicultural Counseling Competencies* have been developed by our profession and help to drive the training of counselors (Arredondo et al., 1996; Roysircar, Arredondo, Fuertes, Ponterrotto, & Toporek, 2003). These competencies, which will be discussed in more detail later in the chapter, represent minimum standards needed by counselors if they are to work effectively with diverse clients, and delineate attitudes and beliefs, knowledge, and skills in three areas: (1) counselor self-awareness of assumptions, values, and biases, (2) knowledge of the world view of the culturally different client, and (3) familiarity with intervention strategies and techniques (see Appendix A for the Competencies).

Why Multicultural Counseling?

Diversity in America

The most obvious answer to the question, "Why multicultural counseling?" is that America is the most diverse country in the world—a country that is truly a conglomerate of ethnicities, races, cultures, and religions. Examine Table 14.1, and you will see individuals from every race, culture, and ethnicity; individuals whose roots are from all parts of the globe; individuals with different sexual orientations; and individuals who embrace a wide range of religious affiliations. We live in a truly multicultural nation and thus are called to offer counseling services to individuals from many diverse backgrounds. However, besides the sheer number of individuals from diverse backgrounds, there are numerous other reasons why the profession must make special efforts at focusing upon multicultural counseling. Let's explore some of those.

Counseling Is Not Working for a Large Segment of Our Population

If you were distrustful of therapists, confused about the counseling process, or felt worlds apart from your helper, would you want to go to or continue counseling? Assuredly not. Unfortunately, this is the state of affairs for many diverse clients. In fact, it is now assumed that when clients from nondominant groups work with majority helpers, there is a possibility that the helper will (1) minimize the impact of social forces on the client, (2) interpret cultural differences as psychopathological issues, and (3) misdiagnose the client (Buckley & Franklin-Jackson, 2005; Constantine & Sue; 2005). Perhaps this is why a large body of evidence shows that diverse clients are frequently misunderstood, often misdiagnosed, find counseling and therapy less helpful than their majority counterparts, attend counseling and therapy at lower rates than majority clients, and tend to terminate from counseling more quickly than Whites (Evans, Delphin, Simmons, Omar, & Tebes, 2005; Sewell, 2009; United States Department of Health and Human Services, 2001). In addition, many people of color who seek counseling appear to feel more satisfied when seeing a counselor of their own cultural background. This is particularly disconcerting when we know that over 80% of counselors are White (Neukrug & Milliken, 2011), thus making it more difficult for clients of color to find counselors with whom they feel comfortable. Why is counseling not working for a good segment of our population? Often times it is helper incompetence because the helper holds one or more of the following viewpoints (Buckley & Franklin-Jackson, 2005; Constantine & Sue; 2005; McAuliffe, Goméz, & Grothaus, 2008; Sue & Sue, 2008; Suzuki, Kugler, & Aguiar, 2005):

TABLE 14.1

Number and Percentage of Individuals from Select Racial, Ethnic, Religious, and Sexual Identity Backgrounds in the U.S.

ETHNICITY/RACE*	NUMBER (IN MILLIONS)	PERCENTAGE	RELIGION***	NUMBER (IN MILLIONS)	PERCENTAGE
White	199.8	65.1	Christian	173	76.0
Hispanic	48.4	15.8	Christian (non Catholic)	116	50.9
Black or African American	41.8	13.6	Catholic	57	25.1
Asian	16.0	4.3	Select Religions (Christian and Non-Christian)		
American Indian and Alaska Native (AIAN)	5.0	1.6	Baptist	36	15.8
			Christian Generic	32	14.2
Native Hawaiian and other Pacific Islander (NHPI)	1.1	<1	Mainline Christians (Methodist, Lutheran, Episcopalian, United Church of Christ)	29	12.9
Two or more races	5.4	1.7	Pentecostal	7.9	3.5
			Mormon	3.2	1.4
			Jewish	2.7	1.2
			Eastern Religions (e.g., Buddhist)	2.0	.9
SEXUAL ORIENTATION**			Muslim	1.3	.6
Gay		2.5	Other		
Lesbian		1.4	Atheist/Agnostic	3.5	1.6
Gay, lesbian, or bisexual		4.1	None	34	15.0

  * Figures from United States Census Bureau (2009). Hispanics are treated as one group, and they identify as 92% White, 4% African American, 1.6% AIAN, 1.5% two races, .6% Asian, and .3% NHPI. Group members may identify with more than one race. Thus, the groups add up to more than the total population of the United States. Whites listed are non-Hispanic. White with White Hispanic equals 84% of the population.

 ** Gay and lesbian figures are based on a narrow definition of individuals who have engaged exclusively in same-sex sex over one year (Black, Gates, Sanders, & Taylor, 2000). Gay, lesbian, or bisexual figures are difficult to assess (Center for Disease Control, 2002).

*** From Kosmin, B. A., & Keysar, A. (2008). Number of Jews is based on religious identification and is a smaller number than those who identify as Jewish. The number of Muslims is probably much higher, as many mosques do not officially affiliate as a religious denomination.

1. *Believing in the Melting Pot Myth.* Some believe this country is a melting pot of cultural diversity. However, this is not the experience of many diverse clients who find themselves on the fringe of American culture, view themselves as different from the mainstream, and cannot relate to many of the values and beliefs

held by the majority. In truth, most cultures want to maintain their uniqueness and are resistant to giving up their special traditions. Thus, the helper who assumes the client should conform to the values of the majority culture may turn off some clients. Viewing America as a society with a myriad of diverse values and customs, or a *cultural mosaic*, more accurately represents the essence of diversity that we find today.

2. *Having Incongruent Expectations about Counseling.* The Western, particularly American, approach to counseling and psychotherapy tends to contain a number of assumptions, including: presuming that the counseling process should emphasize the individual; stressing the expression of feelings; encouraging self-disclosure, open-mindedness, and insight; and showing cause and effect. In addition, most helpers are not bilingual, approach counseling from a nonreligious perspective, and view the mind and body as separate. These beliefs and behaviors create barriers that result in diverse clients entering helping relationships with trepidation, feelings of disappointment, and sometimes being harmed by techniques that should not be used with them. For example, the Asian client who is proud of her ability to restrict her emotions may leave counseling feeling as if she disappointed her helper who has been pushing her to express feelings.

3. *De-emphasizing Social Forces.* Although helpers may be effective at attending to clients' *feelings* concerning how they have been discriminated against, abused, or affected by other "external" factors, the same helpers will often de-emphasize the actual influence these social forces have on clients. Helpers often assume that most, if not all, negative feelings are created by the individual, and they often have difficulty understanding the power of social influences. The helper's negation of social forces results in an inability to build a successful relationship with a client who has been considerably harmed by external factors. For instance, the client who has been illegally denied jobs due to his disability may be discouraged when a helper says, "What have you done to prevent yourself from obtaining the job?"

4. *Holding an Ethnocentric Worldview.* Ethnocentric helpers, or helpers who see the world only through their own lenses, tend to falsely assume that their clients view the world in a similar manner or believe that when their clients present a differing view of the world they are emotionally disturbed, culturally brainwashed, or wrong. Although the importance of understanding a client's unique worldview is crucial to an effective helping relationship, it becomes particularly significant when working with diverse clients whose experience of the world may be particularly foreign to the helper's. For instance, a helper may inadvertently turn off a client who is a Muslim by saying, "Have a wonderful Christmas."

5. *Ignorance of One's Own Racist Attitudes and Prejudices.* Of course, the helper who is not in touch with his or her prejudices and racist attitudes cannot work effectively with diverse clients and will often cause harm to those clients. Understanding our own stereotypes and prejudices takes a particularly vigilant effort, as many of our biases are unconscious. For instance, the heterosexual helper who unconsciously believes that being gay or lesbian is a disorder but consciously states he is accepting of all sexual orientations may

subtly treat a gay or lesbian client as if there is something wrong with him or her.

6. *Misunderstanding Cultural Differences in the Expression of Symptomatology.* What may be seen as "abnormal" in the United States may be usual and customary in another culture. The helper's lack of knowledge about cultural differences as they relate to the expression of symptoms can seriously damage a counseling relationship and result in misdiagnosis, mistreatment, and early termination. For instance, whereas many individuals from Anglo-European cultures would show grief through depression, agitation, and feelings of helplessness, a Latino/Latina might present with somatic complaints.

7. *Misjudging the Accuracy of Assessment and Research Procedures.* Over the years, assessment and research procedures have notoriously been culturally biased. Although advances have been made, one can still readily find tests that have cultural bias and research that does not control adequately for cultural differences. One common problem in the use of assessment instruments is that individuals from different cultures may inadvertently be answering questions in a manner that would be considered "abnormal" by "American" (i.e., White Eurocentric) standards when indeed they do not have an emotional disorder. For example, when an item on a test asks if a person "hears voices," a religious Latina client might answer "yes," thinking that she "talks to God"—a normal response in her culture. Although acculturated Americans might also "talk to God," they have learned to deny that they "hear voices" because that implies psychopathology in traditional American culture.

8. *Ignorance of Institutional Racism.* Because institutional racism is embedded in society, and some would argue, even within the helping professional organizations, it is likely that materials used by helpers will be biased and helpers will unknowingly have a skewed understanding of culturally different clients. Examples are plentiful. For instance, some diagnoses that have been listed in the *Diagnostic and Statistical Manual-IV* (Text Revision, DSM-IV-TR) have been shown to be culturally biased; counseling approaches that have been given precedence in the professional journals have been shown to be practically useless when working with clients from some cultures; and training programs have, until recently, not stressed multicultural issues. No doubt there are culturally biased statements in this text of which I am not aware.

In recent years, the emphasis on multicultural counseling has taken center stage, with increasing publications and great focus in counselor education programs (D'Andrea & Heckman, 2008a). As we continue to move forward as a profession, the need to continually focus and expand on different aspects of multicultural counseling will undoubtedly remain strong:

> *. . . 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)

▪ *Some Definitions*

In understanding differences within American society, it is important to distinguish among a number of terms, such as *culture; discrimination* and *microaggressions; ethnicity; minority* and *nondominant group; power differentials; race; religion* and *spirituality; sexism, heterosexism,* and *sexual prejudice; sexual orientation; social class ("class")*; and *stereotypes, prejudice,* and *racism.* Understanding these terms gives all of us a common framework within which to communicate. The following are brief definitions of some of these terms.

Culture

Shared values, symbols, language, and ways of being in the world are some of the words and phrases I think of when reflecting on the word *culture.* Culture is expressed through common values, habits, norms of behavior, symbols, artifacts, language, and customs (McAuliffe, 2008; Sewell, 2009; Spillman, 2007). For instance, despite great diversity in the United States, most Americans share a similar cultural heritage because there is a shared language, symbols that most of us recognize, and patterns of behavior with which most are familiar. Traveling throughout this country, we find many symbols of a common culture (e.g., fast-food restaurants, music, laws, basic values, shared language). Yet, even as I acknowledge this common culture, I am acutely aware of the bi-cultural or even tri-cultural nature of many individuals in the United States. For instance, there are those who share the culture of urban gays and lesbians; of their racial, ethnic, and religious groups; of their gender; and of their region (e.g., "the South"). In attempting to delineate cultural identity, Whitfield, McGrath, and Coleman (1992) suggest 11 elements that can be used in helping to understand specific cultural patterns. They include how considering how each culture:

- defines its sense of self
- dresses and values appearances
- embraces specific beliefs and attitudes
- relates to family and significant others
- plays and makes use of leisure time
- learns and uses knowledge
- communicates and uses language
- embraces certain values and mores
- uses time and space
- eats and uses food in its customs
- works and applies itself

Discrimination and Microaggressions

Active, harmful, conscious and unconscious acting out, is what I think of when I reflect on these words. Whereas the words stereotypes, prejudice, and racism refer, in some capacity, to attitudes held by people, *discrimination* is an active behavior, such as gay bashing or unfair hiring practices that results in differential treatment of individuals within specific ethnic or cultural groups (Law, 2007; Lum, 2004).

Although we have undoubtedly made progress, there is still quite a bit of discrimination in the United States. For instance, the most recent hate crime statistics from the FBI (United States Department of Justice, 2008) indicate that 51% of the 9,168 hate crime offenses were for racial bias, while religious and sexual-orientation each represented about 18% of the crimes, ethnicity/national origin about 13%, and disability approximately 1% (United States Department of Justice, 2008). Perceptions of Americans seem to verify the notion that as a country, we still discriminate, with fairly high percentages of Americans believing that the following groups face "a lot" of discrimination: gays and lesbians (64%), Muslims (58%), Hispanics (52%), Blacks (49%), Women (37%), Jews (35%), Evangelical Christians (27%), Atheists (26%), and Mormons (24%) (The Pew Forum on Religion and Public Life, 2009).

Although discrimination is generally thought of as obvious transgressions against a group, in recent years a more subtle form of discrimination, called *microaggression*, has been identified. This type of discrimination is conscious or unconscious and includes brief, subtle, and common putdowns or indignities directed toward individuals from diverse cultures (Constantine, Smith, Redington, & Owens, 2008; Sue, 2010). Some examples include statements like, "you don't seem 'gay' (or Black, or . . .)," "My ancestors made it in this country without anything, I don't see why your family can't," poor or slow service at a restaurant or store, and differential treatment by individuals, such as police or others in positions of power. Such discrimination is probably more commonplace by those who "know" that outward discrimination is wrong, yet carry with them subtle, embedded feelings of prejudice toward others.

Ethnicity

Heritage, ancestry, and tradition are some of the words that come to mind when I reflect on the word *ethnicity*. More specifically, when a group of people shares a common ancestry, which may include specific cultural and social patterns such as similar language, values, religion, foods, and artistic expressions, they are said to be of the same ethnic group (Jenkins, 2007). Ethnicity, as opposed to race, is not based on genetic heritage but on long-term patterns of behavior that have some historical significance and may include similar religious, ancestral, language, and/or cultural characteristics. Therefore, many (but not all) Jews share common ancestry, religion, and cultural practices, and therefore Jewish people are often considered an ethnic group while people of Asian heritage, given the diverse religious, political, historical, and cultural experiences of this region of the world, may not share the same culture or ethnic background.

Minority and Nondominant Group

Oppression of one group over another is my immediate reaction to the word *minority*. A minority is any person or group of people who are being singled out due to their cultural or physical characteristics and are being systematically oppressed by those individuals who are in a position of power. Using this definition, a minority could conceivably be the numerical majority of a population, as was the case for many years for Blacks in South Africa and as is the situation with women in the United States (Atkinson, 2004a; Macionis, 2009). In recent years, we have seen the counseling profession increasingly use the term *nondominant group* rather than the word minority because of the negative

connotations the word minority holds and because the term nondominant group suggests there are social causes (the oppression by dominant groups) that cause distress to other (nondominant) groups.

Power Differentials

Potential abuse, force, control, and superior/underling are some of the words and phrases that come to my mind when I think of the term *power differential*. Power differentials may represent greater disparities between people than culture, ethnic group, race, or social class (Kuriansky, 2008). Power can be a function of race, class, gender, occupation, and a host of other factors and can easily be misunderstood. Whether perceived or real, power can be abused. For instance, a professor may abuse his or her power by sexually harassing a student. An upper-management Mexican-American female who does not abuse her power may still be disliked because the workers believe that Latina females should not hold positions of power. And a White male may be given a leadership position in a management group, not because of his expertise, but because it is unconsciously believed by the other group members that White males have power.

Race

Genetic heritage, skin color, ambiguity are some of the words and phrases I think of when reflecting on the word *race*. Whereas the concept of culture has been based on such characteristics as shared, learned characteristics generally agreed upon by those in the culture, race has traditionally been defined as permanent physical differences as perceived by an external authority (Arthur, 2007). Although traditionally this notion was based on genetics, in recent years this concept has been challenged. For instance, research on the human genome shows that humans share much more genetically than was at one time thought (National Human Genome Research Project, 2010). In fact, genetic differences between any two people are only 0.1% (1/1000!). In addition, gene pools throughout the world, and especially in the United States, have become increasingly mixed due to migration, exploration, invasions, systematic rape as a result of wars and oppression of minorities, and intermarriage (see Box 14.1). Also, behaviorally, there seem to be more differences within racial groups than among them (Atkinson, 2004b). With some sociologists saying there are no races, others saying there are three,

BOX 14.1

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 this one study that genetically examined 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)

and still others concluding that there are as many as 200, the issue of race is cloudy and perhaps doesn't matter. However, it is undeniable that race and the perception of race have had some effect at every level of society. At its best, race represents perceived differences, at its worse, those perceived differences become translated into real differences that result in oppression of "racial" groups. This is why I try avoiding the use of the word "race."

Religion and Spirituality

Religion is seen as an organized or unified set of practices and beliefs that have moral underpinnings and define a group's way of understanding the world (Cipriani, 2007; McAuliffe, 2008). In contrast, *spirituality* is seen as residing in a person, not a group, 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. Because religion is concerned with values from an external referent group and spirituality has more to do with internal processes, there are important differences in how one would counsel a person who is struggling with religious concerns (e.g., value differences between self and a self-chosen religious group) versus how one would counsel a person who is struggling with spiritual concerns (e.g., finding meaning in life).

Sexism, Heterosexism, and Sexual Prejudice

Denigrating and consciously putting another person down due to his or her gender and/or sexual orientation, are some of the terms I think of when I hear these words. Whenever a person discriminates, denigrates, or stigmatizes another due to his or her gender, that person is said to be *sexist*. In a similar fashion, when a person discriminates, denigrates, or stigmatizes a person for nonheterosexual behaviors, that person is said to be heterosexist. The word *heterosexism* has become preferred over homophobia as homophobia implies there is a "phobia" or "disorder" within a person that makes the person act in a stigmatizing or denigrating fashion, whereas heterosexism suggests that language and social institutions are at play in fostering such attitudes (Adam, 2007). Finally, *sexual prejudice* is a more inclusive term that refers to negative attitudes targeted toward homosexual, bisexual, or heterosexual individuals (Herek, 2000).

Sexual Orientation

Sexual orientation refers to the predominant gender "for which a person has consistent attachments, longings, and sexual fantasies" (McAuliffe, 2008, p. 14). One's sexual orientation, therefore, can be toward the same sex, the opposite sex, or to both sexes. Common terms associated with sexual orientation include being gay, lesbian, or bisexual. In recent years, some have questioned even the use of the words gay and lesbian, suggesting that their very use reinforces existing power structures in society. Some have suggested using the word *queer* instead of lesbian or gay as a means of regaining power and not buying into existing ways of seeing the world. Meanwhile, in 1975 the American Psychological Association stopped viewing homosexuality as a disorder and the American Counseling Association (ACA) has continually supported this change. Today, being gay, lesbian, or bisexual is seen as no more or less disordered as being heterosexual!

Social Class ("Class")

Money, power, status, and hierarchy—these are the words that come to mind when I think of the term *social class*. Defining social class as "a person's position in a society's hierarchy based on education, income, and wealth" (McAuliffe, 2008, p. 13), this term represents the perceived ranking of an individual within a society and the amount of power an individual wields (Macionis, 2009). An individual's social class may cut across a person's ethnicity, cultural identification, or race. Therefore, even though individuals may share a similar culture, ethnicity, or race, they may have little in common with one another due to differences in social class. For instance, it is not unusual to find a poor, undereducated African American who may have little in common with a well-to-do, highly educated African American.

Prejudice, Stereotypes, and Racism

Generalizing, falsehoods, irrational fears, and anger is what I think of when I consider these words. Generally, all three of these words are related to preconceived ideas or attitudes people have towards others. Whereas *prejudice* has to do with judging a person or a group based on preconceived notions about the group (e.g., gays are no good; therefore, I hate John because he's gay), *stereotyping* is the rigidly held belief that most or all members of a group share certain characteristics, behaviors, or beliefs (e.g., Asians are intelligent people, American Indians are alcoholics) (Jennings, 2007; Lum, 2004). *Racism* is a specific belief that one race is superior to another (e.g., Whites are better than Blacks) and is considered a social construction that leads to prejudice, stereotyping, and discrimination (McAuliffe et al., 2008).

■ Political Correctness, or, Oh My God, What Do I Call Him or Her?

Hispanic, Latino, Latina, Chicano, Chicana, Black, African American, Afro-American, Oriental, Asian American, Chinese American, Japanese American, Native American, Indian, Eskimo, Inuit, Aleut, Native American, American Indian, Asian Indian, Jew, Hebrew, Jewish American, Protestant, WASP, Muslim, Moslem, Islamic, Born Again, Fundamentalist Christian, Christian, Catholic, White, Caucasian, European American, American, gay, homosexual, heterosexist, straight, heterosexual, bisexual, lesbian, queer, transgendered, transsexual, crossdresser, transvestite, disabled person, individual with disability, mentally retarded, intellectual disability, handicapped person, physically challenged, and on and on.

Did I offend anybody? I hope not, but in these days of political correctness, finding the correct term is often difficult. And, even once you find the correct term, you will offend somebody.

Although there is great variety in how individuals prefer to be addressed, it is often for a specific reason. For example, words like "Hispanic" and "Negro" are associated with a long history of oppression for people who have historically been labeled as such by their oppressors. More than simple "Political Correctness," naming

conventions can represent a way for people to reclaim their identity, and should be taken seriously. That said, the next paragraph describes some terms that have been used recently.

For Americans with African heritage, the term *African American* is generally used, although *Black* is still acceptable and even preferred in some circles. *Asian American* refers to any of a number of individuals with heritage from Asia and the Pacific Islands, including approximately 40 distinct subgroups that differ in language and cultural identity (Sandhu, 1997). *Hispanic,* the word which the Census Bureau uses, refers to Mexican Americans, Puerto Ricans, Cuban Americans, individuals with Central and South American heritage, and individuals with roots from Spanish-speaking countries in the Caribbean. However, not all individuals from these countries are comfortable with the word Hispanic, as it refers to anyone with Spanish roots and connotes a history of colonialism. Thus, in recent years, the words *Latino* or *Latina* have become preferred by many over the word Hispanic. Islam is a religion whose followers are called *Muslim* (less commonly called Moslem). Homosexuals today generally use the terms *gay* for men and *lesbian* for women, although as noted earlier, some have now moved to the word "queer" to define their sexual orientation. The term straight is becoming less acceptable to describe heterosexuals because of the implication that it is better than another type of orientation (e.g., "on the straight and narrow"), and *heterosexist* is now the preferred term over homophobic. Individuals who have been born in this country and identify with their cultural or ethnic background often place the word American following their heritage. Therefore, it is not unusual for us to find individuals referring to themselves as Irish American, Italian American, Arab American, and so forth. Individuals who are naturalized citizens tend not to use the word "American" following their country of origin. For instance, a colleague of mine who was raised in Mexico and became a U.S. citizen refers to herself as "Mexican." Rather than saying handicapped or disabled person, generally people now say "individual with a disability" although some prefer the term "physically challenged" (Notice the importance of placing the word "individual" prior to the word disability). Finally, although the term *mentally retarded* has been used in recent years, the new *Diagnostic and Statistical Manual* (5th ed.), which is scheduled to be published in 2013, is replacing that term with *individual with an intellectual disability*, and we are likely to see the term mentally retarded used less frequently.

Although it is not within the scope of this text to detail the accepted nomenclature for all cultural groups, I have attempted to use commonly accepted terms throughout Chapters 14 and 15. Of course, people vary in how they wish to be addressed. However, I believe that making an effort to use terms correctly shows our sensitivity to individuals from diverse cultures.

Understanding Your Diverse Client: Conceptual Models

> *Every man is in certain respects (a) like all other men, (b) like some other men, (c) like no other man.* (Kluckhohn & Murray, 1948, p. 35)

A number of models exist that can help us understand clients from nondominant groups. The following briefly describes the *Existential Model of Identity*, the *Tripartite Model of*

FIGURE 14.2
**Existential Model of
Understanding the Person**
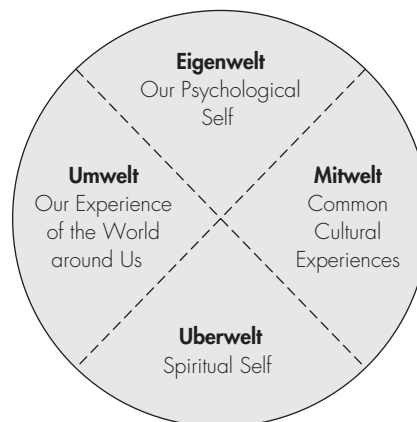
Eigenwelt
Our Psychological
Self

Umwelt
Our Experience
of the World
around Us

Mitwelt
Common
Cultural
Experiences

Uberwelt
Spiritual Self

Personal Identity, the *Interpersonal Model of Racial Identity*, *Developmental Models of Cultural and Racial Identity*, and the *White Identity Development Model*.

Existential Model of Identity

One of the first attempts to understand the individual from a cross-cultural perspective was given to us by the existential therapists who believed, and continue to believe, that the individual can be examined in a number of spheres (Binswanger, 1963; van Deurzen, 2002). Using German words from the early existential philosophers, they suggested that *Eigenwelt* is our psychological world, or how we come to understand ourselves; *Mitwelt* is our common experiences that we share through our culture; *Umwelt* is grounded in our biology and has to do with how we experience the world around us; and *Uberwelt* is the manner in which we relate to our spiritual self, or to the unknown. We all, say the existentialists, have these common concerns or ways of being in the world, and it is only through empathy and understanding that we can come to know each individual in these four essential domains. These common concerns are fluid, in the sense that they all influence each other, and thus we see dashes in the lines on Figure 14.2 representing this notion.

Tripartite Model of Personal Identity

Perhaps borrowing somewhat from the existential model, Sue and Sue (2008) suggest that we understand our client in three spheres: the *Individual Level*, which represents the client's 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 client belongs, 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. 39) (see Figure 14.3).

FIGURE 14.3
The Tripartite Model of Personal Identity

SOURCE: Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley, p. 38.
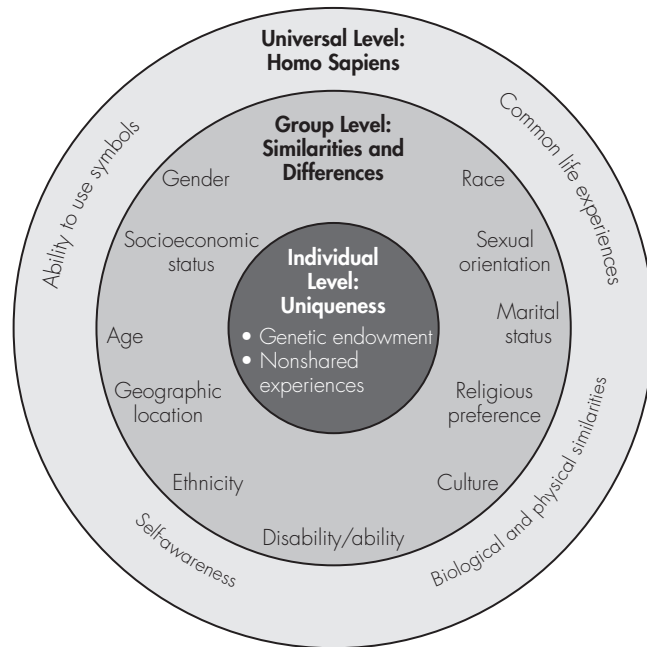
Interpersonal Model of Racial/Cultural Identity

Although most counselors today would agree with the basics of the existential and tripartite models just described, over the years there has been an increased focus on understanding how clients from traditionally oppressed groups might respond in counseling. One such model developed by Bell and Evans (1981) suggests that there are four interpersonal styles. Understanding a client's interpersonal style can give a counselor insight into how a client might respond in counseling.

THE ACCULTURATED INTERPERSONAL STYLE   The acculturated individual rejects, on both conscious and unconscious levels, his or her racial/ethnic or cultural background in order to assimilate into the dominant culture. Uncomfortable with his or her own culture, this individual acts, sounds, and lives a life as if he or she is from the majority culture with the purpose of escaping the oppression of the dominant group. This person experiences self-hate and is uncomfortable with members of his or her own racial/ethnic or cultural group. Counseling around cross-cultural issues is particularly difficult for this person, and he or she is likely to be more comfortable with a counselor from the majority culture.

THE BICULTURAL INTERPERSONAL STYLE   The bicultural individual feels comfortable in his or her cultural group as well as in the majority culture and can flow into and out of either culture. As opposed to the acculturated individual, this person has not rejected

his or her culture but may at times feel a sense of split personality, being torn between the two cultures. Recognizing that all cultures have positive features, this person is often found seeking out experiences from many cultures. This individual feels at ease with a White counselor or a counselor from a nondominant group. Although the counselor will tend to feel comfortable with the bicultural client, at times he or she may not recognize the tension the client feels concerning living in both cultures.

THE CULTURALLY IMMERSED INTERPERSONAL STYLE   Having rejected the majority culture, this individual is convinced that the majority's only goal is to oppress minorities. This person is often called radical, fundamentalist, or militant. A political activist, this person is often very intelligent and views society and those in positions of power as the cause of social problems. This individual may be particularly guarded during counseling sessions, and such sessions will often deteriorate into power plays, especially if the individual is faced with a majority counselor. Counselors who work with culturally immersed clients must focus on why the client came to counseling as opposed to being drawn into discussions around issues of societal oppression.

THE TRADITIONAL INTERPERSONAL STYLE   Being deeply rooted in his or her cultural style, this individual is immersed in the symbols, customs, and traditions of his or her culture. This person does not accept or reject his or her cultural identity—this person knows only this cultural identity. Often, these individuals may be older than the individuals in any of the other three styles. This person is difficult to counsel cross-culturally, as his or her language or dialect may be foreign to the counselor, and the individual usually has little, if any, familiarity with the counseling process.

Developmental Models of Racial/Cultural Identity

In contrast to the *interpersonal model* of racial/cultural identity, *developmental models* examine how specific ethnic and cultural groups pass through unique stages of development as they become increasingly aware of their cultural selves (Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue & Sue, 2008). As an emerging counselor, you may want to examine some of the many different identity models that currently exist, such as those for African Americans, Latinas and Latinos, Native Americans, Asian Americans, Native Hawaiians, Multiracial Individuals, and more.

In addition to these specific models of racial and cultural identity development, generic models that encompass most ethnic groups have been developed. For instance, Atkinson, Morten, and Sue (1998) offer a five-stage model of development that "oppressed people experience as they struggle to understand themselves in terms of their own culture, the dominant culture, and the oppressive relationship between the two cultures" (Sue & Sue, 2008, p. 242). This model moves from complete immersion in the dominant culture, through complete immersion in nondominant cultures, to the final stage in which the individual has pride and acceptance of his or her cultural identity and is able to reject or accept values from other cultures (See Table 14.2). The model helps counselors understand the experience and attitudes that culturally diverse clients hold toward self, toward others from their cultural group, toward individuals from different cultural groups, and toward Whites as they traverse the five stages of development. Using this model, consider how the counseling process might differ for clients from nondominant groups who are at different stages of development. In addition, culturally diverse counselors may want to assess where they fall on this model and how their developmental stage affects their work with clients.

TABLE 14.2

The Racial/Cultural Identity Development Model				
STAGES OF MINORITY DEVELOPMENT MODEL	ATTITUDE TOWARD SELF	ATTITUDE TOWARD OTHERS OF THE SAME MINORITY	ATTITUDE TOWARD OTHERS OF A DIFFERENT MINORITY	ATTITUDE TOWARD DOMINANT GROUP
Stage 1— Conformity	Self-depreciating or neutral due to low race salience	Group-depreciating or neutral due to low race salience	Discriminatory or neutral	Group-appreciating
Stage 2— Dissonance and appreciating	Conflict between self-depreciating and group-appreciating	Conflict between group-depreciating views of minority hierarchy and feelings of shared experience	Conflict between dominant-held and group-depreciating	Conflict between group-appreciating
Stage 3— Resistance and immersion	Self-appreciating	Group-appreciating experiences and feelings of culturocentrism	Conflict between feelings of empathy for other minority	Group-depreciating
Stage 4— Introspection	Concern with basis of self-appreciation	Concern with nature of unequivocal appreciation	Concern with ethnocentric basis for judging others	Concern with the basis of group-depreciation
Stage 5— Integrative awareness	Self-appreciating	Group-appreciating	Group-appreciating	Selective appreciation

White Identity Development

A number of models have been developed to assess the racial consciousness and developmental maturity of White counseling students in their ability to relate to and work with individuals from diverse backgrounds (see D'Andrea & Daniels, 1991, 1999; Hardiman, 1982; Helms, 1984; Ponterotto, 1988). As in the Atkinson, Morten, and Sue model, it is assumed there is a stage progression in the development of racial consciousness that can be identified for White counseling students. Teachers and supervisors can facilitate the movement of students through the stages by developing activities to support and challenge students' self-understanding. Research on White identity models suggests that development of White identity may be positively correlated with one's ability to work with diverse clients (Constantine, Warren, & Miville, 2005; Middleton, et al., 2005; Sciarra, Chang, & McLean, 2005; Vinson & Neimeyer, 2003).

In an effort to find common themes running through some of the more prevalent models in the literature, Sabnani and associates (1991) examined three models of White identity development. They subsequently formed a five-stage model incorporating the basic themes that ran through these models. The three models are listed in Table 14.3 and separated into the five stages as identified by Sabnani and associates. In addition to the

TABLE 14.3

Comparison of Models of White Racial Identity				
	WHITE IDENTITY DEVELOPMENTAL MODEL (HARDIMAN, 1982)	WHITE RACIAL CONSCIOUSNESS DEVELOPMENT MODEL (HELMS, 1984)	RACIAL CONSCIOUSNESS DEVELOPMENT MODEL (PONTEROTTO, 1988)	STAGES OF RACISM DEVELOPMENT MODEL (D'ANDREA & DANIELS, 1991, 1999)**
Stage 1: Preexposure/ precontact	*Lack of social awareness** Presocialization stage marked by unawareness of social expectations and roles. Beginning awareness of racial differences. *Acceptance:* Unconscious identification with whiteness. Acceptance of stereotypes about own group and other groups.	*Contact* Unaware of self as racial being. Oblivious to cultural/racial issues. Naiveté regarding the impact of race on self and others.	*Preexposure* Little thought given to multi-cultural issues or to one's role as a white in an oppressive society. Has not begun to explore own ethnic identity.	*Affective-impulsive* Hostile, illogical ways of thinking. Overt feelings of hostility and aggressiveness toward different racial/ cultural/ethnic backgrounds. Marginal impulse control.
Stage 2: Conflict	*Transition* from *acceptance to resistance* Reexamination of assumptions about whites. Begins to face dissonant issues challenging accepted ideology and self-definition as white. Guilt and anger.	*Contact* and *disintegration* Forced to acknowledge that he or she is white. Caught between white and black culture and between oppression and humanity.	*Exposure* Forced to examine role as white member of U.S. society. Examines his or her own cultural values. Confronted with the realities of race and racism. Guilt and anger.	*Dualistic rational* Dualistic thinking. Superficial politeness but underlying fear and negativity toward individuals from diverse backgrounds. Impulse control over strong feelings—but feelings still persist.
Stage 3: Prominority/ Antiracism	*Resistance* Rejection of internalized racist beliefs and rejection of whiteness. Guilt and anger at having conformed to socialization. Anger at whites and whiteness. Compassion and concern for minorities.	*Disintegration* Overidentification with blacks. Paternalistic attitudes toward blacks.	*Zealot* half of *zealot-defensive* Taking on the minority plight. Maintaining a prominority stance.	*Liberal* Beginning of multiple perspective taking. Expression of liberal views. Despite liberal views and multiple perspective taking, there is little follow-through. Avoidance of advocacy or risk-taking behaviors. Apathetic relative to taking action.
Stage 4: Retreat into White Culture		*Reintegration* Antiblack, prowhite attitudes. Anger, fear.	*Defensive* half of *zealot-defensive* Retreating from multicultural contact and retreating to only same-race relations.	
Stage 5: Redefinition and Integration	*Redefinition* Development of a white identity that transcends racism. Defining whiteness in a way that is not dependent on racism. Recognition that all races are unique. Development of pride in ethnic group membership. *Internalization* Integration of the new white identity into all other aspects of self.	*Pseudo-independence* Intellectual acceptance and curiosity regarding blacks and whites. Internalization of whiteness. *Autonomy* Biculturally or biracially transcendent world view.	*Integration* Greater balance in multicultural interest and endeavors. Renewed interest, respect, and appreciation for cultural differences.	*Principled* Truly relativistic thinker. Mature understanding of social problems. Greater awareness of inner experience and greater ability to express complex thinking regarding racism. Compelled to address social ills personally and professionally, but lack of commitment to work toward deeply rooted systemic change. Principled activistic stage of racism: All of qualities of principled stage person plus: willing to work toward systemic change; compelled to action; hopeful for social reform; tenacious and committed.

three models, I incorporated into their table one additional model developed by D'Andrea and Daniels (1991, 1999), which has recently taken on some prominence. A description of the five stages is followed by an analysis of how different individuals might pass through the stages. If you are White, where do you think you fall on these stages?

Stage 1: Pre-Exposure

In this stage, White graduate students show naiveté and ignorance about multicultural issues. Sometimes, these students believe that racism does not exist or, if it does, 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: Exposure

Students enter this stage when first confronted with multicultural issues. Often this occurs when students take a course in multicultural counseling or encounter multicultural issues as a component of a class. Increasing awareness concerning how racism is embedded in society leads students in this stage to have feelings of guilt over being White, depression with this newfound awareness, and/or anger over the current state of affairs. This stage is often highlighted by a sense of conflict between wanting to maintain majority views and the desire to uphold more humanistically oriented nonracist and nonprejudicial views.

Stage 3: Prominority/Antiracism

With movement into this stage, 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: Retreat to White Culture

In this stage, some White students tend to retreat into their own culture as they experience rejection from some individuals from nondominant groups as they, of course, are dealing with their own identity issues (see Table 14.3). As students enter this stage, intercultural contact is ended because they feel hostile toward and fearful of minorities. The cozy home of the student's culture of origin is feeling quite safe at this point in time.

Stage 5: Redefinition and Integration

Students who enter this stage are developing a worldview of multiculturalism and are integrating this into their identity. Such students are able to feel good about their own identity and their roots, and simultaneously have a deep appreciation of the culture of others. Students in this stage are able to expend energy toward deeply rooted structural changes in society.

Sabnani and associates (1991) note that there are a number of variations in the ways students can move through the stages. A few examples are shown in Figure 14.3. For instance, Student A is stuck in stage 1. As the student is confronted with multicultural issues, perhaps in a course on multicultural counseling, he or she retreats back to

FIGURE 14.4
Examples of Four Students' Movement through Stages of White Racial Identity Development

Student A	Student B	Student C	Student D
Stage 1	Stage 1	Stage 1	Stage 1
Stage 2	Stage 2	Stage 2	Stage 2
	Stage 3	Stage 3	Stage 3
	Stage 4	Stage 4	Stage 4
	Stage 5	Stage 5	Stage 5
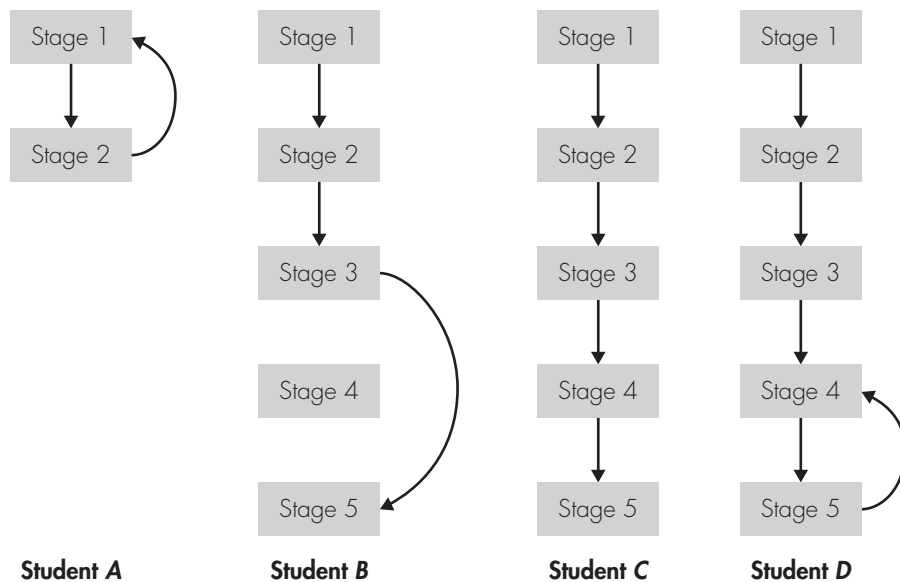
stage 1 behavior, preferring to be in denial about racism and prejudice in society. The change process is too fearful for him or her. Student B moves through the first three stages, does not feel a strong need to retreat into his or her own culture in stage 4, and moves on to stage 5, where the student can feel good about his or her own culture while having an understanding and appreciation for others. Student C, on the other hand, feels a need to retreat as he or she is rejected by some individuals from nondominant groups (stage 4). This student becomes angry, 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 those 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, poke their heads out as they consider moving on to stage 5; but, because they continue to struggle with feelings of rejection and anger, will quickly move back to stage 4. Keep in mind that because this is a developmental model, it is assumed that any student, if given a conducive environment, can move to the higher stages.

Working with Diverse Clients in the Helping Relationship

Understanding our clients is certainly a critical first step in working with clients, and allows us to view clients from a perspective that we may not have previously. However, after understanding our clients, it is critical that we have some ways to apply this

understanding. Two ways of working with clients include using the *RESPECTFUL* acronym and applying the *Multicultural Counseling Competencies*.

Using the RESPECTFUL Acronym

If you remember from Chapter 1, 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 client's Language and location of residence (D'Andrea & Daniels, 2005).

Using the Multicultural Counseling Competencies

In addition to the RESPECTFUL acronym, the Association for Multicultural Counseling and Development (AMCD), ACA, and other counseling associations have endorsed the *Multicultural Counseling Competencies* that were mentioned earlier in the chapter. These competences focus on the importance of counselors having: (1) the appropriate *attitudes and beliefs* in the sense that they are aware of their assumptions, values, and biases, (2) the *knowledge* needed about their clients' culture so that they can better understand their clients, and (3) a repertoire of *skills* or tools that can be effectively applied to clients from diverse backgrounds (Arredondo, 1999; Sue & Sue, 2008). Let's examine each of these areas in a little more detail.

Attitudes and Beliefs

The effective cross-cultural counselor has an awareness of his or her own cultural background and has actively pursued gaining further awareness of his or her own biases, stereotypes, and values. Although the effective cross-cultural counselor may not hold the same belief system as his or her client, he or she can accept differing worldviews as presented by the helpee. In other words, "Differences are not seen as being deviant" (Sue & Sue, 2008, p. 48). Being sensitive to differences and tuned into his or her own cultural biases allows the effective cross-cultural counselor to refer a client from a nondominant group to a counselor of the client's own culture when a referral will benefit the helpee. Unfortunately, examples of how mental health professionals have failed clients who are culturally different from themselves as a result of their own biases and prejudices are common (Sue & Sue, 2008) (see Box 14.2).

Knowledge

The effective cross-cultural counselor has knowledge of the group from which the client comes and does not jump to conclusions about the client's ways of being. In addition, he or she shows a willingness to gain greater depth of knowledge of various cultural groups. This counselor is also aware of how sociopolitical issues such as racism, sexism, and heterosexism can negatively affect clients. In addition, this counselor knows how different theories of counseling carry values that may be detrimental for some clients in the counseling relationship. This counselor understands how institutional barriers can affect the willingness of clients from nondominant groups to use mental health services. Unfortunately, lack of knowledge of a cultural group can cause counselors and others to jump to incorrect conclusions (see Box 14.3).

BOX 14.2

Lack of Awareness of Own Biases and Prejudices

Robertiello and Schoenewolf (1992) note a number of mistakes that were made by helpers due to their lack of awareness of their own biases:

1. The liberal White therapist who refuses to deal with a Black client's mistrustful and suspicious dreams of him due to the helper's denial of the tension in the relationship.

2. The feminist helper who blindly encourages her client to leave her husband because he is a batterer. The client leaves her husband but ends up in another battering situation because the helper did not examine the part the woman was playing in picking abusive men.

3. The helper who reassures her client that the client's homosexual feelings do not mean she is a lesbian. The helper does this out of fear of dealing with the client's sexuality and instead tries to ignore the subject. The client may or may not be homosexual, but reassuring her that she is not does not allow the client to explore her sexuality.

4. The helper who refuses to hear her client's atheistic views because they are contrary to her own religious beliefs. This has the effect of cutting off meaningful conversations in other areas because the client loses trust in the helper.

BOX 14.3

Lack of Knowledge: Blackbirds Sitting in a Tree

A White female elementary school teacher in the United States posed a math problem to her class one day. "Suppose there are four blackbirds sitting in a tree. You take a slingshot and shoot one of them. How many are left?" A White student answered quickly, "That's easy. One subtracted from four is three." An African immigrant youth then answered with equal confidence, "Zero." The teacher chuckled at the latter response and stated that the first student was right and that, perhaps, the second student should study more math. From that day forth, the African student seemed to withdraw from class activities and seldom spoke to other students or the teacher. . . .

If the teacher had pursued the African student's reasons for arriving at the answer zero, she might have heard the following: "If you shoot one bird, the others will fly away." Nigerian educators often use this story to illustrate differences in world views between United States and African cultures. The Nigerians contend that the group is more important than the individual, that survival of all depends on interrelationships among the parts. . . . (from Sue, 1992, pp. 7–8)

Skills

The cross-culturally effective 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 clients from diverse cultural groups. This counselor also has knowledge of and understands the verbal and nonverbal language of the client and can communicate effectively. In addition, the culturally skilled helper appreciates the importance of having a systemic perspective, such as an 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. What happens when a counselor does not have the appropriate skills when working with a culturally diverse client? Most

BOX 14.4

Lack of Awareness of Own Biases and Prejudices

A female [Asian] client complained about all kinds of physical problems such as feeling dizzy, having a loss of appetite, an inability to complete household chores, and insomnia. She asked the therapist if her problem could be due to "nerves." The therapist suspected depression since these are some of the physical manifestations of the disorder and asked the client if she felt depressed and sad. At this point, the client paused and looked confused. She finally stated that she felt very ill and that these physical problems were making her sad. Her perspective was that it was natural for her to feel sad when sick. As the therapist followed up by attempting to determine if there was a family history of

depression, the client displayed even more discomfort and defensiveness. Although the client never directly contradicted the therapist, she did not return for the following session. (Tsui & Schultz as cited in Sue & Sue, 2008, p. 366)

If this counselor had the appropriate knowledge and skills, he would have known that for Asian clients the mind and body are inseparable, and physical complaints are a common and acceptable means of expressing emotional problems. An appropriate response to this client would have been to focus on the somatic complaints and suggest physical treatments prior to working on emotional problems. (Sue & Sue, 2008)

likely, the client will drop out of counseling early, feel discouraged and dissatisfied with counseling, and/or have little success in counseling (see Box 14.4).

As you can see by the example in Box 14.4, there is a close connection between our beliefs about culturally diverse clients, our knowledge base regarding such clients, and our effective use of skills.

Multicultural/Social Justice Focus

Multicultural Counseling as the "Fourth Force"

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. 223)

In 1996, Essandoh wrote an article that raised the possibility that multicultural counseling could be representing a new paradigm in the counseling profession—a *fourth force*, following the first three forces in our profession: psychoanalysis, behaviorism, and humanistic psychology. Today, there is little doubt that his prediction was correct. For instance, one study showed that from 1990-2001 there were 102 multicultural-centered articles in the *Journal of Counseling and Development* alone (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). And since that time, the rate of articles in this area has increased. Another study demonstrated that in the past 20 years, there have been 75 articles that researched the *Multicultural Counseling Competencies* (Worthington, Soth-McNett, & Moreno, 2007). Also, one other study showed that there has been a large increase in the number of multicultural counseling outcome research articles (D'Andrea & Heckman, 2008b). In addition, texts and coursework on multicultural counseling have increased tremendously.

Despite these strides, many suggest that we are just at the beginning of this journey (e.g., Arredondo, Tovar-Blank, & Parham, 2008; Atkinson & Israel, 2003; D'Andrea & Heckman, 2008a). They advocate for better and more focused training, research that more effectively examines the efficacy of different approaches to multicultural counseling, counselors increasingly looking at their own resistance toward working with clients of color, and that our profession spend more time devising mechanisms that can highlight and reinforce this new paradigm. Clearly, we have come a long way, but have a ways to go.

Can We Have Multicultural Counseling Without Social Justice Action?

Social justice counseling includes empowerment of the individual as well as active confrontation of injustices and inequality in society because they affect clientele as well as those in their systemic contexts. (Crethar, Rivera, & Nash, 2008, p. 270)

It used to be that multicultural counseling was solely focused on how to counsel diverse clients. However, as this new paradigm has unfolded, it has become abundantly clear that there is a thin line between being a counselor for a client and advocating for a client. When we see that our clients are being mistreated, oppressed, and harassed, we no longer can remain idly by in our offices and do nothing. As is evidenced by the recent *Advocacy Competencies* (Toporek, Lewis, & Crethar, 2009) (see Chapter 3), counselors have a calling to periodically step out of the safety of their offices and work for systemic change—change that will help our clients in broad and significant ways. For instance, we often get notices asking us to advocate for a law that will better the conditions of nondominant groups and those with mental health problems. Unfortunately, many of us are used to sitting around and letting others do the work. Next time you have a chance—take a stand, do something, advocate, push for change, and be a voice in the field.

Ethical, Professional, and Legal Issues

Standards and Multicultural Counseling

Increasingly, every standard, competency, and guideline within the counseling profession has addressed multicultural issues. The following briefly describes some of these.

ETHICAL CODE   The last revision of ACA's *Code of Ethics* (ACA, 2005) took particular aim at addressing multicultural issues. Throughout the code, counselors are reminded to consider how cross-cultural issues affect the counseling relationship, the diagnosis of the client, research that is conducted, and assessment instruments that are used (see Table 14.4). In addition, this code removed aspects that were deemed to not be cross-culturally sensitive. For instance, whereas the earlier ACA code stressed the importance of client autonomy, this code lessens its significance, recognizing that in some cultures collectivism takes precedence over autonomy. Also, whereas past codes have stressed the importance of not having a dual relationship, this code suggests considering the impact that "multiple relationships" might have on the client and recognize that in some areas of the country, it is difficult to avoid dual relationships and in some cultures, dual relationships are considered appropriate.

T A B L E 14.4

Select Subsections that Address Diversity in ACAs 2005 Code	
A. Counseling Relationship	**A.2.c. Developmental and Cultural Sensitivity**. Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.
	A.4.b. Personal Values. Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.
B. Confidentiality, Privileged Communication, and Privacy	**B.1.a. Multicultural/Diversity**. Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.
C. Professional Responsibility	**C.5. Nondiscrimination.** Counselors do not condone or engage in discrimination 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. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.
E. Evaluation, Assessment, and Interpretation	**E.5.a. Proper Diagnosis.** Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.
	E.5.b. Cultural Sensitivity. Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders.
	E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology. Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.
	E.6.c. Culturally Diverse Populations. Counselors are cautious when selecting assessments for culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for the client population.
	E.8. Multicultural Issues/Diversity in Assessment. Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors.
F. Supervision, Training, and Teaching	**F.6.b. Infusing Multicultural Issues/Diversity.** Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.
	F.11.a. Faculty Diversity. Counselor educators are committed to recruiting and retaining a diverse faculty.
	F.11.b. Student Diversity. Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing diverse cultures and types of abilities students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.
	F.11.c. Multicultural/Diversity Competence. Counselor educators actively infuse multicultural/ diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice. Counselor educators include case examples, role-plays, discussion questions, and other classroom activities that promote and represent various cultural perspectives.

*Additional parts of all the sections of the code also address diversity and generally encourage counselors to take into account the unique values of diverse clients.

CACREP STANDARDS   For a number of years, CACREP has required that programs address "Social and Cultural Issues" within their curriculum. To meet CACREP's requirement, many counselor training programs weaved multicultural perspectives throughout their counseling program, offered a separate course in multicultural counseling, or did both (Arthur & Achenbach, 2002). In recent years, most programs have increasingly moved toward doing both as they have realized the importance of training in multicultural counseling.

MULTICULTURAL COUNSELING COMPETENCIES   Already discussed in this chapter, the *Multicultural Counseling Competencies*, which focus on attitudes and beliefs, knowledge, and skills have become an important training standard in our profession and are described in Appendix A.

ADVOCACY COMPETENCIES   Discussed in Chapter 3 and earlier in this chapter, the *Advocacy Competencies* are relatively new and encompass three areas of competence (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 (e.g., acting on behalf of my client to assist him or her in obtaining needed services, or acting with the client to empower him or her to obtain needed services) (see Figure 3.2 and Appendix B). Advocacy is closely intertwined with multicultural counseling and should be considered one additional aspect of the counselor role.

ASSESSMENT STANDARDS   In the past, assessment instruments have notoriously been known for cross-cultural bias. However, with the advent of the computer, it has become much easier to assess for problems with assessment instruments, including problems related to cross-cultural fairness. However, that does not mean that such instruments, and the people who administer them, are immune to cross-cultural bias. To help address such bias, a number of assessment standards have been created that ask those who create, administer, and interpret assessment instruments to consider problems related to the assessment of individuals from nondominant groups (Neukrug & Fawcett, 2011; see Chapter 12).

Training Models and Checklists

Training models are increasingly being developed to ensure that students are working effectively with culturally different clients ("First annual . . . ," 2003). For instance, one model speaks of the importance of an immersion activity that allows students enough time to experience and reflect on another culture (e.g., spend a few weeks attending an all-Black church) (DeRicco & Sciarra, 2005). Another model, called the *triad model*, was developed by Pedersen (2001; Seto, Young, Becker, & Kiselica, 2006) and suggests that the client, the counselor, an *anticounselor*, and a *procounselor* all meet together during an interview. The procounselor and anticounselor give continual and immediate feedback to the counselor in an effort to increase the counselor's ability to understand the client's perspective, recognize client resistance, recognize the counselor's defensiveness, and learn how to recover from mistakes that the counselor might make during the interview. Training models such as DeRicco and Sciarra's, and Pedersen's, offer innovative and challenging ways to stimulate students' learning of cross-cultural counseling skills.

Ponterotto, Alexander, and Grieger (1995) offer a checklist to assess whether or not programs meet minimum competencies and standards for training in multicultural

counseling. Your professor may want to review this checklist and discuss whether your program addresses multicultural competencies and standards. Finally, research abounds in this area and it is common these days to see new checklists and inventories that assess counselor cross-cultural competency.

Association for Multicultural Counseling and Development

In an effort to supply leadership for helping professionals in the area of multicultural counseling, the Association of Multicultural Counseling and Development (AMCD), a division of ACA, provides workshops, graduate program training standards in multicultural counseling, and publications, such as the *Journal of Multicultural Counseling and Development.* If you have a particular interest in multicultural counseling, training, and research, you might consider joining AMCD (go to www.amcdaca.org).

Knowledge of Legal Trends

In just about every chapter of this text, you will find some legislative initiative that addresses multicultural concerns, and every year new laws are passed and old ones are amended. Counselors need to have intimate knowledge of the law and how it affects the culturally different client if they are to (1) assist the client in advocating for his or her rights; (2) be an advocate for the client; (3) campaign for legislative initiatives on the local, state, and national level; and (4) protect themselves from potential malpractice suits.

The Counselor in Process: Working with Culturally Different Clients

Sue and Sue (1999) note that working with culturally different clients should be viewed as a constantly changing process. In this context, they state that the helping relationship "is an active process, that it is ongoing, and that it is a process that never reaches an end point. Implicit is recognition of the complexity and diversity of the client and client populations, and acknowledgment of our own personal limitations and the need to always improve" (p. 227).

One way that counselors can ensure that they are continually improving their ways of interacting with clients from diverse backgrounds is through supervision (Estrada, Frame, & Williams, 2004; Ober, Granello, & Henfield, 2009). Although supervision is crucial throughout the counselor's professional life, with clients from nondominant groups having higher dropout rates from counseling and being less satisfied with counseling, adequate supervision of cross-cultural counseling relationships becomes even more critical. Counselors must ensure that they are reaching all of their clients. They cannot idly stand by and assume that their work with clients from diverse cultures is as effective as their work with majority clients.

Summary

This chapter reviewed theoretical and practical issues related to multicultural counseling. We started by noting that there is not one hard and fast definition of multicultural counseling but suggested one that is encompassing of a client's individual, group, and universal

identities and that the counselor should take into account individualism and collectivism in making assessment, diagnosis, and treatment decisions. This definition also highlighted the importance of culture specific and universal techniques in reaching client goals. We also pointed out that *Multicultural Counseling Competencies* have been developed by the profession to help in the training of counselors and that such training is often focused on attitudes and beliefs, knowledge, and skills in three areas: (1) counselor self-awareness of assumptions, values, and biases, (2) knowledge of the world view of the culturally different client, and (3) familiarity with intervention strategies and techniques.

We next discussed some of the reasons why multicultural counseling has become so important. We first pointed out the fact that we live in the most diverse country in the world, and offered some statistics highlighting this. Despite being a multicultural nation (or perhaps because of it), we noted that many clients from nondominant groups are misdiagnosed, dissatisfied with counseling, and drop out of counseling at high rates. We then noted why nondominant clients sometimes have been poorly served by counselors, including the fact that some counselors (1) view this country as a melting pot instead of a cultural mosaic, (2) have incongruent expectations about counseling, (3) de-emphasize social forces, (4) have an ethnocentric worldview, (5) are ignorant of their own prejudices, (6) are unable to understand that the expression of symptomatology is often a function of culture, (7) misjudge the accuracy of assessment and research instruments, and (8) are unaware of how institutional racism affects the counseling process.

In an effort to give us common ground on which to communicate, a number of words and terms were defined in this chapter. Thus, we defined: culture; discrimination and microaggressions; ethnicity; minority and nondominant group; power differentials; race; religion and spirituality; sexism, heterosexism, and sexual prejudice; sexual orientation; social class ("class"); and stereotypes, prejudice, and racism. We also discussed words and terms that are generally used to describe various cultural groups in the United States.

In this chapter, a number of conceptual models were offered to help us better understand our work with clients from diverse backgrounds. We first briefly described the existential model, which includes understanding our client in four realms: Eigenwelt, our psychological world; Mitwelt, our common experiences; Umwelt, our experience of the world around us; and Uberwelt, our spiritual self. Next, we described the tripartite model of personal identity, which suggests that we understand our clients in three spheres: the Individual Level, which represents the client's 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 client belongs; and the Universal Level, which is related to common experiences (e.g., physical similarities, life experiences, and self awareness).

We next described Bell and Evans' interpersonal model of racial/cultural identity, which could help us understand how a client might respond in counseling. We noted that they identified four styles of relating to the world, which included the acculturated, bicultural, culturally immersed, and traditional interpersonal styles. Offering a developmental perspective, we suggested that a number of models have been developed to help us understand clients from different ethnic/cultural groups. One generic model we looked at was developed by Atkinson, Morten, and Sue who proposed a five-stage model of racial/cultural development, which included conformity, dissonance, resistance and immersion, introspection, and synergetic awareness and integration.

Whereas racial/cultural developmental models help the counselor understand the client from nondominant groups and can assist culturally diverse counselors in understanding

themselves, models of White identity development help the White graduate student in counseling understand how he or she might react to clients from nondominant groups. Finding common themes running through three models of White identity, Sabnani and colleagues (1991) developed a stage model through which White students might typically pass as they go through graduate school. The stages included pre-exposure, exposure, prominority/antiracism, retreat to White culture, and redefinition and integration. We looked at how four White identity models could be explained using these stages.

As the chapter continued, we took a look at how the "RESPECTFUL" acronym and the *Multicultural Counseling Competencies* are both important to our ability to work effectively with clients from diverse backgrounds. Relative to the competencies, we noted the importance of counselors having (1) the appropriate attitudes and beliefs in the sense that they are aware of their assumptions, values, and biases, (2) the knowledge needed about their clients' culture so that they can better understand their clients, and (3) a repertoire of skills or tools that can be effectively applied to clients from diverse backgrounds.

Focusing on multicultural and social justice issues, we noted that multicultural counseling has become the "fourth force" in the counseling profession, following psychoanalysis, behaviorism, and humanistic psychology. We pointed out that despite great strides, we still have a ways to go in the training of culturally competent counselors. We also noted that today, multicultural counseling includes social justice action, and that counselors must advocate for clients if it seems like such advocacy would benefit the client.

Highlighting the push toward more and better standards in multicultural counseling, we noted that a number of standards now stress this important area including: ACAs *Code of Ethics,* the CACREP standards, the *Multicultural Counseling Competencies,* the *Advocacy Competencies,* and a wide range of assessment standards. We also noted that a number of training models are now being used to help students become culturally competent such as immersion activities and the Triad Model. We also noted that a number of checklists and inventories have been developed to examine whether programs meet minimum competencies for training in multicultural counseling.

Near the end of the chapter we highlighted some of the important activities of the Association of Multicultural Counseling and Development (AMCD), a division of ACA. We also noted the fact that many laws now protect minority clients, and counselors need to have intimate knowledge of legal issues if they are to best serve their clients and be advocates for multicultural issues.

Finally, we concluded the chapter by presenting Sue and Sue's (1999) belief that multicultural counseling is a constantly changing process that is active, ongoing, and never ending. We discussed the significance of obtaining supervision when working with diverse clients and noted the importance of actively working to be effective with all of our clients.

▪ *References*

Adam, B. D. (2007). Homophobia and heterosexism. In R. George, (Ed.), *Blackwell Encyclopedia of Sociology*. Retrieved from: http://www.blackwellreference.com.proxy.lib.odu.edu/subscriber/uid=2165/tocnode?query=heterosexism&widen=1&result_number=1&from=search&fuzzy=0&type=std&id=g9781405124331_chunk_g978140512433114_ss1-43&slop=1

American Counseling Association. (2005). *Code of ethics.* Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling and Development, 77*(1), 102–108.

Arredondo, P., Rosen, D., Rice, T., Perez, P., & Tovar-Gamero, Z. (2005). Multicultural counseling: A 10-year content analysis of the Journal of Counseling and Development. *Journal of Counseling and Development, 83*(2), 155.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42–78.

Arredondo, P., Tovar-Blank, Z., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling and Development, 86,* 261–268.

Arthur, M. M. L. (2007). Race. In G. Ritzer (Ed.), *Blackwell Encyclopedia of Sociology.* Retrieved from http://www.blackwellreference.com/subscriber/tocnode?id=g9781405124331_chunk_g978140512433124_ss1-1

Arthur, N. & Achenbach, K. (2002). Developing multicultural counseling competencies through experiential learning. *Counselor Education and Supervision, 42*(1), 2–14.

Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American Minorities: A Cross Cultural Perspective* (5th ed.). Dubuque, IA: Wm. C. Brown Publishers.

Atkinson, D. R. (2004a). Defining populations and terms. In D. R. Atkinson (Ed.), *Counseling American minorities* (6th ed., pp. 3–26). Boston: McGraw-Hill.

Atkinson, D. R. (2004b). Within-group differences among ethnic minorities. In D. R. Atkinson (Ed.), *Counseling American minorities* (6th ed., pp. 27–56). New York: McGraw-Hill.

Atkinson, D., & Israel, T. (2003). The future of multicultural counseling competence. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Lieu, & R. Toporek (Eds.), *Handbook of multicultural competencies: In counseling and psychology* (pp. 591–606). Thousand Oaks, CA: Sage.

Bell, P., & Evans, J. (1981). *Counseling the Black client: Alcohol use and abuse in Black America.* Center City, MN: Hazelden Educational Services.

Binswanger, L. (1963). *Being-in-the-world: Selected papers.* New York: Basic Books.

Black, D., Gates, G., Sanders, S., & Taylor, L. (2000). Demographics of the gay and lesbian population in the United Sates: Evidence from available systematic data sources. *Demography, 37*(2), 139–154.

Buckley, T. R., & Franklin-Jackson, C. F. (2005). Diagnosis in racial-cultural practice. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (vol. 2, pp. 286–296). Hoboken, NJ: John Wiley.

Center for Disease Control. (2002). *Key statistics from the national survey of family health.* Retrieved from www.cdc.gov/nchs/nsfg/abc_list_s.htm

Cipriani, R. (2007). Religion. In R. George, (Ed.), *Blackwell Encyclopedia of Sociology.* Retrieved from http://www.blackwellreference.com/subscriber/tocnode?id=g9781405124331_chunk_g978140512433124_ss1-48

Constantine, M. G., Smith, L., Redington, R. M., & Owens, D. (2008). Racial microaggressions against Black counseling and counseling psychology faculty: A central challenge in the multicultural counseling movement. *Journal of Counseling and Development, 86*(3), 348–355.

Constantine, M. G. & Sue, D. W. (2005). *Strategies for building multicultural competence in mental health and educational settings.* Hoboken, NJ: John Wiley.

Constantine, M. G., Warren, A. K., & Miville, M. L. (2005). White racial identity dyadic interactions in supervision: Implications for supervisees' multicultural counseling competence. *Journal of Counseling Psychology, 52*(4), 490–496.

Crethar, H., Rivera, E., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist, and social justice counseling paradigms. *Journal of Counseling and Development, 86*(3), 269–278.

D'Andrea, M., & Daniels, J. (1991). Exploring the different levels of multicultural counseling training in counselor education. *Journal of Counseling and Development, 70,* 78–85.

D'Andrea, M., & Daniels, J. (1999). *Exploring the psychology of White racism through naturalistic inquiry. Journal of Counseling and Development, 77*(1), 93–101.

D'Andrea, M., & Daniels, J. (2005, July). A socially responsible approach to counseling, mental health care. *Counseling Today,* 36–38.

D'Andrea, M., & Heckman, E. F. (2008a). Contributing to the ongoing evolution of the multicultural counseling movement: An introduction to the special issue. *Journal of Counseling and Development, 86,* 259–260.

D'Andrea, M., & Heckman, E. F. (2008b). A 40-Year Review of Multicultural Counseling Outcome Research: Outlining a Future Research Agenda for the Multicultural Counseling Movement. *Journal of Counseling and Development,* 86(3), 356–363.

Debunking the concept of race. (2005, July 30). Editorial Page Editor, *New York Times,* A28.

DeRicco, J. N., & Sciarra, D. T. (2005). The immersion experience in multicultural counselor training: Confronting covert racism. *Journal of Multicultural Counseling and Development, 33*(1), 2–16.

Essandoh, P. K. (1996). Multicultural counseling as the "fourth force": A call to arms. *Counseling Psychologist, 24,* 126–138. doi:10.1177/0011000096241008

Estrada, D., Frame, M. W., & Williams, C. B. (2004). Cross-cultural supervision: Guiding the conversation toward race and ethnicity. *Journal of Multicultural Counseling and Development, 32,* 307–319.

Evans, A. C., Delphin, M., Simmons, R., Omar, G., & Tebes, J. (2005). Developing a framework for culturally competent systems care. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (vol. 2, pp. 492–513). Hoboken, NJ: John Wiley.

First annual diversity challenge: "How to survive teaching courses on race and culture." (2003). [Special section]. *Journal of Multicultural Counseling and Development, 31*(1).

Hardiman, R. (1982). White identity development: A process-oriented model for describing the racial consciousness of White Americans. *Dissertation Abstracts International, 43,* 104A (University Microfilms No. 82-10330).

Helms, J. E. (1984). Toward a theoretical model of the effects of race on counseling: A black and white model. *The Counseling Psychologist, 12,* 153–165. doi:10.1177/0011000084124013

Herek, G. M. (2000). The psychology of sexual prejudice. *Current Directions in Psychological Science, 9*(1), 19–22. doi:10.1111/1467-8721.00051

Jenkins, R. (2007). Ethnicity. In R. George (Ed.), *Blackwell Encyclopedia of Sociology.* Retrieved from http://www.blackwellreference.com/subscriber/tocnode?id=g9781405124331_chunk_g978140512433111_ss1-68

Jennings, L. (2007). Prejudice. In R. George (Ed.), *Blackwell Encyclopedia of Sociology.* Retrieved from http://www.blackwellreference.com.proxy.lib.odu.edu/subscriber/uid=2165/tocnode?id=g9781405124331_chunk_g978140512433122_ss1-97

Kluckhohn, C., & Murray, H. A. (Eds.). (1948). *Personality in nature, society, and culture.* New York: Alfred A. Knopf.

Kosmin, B. A., & Keysar, A. (2008). *American Religious Identification Survey.* Hartford, CO: Trinity College.

Kuriansky, J. (2008). A clinical toolbox for cross-cultural counseling and training. In U. P. Gielen, J. G. Draguns, & J. M. Fish (Eds.), *Principles of multicultural counseling and therapy.* New York: Routledge.

Law, I. (2007). Discrimination. In R. George (Ed.), *Blackwell Encyclopedia of Sociology.* Retrieved from http://www.blackwellreference.com/subscriber/tocnode?id=g9781405124331_chunk_g98140512433110_ss2-27

Lum, D. (2004). *Social work practice and people of color: A process-stage approach* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Macionis. J. J. (2009). *Sociology* (13th ed.). Upper Saddle River, NJ: Prentice Hall.

McAuliffe, G. (2008). What is culturally alert counseling? In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 2–44). Los Angeles: Sage Publications.

McAuliffe, G., Goméz, E., & Grothaus, T. (2008). Race. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp 105–145). Los Angeles: Sage Publications.

Middleton, R., Stadler, H., Simpson, C., Guo, Y., Brown, M., Crow, G., …Lazarte, A. A. (2005). Mental health practitioners: The relationship between White racial identity attitudes and self-reported multicultural counseling competencies. *Journal of Counseling and Development, 83*(4), 444–456.

National Human Genome Research Project. (2010). *From blueprint to you.* Retrieved from http://www.genome.gov/Pages/Education/Modules/BluePrintToYou/BlueprintCoverto2.pdf

Neukrug, E. S., & Fawcett, R. C. (2011). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (2nd ed.). Belmont, Ca: Brooks/Cole.

Neukrug, E., & Milliken, T. (2011). Counselors' perceptions of ethical behaviors. *Journal of Counseling and Development, 89,* 206–217.

Ober, A., Granello, D., & Henfield, M. (2009). A synergistic model to enhance multicultural competence in supervision. *Counselor Education and Supervision, 48*(3), 204–221.

Pedersen, P. B. (2001). Triad counseling. In R. Corsini (Ed.), *Handbook of innovative psychotherapies* (2nd ed., pp. 704–714). New York: Wiley.

Pedersen, P. B., Crethar, H., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy.* Washington, DC: American Psychological Association.

Ponterotto, J. G. (1988). Racial consciousness development among white counselor trainees: A stage model. *Journal of Multicultural Counseling and Development, 16*(4), 145–156.

Ponterotto, J. G., Alexander, C. M., & Grieger, I. (1995). A multicultural competency checklist for counseling programs. *Journal of Multicultural Counseling and Development, 23,* 11–20.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling* (3rd ed., Section IV). Thousand Oaks, CA: Sage.

Robertiello, R. C., & Schoenewolf, G. (1992). *Common therapeutic blunders: Countertransference and counterresistance in psychotherapy.* Northvale, NJ: Jason Aronson.

Roysircar, G., Arredondo, P., Fuertes, J. N., Ponterotto, J. G., & Toporek, R. L. (Eds.). (2003). *Multicultural counseling competencies 2003.* Alexandria, VA: Association for Multicultural Counseling and Development.

Sabnani, H. B., Ponterotto, J. G., & Borodovsky, L. G. (1991). White racial identity development and cross-cultural counselor training: A stage model. *The Counseling Psychologist, 19*(1), 76–102. doi: 10.1177/0011000091191007

Sandhu, D. S. (1997). Psychocultural profiles of Asian and Pacific Islander Americans: Implications for counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 25*(1), 7–22.

Sciarra, D., Chang, T., & McLean, R. (2005). White racial identity and attitudes toward people with disabilities. *Journal of Multicultural Counseling and Development, 33*(4), 232–242.

Seto, A., Young, S., Becker, K., & Kiselica, M. (2006). Application of the triad training model in a multicultural counseling course. *Counselor Education and Supervision, 45*(4), 304–318.

Sewell, H. (2009). *Working with ethnicity, race and culture in mental health.* Philadelphia: Jessica Kingsley Publishers.

Spillman, L. (2007). "Culture." In G. Ritzer (Ed.) *Blackwell Encyclopedia of Sociology.* Retrieved from www.blackwellreference.com/subscriber/tocnode?id=g9781405124331_chunk_g97814051243319_ss1-183

Sue, D. W. (1992). The challenge of multiculturalism: The road less traveled. *American Counselor, 1*(1), 6–15.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* New York: Wiley.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

Sue, D. W., & Torino, G. C. (2005). Racial-cultural competences: Awareness, knowledge and skills. In Carter, R. T. (Ed.), *Handbook of racial-cultural psychology and counseling: theory and research* (pp. 3–18). Hoboken, NJ: Wiley.

Suzuki, L. A., Kugler, J. F., & Aguiar, L. J. (2005). Assessment practices in racial-cultural psychology. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (vol. 2, pp. 297–315). Hoboken, NJ: John Wiley.

The Pew Forum on Religion and Public Life (2009). *Results from the 2009 annual religion and public life survey.* Retrieved from http://people-press.org/reports/pdf/542.pdf

Toporek, R. L., & Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling and Development, 87,* 260–268.

United States Census Bureau. (2009). *Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2000 to July 1, 2009* (NC-EST2009-03). Retrieved from http://www.census.gov/popest/national/asrh/NC-EST2009-srh.html

United States Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report to the Surgeon General.* Retrieved from http://download.ncadi.samhsa.gov/ken/pdf/SMA-01-3613/sma-01-3613.pdf

United States Department of Justice. (2008). *Hate crime statistics.* Retrieved from http://www.fbi.gov/ucr/hc2008/data/table_01.html

van Deurzen, E. (2002). *Existential counseling and psychotherapy in practice* (2nd ed.). London: Sage publications.

Vinson, T. W., & Neimeyer, G. J. (2003). The relationship between racial identity development and multicultural counseling competency: A second look. *Journal of Multicultural Counseling and Development, 31,* 262–277.

Whitfield, W., McGrath, P., & Coleman, V. (1992, October). *Increasing multicultural sensitivity and awareness.* Symposium presented at the Annual Conference of the National Organization for Human Service Education, Alexandria, VA.

Worthington, R., Soth-McNett, A., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, *54*(4), 351–361. doi:10.1037/0022-0167.54.4.351

Knowledge and Skills of Multicultural Counseling

You scorn us, you imitate us, you blame us, you indulge us, you throw up your hands, you tell us you have all the answers, now shut up and listen. (Lamar, 1992, p. 90)

Within our borders there are a large number of cultural/ethnic groups, each with its own unique story. Each story reflects the group's identity and offers us a picture of how it has been assimilated into the broader culture we call the United States. For instance, when editing this chapter, I was astounded and ashamed by the number of slaves who died coming over to this country and how Japanese people were interned in the United States during the Second World War. I was reminded of the strong nationalism felt by many Latinos/Latinas and of the uniqueness of each American Indian tribe. I read again the fact that most gays do not live a "gay and lesbian lifestyle" and that there are some very distinct skills one may want to consider when counseling women and when counseling men. I was taken aback by the number of hate crimes that continue to be perpetrated against nondominant groups, and I was reminded of the many, many different religions across this land that hold deeply different beliefs. Finally, I remembered that each of us has special needs that can be addressed in the counseling relationship if the counselor wants to take the time to find out what those needs are.

Although we should not assume that if a person comes from a nondominant group he or she shares the perceived characteristics of that group, we should realize that knowledge about different groups could assist us in understanding individuals who do share a common story. The fact is that most of us are blind to the history and cultural values of many of the cultural/ethnic groups outside of our own sphere. Therefore, this chapter is designed to give you a taste of the history and culture of some diverse groups while stimulating your interest in multicultural counseling. We cannot touch on all diversity in America, for to do so would require much more than one chapter. However, we can spend a little time

focusing on some of the groups of people that have been most obviously discriminated against. Finally, by noting special issues and identifying counseling strategies unique to the groups identified, we will attempt to offer you ways in which you can optimally work with clients from diverse groups.

After discussing a number of cultural/ethnic groups, we will examine the debate in the profession concerning whether one need be knowledgeable of all cultures when doing counseling. Near the end of the chapter, we will discuss the American Counseling Association's (ACA) ethical code, its relevance to cross-cultural counseling, and ethical decision making from a cross-cultural perspective. We will conclude the chapter by considering the future of cross-cultural counseling. But first, let's look at just how diverse we are!

The Changing Face of America

America is the most diverse country in the world and is becoming increasingly more so. In fact, today, over 33% of Americans are racial and ethnic minorities, and nondominant groups are expected to become the majority by the year 2042 (United States Census Bureau, 2008). By the year 2050, the makeup of America will be quite different than it is today (see Figure 15.1).

The changing demographics highlighted in Figure 15.1 are a function of a number of factors, including higher birth rates of culturally diverse populations, the fact that most immigrants no longer come from Western countries, and immigration rates that are the largest in American history. Today, the great majority of immigrants are Latin American (53.6%) and Asian (26.8%) (United States Census Bureau, 2010) as compared to past immigrants who were mostly White European, and they have a greater tendency to want to assert their cultural heritage rather than be swallowed up by the Western-based American culture. In actuality, this has always been the case, as Italian Americans, Irish

FIGURE 15.1
Changes in Population by Race/Cultural Background
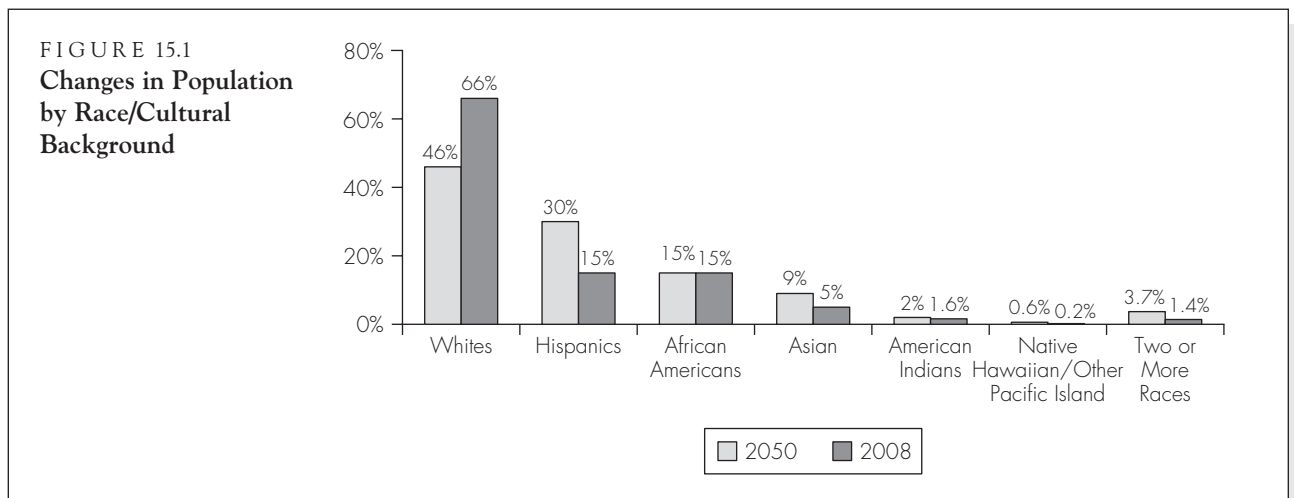
Americans, Jewish Americans, German Americans, and others all developed their own communities and maintained their unique heritages when they first came to this country. After all, there is some sense of safety when you live with those who are familiar in a new, yet strange land.

Changes in the racial, ethnic, and cultural makeup of Americans bring with them changes in the religious composition of the country. As increasing numbers of Asians, Latinos/Latinas, and people from the Middle East arrive at our shores, we will more frequently encounter religions that were previously rare in America. But diversity in religion is not only brought to us by our immigrants. Although America is a country that is largely Christian, diversity in Christianity is now greater than ever. From a multitude of generic and mainline Christian faiths, to Roman Catholics who are increasingly varied in their beliefs, to Eastern Orthodox, Mormons, Christian Scientists, Seventh Day Adventists, Amish, Mennonites, and on and on. Christian religion in America is a religious mosaic in and of itself.

In addition to the changing ethnic, cultural, and religious diversity in America, today there are also changes in sex-role identity. The macho male is no longer considered the model for maleness, while expectations concerning the role of women in the workplace and as childcare providers have changed dramatically. Also, in America today we see increased awareness and some increased acceptance of sexual minorities, such as those who are gay, lesbian, bisexual, and transgendered. Whereas in the past many individuals felt a need to hide their sexual preference for fear of discrimination, today we find an increasing number of gays, lesbians, and bisexuals coming out. In addition, changes in federal, state, and local laws as well as a gradual move toward more tolerance of differences have given us an increased sensitivity to and awareness of a number of groups, including individuals who are HIV positive, the homeless and the poor, older persons, the mentally ill, people who are physically challenged, and others. Let's spend a little time examining each of these groups.

Understanding and Counseling Select Culturally Diverse Groups

Imagine a future in which all girls and boys are able and encouraged to form an identity free of sexist, racist, classist, ableist, and heterosexist prejudices and expectations; in which all girls and boys are equally supported to explore their emotional, relational, spiritual, cultural, intellectual, and vocational needs, talents, and capacities, and a future in which girls and boys, women and men, feel safe and free from exploitation, violence, and victimization and are encouraged to thrive within environments of mutual support and encouragement.

(Kees et al., 2005, p. 381)

In the following sections of this chapter, you will read about behaviors, values, and customs that some individuals in a variety of diverse groups tend to embrace as well as some broad guidelines for counseling individuals from these groups. In addition,

each section will highlight important points to consider when counseling an individual from the group being examined. As noted in Chapter 14, when reading this section, remember that effective cross-cultural counselors (1) have examined their own attitudes and beliefs, (2) are knowledgeable in that they are willing to learn about the history and customs of various groups, and (3) have knowledge of many counseling skills and are open to learning specific counseling skills applicable to varying populations.

People from Varying Cultural/Racial Heritages

African Americans

Today there are approximately 42 million Americans of African heritage—almost 14% of the population (United States Census Bureau, 2009a). Of these, nearly 90% are descended from slaves. Conditions in the ships that brought the slaves were deplorable, and it is estimated that 6 to 10 million Africans died in passage (Allen & Turner, 1988). By 1790, 19% of the U.S. population was of African heritage, with this percentage dropping after slave trading was made illegal in 1809. By 1860, 90% of African Americans lived in the South and tended to remain there following the Civil War, becoming sharecroppers or working for White farmers. Restrictive work laws and lack of education made it difficult for Blacks to leave the South, and it wasn't until the early 1900s that they began to move to urban centers in the North where there were hopes of better educational and career opportunities and freedom from increasing violence toward Blacks in the South. However, more recently there has been a reversal of this trend, with better-educated Blacks moving to the South to obtain higher-level jobs.

It was not until the *1964 Civil Rights Act* that we finally saw an end to some of the more overt discrimination in the United States including the remnants of *Jim Crow laws*, which promulgated "separate but equal" status for African Americans in the United States (Evans & George, 2008). These laws, which usually resulted in separate but unequal, seemed like a far cry from the underlying moral principles for which our country stood. Despite the passage of the *Civil Rights Act* and the repeal of the Jim Crow laws, other laws restricting access to education, work, and recreational facilities and generally supporting segregation continued in some states until the early 1970s. With racism and prejudice being endemic throughout American society, it was necessary in 1991 to pass an extension of the *Civil Rights Act* to protect minority workers, particularly African Americans, from discriminatory practices in employment. There is no question that African Americans have been particularly oppressed in this country—and we are all still paying the price for this oppression.

Today, African Americans continue to be confronted with discrimination as is apparent when we see that over 37% of all incidents of hate crimes are perpetrated against African Americans (United States Department of Justice, 2008)! However, most racism, prejudice, and discrimination against African Americans today manifests itself in much more subtle, covert, and unconscious ways (e.g., microaggressions). Although, a large number of African Americans have now assimilated into middle-class America, more subtle forms of oppression are responsible for a large underclass of African Americans who continue to have little opportunity for upward mobility in American society (Evans & George, 2008). We must all take responsibility for the continued oppression and

discrimination against African Americans in today's society and work collectively to end it.

Perhaps more than any other cultural group, African Americans' values are differentially affected as a function of their social class, experiences with racism and other forms of oppression, and the degree to which they have been exposed to African heritage. However, some commonalities may exist among many African Americans. Generally, African Americans are group-oriented and value cooperation and interdependence, especially in relation to the extended family and the community (Sue & Sue, 2008). The extended family can be varied and is particularly important, and family matters tend to be kept within the family or extended family (McGoldrick, 2005). In addition, African Americans as a group tend to value the Church and counselors should understand the important connection that many African Americans have with their church (Evans & George, 2008). Also, exposure to racism may justifiably make some African Americans guarded, defensive, and minimally verbal with Whites and mistrustful of the mental health system (Evans & George, 2008; Phelps, Taylor, & Gerard, 2001). On the other hand, these same individuals may be open, expressive, and responsive with other African Americans. Today, many African Americans have rediscovered some of the cultural values of their African heritage, as reflected in the commemoration of Kwanzaa, in which the principles of "unity, self-determination, collective work and responsibility, collective sharing, purpose, creativity, and faith" are celebrated (Axelson, 1999, p. 119).

Finally, African Americans vary widely in their connectedness to their roots, and counselors must assess the role that cultural background plays when working with an African American client (see "Racial/Cultural Identity Models," Chapter 14).

Latinos/Latinas/Hispanics: People of Central American, South American, and Caribbean Origin

Collectively, people of Central America, South America, and from various islands in the Caribbean are called Hispanic, Latinos, or Latinas. Today, there are over 48 million (16%) Latinos/Latinas in the United States, 64% of who have their origins from Mexico, while another 15% have their origins from Puerto Rico (United States Census Bureau, 2010). About 3.5% of Latinos/Latinas are Cuban, 3.2% are Salvadoran, and 2.7% are Dominican. Although "Hispanic" is the official word used by the U. S. government, some have felt that it has been too closely associated with colonial heritage and prefer the word Latino or Latina (Delgado-Romero, Galvan, Hunter, & Torres, 2008). In addition, when counseling Latinos/Latinas it is best to have knowledge of the client's country of origin or ancestry, as most would culturally identify with their country of heritage in contrast to the broader culture that the word "Hispanic" implies (Casas, Raley, & Vasquez, 2008).

Because much of California was a northern province of Mexico, a large number of Mexicans became citizens of California when it achieved statehood in 1850 (Allen & Turner, 1988). Other Mexican Americans first emigrated here in the middle 1800s, traveling north from Mexico to the Southwest and West, looking for gold in California, good grazing land for cattle, and economic prosperity. A second wave of Mexican immigrants arrived here in the late 1800s and early 1900s with many moving to California. Today, over 50% of the Mexican American population lives in California.

Most Puerto Ricans settled in the United States during the twentieth century. In 1898, following the Spanish American War, Puerto Rico became a territory of the United States. In 1917, Puerto Ricans were given citizenship, and in 1952 Puerto Rico became a Commonwealth of the United States. Over the years many Puerto Ricans have moved to New York City where there were hopes of a better life, and more recently there has been a large migration of Puerto Ricans west in search of better employment opportunities. Although Puerto Rico has one of the best economies of Latin America, it lags far behind the economy in the 50 states.

Most Cubans came to the United States in the late 1950s and early 1960s following Fidel Castro's overthrow of the Cuban dictatorship under Batista. Cubans came to the United States out of fear of persecution and imprisonment and out of ideological differences with the communist regime. The vast majority of Cubans settled in southern Florida, although there are sizable communities in New York, Chicago, and Los Angeles.

In the United States today there is a sizable group of Americans of Spanish descent who arrived here from Central and South America. Many of these people settled along the Rio Grande, although during the 1800s many migrated to New Mexico, Arizona, and Colorado. Finally, from the 1960s until recently, due to political turmoil in their countries of origin, many people from Central America have migrated to the United States.

Although a sizable number of Latinos/Latinas have done well in the United States, there continues to be a disproportionate number of Latinos/Latinas who are poor and have had a difficult time acculturating and becoming upwardly mobile. A number of reasons account for this. For instance, many Latinos/Latinas have not established roots in this country due to the proximity of their countries of origin, the lack of economic opportunity today in comparison with what was available to past immigrants, the ability to make frequent trips back to their countries of origin, and the fact that sharing a common language with other Hispanics makes it easier to maintain a Latinos/Latinas culture (Axelson, 1999).

Despite many differences, there are certain values and customs that are shared by most Latinos/Latinas. For instance, the extended family is emphasized and interdependence is valued over independence. Also, the family tends to be patriarchal and follow traditional sex roles. In addition, in Latino/Latina culture, individuals are respected based on their age, socioeconomic status, gender, and the perception of the individual's importance. Finally, many Latinos/Latinas deeply embrace traditional Catholic values while at the same time believe in *cultural fatalism* (fatalismo), or the belief that life is out of one's control (Delgado-Romero et al., 2008; Sue & Sue, 2008).

When working with Latino/Latina clients it is crucial that the counselor understands the client's unique values, behaviors, symbols, and even language, all of which are functions of the client's country of origin. At the same time, the counselor should assess the degree to which some of the common qualities noted above may motivate the Latino/Latina client.

People of Asian and Pacific Island Origin

Americans of Asian and Pacific Island origin include fairly large numbers of Chinese, Filipinos, Japanese, Koreans, Asian Indians, Vietnamese, and native Hawaiians, and lesser numbers of Laotian, Thai, Samoans, and Guamanians. In 1965, major changes in

immigration laws created more equity in who could immigrate to the United States and resulted in an increase in Asian and Pacific Island immigrants from all of the 25 countries that make up this part of the world.

To escape poverty, many Chinese people immigrated to the United States during the California gold rush of the mid-1800s. However, Whites ousted many Chinese people from the mines, and a large number ended up taking low-paying farm and blue-collar jobs. Because of prejudice and poor working conditions, many Chinese people dispersed to Midwestern and Eastern cities. In addition, the development of Chinatowns represented a haven for many of the Chinese. Today, many Chinese people have moved out of the Chinatowns, and these areas now generally house the poorer Chinese.

In the late 1800s, a large number of Japanese, Asian Indians, and Koreans settled in California, and like the Chinese, took low-paying farm jobs. During the Second World War, many West Coast Japanese Americans were forcibly removed from their homes and placed in internment camps. In 1943, some of the Japanese who were interned were able to leave the camps if they promised not to live on the West Coast. Many of these moved to the Midwest while others chose to remain in the camps until the end of the war when they were allowed to resettle on the West Coast. Japanese Americans who were placed in internment camps recently won a monetary settlement from the government for their hardship.

When the Spanish-American War ended in 1898, the United States set up colonial rule in the Philippines. Although this takeover of the Philippines was not met calmly by the Filipino people, it did lead to a large influx of Filipinos to this country. Many went to Hawaii and worked as sugar growers. In the 1920s and 1930s, many Filipinos moved to California and Alaska, some to take low-paying jobs and others to pursue an education. In addition, until recently, Filipinos who enlisted in the American armed services for a specified length of time could obtain citizenship, and many therefore relocated to naval cities such as San Diego, California and Norfolk, Virginia.

Following the wars in Korea and Vietnam, large numbers of Koreans and Vietnamese people immigrated to this country. A sizable number of Korean immigrants were war brides, war orphans, and professionals, whereas many of the Vietnamese immigrants were refugees from the Vietnam War and were brought to this country following the fall of South Vietnam to the North Vietnamese.

Although some general customs are shared among people of Asian and Pacific Island origin, as with Hispanics there is great variability in the customs and traditions among the varying countries. A few of the similar values include the fact that children tend to be obligated to parents and place them first, family members are highly interdependent, families are generally patriarchal and sons are highly valued, guilt and shame are used to control the behavior of family members, individuals are restrained and pride themselves on their ability to control their feelings, there is formality in social relationships, the mind and body are seen as one, emotional distress should be handled on one's own, the needs of others should be placed above one's own, and physical complaints are often an accepted way of expressing psychological problems (Kim & Park, 2008; Sue & Sue, 2008).

When working with an Asian client, it is important to have knowledge about the client's country of origin. Differences in language, social behavior, economic development,

and history are vast and should not be underestimated because they greatly affect the Asian client's way of living in the world. On the other hand, a counselor should also assess the degree to which some common qualities, as noted above, may be embraced by the Asian client.

Native Americans

In the United States, Native Americans consist of two major groups: American Indians and Alaskan Natives. About 5 million (1.6%) of Americans report being Native American as well as one other race, while 3.2 million (1.0%) report being only Native American (U.S. Census Bureau, 2009a). Of these, most report being from one or more of ten American Indian tribes while another 120,000 are Alaskan Native (United States Census Bureau, 2006). These groups have dramatically different histories and cultural values and should not be confused with one another.

Approximately 10,000 years ago, people from Siberia crossed over the Bering Strait land bridge to what is now Alaska. Some of these people headed westward toward the Aleutian Islands and are now called Aleuts, whereas others headed north and east and are now called Inuits (Eskimos). Alaska, which was owned by Russia, sent Russian Orthodox missionaries to bring Christianity to Alaskan natives. Today, there are approximately 57,000 Inuit (Eskimo), 23,000 Tlingit-Haida, 22,000 Alaska Athabascan, and 18,000 Aleut (United States Census Bureau, 2006).

Prior to the colonization of North America, American Indians were numerous, with estimates ranging between 1 and 18 million (Thornton, 1996). However, due to disease brought by the Europeans and the wars they initiated, a large percentage died or were killed. Today, six tribes account for about 40% of the close to 5 million Americans who identify as American Indians: Cherokee, Navajo, Latin American Indian, Choctaw, Sioux, and Chippewa. Although American Indians are a diverse group, as is evidenced by the fact that there exists 252 languages, there are many commonalities among tribes (Garrett, 2004):

> . . . a prevailing sense of "Indianness" based on common worldview and common history seems to bind Native Americans together as a people of many peoples. Although acculturation plays a major factor in Native American worldview, there tends to be a high degree of psychological homogeneity, that is, a certain degree of shared cultural standards and meanings based on common core values . . . (p. 148)

Approximately 22% of American Indians live on reservations where living conditions are not good and social problems, which can be traced back to the uprooting of their civilization, are great (Garrett, 2004). Social problems include high rates of poverty, unemployment, suicide, and substance abuse; poor health care; malnutrition; shortened life expectancy; and limited educational opportunities (Herring, 2004). American Indians also have higher rates of emotional illness, most likely related to their serious social problems. Unfortunately, American Indians tend to underutilize available mental health services.

Although many Native Americans have acculturated to broader, societal customs, some of the traditional values of Native Americans include humility, generosity, patience, living by the clock of Mother Nature, "being" or living with the flow of life energy and connectedness to others, and spirituality (harmony, connection, and listening to one's life rhythm) (Garrett, 2008). American Indians tend to view mental health problems

from a spiritual and holistic perspective (Garrett, 2004; Juntunen & Morin, 2004). Such problems are seen as an extension of the community, and thus the community is often actively involved in the healing process. In this process the use of ceremony, storytelling, and metaphor are important in understanding the individual.

As with Latinos/Latinas and Asians, it is important to understand the unique language and cultural traditions of the tribe with which the Native American has been affiliated (Rayle, Chee, & Sand, 2006). In addition, as many Native Americans have acculturated, when counseling Native Americans it is important to assess how much their culture of origin continues to influence their lives.

Counseling Individuals from Different Cultures

As you can tell from the preceding sections, values vary considerably as a function of cultural group and even within cultural groups. Thus, it is difficult to ascribe one specific approach to working with a broad range of groups such as these. However, there are some common ingredients that we can take into account when working with African Americans, Asian Americans, Latinos/Latinas, and Native Americans:

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with clients with varying cultural heritages by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Encourage clients to speak their own language.* Make an effort to know meaningful expressions of the client's language. When language becomes a significant barrier, refer to a counselor who speaks the client's language.
3. *Assess the cultural identity of the client.* Use the racial/cultural identity models in Chapter 14 to assist in knowing how to work with clients. For example, a client who has acculturated and has little identification with his or her culture of origin is very different from a client from the same culture of origin who is a new immigrant.
4. *Check the accuracy of your interpretation of the client's nonverbals.* Don't assume that nonverbal communication is consistent across cultures. Ask the client about his or her nonverbals when in doubt.
5. *Make use of alternate modes of communication.* Use appropriate alternative modes of communication, such as acting, drawing, music, storytelling, collage making, and so forth, to draw out clients who are reticent to talk or have communication problems.
6. *Assess the impact of sociopolitical issues on the client.* Examine how social and political issues affect your client and make a decision about whether advocacy of client concerns can be helpful to the client's present problems.
7. *Encourage clients to bring in culturally significant and personally relevant items.* Have clients bring in items to help you to better understand them and their culture (e.g., books, photographs, articles of significance, culturally meaningful items, and the like).
8. *Vary the helping environment.* When appropriate, explore alternative helping environments to ease the client into the helping relationship (e.g., take a walk, have a cup of coffee at a quiet restaurant, initially meet your client at his or her home, and so forth).

Religious and Spiritual Diversity in America

The religious makeup of the American people has shifted dramatically since 1960, and there is every indication that those trends will continue in the future. In general, the nation has become more pluralistic in character (Newport, 2009). As with racial and cultural background, the United States is truly a diverse country when it comes to religion. In the United States today there are close to 79 religious groups each having over 60,000 members (Lindner, 2009). Today, about one-fourth of Americans identify as Roman Catholic and about one-half as Protestant. However, the word Protestant is used less frequently these days because people had a tendency to lump together the many religious beliefs the word encompassed. For instance, within this religious tradition we find such varied groups as Baptists, Methodists, Lutherans, Presbyterians, Episcopalians, Pentecostals and others (see Chapter 14, Table 14.1). In addition to these religions, smaller numbers of Americans identify as Muslim, Jewish, Buddhist, Hindu, Unitarian, as well as a number of other religions (Kosmin & Keysar, 2008). With 83% of Americans claiming a religious affiliation and 88% saying that religious activities are important in their lives (Exploring Religious America, 2002), it is clear that counselors must understand the diversity of religious beliefs in America.

As one might expect, there is a relationship between religious affiliation and social class, culture, ethnicity, race, and political attitudes (Macionis, 2009), although one should be careful not to stereotype a person too readily based on his or her religious affiliation. Religion can be divisive, such as when wars are started over sectarian differences and individuals are oppressed because of their religious beliefs. However, for many within a specific cultural group, religion can be a unifying factor and offer a sense of community, direction, and strength (Ericksen, Jackson, & Weld, 2008). In addition, religion has also offered answers to questions about life's meaning and has been an important factor in focusing world attention on the importance of assisting those in need. In this spirit, many counseling theorists believed that religions fashioned God, and God's image, to be the perfect reflection of what we all should strive for in life (Neukrug, 2011).

Although religion and spirituality are often used synonymously, Ericksen et al. (2008) suggest that religion is "the organized set of beliefs that encode a person or group's attitudes toward, and understanding of, the nature of reality" while spirituality is: "mindfulness about the existential qualities of life, especially the relationship between self, other, and the world" (pp. 510–511). With the great diversity of religious and spiritual beliefs in this country, and knowing that religious affiliation is closely aligned with cultural factors, it is a sad statement that in many texts and articles on multicultural counseling religion and spirituality have been given little or no mention. With this in mind, we will briefly examine five religions and then offer general guidelines when counseling individuals with strongly held religious and spiritual beliefs.

Christianity

Founded 2,000 years ago on the teachings of Jesus of Nazareth, adherents of Christianity now include close to two billion (33%) people. Starting as a Judaic movement, followers of Jesus believed him to be the Christ, "the chosen one," fulfilling God's promise of salvation. Although Judaism eventually rejected Jesus as the Christ/Messiah, Christianity was born, and the teachings of Jesus were consolidated into what we now call the

New Testament or Christian Scriptures. Over the centuries, interpretation of the Gospel (the "good news" of Jesus) has varied greatly as a function of religious scholars or leaders. Thus, throughout the world we have seen the development of many different Christian religious groups that have ranged from conservative to liberal in their interpretations of the Gospel. Differences among Christians' values and beliefs can vary dramatically with respect to a number of core issues that may impact the counseling relationship, such as beliefs around marriage and divorce, sexuality, abortion and birth control, views on counseling, and spiritual practices (Ericksen et al., 2008). Therefore, some understanding of a person's particular religious background and spiritual orientation is important when counseling individuals who hold strong Christian beliefs. Finally, differences among Christian churches and between Christian religions and non-Christian religions have led to tensions among people throughout the world. On the other hand, Christianity has also brought people together in a common worship of Jesus as part and whole of the Holy Trinity along with God the Father and the Holy Spirit. And, based on Christian beliefs, many Christian churches have understood their mission to include helping others by housing the poor, counseling the weary, feeding the hungry, and bringing unity among people.

Buddhism

Founded in 6th century BCE India, Buddhism is based on the Tripaka, which are teachings of Gautama Siddhartha, who, after becoming enlightened, became known as the Buddha. Also of significance in Buddhism are comments about the Buddha's writings, called the Sutras. Four truths of Buddhism include (1) the truth of suffering; (2) the cause of suffering, which is desire; (3) the cessation of suffering, which is the renunciation of desire; and (4) the way that leads to the cessation of suffering (Tsering, 2005). Related to these truths, Buddhists believe that what we understand to be reality is an illusion, that one lives and is reborn due to attachment to an illusory self, and that Nirvana is reached when, through meditation, you can transcend attachment to the illusory self. The actual practice of Buddhism varies greatly depending on the sect to which the person belongs. Although Buddhists represent 6% of the population of the world, in American culture, Buddhism continues to be misunderstood.

Hinduism

The collection of traditions known today as Hinduism began to develop around 1500 BCE when Aryan invaders of India intermingled their religious practices and beliefs with those of the native Indians. The sacred texts include the Veda, Upanishads, Bhagavadgita, Mahabharata, and Ramayana. These texts are mythological and philosophical commentaries about life. Although the religion speaks of many gods, heroes, and saints, Hindus believe in one divine principle—that many gods are aspects of a single divine unity. Hindus believe that people are born and reborn based on their samsara, or separation from the divine, and that one's karma, or total way of acting and being, can be improved through pure actions and meditation. Through these pure acts, one can eventually become closer to the divine. Hindus believe that reincarnation is the road to unity with the divine and that it answers many perplexing questions, such as why there are so many personalities in this world. Although Hindus represent 13% of the population of the world, like Buddhists, Hindus are misunderstood and considered strange by many Americans.

Islam

Fully 18% of the world is Islamic, and yet this mostly nonauthoritarian and egalitarian religion continues to be confusing for most Americans. Following the beliefs established in 622 by the Prophet Muhammad, Muslims accept Allah (God) as the merciful, kind, and all-powerful creator of the universe. Humans are seen as the highest creation of God, good by their very nature, although they are capable of forgetting their true nature and can be misled by Satan. However, Muslims believe that if people forget their true nature, they can repent, return to a state of remembering, and go to Paradise. Two of the major texts of Islam are the Quran, which is said to be the true word of God given by the angel Gabriel to Muhammad, and the Hadith, traditions that developed from the life and teachings of the Prophet. Muslims have five duties or pillars to which they should adhere: to profess their faith to Allah, to pray five times a day, to give regularly a portion of their material wealth to charity, to fast daily until sundown during the month of Ramadan, and to attempt to make at least one pilgrimage to Mecca.

In the United States, Muslims have obtained an undeserved negative reputation. This has been particularly so since the tragedy at the World Trade Center, which led some Americans to wrongfully view the majority of Muslims and Arabs as terrorists. Certainly, the vast majority of Muslims are peace loving and in sync with the teachings of Muhammad as depicted in the Quran. Finally, it should be noted that although a large percentage of Arabs are Muslim, Muslims are found around the world and only a small percentage are Arab. Also, not all Muslims are religious or follow their religion, and a counselor should not assume that a Muslim client is religious any more than he or she would assume a Christian is devout.

Judaism

A monotheistic religion that coalesced around 1300 BCE, Judaism is based on the Hebrew Bible, which includes the five books attributed to Moses (called the Torah), the writings of the prophets, and the writings of the ancient historians, kings, and wisdom-teachers. Later writings, called the Talmud, are interpretations by teachers (Rabbis) and judges of the early writings, and are also used as a basis for knowledge and worship. Adherence to Jewish laws varies from those who are very orthodox to those who are very liberal, although the majority of Jews in America fall somewhere in the middle. Some of the major holidays include Rosh Hashanah, the New Year; Yom Kippur, the Day of Atonement for one's sins; Hanukkah, the Festival of Lights; and Passover, which celebrates the liberation of Jews from slavery in Egypt and is symbolic of liberation in general. Finally, the Bat Mitzvah ("Bar" for a boy), is another major Jewish ceremony, which celebrates a child entering adulthood at age 13.

The Jewish people have faced a particularly long history of oppression. Despite the fact that the Jewish religion is a peaceful, forward-thinking religion, and that Jewish individuals have fully assimilated into American society, false stereotypes of Jews continue, and prejudice and discrimination against Jews is still evident. In fact, although fewer than 2% of Americans are Jewish, one survey found that 14% of Americans hold anti-Semitic propensities, and hate crime statistics indicate that close to two-thirds of all religious hate crimes and 12% of all hate crimes have been committed against Jews (Martila Communications Group, 2005; United States Department of Justice, 2008).

Counseling Individuals from Diverse Religious Backgrounds

A client's religious beliefs and spiritual orientation may hold the keys to understanding the underlying values that motivate him or her. To help guide counselors in working with clients around religious beliefs and spirituality, the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), a division of ACA, has developed fourteen competencies built around six core values. In working with clients, counselors can be guided by these (ASERVIC, 2009):

I. Culture and Worldview

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.
2. The professional counselor recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning (see Box 15.1).

II. Counselor Self-Awareness

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.
4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.
5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer.

III. Human and Spiritual Development

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

BOX 15.1

Religion as Projection of Self

My wife was raised Catholic, and I was raised Jewish. We have two daughters, who are 11 and 6, and we consider them Jewish and Catholic. When my oldest child was still an infant I remember telling a therapist I had been seeing how Jewish my daughter seemed and that I thought my wife would see her in this light also. After reflecting on this for a moment, he gave me one of those looks that said, "Yeah, get real—you best check this out," but his only comment was "Uh huh." As soon as I got home I asked my wife, "Do you see Hannah as Jewish?" She laughed and said, "No, I think she seems Catholic." I was quickly reminded how so much of our inner experience is projected onto the world.

IV. Communication

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.
8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and that are acceptable to the client.
9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

V. Assessment

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

VI. Diagnosis and Treatment

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms.
12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.
13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.
14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices. (ASERVIC, 2009, "Spiritual Competencies")

Gender Differences in America and Gender-Aware Therapy

The words sex and gender are often confused, and are critical to any conversation about gender differences. Whereas one's sex is biologically determined, one's gender includes the social, cultural, and psychological roles that are assumed of a person based on his or her sex (Wester & Trepal, 2008). In recent years, controversy has emerged over whether differences between men and women are biological, sociological, or even relatively non-existent (Else-Quest, Hyde, & Linn, 2010; Harkins, Hansen, & Gama, 2008; Hyde, 2005; Petersen, & Hyde, 2010; Wester & Trepal, 2008). Although some may argue about whether "real" differences exist, it is clear that men and women are treated differentially in society and how they respond to cultural expectations varies dramatically. Research, as well as commonly held assumptions show that differences based on gender are many, and some of which are listed in Table 15.1 (Anderson, 2009; Harkins, Hansen, & Gama, 2008; Sue & Sue, 2008; Wester & Trepal, 2008).

Whether working with a man or a woman, knowledge of gender bias can allow a counselor to be effective at what some have labeled *gender-aware therapy* (Good, Gilbert, &

TABLE 15.1

Some Common Differences Between Men and Women	
- Women are more nurturing, more compassionate, more relational, less focused on "doing" and more on "being" in relationships. - Women have more difficulty expressing anger than men. - Women struggle more with self-esteem and depression than men. - Women earn less money for doing the same work as men. - Job and advancement opportunities are fewer for women. - Women are more frequently sexually harassed on the job and at other places. - Women are physically abused by their spouses or partners at alarming rates. - Single and divorced women and their children live below poverty level at alarming rates. - Assumptions about the abilities of girls and women may prevent females from realizing their potential. - Women tend to be more comfortable with expression of sad feelings, intimacy, and nurturing behavior and less comfortable with the expression of anger and assertive behavior. - Women tend to be more socially compassionate and hold more traditional moral values. - Women, on average, tend to be less comfortable in competitive situations. - Women are more frequently misdiagnosed than are men when seeking mental health services. - Women are sometimes torn between their roles as nurturer and child-care provider and their place in the world of paid work. - Nearly all cases of complaints made against therapists for sexual exploitation are from women complaining about male therapists. - Women have unique biological problems (e.g., premenstrual syndrome, breast cancer, pregnancy, ovarian cysts, ovarian cancer).	- Men tend to seek counseling less frequently than women and have a more negative attitude toward the helping process. - Men are more restrictive emotionally, less communicative, less affectionate, and less comfortable with sad feelings, collaboration, self-disclosure, and intimacy. - Men tend to be more comfortable with angry feelings, aggression, and competitiveness. - Men are sometimes ostracized for expressing feelings, especially those considered to be traditionally feminine feelings, and yet criticized for not being more sensitive. - Men are criticized for being too controlling and self-reliant and made to feel inadequate if they do not take control. - Men are socialized to be more aggressive and individualistic and are thus more prone to accidents, suicide, early death through wars, and acts of violence. - Men are encouraged to be competitive and controlling (take charge), and yet these very behaviors lead to increased stress and are likely to play a factor in the shorter life expectancy of men in comparison with women. - Men are socialized to not be engaged in child rearing and yet are criticized for being distant fathers. - Men have biological problems unique to them (e.g., prostate cancer, prostatitis, higher rates of stress-related diseases, and testicular cancer). - Men are placed in a position of being in charge of others, which sometimes results in the oppression of women. Such oppression not only harms women, but harms men's psyche. - Men commit the vast majority of crimes, and a particularly high percentage of violent crimes. - Men have higher rates of substance abuse.

Scher, 1990; Seem & Johnson, 1998). Such therapy considers gender central to counseling, views problems within a societal context, encourages counselors to actively address gender injustices, encourages the development of collaborative and equal relationships, and respects the client's right to choose the gender roles appropriate for him- or herself regardless of their political correctness (Kees, 2005; Mejia, 2005). Let's take a look at two variations on gender aware therapy: feminist therapy and counseling men.

Feminist Therapy[1]

Feminist therapy had its basis in the feminist political movement of the 1960s and 1970s, which sought to offer women a new vantage point that was not based on traditional gender role expectations (Funderburk & Fukuyama, 2002). Broadly, feminist theory recognized the impact of gender, the oppression of women, and the influence of politics. Feminist

[1] Thanks to Julia Forman for her assistance with this section.

therapy understood that as a function of a male dominated society, women were often devalued, and therefore awareness of gender issues, and the battle to decrease oppression against women and other minorities through social justice actions, became significant principles of feminist theory (Robinson-Wood, 2009).

Today, the overarching goal of feminist therapy is empowerment of female clients (Brown & Bryan, 2007). Several components comprise feminist theory and the empowerment of women. The first is viewing the person as a political entity (Funderburk & Fukuyama, 2002). Specifically, this refers to the fact that no client is an isolated individual but one who is impacted by the political and social environments. Historically and currently, women and minorities have been at a disadvantage politically, and one focus of feminist therapy is to encourage these marginalized clients to find their voice and create societal change.

A second guiding principle is recognition of the power and authority the counselor holds in the relationship (Brown & Bryan, 2007). The feminist counselor actively seeks to establish a therapeutic alliance that is collaborative and effectively balances the relationship's power dynamics (Brown, Weber, & Ali, 2008). The third critical component is to focus on wellness (Brown & Bryan, 2007). Feminist helpers do not see problems arising from psychopathology, otherwise termed the "disease model." On the contrary, feminist therapists tend to view problems as a function of external factors; that is, symptomatic behaviors are seen as coping responses to societal and political stress and oppression.

In addition to the three critical components, the American Psychological Association (APA, 2007) adopted the *Guidelines for Psychological Practice with Girls and Women*, which should be integrated into the practice of feminist therapy, and include three sections: (1) Diversity, Social Context, and Power, (2) Professional Responsibility, and (3) Practice Applications (see Table 15.2). Finally, in the actual practice of feminist therapy, 12 steps are offered that take into account the critical components of feminist therapy and the APA guidelines in counseling:

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with women by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them (e.g., know and incorporate the APA guidelines in Table 15.2).

2. *Ensure that the counseling approach you use has been adapted for women.* Conduct an inventory of your theoretical approach for any inherent sexist leanings it may have. Discard it or adapt as necessary.

3. *Establish a collaborative relationship, give up your power, and demystify the counseling process.* Recognize the importance that power plays in all relationships and attempt to equalize the counselor-client relationship. This can be done by downplaying the "expert" role, encouraging women to trust themselves, and using appropriate self-disclosure. The counselor and client should work toward a relationship that focuses on cooperatively created actions and objectives.

4. *Identify social/political issues related to client problem(s) and use them to set goals.* Help women understand the nature of the problem within its sociocultural context and help them see how the unique dynamics of women tend to cause them to internalize these issues. For instance, it is common for abused women to

T A B L E 15.2

APA Guidelines for Psychological Practice with Girls and Women

Section 1: Diversity, Social Context, and Power

Guideline 1: Psychologists strive to be aware of the effects of socialization, stereotyping, and unique life events on the development of girls and women across diverse cultural groups (p. 35).

Guideline 2: Psychologists are encouraged to recognize and utilize information about oppression, privilege, and identity development as they may affect girls and women (p. 37).

Guideline 3: Psychologists strive to understand the impact of bias and discrimination upon the physical and mental health of those with whom they work (p. 39).

Section 2: Professional Responsibility

Guideline 4: Psychologists strive to use gender and culturally sensitive, affirming practices in providing services to girls and women (p. 46).

Guideline 5: Psychologists are encouraged to recognize how their socialization, attitudes, and knowledge about gender may affect their practice with girls and women (p. 50).

Section 3: Practice Applications

Guideline 6: Psychologists are encouraged to employ interventions and approaches that have been found to be effective in the treatment of issues of concern to girls and women (p. 52).

Guideline 7: Psychologists strive to foster therapeutic relationships and practices that promote initiative, empowerment, and expanded alternatives and choices for girls and women (p. 55).

Guideline 8: Psychologists strive to provide appropriate, unbiased assessments and diagnoses in their work with women and girls (p. 58).

Guideline 9: Psychologists strive to consider the problems of girls and women in their sociopolitical context (p. 60).

Guideline 10: Psychologists strive to acquaint themselves with and utilize relevant mental health, education, and community resources for girls and women (p. 62).

Guideline 11: Psychologists are encouraged to understand and work to change institutional and systemic bias that may impact girls and women (p. 64).

Source: American Psychological Association. (2007). *Guidelines for psychological practice with girls and women*. Washington, D.C.: Author.

---

blame themselves for the abuse. Help them see that they are not responsible and help them set goals to break free of the abuse.

5. *Use a wellness model and avoid the use of diagnosis and labels.* Diagnosis and labels can be disempowering to women and tend to focus treatment toward psychopathology. A wellness orientation that uplifts women can help them get in touch with their strengths.

6. *Validate and legitimize a woman's angry feelings toward her predicament.* As women begin to recognize how they have internalized social and political issues, they begin to understand how they have been victimized. Helpers should assist women in combating feelings of powerlessness, helplessness, and low self-esteem and help them identify their strengths.

7. *Actively promote healing through learning about women's issues.* Helpers should encourage women to learn more about women's issues. This can be done by

providing written materials to women, suggesting seminars to attend, and providing a list of women's groups or women's organizations that support women's issues.

8. *Provide a safe environment to express feelings as clients begin to form connections with other women.* As female clients gain clarity regarding their situation, they see how society's objectification of women has led to fear and competition among women. This newfound knowledge will lead to a desire to have deeper, more meaningful connections with other women. Helpers can validate feelings of fear and competition with other women that result from such objectification. As these feelings dissipate, women will move toward a strong and special connection with women. At this point in counseling, helpers should consider the possibility of providing a women's support group.

9. *Provide a safe environment to help women understand their anger toward men.* As women increasingly see that a male-dominated society has led to the objectification of women, they will begin to express increasing anger toward men. However, helpers can assist clients in understanding the difference between anger at a man and anger at a male-dominated system. Slowly, women will see that some men can also be trusted.

10. *Help clients deal with conflicting feelings between traditional and newfound values.* As women develop newfound feminist beliefs, they become torn between those beliefs and values that do not seem congruent with those beliefs (e.g., wanting to stay home to raise the children). Helpers should validate these contradictory feelings, acknowledge the confusion, and assist clients in exploring their contradictory belief systems.

11. *Facilitate integration of client's new identity.* Helpers can assist clients in integrating their newfound feminist beliefs with their personal beliefs, even those personal beliefs that may not seem to be traditionally feminist. Clients are able to feel strength in their own identity development and no longer need to rely on an external belief system.

12. *Say goodbye.* It is important to help women move on with their newfound identity, and helpers should encourage women to try being in the world without counseling. Counseling is always an option for the future.

Counseling Men

> *In order for us to be able to "hold" others we have to imagine ourselves being held by our fathers, perhaps the first male we wanted to hold and be held by.* (Osherson, 1986/2001, p. 195)

Although concerns of men are generally quite different from those of women, they are no less important, especially in light of the fact that compared to women, men seek counseling less and have a more negative attitude toward the helping process (Addis & Mahalik, 2003; Berger, Levant, McMillan, Kelleher, & Sellers, 2005). As with women, men need to feel supported in counseling and not feel judged for having their own issues—issues that are common to the male experience and that cut across all racial, ethnic, and cultural groups (see Table 15.1). As with women, counselors need to be aware of men's issues and have empathy for a man's situation. A number of ideas can be

incorporated into a set of guidelines when working with male clients (Berger et al., 2005; Good & Brooks, 2005; Greer, 2005; McCarthy & Holliday, 2004; Mejia, 2005; Osherson, 1986/2001; Pollack & Levant, 1998; Wexler, 2009):

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Embrace the appropriate knowledge, skills, and beliefs prior to meeting with a male client.
2. *Accept men where they are, as this will help build trust.* Men, who are often initially very defensive, will work hard on their issues once they can trust the counselor.
3. *Don't push men to express what may be considered "softer feelings."* Don't push a man to express feelings, as you may push him out of the helping relationship. Men tend to be uncomfortable with certain feelings (e.g., deep sadness, feelings of incompetence, feelings of inadequacy, feelings of closeness), but more at ease with "thinking things through," problem solving, and expressing some feelings, such as anger and pride (see Box 15.2).
4. *Early on in therapy, validate the man's feelings.* Validate whatever feelings a man expresses, and remember that in order to protect their egos, men may initially blame others and society for their problems.
5. *Validate the man's view of how he has been constrained by male sex-role stereotypes.* Help to build trust by validating a man's sense of being constrained by sex-role stereotypes (e.g., he must work particularly hard for his family).
6. *Have a plan for therapy.* Collaborate with men and together, build a plan for therapy. Men like structure and a sense of goal directedness even if the plan is changed later on.
7. *Begin to discuss developmental issues.* Introduce male developmental issues so a man can quickly examine concerns that may be impinging upon him (e.g., midlife crises) (Levinson, 1978).
8. *Slowly encourage the expression of new feelings.* As you reinforce the expression of newfound feelings, men will begin to feel comfortable sharing what are considered to be more feminine feelings (e.g., tears, caring, feelings of intimacy).
9. *Explore underlying issues and reinforce new ways of understanding the world.* Explore underlying issues as they emerge (e.g., childhood issues, feelings of inadequacy, father–son issues).

BOX 15.2

Men Expressing an Array of Feelings

Close your eyes for a moment and imagine a person running into a burning apartment building to save the lives of children. Stay focused on that image, and let it sink in. Now, close your eyes again and imagine two young children snuggling and being taken care of by their parent. The parent makes "cooing" sounds to get the attention of the infant and show the infant love. Imagine this in your mind's eye.

If you imagined a man running into the building and a woman snuggling with her children, you are probably like many Americans. Our imaginations reinforce our stereotypes. And we tend to see nurturing as a compassionate behavior and running into a building to save lives as a brave behavior. Both are important, and perhaps reflect societal stereotypes of gender specific behaviors. But, in reality, can't we all be nurturing parents and brave heroes? In counseling, men may present with some traditional male behaviors, but are capable of expressing many feelings—if given the time!

10. *Explore behavioral change*. As insights emerge, encourage men to try out new behaviors.
11. *Encourage the integration of new feelings, new ways of thinking and new behaviors.*
12. *Encourage new male relationships*. Encourage new male friendships in which the client can express his feelings while maintaining his maleness (e.g., a men's group).
13. *Say goodbye*. Be able to say goodbye and end the relationship. Although some men may want to continue in counseling, many will see it as a time-limited means to a goal.

Differences in Sexual Orientation

In his famous studies of the 1940s, Kinsey found that 50% of the men he surveyed had some sexual history with other males during their adult life, 13% had more homosexual than heterosexual experiences, 8% were exclusively homosexual for three years of their lives between the ages of 16 and 55, and 4% were exclusively homosexual throughout their lives (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Kinsey also found that most individuals were not purely homosexual or heterosexual but rather fell on a continuum between homosexual and heterosexual feelings. Those who fell in the middle of the scale, Kinsey discovered, sometimes identified themselves as bisexual, but more often identified themselves as either homosexual or heterosexual. Although some have questioned Kinsey's results (Cole, Gorman, Barrett, & Thompson, 1993), there is little doubt that his research helped to change the mental health professions' belief that homosexuality and bisexuality were disorders toward the current view that they, like heterosexuality, are simply sexual orientations (Chiang, 2008).

Although research suggests that about 4.1% of Americans currently identify as gay, lesbian, or bisexual (see Chapter 14, Table 14.1), this percentage is likely much higher if you take into account those gays who have not come out, bisexuals who identify as heterosexual, and others who had once lived a gay or bisexual lifestyle and now identify as heterosexual. In either case, determining percentages is less important than approaching every individual with dignity and respect, regardless of their sexual orientation. No matter what the number of gays, lesbians, bisexuals, or heterosexuals there are in society, the most current research suggests that sexual orientation is determined very early in life, most likely related to biological and genetic factors, may be influenced by sociological factors, and has little if anything to do with choice (Saravi, 2007).

Unfortunately, despite the fact that the mental health professional associations have depathologized sexual orientation, 48% of Americans continue to believe that homosexually is morally wrong (Saad, 2008). Other polls show mixed views about homosexuality (Gallup, 2010; Saad, 2006):

- 89% believe that gays should have equal job opportunities
- 56% believe that homosexual relations should be legal (36% believe it should be illegal)
- 54% view homosexuality as an acceptable alternative lifestyle
- 39% believe gay marriage should be legally valid

Today, many Americans still hold heterosexist attitudes, which like racism, are likely a reflection of an unconscious fear of the "other." In fact, in one study, when heterosexual men were shown homosexual videos, only the group of men who had scored high on a scale to measure homophobia showed increased penile erection, indicating the possibility that these men carry heterosexist attitudes due to fears about their own sexuality (Adams, Wright, & Lohr, 1996). Heterosexism leads to prejudice and discrimination, which, unfortunately, are still quite prevalent (see Box 15.3). For instance, FBI hate crime statistics indicate that nearly 18% of all hate crimes were perpetrated against individuals due to their sexual orientation, with the vast majority of those directed toward male homosexuals (United States Department of Justice, 2008).

Unfortunately, stereotypes concerning gays and lesbians continue to flourish despite the fact that most gays and lesbians do not fit them. For instance, one falsehood is that sexual orientation is related to gender affiliation. Denouncing this misconception, Atkinson and Hackett (2004) point out that "gay men are men, and lesbian women are women" (p. 29) and that gay men and lesbian women exhibit the same range of gender-role behaviors as do male and female heterosexuals. But even if stereotypic behaviors were reflective of actual behaviors, it still is horrific that people would discriminate against others based on such stereotypes.

Another persistent misconception is the confusion between *transgenderism, intersexuality, transsexuality, transvestism*, and *homosexuality* (Carroll, Gilroy, & Ryan, 2002). Transgenderism refers to 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. A transsexual strongly disidentifies with his or her sex and uses hormones and/or surgery to realign his or her sex with gender identity. A transvestite, or "cross-dresser," is an individual who enjoys wearing clothes of the opposite sex. And an intersex person, formerly called a hermaphrodite, is a person born with a combination of male and female genitalia (see Carroll, Gilroy, & Ryan, 2002, for an excellent glossary of these and other terms). None of these individuals are uniquely homosexual or heterosexual.

BOX 15.3

Lesbian Student Sent to "Fake Prom"

"To prevent Constance McMillen from bringing a female date to her prom, the teen was sent to a 'fake prom' while the rest of her class partied at a secret location at an event organized by parents… 'They had two proms and I was only invited to one of them…The one that I went to had seven people there, and everyone went to the other one I wasn't invited to.'

In March, after the Itawamba County School District refused to allow McMillen to bring a female date to the prom, the district canceled the event altogether. McMillen and her lawyers from the American Civil Liberties Union challenged that decision in court, and a judge ruled the district could not bar McMillen and her date.

The judge declined to force the school district to hold the prom because a parent-sponsored, private prom was being organized—and the understanding was that McMillen and her date were invited to that event. But… McMillen was never invited and organizers made it very difficult for her to find information on the time and location. That prom was later mysteriously canceled, with the Friday night event [that McMillen was sent to] replacing it." (Broverman, 2010, para 1, 3, 4, & 5)

Counselors and therapists generally have held more liberal views toward individuals who are gay, lesbian, bisexual, or transgendered than the general public, and female counselors appear to be less heterosexist than male counselors (Eberz & Bieschke, 2002; Gelso, Fassinger, Gomez, & Latts, 1995; Rainey & Trusty, 2007). However, research has clearly shown that most counselors still need to work on the biases they hold toward individuals who are lesbian, gay, bisexual, or transgendered (Dillon, et al., 2004; McAuliffe, 2006; Mohr, Weiner, Chopp, & Wong, 2009; Szymanski, Kashubeck-West, & Meyer, 2008). Perhaps this is why the American Psychological Association endorsed guidelines for psychotherapy for lesbian, gay, and bisexual clients ("Guidelines for…," 2000). And, this is probably why the American Counseling Association found it necessary to develop a statement against the practice of conversion or reparative therapy—or therapy that seeks to change a person's sexuality from homosexual to heterosexual.

> *Considering all the above deliberation, the ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients.* (Whitman, Glosoff, Kocet, & Tarvydas, 2006, interpretation section, para. 10)

So, keeping in mind that many of us still hold biases, let's take a look at some points to consider when counseling individuals who are gay, bi, or lesbian.

Counseling Gay, Bi, and Lesbian Individuals

A number of important points regarding the counseling of gay, bi, and lesbian individuals have been highlighted by many authors, some of which are summarized below (e.g., Pope, 2008; Szymanski, 2008; Sue & Sue, 2008):

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with gay, lesbian, and bisexual clients by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Have a gay, lesbian, and bisexual friendly office.* Make sure that your intake forms are gay, lesbian, and bisexual friendly. Some counselors may choose to have literature in their office that promotes a gay friendly atmosphere. Others may just want to ensure that there are not heterosexist materials in the office.
3. *Help gays, lesbians, and bisexuals understand and combat societal forms of oppression.* Oppression and discrimination of gays, lesbians, and bisexuals is rampant throughout American culture, and it is important that gays, lesbians, and bisexuals understand how it affects them, what they can do to combat it, and how they can gain a sense of empowerment despite it.
4. *Adopt an affirmative and nonheterosexist attitude.* The importance of adopting an attitude that affirms your client's right to his or her sexuality cannot be stressed enough, as so many individuals (including counselors!) have embedded biases and stereotypes about gays and lesbians.
5. *Don't jump to conclusions about lifestyle.* There is no "one" gay, lesbian, or bisexual lifestyle, and counselors should not jump to conclusions about how their clients live out their sexuality.

6. *Understand the differences among people who are gay, lesbian, and bisexual.* Although lumped together here, and often confused as embodying many of the same characteristics, there are great differences among gay, lesbian, and bisexual individuals. For instance, bisexuals are often ostracized by heterosexuals and sometimes by gays and lesbians. Moreover, identity development for gays, lesbians, and bisexuals is considerably different.

7. *Know community resources that might be useful to gay men and lesbian women.*

8. *Know identity issues.* Be familiar with the identity development of gays, lesbians, and bisexuals, especially as it relates to the coming-out process (e.g., Morrow, 2004; Szymnaski, 2008).

9. *Understand the complexity of sexuality.* People express sexuality in different ways. For instance, gay and bi men are generally more sexually active than lesbians. Also, the expression of sexuality in men and women sometimes differs, with women being more focused on relationship issues.

10. *Understand the idiosyncrasies of religious views of homosexuality.* Some religions view being gay, lesbian, or bisexual as sinful, while others are empowering of different sexual orientations. Also, how an individual adheres to the beliefs of his or her religious sect can vary dramatically. For instance, one Catholic might view his being gay as sinful, while another might see it as being normal.

11. *Recognize the importance of addressing unique issues that some gays, lesbians, and bisexuals may face.* Although the research is mixed, there is some evidence that gay and bisexual men may face a higher rate of substance abuse and sexually transmitted diseases, and that lesbians may face a higher rate of domestic violence, sexual abuse, and substance abuse. Know the prevalence of these and other issues within the specific population and the unique ways of treating them in counseling.

Individuals Who Are HIV Positive

Today, over 1 million people in the United States are living with HIV, and about one in five of them don't know it (Centers for Disease Control, 2010). It is also estimated that about 56,000 new cases of HIV arise each year, about 18,000 individuals die of the disease each year, and that close to 600,000 Americans have died since the disease was first identified. AIDS continues to spread in this country, and worldwide an estimated 33 million children and adults are living with HIV (UNAIDS, 2010). With 10% of the world's population, and 67% of the world's cases of AIDS, sub-Saharan Africa has been most affected by the AIDS epidemic. With access to drugs to slow the disease difficult to obtain in some third world countries, it is clear that this epidemic has had a personal and economic cost to people throughout the world.

The response of social services to the AIDS epidemic has been varied and includes programs that offer support and counseling groups for HIV-positive individuals and their families, assisting HIV-positive individuals with the disclosure process, programs for children who have AIDS, prevention and education programs, and hotlines to respond to questions about AIDS (Kalichman, et al., 2007; Lum, 2009; Yarhouse, 2003). Workshops and articles about the AIDS virus and how to counsel individuals who have tested HIV

positive are now commonplace at conferences and in professional journals. No doubt, until a cure to this disease is found, AIDS will continue to have a major impact on America's health care system.

Increasingly, the counselor will play an important role in offering education and prevention activities about the disease, counseling individuals who are HIV positive, dealing with issues related to death and dying for those at the end-stage of the disease, and advocating for HIV treatment programs (Britton, Cimini, & Rak, 1999; Britton, Rak, Cimini, & Shepherd, 1999; Naidoo & Kagee, 2009; Orsulic-Jeras, Shepherd, & Britton, 2003). As sexual activity with an HIV-positive individual is potentially life-threatening, counselors who are in a helping relationship with HIV-positive clients may be challenged with ethical dilemmas concerning confidentiality with their client versus the duty to warn those who may be unwittingly exposed to the virus (Wong-Wylie, 2003; Yarhouse, 2003) (see ACA, 2005, ethical code, section B.2.b).

Counseling Individuals Who Are HIV Positive

A number of challenges face the counselor who works with an individual who is HIV positive or who has AIDS. Some points to consider when counseling an individual who is HIV positive include the following:

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with HIV-positive individuals by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Know the cultural background of the client.* Keep in mind that HIV-positive individuals are found in all cultures, races, and ethnic groups. Counselors need to remember that a client's background may change how the counselor works with him or her.
3. *Know about the disease and combat myths.* Knowledge helps fight fear. Armed with knowledge, counselors can become advocates for the HIV-positive person.
4. *Be prepared to take on uncommon counselor roles.* Realize that the counselor may need to be an advocate, caretaker, and resource person for the client, roles in which the counselor has not always been comfortable.
5. *Be prepared to deal with unique treatment issues.* Be prepared to deal with unique problems, including feelings about the loss of income from the loss of work or the high cost of medical treatment, depression and hopelessness concerning uncertain health, changes in interpersonal relationships when others discover the client is HIV positive (rejection, pity, fear, and so forth), and the probability that the client will have friends and loved ones who are HIV positive or have died of AIDS if he or she is from a high-risk group.
6. *Deal with your own feelings about mortality.* Be able to deal effectively with your own feelings about a client's health and mortality issues and how those feelings may raise issues concerning your own mortality.
7. *Understand the legal and ethical implications of working with individuals who may pose a risk to others or may be considering end-of-life decisions.*
8. *Offer a "strength-based" approach to treatment.* Help clients focus on what is positive in their lives and the possibilities that exist for them instead of focusing on diagnosis and the dread of the disease.

The Hungry, the Homeless, and the Poor

It is estimated that over 700,000 people are homeless in America on any particular day and about 3.5 million Americans experience homelessness in a given year, with close to 40% of them being children (National Coalition for the Homeless, 2009). Although homelessness has always existed throughout history, the faces of the homeless have changed dramatically. Today, the homeless include children who have run away from home, single-parent families, intact families who have no place to live, poor single men and women, and the deinstitutionalized mentally ill. In addition, the homeless of today are more likely not to have shelter, are younger, are less apt to find employment, and are heavily overrepresented by minorities. In addition, up to 37% of homeless who are sheltered have a chronic substance abuse issue and 26% have a severe mental illness (Substance Abuse and Mental Health Services Administration, 2008). Despite these statistics, resources to serve these individuals have remained minimal.

In past years being poor did not necessarily mean one was at greater risk of being homeless, but today, being poor is often one step away from not having a roof over one's head. The number of poor Americans is about 40 million, a little over 13% of the population (United States Census Bureau, 2009b). In addition, a staggering 14 million children—19% of all children in the United States—live in poverty. Also, poverty is associated with race, as 24.7% of African Americans, 23.2% of Hispanics, 11.8% of Asians or Pacific Islanders, and 8.6% of Whites are living below the poverty level (see Figure 15.2).

Poverty is somewhat more prevalent in the cities and the Southern and Western regions of the U.S. (United States Census Bureau, 2009b). In addition, poverty is related to educational level, as the more educated have lower poverty rates. Although the *McKinney Act of 1987* provides mental health services, substance abuse treatment, outreach services, emergency food and shelter, housing, health care, education, job training, and child care, the outlook for this section of society seems bleak (United States Department of Housing and Urban Development, 1995).

Counseling the Homeless and the Poor

A number of unique points should be considered when counseling the homeless and the poor (Chinman, Bailey, Frey, & Rowe, 2001; Lum, 2009; Steinhaus, Harley, & Rogers, 2004; Substance Abuse and Mental Health Services Administration, 2008):
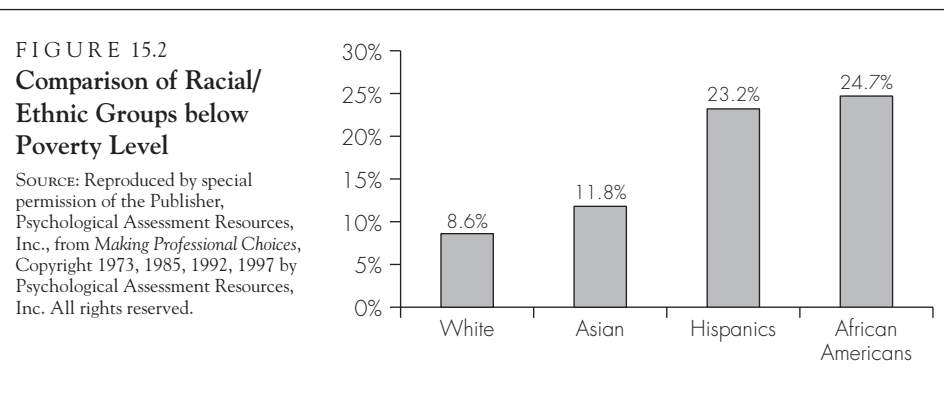
FIGURE 15.2

Comparison of Racial/ Ethnic Groups below Poverty Level

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with the homeless and the poor by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Focus on social issues.* Help clients obtain basic needs such as food and housing, as opposed to working on intrapsychic issues.
3. *Know the client's racial/ethnic/cultural background.* Be educated about the cultural heritage of clients, because a disproportionate number of the homeless and the poor come from diverse racial/ethnic/cultural groups.
4. *Be knowledgeable about health risks.* Be aware that the homeless and the poor are at much greater risk of developing AIDS, tuberculosis, and other diseases, and be able to do a basic medical screening and have referral sources available.
5. *Be prepared to deal with multiple issues.* Be prepared to deal with mental illness, chemical dependence, and other unique problems, because as much as 50% of the homeless are struggling with these problems.
6. *Know about developmental delays and be prepared to refer.* Know how to identify developmental delays and have potential referral sources, because homeless and poor children are much more likely to have retarded language and social skills, be abused, and have delayed motor development.
7. *Know psychological effects.* Be prepared to deal with the client's feelings of despair, depression, and hopelessness as a result of being poor and/or homeless.
8. *Know resources.* Be aware of the vast number of resources available in your community and make referrals when appropriate.
9. *Be an advocate and stay committed.* Because the homeless and the poor are often dealing with multiple issues, and because a high percentage of them have mental illness, advocating for their unique concerns and being committed to them is particularly important as you give them the message that you are truly there for them.

Older Persons

In 1900, 4% of the U.S. population was over 65 years of age. By 1960, this figure rose to about 9% and to about 13% in 2010 (United States Census Bureau, 2003a). It is estimated that by the year 2030 close to 20% of the population will be over 65 years old (United States Census Bureau, 2008).

With these changing demographics, there has been an increased focus on treatment for and care of older persons. Across the country, we have seen an increase in day-treatment programs for older persons and in long-term care facilities such as nursing homes. In addition, housing that is specially designed for older persons, senior centers, and programs for older persons offered through religious organizations and social service agencies are now prevalent around the country. Of course, as America has become increasingly diverse, so has our aging population and counselors will need to be familiar with both the unique concerns of older persons and the race/ethnicity/culture of their clients. With a high percentage of older persons having mental health concerns and yet attending counseling at low rates, counselors will become increasingly important in treating this population (Myers & Harper, 2004; Stickle & Onedera, 2006).

Counseling Older Persons

Older persons have a number of problems and concerns that need to be addressed when they are counseled (Goodman, Schlossberg, & Anderson 2006; Lum, 2009; Myers & Harper, 2004; Schwiebert, Myers, & Dice, 2000). Below are some guidelines for working effectively with older clients:

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Counselors' own stereotypes and biases may affect their prognosis of clients from this population. Be prepared to work with older clients by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Adapt your counseling style.* Adapt your counseling style to fit the needs of the older client. For instance, for the older person who has difficulty hearing, the counselor may use journal writing or art therapy. For clients who are not ambulatory, the counselor may need to have a session in the client's home. In addition, certain types of counseling, such as group and life review therapy, seem particularly advantageous with older persons if used appropriately.
3. *Build a trusting relationship.* Spend time building a trusting relationship. Remember that older persons seek counseling at lower rates than other clients, and those who do seek out counseling may be less trustful of therapy, having grown up in a generation when counseling was much less common.
4. *Be knowledgeable about issues many older persons face.* There are a number of issues that are more prevalent within the geriatric population, including loss and grief, depression, elder abuse, sleep disturbance, health concerns, identity issues, substance abuse, dementia, and others. Be knowledgeable of and assess for these issues.
5. *Know about possible and probable health changes.* Be aware of the many potential health problems common to older persons and have readily available referral sources. Predictable changes in health can lead to depression and concern about the future. Unpredictable changes in health can lead to loss of income and a myriad of emotional problems.
6. *Have empathy for changes in interpersonal relationships.* Changes in relationships may result from such things as retirement; the death of spouses, partners, and friends; changes in one's health status that prevent visits to and/or from friends; and relocations, such as to a retirement community, retirement home, or nursing home.
7. *Know about physical and psychological causes of sexual dysfunction.* Be aware of the possible physical and psychological causes of sexual dysfunction in older persons. As individuals age, it is fairly common for both men and women to have changes in their sexual functioning. Remember that regardless of our age, we are always sexual beings.
8. *Involve the client's family and friends.* As social networks change, it may become important to involve family and friends in treatment planning. Families and friends can offer great support to older persons.

With an increasing number of older persons in the United States, it is likely that more mental health providers who are trained in geronotological counseling will be needed. Unfortunately, there has been little emphasis on this important area within the

counseling profession and few counselors are actually choosing to work with older persons (Clawson, Henderson, Schweiger, & Collins, 2008; Stickle & Onedera, 2006). Perhaps its time for the counseling profession to place more emphasis on this important area.

The Chronically Mentally Ill

In 1955, there were well over half a million individuals with severe mental illness hospitalized in inpatient psychiatric hospitals (Burger, 2008; Torrey, 1997). Although today fewer than 100,000 individuals are now hospitalized, the number of psychiatric facilities that offer mental health services has mushroomed from a few hundred to well over 4,000 (Substance Abuse and Mental Health Services Administration, 2002). Unfortunately, the reduction in the number of inpatients is not the result of the sudden increase in mental health of Americans, but the consequence of a number of important events since the 1950s. In fact, 26 percent of Americans are diagnosed with a mental disorder every year, with the types of disorders varying dramatically (see Figure 15.3).

The reasons for deinstitutionalization of psychiatric patients are many. First, the development of new psychotropic medications, such as antipsychotics (e.g., Abilify, Haldol), mood-stabilizing drugs (e.g., Lithium), antidepressants (e.g., Prozac, Zoloft, Elavil), and anti-anxiety agents (e.g., Valium, Tranxene, Xanax), has made the

FIGURE 15.3

Percentage of Adults with Select Mental Disorders Per Year

SOURCE: National Institute of Mental Health (2010). The numbers count: Mental disorders in America. Retrieved, July 15, 2010, from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml
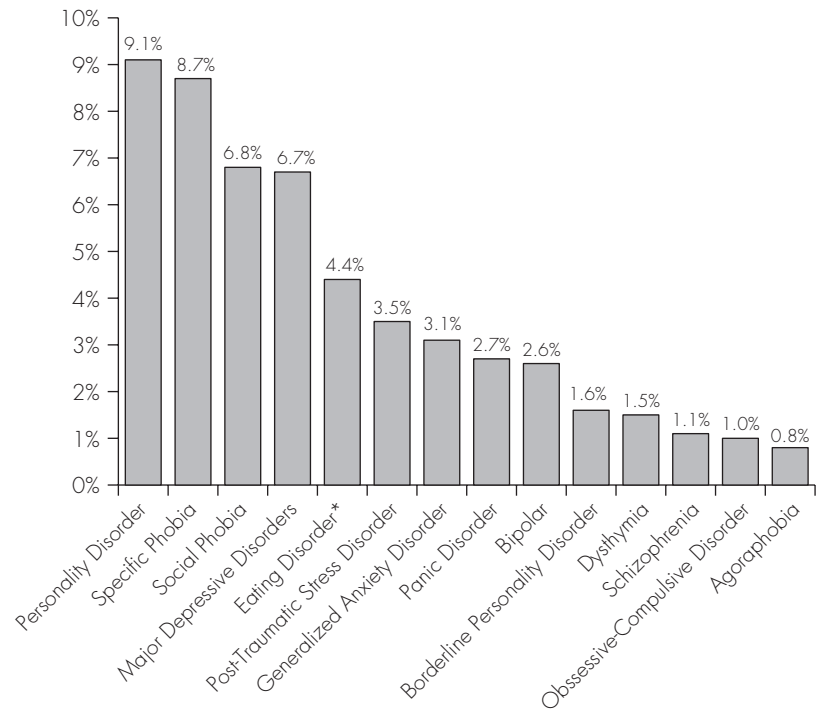
*Percentage of eating disorders are over a lifetime

management of severe emotional conditions possible outside the inpatient setting. Second, the passage of the *Community Mental Health Centers Act of 1963* funded the establishment of mental health centers and made it possible for many with severe emotional problems to obtain outpatient mental health services for free or at low cost (Neukrug, 2008). Third, the proliferation of social service programs introduced through the *Great Society* initiatives of the Johnson presidency created a wide range of social service agencies, many of which service the multiple needs of the chronically mentally ill. Finally, in 1975, the Supreme Court decision of *Donaldson v. O'Connor* stated that a person who is not dangerous to self or others could not be institutionalized against his or her will at inpatient psychiatric hospitals (see Box 2.3 in Chapter 2).

Unfortunately, many of the chronically mentally ill find themselves on the streets and homeless, with some sources stating that as many as 26% of all homeless people may have severe psychiatric problems (Substance Abuse and Mental Health Services Administration, 2008). Counselors who will be working with the chronically mentally ill will need to understand psychiatric disorders, psychotropic medications, and the unique needs of the chronically mentally ill, such as dealing with homelessness, continual transitions, difficulty with employment, and dependent family relationships.

Counseling the Chronically Mentally Ill

As just noted, a large percentage of Americans will have a mental disorder every year. However, most of these individuals will live functional and relatively normal lives and learn how to live with or be able to overcome their mental health problem. However, some of those individuals will become chronically mentally ill and will suffer throughout their lifetimes with a mental disorder, which leads to severe debilitation. The following treatment guidelines are focused on working with such individuals (Garske, 2009; Lum, 2009; Walsh, 2000; Wong, 2006):

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with the mentally ill by embracing the appropriate knowledge, skills, and beliefs prior to meeting with them.
2. *Help the client understand his or her mental illness.* Fully inform clients with up-to-date knowledge about their mental illness. Many do not have an understanding of their illness, the course of the illness, and the best methods of treatment.
3. *Help the client work through feelings concerning his or her mental illness.* Mental illness continues to be stigmatized in this society, and clients are often embarrassed about their disorder. Support groups and a nonjudgmental attitude can go a long way in normalizing the view clients have of themselves.
4. *Ensure attendance in counseling.* Increase the chances of clients coming to counseling by calling the day before, having a relative or close friend assist the client in coming to counseling, or having counselors develop specific strategies to help clients make their appointments (e.g., putting Xs on a calendar). Clients will miss appointments due to denial about their illness, embarrassment about seeing a counselor, problems remembering, or not caring.
5. *Ensure compliance with medication.* Be vigilant about encouraging clients to take their medication and assess its functionality. Clients will discontinue medication due to forgetfulness, denial about the illness, the false belief that they will

not have a relapse because they feel better (the medication is working), and because the dosage is too small or too large.

6. *Ensure accurate diagnosis.* Accurately diagnose clients to ensure proper treatment planning and the appropriate choice of medication. Accurate diagnosis can be ensured through testing, clinical interviews, interviews with significant others, and appropriate use of supervision.

7. *Reevaluate the client's treatment plan and do not give up.* Be committed to working with clients and reevaluate treatment plans as often as is necessary. The mentally ill are some of the most difficult clients to work with. Progress, if any, is slow, and it is easy to become discouraged.

8. *Involve the client's family.* Ensure adequate family involvement and have the family understand the implications of the client's diagnosis. Families can offer great support to clients with mental illness and can be a window into the client's psyche.

9. *Know resources.* Have a working knowledge of resources, as the mentally ill are often involved or need to become involved with many other resources in the community (e.g., Social Security disability, housing authority, support groups).

People with Disabilities

According to the census, nearly 49.7 million (19.3%) of Americans age 5 or older have a disability including 9.3 million (3.4%) with a sight or hearing disability, 21.2 million (8.2%) with a disability that limits physical activities, and 12.4 million (4.8%) with a disability affecting learning, remembering, or concentration, and 6.8 million (2.6%) with a disability that affects their ability to dress, bathe, or get around their home (United States Census Bureau, 2003b). In addition, you are more likely to have a disability if you live in the South, are poor, and are a minority.

Individuals with disabilities are discriminated against in many ways. For instance, some are illegally denied job opportunities, educational opportunities, and access to business and recreational facilities. But as disturbing as the above facts are, perhaps the worst mistreatment of people with disabilities is the reaction many get from others, for many individuals with disabilities are feared, ignored, stared at, infantilized, treated as intellectually inferior, accused of faking their disability, or pitied.

A number of federal laws have had an impact on the ability of individuals with disabilities to receive services. The *Education for All Handicapped Children Act of 1975* (PL94-142) and the subsequent *Individuals with Disabilities Education Act* (IDEA) ensure the right to an education within the least restrictive environment for all children who are identified as having a disability that interferes with learning. The *Rehabilitation Act of 1973* ensures access to vocational rehabilitation services for adults with disabilities who are in need of employment. The *Americans with Disabilities Act of 1992* ensures that individuals with disabilities cannot be discriminated against in job application procedures, hiring, firing, advancement, compensation, fringe benefits, job training, and other terms, conditions, and privileges (United States Department of Labor, 2001).

Counseling Individuals with Disabilities

As federal laws have increasingly supported the right to services for individuals with disabilities, the counselor has taken an increasingly active role in the treatment and rehabilitation of such individuals (Livneh & Antonak, 2005; Lum, 2009; Smart, 2009).

Some treatment guidelines for working with the individual who has a disability include the following:

1. *Have the right attitudes and beliefs, gain knowledge, and learn skills.* Be prepared to work with clients who have a disability by embracing the appropriate knowledge, skills, and beliefs prior to meeting with clients.
2. *Have knowledge of the many disabling conditions.* To be effective, a counselor should understand the physical and emotional consequences of the client's disability.
3. *Help clients know their disabilities.* Help clients understand their disabilities, the probable course of treatment, and the prognosis. Such knowledge allows them to be fully involved in the counseling process.
4. *Assist the client through the grieving process.* Help clients pass through stages of grief as they deal with their loss and move toward acceptance. Similar to the stages of bereavement (Kubler-Ross & Kessler, 2005), it is usual for a client to experience denial, anger, negotiation, resignation, and acceptance.
5. *Know referral resources.* Be aware of potential resources in the community (e.g., physicians, social services, physical therapists, experts on pain management, vocational rehabilitation). Individuals with disabilities often have a myriad of needs.
6. *Know the law and inform your client of the law.* Know the law to ensure that the clients are receiving all necessary services and not being discriminated against. In addition, clients often feel empowered when they know their rights.
7. *Be prepared to do, or refer for, vocational/career counseling.* Be ready to conduct career counseling or to refer a client to a career counselor. Often, when faced with a disability, clients are also faced with making a career transition.
8. *Include the family.* Whenever possible and reasonable, include the client's family in the treatment process, as they can offer support, assist in long-term treatment planning, and help with the client's emotional needs.
9. *Be an advocate.* Advocate for clients by knowing the law, fighting for clients' rights, and assisting clients in fighting for their own rights. Individuals with disabilities are faced with prejudice and discrimination.
10. *Empower your clients.* Avoid being overly sympathetic and having low expectations, and listen and support your client. Assume your client knows what is best for him or her.

Multicultural/Social Justice Focus

Is All Counseling Multicultural?

First counselor asserts: *"All counseling is multicultural, for* everyone *is different and just because you're African American, Asian, or Hispanic or whatever, doesn't mean you're more different than the person I counsel who comes from the same background as me but still has some different values than I have."*

Second counselor retorts: *"You do not understand what it's like to be culturally different. To assert that all counseling is multicultural just shows your ignorance."* Clearly, *some individuals have roots in their unique culture, are dramatically different from you, and you best learn about their unique culture if you are to work with them effectively.*

At the beginning of Section VI, you were asked to consider whether a person can truly understand a client from a different culture. Now that you've read these two chapters, you may want to consider whether you believe, like the first counselor does, that all counseling is multicultural, or like the second counselor, that some groups' cultural differences are great, and one must have basic knowledge of these groups and skills to work with clients from these groups.

I'll let you decide where you stand, but my answer to this challenge lies somewhere in the middle. Is it necessary to gain knowledge and skills about different cultural and ethnic groups? I say, "Yes," because to have empathy and understanding of others, we need to be able to understand fully the world in which the client lives. However, knowledge of specific cultures can also lead to stereotyping and generalizing and not fully seeing the uniqueness of the client. Perhaps we have to have the knowledge and skills but also treat the individual as a unique person just like any other person:

> There is little empirical evidence to support the strict particularist matching of specific culturally based counseling methods with corresponding clients from those cultures (Atkinson & Israel, 2003). Any such practices must always be qualified by individual client differences, due to such factors as enculturation, acculturation, and the convergence of multiple cultural identities (e.g., gender, class, multiple ethnicities) in one person . . . (McAuliffe, Grothaus, Paré, & Wininger, 2008, p. 572)

Client-Counselor Match versus Cultural Competence

Despite the fact that clients tend to "initially seek out counselors of the same race, gender, sexual orientation, and ethnicity as themselves" (McCauliffe et al., 2008, p. 587), the research on counseling outcomes when client and counselor are matched based on any of a number of ethnic/cultural/gender demographics, is mixed (see Gamst, Dana, Der-Karabetian, & Kramer, 2001, 2004; Whitfield, Venable, & Broussard, 2010). In fact, Sue and Lam (2002) note that counselor-client match is probably most important for unacculturated ethnic minorities. In addition, sometimes what appears to be a cultural match actually is not. For instance, a highly acculturated, middle-class, male, African-American counselor may have difficulty relating to a poor African-American male client. In this case, although culture is matched, social class and acculturation are not—both of which may be more important factors. In the long run, it appears that what might be most important is the counselor's cultural competence—that is, whether the counselor has gained the necessary knowledge and skills about the client's culture to work effectively with him or her and is able to demonstrate to the client that he or she is understood (McAuliffe et al., 2008).

Ethical, Professional, and Legal Issues: Making Wise Ethical Decisions

The ACA (2005) ethics code includes many statements that focus on diversity, and you are encouraged to review them (see Chapter 14, Table 14.4). However, the use of codes alone can be problematic, as they tend to "reflect the dominant culture's values at the expense of minority values" (Ridley, Liddle, Hill, & Li, 2001, p. 187). In addition,

some counselors rigidly adhere to codes, which can negate the deeply reflective process that is sometimes needed when faced with difficult ethical dilemmas.

Some suggest that rather than using ethical codes, it would be more advantageous to consider the moral underpinnings of codes, such as admonitions to: respect the autonomy of the client, do no harm to others, promote the good of society, act in a fair manner, and maintain trust (Kitchener, 1984). However, others suggest that such moral codes are based on particular values that may not be cross-culturally relevant. For instance, how one person defines the good of society may be drastically different from how another person defines it—or how another culture defines it.

Clearly, ethical decision-making is complex. On the one hand, we must be careful when using the ethical guidelines, as they might hold some inherent bias and can be used in an absolutist and dualistic fashion. On the other hand, using a moral model may also be biased. At the very least, when making ethical decisions we must make careful, wise decisions based on all of the evidence. Such wise decisions often involve a deeply self-reflective process as well as the attainment of as much knowledge as possible of the situation at hand.

The Counselor in Process: The Ongoing Process of Counseling the Culturally Different

Despite the fact that throughout this text we have stressed specific methods of working effectively with clients, it should be emphasized that counseling methods are not fixed. This is particularly true in the realm of multicultural counseling, as new approaches to working with clients from diverse backgrounds are quickly finding their way into the professional literature. For instance, international counseling theories, which have been largely ignored by American counselors and psychotherapists and which approach counseling in ways that vary greatly from what we are used to, are now finding their way into the literature (Gerstein, Heppner, Aegisdóttir, Leung, & Norsworthy, 2009). This is particularly important because counseling theories are almost exclusively based around Western values (Neukrug, 2011). As counselors, we must continue to find the best ways to assist all individuals. We must continue to examine new treatment approaches, explore new counseling theories, and be open to an expansive view of counseling all individuals. Perhaps we can learn from Romano (1992), who wisely noted:

> *Not ours, not theirs; no one way of counseling surpasses another. . . . As cultures differ, so must counseling.* (Romano, 1992, p. 1)

Summary

In this chapter, we examined the changing face of America and noted that the United States is becoming increasingly diverse and pointed out that by 2050, the majority of Americans will be from nondominant groups. We then highlighted a number of diverse groups, starting with a discussion of people from varying cultural/racial heritages. We first

presented some background information about African Americans, Latinos/Latinas/Hispanics, Asian Americans, and Native Americans. In addition, while encouraging the reader not to overgeneralize, we examined some common customs, values, and behaviors held by many individuals within each of these groups. Also, we highlighted important issues that should be addressed in the counseling relationship with these groups and presented specific suggestions for working with individuals from these groups.

In addition to examining people from varying cultural/racial heritages, we explored a number of other groups because of their unique needs and their tendency to face discrimination. We discussed diversity in religious affiliation and spiritual beliefs, differences between women and men, differences in sexual orientation, and the special issues of individuals who are HIV positive, homeless and poor, older persons, the mentally ill, and individuals with disabilities. No doubt, other groups with unique needs could have also been highlighted.

For each diverse group discussed, we highlighted some of the major issues that individuals within that group are likely to face. For instance, we discussed the importance of recognizing the differences among religions in the United States and throughout the world; the sociopolitical and psychological differences between men and women; some of the myths about and biases against gays, bisexuals, lesbians, and transgendered individuals; the physical and emotional needs of individuals who are HIV positive; the unique characteristics and needs of many individuals who are homeless and/or poor; the interpersonal, psychological, and physical changes that face many older persons; the changes in the treatment of the mentally ill over the years; and the emotional, physical, psychological, and legal concerns of individuals with disabilities. For each of the groups discussed, we stressed that the counselor must be aware of the unique needs and issues that face the culturally diverse client if he or she is to counsel such a client effectively, and we offered specific steps for working with these groups in the helping relationship. Two specific standards we pointed out included the ASERVIC competencies around religion and spirituality, and the APA Guidelines for the Psychological Practice with Girls and Women.

As we neared the end of this chapter, we reminded you of the debate in the field concerning the definition of multicultural counseling, and asked you to decide where you fall. Some assert that all counseling is multicultural and that being culturally sensitive and culturally appropriate by gathering specific knowledge of ethnic/cultural groups can lead to stereotyping and gross generalizations. Others assert that knowledge of a client's cultural background is essential if we are to understand and work effectively with that client. We concluded that in order to gain empathy for the culturally different client it may be important to learn about cultures. However, we also warned that the counselor be vigilant in not stereotyping a client.

Next, we discussed the fact that outcome research on matching client and counselor demographics is mixed, and we suggested that although clients may initially seek out counselors of a similar race, gender, sexual orientation, and ethnicity, such matching does not always lead to better outcomes. We suggested that what is most important is whether the counselor has gained the necessary knowledge and skills to be an effective cross-cultural counselor and whether the client feels understood by the counselor.

We also noted that a controversy exists around the use of the ACA ethical guidelines, with some stating that, despite recent changes in the code, they are inherently biased because codes, in general, reflect the dominant culture's values. We suggested that a moral-based model might be used as an adjunct to the ethical guidelines.

However, we noted some potential problems with that model also and suggested that being wise, self-reflective, and careful when faced with ethical dilemmas is crucial.

Finally, we concluded the chapter by noting that the theories and skills important to the multicultural counseling relationship will continue to change in the future, perhaps more rapidly than in other counseling disciplines. We highlighted the importance of staying current with these changes if we are to be effective with clients from diverse backgrounds.

◼ *References*

Adams, H E., Wright, L.W., & Lohr, B. A. (1996). Is homophobia associated with homosexual arousal? *Journal of Abnormal Psychology, 105*(3), 440–445. doi:10.1037/0021-843X.105.3.440

Addis, M. E., & Mahalik, J. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5–14. doi:10.1037/0003-066X.58.1.5

Allen, J. P., & Turner, E. J. (1988). *We the people: An atlas of America's ethnic diversity*. New York: Macmillan.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Psychological Association. (1997). *Appropriate therapeutic responses to sexual orientation*. Retrieved from http://www.apa.org/about/governance/council/policy/appropriate.aspx

American Psychological Association. (2007). *Guidelines for psychological practice with girls and women*. Washington, D.C.: Author.

Anderson, E. (2009). *Inclusive Masculinity: The changing nature of masculinities*. New York: Routledge.

Association for Spiritual, Ethical, and Religious Values in Counseling. (2009). *Spiritual competencies*. Retrieved from http://aservic.org/?page_id=133

Axelson, J. A. (1999). *Counseling and development in a multicultural society* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Atkinson, D. R., & Hackett, G. (2004). An introduction to nontraditional interventions and diverse populations. In D. R. Atkinson & G. Hackett (Eds.), *Counseling diverse populations* (3rd ed., pp. 3–35). Boston: McGraw-Hill.

Berger, J. M., Levant, R. F., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help seeking. *Psychology of Men and Masculinity, 6*(1), 73–78. doi:10.1037/1524-9220.6.1.73

Britton, P. J., Cimini, K. T., & Rak, C. F. (1999). Techniques for teaching HIV counseling: An intensive experiential model. *Journal of Counseling and Development, 77*(2), 171–176.

Britton, P. J., Rak, C. F., Cimini, K. T., & Shepherd, J. B. (1999). HIV/AIDS education for counselors: Efficacy of training. *Counselor Education and Supervision, 39*, 53–65.

Brown, L.S., & Bryan, T.C. (2007). Feminist therapy with people who self-inflict violence. *Journal of Clinical Psychology: In Session, 63*(11), 1121–1133. doi:10.1521/jsyt.2008.27.2.92

Broverman, N. (2010, April 5). *McMillen: I was sent to a fake prom*. Retrieved from http://www.advocate.com/News/Daily_News/2010/04/05/ACLU_Investigating_Fake_Prom/

Brown, C.G., Weber, S., & Ali, S. (2008). Women's body talk: A feminist narrative approach. *Journal of Systemic Therapies, 27*(2), 92–104.

Burger, W., (2008). *Human services in contemporary America* (7th ed.). Belmont, CA: Brooks/Cole.

Casas, J. M., Raley, J. D., & Vasquez, M. J. T. (2008). ¡Adelante! Counseling the Latina/o from guiding theory to practice. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (6th ed., pp. 113–128). Thousand Oaks, CA: Sage.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131–139.

Centers for Disease Control. (2010, July). *HIV and AIDS in the United States*. Retrieved from http://www.cdc.gov/hiv/resources/factsheets/us.htm

Chiang, H. (2008). Effecting science, affecting medicine: Homosexuality, the Kinsey reports, and the contested boundaries of psychopathology in the United States, 1948–1965. *Journal of the History of the Behavioral Sciences, 44*(4), 300–318. doi:10.1002/jhbs.20343

Chinman, M. J., Bailey, P., Frey, J., & Rowe, M. (2001). Developing the case management relationship with seriously mentally ill homeless individuals. In F. Flach (Ed.), *Directions in rehabilitation counseling, 2001*, (vol. 22, 107–119). New York: Hatherleigh Co., Ltd.

Clawson, T., Henderson, D. A., Schweiger, W. K., & Collins, D. R. (2008). *Counselor Preparation: Programs, faculty, trends* (12th ed.). New York: Brunner-Routledge.

Cole, W., Gorman, C., Barrett, L. I., & Thompson, D. (1993, April 26). The shrinking ten percent. *Time, 27–29.*

Delgado-Romero, E. A., Galván, N., Hunter, M. R., & Torres, V. (2008). Latino/Latina Americans. In McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 323–352). Thousand Oaks, CA: Sage Publications.

Dillon, F., Worthington, R., Savoy, H., Rooney, S., Becker-Schutte, A., & Guerra, R. (2004). On becoming allies: A qualitative study of lesbian-, gay-, and bisexual-affirmative counselor training. *Counselor Education and Supervision, 43*(3), 162–178.

Eberz, A. B., & Bieschke, K. J. (2002, August). *Psychologists' attitudes and clinical evaluations for LBG clients.* Paper presented at the annual conference of the American Psychological Association, Chicago, IL. (ERIC Document Reproduction Service No. ED471441)

Else-Quest, N., Hyde, J., & Linn, M. (2010). Cross-national patterns of gender differences in mathematics: A meta-analysis. *Psychological Bulletin, 136*(1), 103–127. doi:10.1037/a0018053

Ericksen, K., Jackson, S. A., & Weld, C. (2008). Religion and spirituality. In McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 506–568). Thousand Oaks, CA: Sage Publications.

Evans, K. M., & George, R. (2008). African Americans. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 146–187). Thousand Oaks, CA: Sage Publications.

Exploring Religious America. (2002, April 26). *A poll conducted for religion and ethics newsweekly and U.S. News & World Report*. Retrieved from http://www.pbs.org/wnet/religionandethics/week534/specialreport.html

Funderburk, J.R., & Fukuyama, M.A. (2002). Feminism, multiculturalism, & spirituality. *Women and Therapy, 24*(3), 1–18. doi:10.1300/J015v24n03_01

Gallup. (2010). *Gay and lesbian rights*. Retrieved from http://www.gallup.com/poll/1651/Gay-Lesbian-Rights.aspx

Gamst, G., Dana, R., Der-Karabetian, A., & Kramer, T. (2001). Asian American mental health clients: Effects of ethnic match and age on global assessment and visitation. *Journal of Mental Health Counseling, 23*(1), 57–71.

Gamst, G., Dana, R., Der-Karabetian, A., & Kramer, T. (2004). Ethnic match and treatment outcomes for child and adolescent mental health center clients. *Journal of Counseling and Development, 82*(4), 457.

Garrett, M. T. (2004). Profile of Native Americans. In D. R. Atkinson (Ed.), *Counseling American minorities* (6th ed., pp. 147–170). Boston: McGraw-Hill.

Garrett, M. T. (2008). Native Americans. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 220–254). Thousand Oaks, CA: Sage Publications.

Garske, G. G. (2009). Psychiatric disability: A biopsychosocial challenge. In I. Marini, & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 647–654). New York: Springer.

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients. The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology, 42,* 356–364. doi:10.1037/0022-0167.42.3.356

Gerstein, L. H., Heppner, P. P., Aegisdóttir, S., Leung, S. A. & Norsworthy, K. L.(Eds.). (2009). *International handbook of cross-cultural counseling: Cultural assumptions and practices worldwide*. Thousand Oaks, CA: Sage.

Good, G. E., & Brooks, G. R. (2005). *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches*. New York: Wiley.

Good, G. E., Gilbert, L. A., & Scher, M. (1990). Gender aware therapy: A synthesis of feminist therapy and knowledge about gender. *Journal of Counseling and Development, 68*, 376–380.

Goodman, J., Schlossberg, N. K., & Anderson, M. L. (2006). *Counseling adults in transition: Linking practice with theory* (3rd ed.). New York: Springer Publishing Company.

Greer, M. (2005, June). Keeping them hooked in. *APA Monitor, 36*(6), p. 60.

Guidelines for psychotherapy with lesbian, gay, and bisexual clients (2000). *American Psychologist, 55*(12), 1440–1451. doi:10.1037/0003-066X.55.12.1440

Harkins, A. K., Hansen, S. S., & Gama, E. M. P. (2008). Updating gender issues in multicultural counseling. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.). *Counseling across cultures* (6th ed., pp. 185–200). Thousand Oaks, CA: Sage.

Herring, R. D. (2004). Physical and mental health needs of Native American Indian and Alaska Native populations. In D. R. Atkinson (Ed.), *Counseling American minorities* (6th ed., pp. 171–192). Boston: McGraw-Hill.

Hyde, J. S. (2005). The gender similarities hypothesis. *American Psychologist, 60*(6), 581–592. doi:10.1037/0003-066X.60.6.581

Juntunen, C. L., & Morin, P. M. (2004). Treatment issues for native Americans: An overview of individual, family, and group strategies. In D. R. Atkinson (Ed.), *Counseling American minorities*. (6th ed., pp. 193–213). Boston: McGraw-Hill.

Kalichman, S. C., Klein, S. J., Kalichman, M. O., O'Connell, D. A., Freedman, J. A., Eaton, L. C. & Cain, D. (2007). HIV/AIDS case managers and client HIV status disclosure: Perceived client needs, practices, and services. *Heatlh and Social Work, 32*(4), 259–267.

Kees, N. L. (Ed.). (2005). Special issue on women and counseling. *Journal of Counseling and Development, 83*(3).

Kees, N. L., Carlson, L. A., Parmley, R., Dahlen, P., Evans, K., Marbley, A. R., …& Snyder, B. (2005). Women and counseling: A vision for the future. *Journal of Counseling and Development, 83*, 381–383.

Kim, B. S., & Park, Y. S. (2008). East and Southeast Asian Americans. In McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 188–219). Thousand Oaks, CA: Sage Publications.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Philadelphia: Saunders.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12*(3), 43–45. doi:10.1177/0011000084123005

Kosmin, B. A., & Keysar, A. (2008). *American religious identification survey*. Hartford, CO: Trinity College.

Kubler-Ross, E., & Kessler, D. (2005). *On grief and grieving*. New York: Scribner.

Lamar, J. (1992). The problem with you people. *Esquire, 117*, 90–91, 94.

Levinson, D. (1978). *The seasons of a man's life*. New York: Knopf.

Lindner, E. (Ed.). (2009). *Yearbook of American and Canadian churches*. Nashville, TN: Abingdon Press.

Livneh, H., & Antonak, R. F. (2005). Psychosocial adaptation to chronic illness and disability: A primer for counselors. *Journal of Counseling and Development, 83*, 12–20.

Lum, C. (2009). *Federal information resources for professional counselors*. Alexandria, VA: American Counseling Association.

Macionis. J. J. (2009). *Sociology* (13th ed.). Upper Saddle River, NJ: Prentice Hall.

Martila Communications Group (2005). *American attitudes toward Jews in America*. Retrieved from http://www.adl.org/anti_semitism/Anti_Semitic_Attitudes_files/frame.htm

McAuliffe, G., Grothaus, T., Paré, D., & Wininger, A. (2008). The practice of culturally alert counseling. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 570–631). Thousand Oaks, CA: Sage Publications.

McAuliffe, G. (2006). Speaking out for the love that dare not speak its name: A challenge to counselors to support lesbian and gay clients. *Counseling Today 48*, 38–41.

McCarthy, J., & Holliday, E. L. (2004). Help-seeking and counseling within a traditional male gender role: An examination from a multicultural perspective. *Journal of Counseling and Development, 82*, 25–30.

McGoldrick, M. (2005). History, genograms, and the family life cycle: Freud in context. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 47–68). Boston: Allyn & Bacon.

Mejia, X. (2005). Gender matters: Working with adult male survivors of trauma. *Journal of Counseling and Development, 83*, 29–40.

Mortola, P., Hiton, H., & Grant, S. (2008). *BAM!: Boys advocacy and mentoring*. New York: Routledge.

Mohr, J. J., Weiner, J., Chopp, R., & Wong, S. (2009). Effects of client bisexuality on clinical judgment: When is bias most likely to occur? *Journal of Counseling Psychology*, 56(1), 164–175. doi:10.1037/a0012816

Morrow, S. L. (2004). Finding the "yes" within ourselves: Counseling lesbian and bisexual women. In D. R. Atkinson & G. Hackett (Eds.), *Counseling diverse populations* (3rd ed., pp. 366–387). Boston: McGraw-Hill.

Myers, J. E., & Harper, M. C. (2004). Evidence-based effective practice with older adults. *Journal of Counseling and Development, 82*, 207–218.

Naidoo, A. V., & Kagee, A. (2009). The quest for relevance. Counseling psychology in South Africa. In. L. H. Gerstein, P. P. Heppner, S. Aegisdóttir, S. A. Leung, & K. L. Norsworthy (Eds.), *International handbook of cross-cultural counseling: Cultural assumptions and practices worldwide* (pp. 421–334). Thousand Oaks, CA: Sage.

National Coalition for the Homeless. (2009). *How many people experience homelessness?* Retrieved from http://www.nationalhomeless.org/factsheets/How_Many.html

National Institute of Mental Health. (2010). *The numbers count: Mental disorders in America*. Retrieved from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml

Neukrug, E. (2008). *Theory, practice, and trends in human services: An introduction* (4th ed.). Belmont, CA: Brooks/Cole.

Neukrug, E. (2011). *Counseling theory and practice*. Belmont, CA: Brooks/Cole.

Newport, F. (2009, December 24). *Gallup: This Christmas, 78% of Americans identify as Christian*. Retrieved from http://www.gallup.com/poll/124793/This-Christmas-78-Americans-Identify-Christian.aspx

Orsulic-Jeras, S., Shepherd, J. B., & Britton, P. J. (2003). Counseling older adults with HIV/AIDS: A strength-based model of treatment. *Journal of Mental Health Counseling, 25*, 233–244.

Osherson, S. (2001). *Finding our fathers: How a man's life is shaped by his relationship with his father*. New York: McGraw-Hill. (Original work published 1986)

Petersen, J., & Hyde, J. (2010). A meta-analytic review of research on gender differences in sexuality, 1993–2007. *Psychological Bulletin*, 136(1), 21–38. doi:10.1037/a0017504

Phelps, R. E., Taylor, J. D., & Gerard, P. A. (2001). Cultural mistrust, ethnic identity, racial identity, and self-esteem among ethnically diverse Black university students. *Journal of Counseling and Development, 79*, 209–216.

Pollack, W. S., & Levant, R. F. (1998). *New psychotherapy for men*. New York: Wiley.

Pope, M. (2008). Culturally appropriate counseling considerations for lesbian and gay clients. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (6th ed., pp. 201–222). Thousand Oaks, CA: Sage.

Rainey, S., & Trusty, J. (2007). Attitudes of master's-level counseling students toward gay men and lesbians. *Counseling and Values*, *52*(1), 12–25.

Rayle, A., Chee, C., & Sand, J. (2006). Honoring their way: Counseling American Indian women. *Journal of Multicultural Counseling and Development*, *34*(2), 66–80.

Ridley, C. R., Liddle, M. C., Hill, C. L., & Li, L. C. (2001). Ethical decision making in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander, *Handbook of multicultural counseling* (2nd ed., pp. 165–188).

Robinson-Wood, T. L. (2009). Advocacy and social justice. In T. L. Robinson-Wood, *The convergence of race, ethnicity, and gender: Multiple identities in counseling* (3rd ed.; pp. 284–294). Upper Saddle River, NJ: Merrill.

Romano, G. (1992). Description of D. Locke's "Counseling beyond U.S. borders." *American Counselor, 1*(2), 13–17.

Saad, L. (2006). *Gallup poll: Americans at odds over gay rights*. Retrieved from http://www.gallup.com/poll/23140/Americans-Odds-Over-Gay-Rights.aspx

Saad, L. (2008). *Gallup poll: Americans evenly divided on morality of homosexuality.* Retrieved from http://www.gallup.com/poll/108115/Americans-Evenly-Divided-Morality-Homosexuality.aspx

Saravi, F. (2007). The elusive search for a 'gay gene.' In D. S. Sergio (Ed.), *Tall tales about the mind and brain: Separating fact from fiction* (pp. 461–477). New York: Oxford University Press.

Schwiebert, V. L., Myers, J. E., & Dice, C. (2000). Ethical guidelines for counselors working with older adults. *Journal of Counseling and Development, 78,* 123–129.

Seem, S. R., & Johnson, E. (1998). Gender bias among counseling trainees: A study of case conceptualization. *Counselor Education and Supervision, 37,* 257–268.

Smart, J. (2009). Counseling individuals with disabilities. In I. Marini, & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 639–646). New York: Springer.

Steinhaus, D. A., Harley, D. A., & Rogers, J. (2004). Homelessness and people with affective disorders and other mental illnesses. *Journal of Applied Rehabilitaiton Counseling, 35*(1), 36–40.

Stickle, F., & Onedera, J. (2006). Teaching gerontology in counselor education. *Educational Gerontology, 32*(4), 247–259. doi:10.1080/03601270500493974

Substance Abuse and Mental Health Services Administration. (2002). *Section V. National service statistics.* Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/Chapter19.asp

Substance Abuse and Mental Health Services Administration. (2008). *Homelessness Resource Center.* Retrieved from http://homeless.samhsa.gov/Resource/View.aspx?id=48800

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.

Szymanski, D. (2008). Lesbian, gay, bisexual, and transgendered clients. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 466–505). Thousand Oaks, CA: Sage Publications.

Szymanski, D., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *Counseling Psychologist, 36*(4), 510–524. doi:10.1177/0011000007309488

Thornton, R. (1996). Population: Precontact to present. In F. E. Hoxie (Ed.), *Encyclopedia of North American Indians* (pp. 500–502). New York. Houghton Mifflin.

Torrey, E. F. (1997). *Out of the shadows: Confronting America's mental illness crisis.* New York: Wiley.

Tsering, G. T. (2005). *The four noble truths: The foundation of Buddhist thought (vol. 1).* Somerville, MA: Wisdom Publications.

UNAIDS. (2010). *UNAIDS report on the global AIDS epidemic: 2010.* Retrieved from http://www.unaids.org/GlobalReport/Global_report.htm

United States Census Bureau. (2003a). *No. HS-3 Population by age: 1900 to 2002*. Retrieved from http://www.census.gov/statab/hist/HS-03.pdf

United States Census Bureau. (2003b). *Disability status 2000: Census 2000 brief*. Retrieved from http://www.census.gov/prod/2003pubs/c2kbr-17.pdf

United States Census Bureau. (2006). *We the people: American Indians and Alaska Natives in the United States*. Retrieved from http://www.census.gov/prod/2006pubs/censr-28.pdf

United States Census Bureau. (2008). *An older more diverse nation by midcentury*. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb08-123.html

United States Census Bureau. (2009a). *Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2000 to July 1, 2009* (NC-EST2009-03). Retrieved from http://www.census.gov/popest/national/asrh/NC-EST2009-srh.html

United States Census Bureau. (2009b). *Income, poverty, and health insurance coverage in the United States: 2008*. Retrieved from http://www.census.gov/prod/2009pubs/p60-236.pdf

United States Census Bureau. (2010). *Race and Hispanic origin of the foreign-born population in the United States: 2007*. Retrieved from http://www.census.gov/prod/2010pubs/acs-11.pdf

United States Department of Housing and Urban Development. (1995). *Stuart B. McKinney Homeless Program*. Retrieved from http://www.huduser.org/portal/publications/homeless/mckin/toc.html

United States Department of Justice. (2008). *Hate crime statistics*. Retrieved from http://www.fbi.gov/ucr/hc2008/data/table_01.html

United States Department of Labor. (2001). *The Americans with Disabilities Act: Public law 101-366*. Retrieved from http://www.dol.gov/odep/pubs/fact/ada92fs.htm

Walsh, J. (2000). *Clinical case management with persons having mental illness: A relationship-based perspective*. Belmont, CA: Brooks/Cole.

Wester, K. L., & Trepal, H. C. (2008). Gender. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 429–465). Thousand Oaks, CA: Sage Publications.

Wexler, D. B. (2009*). Men in therapy: New approaches for effective treatment*. New York: W. W. Norton.

Whitfield, H., Venable, R., & Broussard, S. (2010). Are client-counselor ethnic/racial matches associated with successful rehabilitation outcomes? *Rehabilitation Counseling Bulletin, 53*(2), 96–105. doi:10.1177/0034355209338526

Whitman, J. S., Glosoff, H. L., Kocet, M. M., & Tarvydas, V. (2006). *ACA in the news: Ethical issues related to conversion or reparative therapy*. Retrieved from http://www.counseling.org/PressRoom/NewsReleases.aspx?AGuid=b68aba97-2f08-40c2-a400-0630765f72f4

Wong, D. F. K. (2006). *Clinical case management for people with mental illness: A biopsychosocial vulnerability-stress model*. Binghamton, NY: Haworth Press.

Wong-Wylie, G. (2003). Preserving hope in the duty to protect: Counselling clients with HIV or AIDS. *Canadian Journal of Counselling, 27*(1), 35–43.

Yarhouse, M. A. (2003). Working with families affected by HIV/AIDS. *The American Journal of Family Therapy, 31*, 125–137. doi:10.1080/01926180301124

This page intentionally left blank

Select Specialty Areas in Counseling

Overview

*T*he three chapters in this section represent the most frequently chosen specialty areas of today's counseling students. Chapter 16 focuses on elementary, middle, and secondary school counseling. Chapter 17 examines a large array of agency and private practice settings, and Chapter 18 examines a wide range of settings in which a counselor might work in higher education. Throughout these chapters the same format is used, and includes: a broad definition of what the specialty area encompasses, a brief history of the specialty area, some typical functions and roles of counselors in that specialty area, the theoretical basis by which counselors in the specialty area work, and examples of settings where we find the counselor in the specialty area. As with all previous chapters, we conclude with a discussion of multicultural/social justice issues; ethical, professional, and legal concerns; and some thoughts about "the counselor in process."

Many of you may have already decided the specialty area that best suits you. For you, these sections will likely offer a little more depth about your chosen career goal as they highlight foundational components of each specialty area. For the rest of you, I believe these chapters will help you choose the specialty area that you want to pursue. By understanding the philosophical basis and practical implications of each specialty area, your choice about your future specialty area in counseling will hopefully become clearer. In either case, I hope you find the following chapters interesting and enlightening.

CHAPTER **16**
School Counseling[1]

After several years of teaching middle and high school and serving as a campus and youth minister, I wanted to continue my work with young people but felt a need for additional tools and a new trade. I chose the community/agency counseling track at the local university and completed the program. With degree in hand, I was hired as a counselor in a residential treatment center for adolescents with substance abuse concerns.

It was a challenging and rewarding job. Even though we had our clients for extended periods of time, I was concerned about the high rate of relapse. It seemed that, once our clients left our treatment cocoon, they often returned to an atmosphere that was not recovery-friendly. I wondered what kind of proactive prevention and intervention services could be provided for young people in our schools and communities. When an opening in the prevention branch of my agency was posted, I took the new position and soon found myself hired out to a local middle school as a Student Assistance Counselor.

There I found my professional home. I truly enjoyed and appreciated working with the passionate and dedicated middle school counselors who provided an amazing array of services for all of the students on their rather large caseloads. Soon after, I completed my school counseling endorsement by taking the one school counseling class my alma mater offered. It did strike me that, although the school counseling job was significantly different than my work as an agency counselor, the training to be a school counselor seemed like a rather brief "add on" to the core counseling training in my program.

Times have changed. After ten terrific years as a school counselor, I now have the privilege and pleasure to teach folks who want to become school counselors. Our current preparation program is markedly different from my experience, offering additional coursework and credit hours in school counseling beyond the 48 hours that CACREP requires. This is a welcome opportunity to provide additional educational experiences in developing the knowledge, skills, and awareness needed for school counseling students to successfully serve as advocates, leaders, collaborators, and change agents.

It is my opinion that school counselors are counselors and educators; both identities are needed to promote equity and success for all students. We've made great progress in

---

[1] This chapter was co-written by Ed Neukrug and Tim Grothaus.

the twenty years I've been associated with school counseling. Studies show our students are benefiting from our comprehensive school counseling programs and the many services we now offer. The current challenges we face are considerable but the future for school counselors and those we serve looks promising. *Tim Grothaus*

*T*his chapter will explore the world of the school counselor. You will first be given some brief definitions of school counseling and then be presented with a synopsis of the history of school counseling. This will be followed by a description of the functions and roles of the school counselor and some of the theories school counselors use to do their work. Next, we will examine the settings and the kinds of work school counselors do in elementary, middle, and secondary schools. The chapter will conclude by discussing multicultural/social justice, ethical, professional, and legal issues in school counseling.

■ What Is School Counseling?

The school counselor's roles are many and varied and sometimes much more involved than most people think (see Table 16.1). One moment a school counselor might be chatting with a student about his college application, and the next moment she is engrossed with a sobbing student that is threatening to kill herself. Over the last few decades, school counseling has changed its emphasis from providing services for some students to implementing a comprehensive school counseling program that serves *all* students. The American School Counselor Association (ASCA) suggests that, in addition to asking the question, "What do school counselors do?" school counselors now must also answer the question, "How are students different as a result of what we do?" (2005a, p. 9). So, who is the school counselor? ASCA's role statement for school counselors states:

> *Professional school counselors are certified/licensed educators with a minimum of a master's degree in school counseling making them uniquely qualified to address all students' academic, personal/social and career development needs by designing, implementing, evaluating and enhancing a comprehensive school counseling program that promotes and enhances student success. . . . Professional school counselors serve a vital role in maximizing student success (Lapan, Gysbers, & Kayson, 2007; Stone & Dahir, 2006). Through leadership, advocacy and collaboration, professional school counselors promote equity and access to rigorous educational experiences for all students. Professional school counselors support a safe learning environment and work to safeguard the human rights of all members of the school community (Sandhu, 2000), and address the needs of all students through culturally relevant prevention and intervention programs that are a part of a comprehensive school counseling program* (Lee, 2001). (ASCA, 2009, para. 1–2)

School counselors are employed at the elementary, middle, and high school levels. Some states offer a K-through-12 school counseling credential, whereas others have separate credentialing for elementary, middle, and secondary school counselors. In a small

TABLE 16.1

Examples of the Many Roles and Functions of the Professional School Counselor

- A student is sent to the counselor by his grade two teacher with a note that reads, "Tomas hasn't been himself. He's not getting his work completed and doesn't seem to be paying attention. Would you please talk with him and see what might be going on?"
- The high school counselor notes the disproportionally low number of students of color, students receiving special education services, and students receiving free and reduced lunches enrolled in AP or IB classes and rigorous coursework. She states her concern at the school leadership team meeting, advocates for collaboration with feeder schools to address this situation, and works toward making the system more equitable.
- Some third graders are immersed in a group for students whose parents are deployed in the military.
- Checking in on the new faculty, the school counselor notes that a first year seventh-grade teacher is struggling with classroom management in one of his classes. The school counselor offers to consult with the teacher.
- James, a quiet third-grade boy, comes to school with bruises on his upper arms. He reveals to the school counselor that his parent punches him and hurts him.
- A school counselor conducts a series of classroom guidance lessons on harassment, bullying, and the role of bystanders for the sixth-grade classes. The school counselor consults and collaborates with the sixth-grade faculty teams and administrator to implement school safety measures and enhance the school climate.
- Jamal, a twelfth-grade student, asks his counselor to write a college recommendation letter.
- The school counselor is part of the Response to Intervention team examining services for English Language Learners (ELL) school wide and for those ELL students who have low test scores.
- Two fifth-grade students who were arguing on a school bus begin to push and shove one another. The bus driver tells them to go to the counselor or they will be disciplined. The counselor works with the students to mediate their concern and also has them join a social skills/conflict resolution skills group.
- Concerned about the high rate of ninth-grade retention, the school counselor collaborates with the school improvement team to implement a prevention plan that includes: classroom guidance lessons on study skills, time management, and testing-taking skills (with small groups for those needing additional assistance); establishing a peer tutoring program; and coordinating the training, supervision, and services offered by volunteer mentors from the community.

- Rachel, a fourth-grade student, requests to see the counselor to talk about a problem in one of her classes. In the middle of the conversation, she blurts out that her parents have just separated, and she begins to sob.
- Concerned about the discrepancies in the number of disciplinary referrals along racial or ethnic lines, a school counselor decides to meet with principals and teachers to develop a plan to address this issue.
- A parent shares with the school counselor that his daughter is receiving treatment for substance abuse and asks the counselor to coordinate in-school services with the substance abuse treatment agency.
- A student approaches the school counselor with concerns about being pregnant and not wanting her parents to know.
- A middle school counselor and a high school counselor are asked to join a district-wide task force seeking to increase the number of students completing high school and attending a post-secondary institution.
- The parent of an eighth grader comes to see the counselor with concerns over the violence in her community and how it might affect her son. The counselor connects her with resources in their community, including a community advocacy group to which the counselor belongs.
- Your school system's school counseling director asks all of the counselors to examine aggregated and disaggregated high stakes test scores in their building and then develop a plan to assist students with low test scores.
- Two seventh graders approach the school counselor with a concern that their friend has been cutting and sometimes burning himself on a regular basis.
- The school counselor works with the tenth-grade language arts faculty to develop a career guidance curriculum that fits into the language arts curriculum.
- A group of eleventh-grade girls comes to the school counselor concerned about sexually transmitted diseases.
- A group of several elementary school counselors work together to provide peer supervision. They decide to assist and support each other as all of them apply for Recognized ASCA Model Program (RAMP) status, a national recognition of a fully implemented school counseling program.
- A teacher asks the counselor how to interpret the achievement test scores for her classes.
- The school counselor works with a first-grade teacher to implement behavior plans and classroom management/instructional changes for students struggling in her class.

handful of states, school counselors are required to have teaching certificates and experience, although the trend has been to eliminate this prerequisite. More than three decades of research on the importance and efficacy of being a teacher before being a school counselor appears to indicate that school counselors with and without teaching background are equally capable and competent (Baker & Gerler, 2008).

In order to become a school counselor, one must have a master's degree in school counseling. Such degrees often are similar to master's degrees in other counseling specialty areas. The preparation program requirements range from having one distinctive course in school counseling (along with practicum and/or internship experiences in the schools) to having most of the classes geared specifically to school counseling. In many programs, students who are in the school counseling "track" are asked to focus their projects on school counseling as they take all of their courses.

Although school counseling is commonplace today, this was not always the case. Let's review the history of school counseling and then take a more extensive look at the roles and functions of school counselors at the elementary, middle, and secondary levels.

A History of School Counseling

Early Developments

Although societies throughout the world have long provided means and methods to support or train their youth to assume adult roles, the systematic provision of counseling and guidance to young people appears to be an American innovation (Herr & Erford, 2011). Against the backdrop of the Industrial Revolution and the Progressive Education movement, vocational guidance interventions attempted to assist young people in their moral or character development and to negotiate the work environment (Schmidt, 2008). Early efforts included George Merrill's vocational guidance program at the California School of Mechanical Arts in San Francisco in 1895, Jesse B. Davis' initiation of a systematic guidance program at Central High School in Detroit in 1898, and the work of Anna Y. Reed in Seattle schools and Eli Weaver at Boys High School of Brooklyn (Baker & Gerler, 2008; Schmidt, 2008).

From the start, school counselors' roles and functions have been responsive to the influential social, political, and economic concerns of the times (Gysbers, 2010). At the beginning of the twentieth century, the first school counselors were trained in response to an increased need for vocational guidance. Society was becoming more complex, and individuals struggled to find their place in a rapidly changing world. Recognizing the need to train experts in vocational guidance, Frank Parsons organized the Boston Vocational Bureau in 1908, which trained teachers and others in vocational guidance. Parsons, who developed the *trait-and-factor* approach to vocational guidance, believed that successful vocational choice was based on (1) an understanding of self (e.g., abilities, interests, basic personality dynamics), (2) knowledge of the principles of success and of occupational information, and (3) the ability to make a reasoned vocational choice based on one's understanding of self and one's knowledge of the world of work (Schmidt, 2008).

Parsons (1909) was very concerned about the counseling process, and many of his ideas were ahead of his time. For instance, Parsons believed that counselors should possess the following qualifications:

1. A practical working knowledge of the fundamental principles and methods of modern psychology.
2. An experience involving sufficient human contact to give them an intimate acquaintance with human nature in a considerable number of its different phases; they must understand the dominant motives, interests, and ambitions that control people's lives, and be able to recognize the symptoms that indicate the presence or absence of important elements of character.
3. An ability to deal with young people in a sympathetic, earnest, searching, candid, helpful, and attractive way.
4. A knowledge of requirements and conditions of success, compensation, prospects, advantages, and disadvantages, etc., in different lines of industry.
5. Information relating to courses of study and means of preparing for various callings and developing efficacy therein.
6. Knowledge of scientific method analysis and principles of investigation by which laws and causes are ascertained, facts are classified, and correct conclusions drawn. (Parsons, 1909, pp. 94–95)

Widely recognized as the *Founder of Vocational Guidance*, Parsons helped to identify and launch a new profession, *guidance counseling* (Pope & Sveinsdottir, 2005). His work, along with the efforts of Merrill, Davis, Weaver, Reed, and others, greatly influenced American education and was an impetus for the spread of vocational guidance to school systems around the country (Gysbers & Henderson, 2006; Schmidt, 2008) (see Chapter 2). Although Parsons died at a relatively young age in 1908, his efforts were responsible for the first use of school counselors; they were teachers that added vocational counselor duties to their full time job (Gysbers, 2010). This eventually led to the first required certification for guidance personnel, which was mandated in New York State in 1926 (Herr & Erford, 2011). Counseling, at least vocational counseling, was establishing itself in the schools.

Developments in the area of assessment came on the heels of the vocational guidance movement. Soon, psychometrics was to become a crucial piece of vocational guidance, as it was the vehicle to help students and others identify their abilities and interests. Guidance work in schools was also influenced in these early decades by the burgeoning mental hygiene movement with its emphasis on individual adjustment and mental health (Baker & Gerler, 2008; Gysbers & Henderson, 2006). As vocational guidance spread throughout the United States, individuals began to advocate for a broader approach to school counseling that attended to a large variety of students' psychological and educational needs (Herr & Erford, 2011). For instance, advocates like John Brewer (1932) suggested that guidance be seen in a total educational context and that guidance counselors be involved in a variety of functions in the schools, including adjustment counseling, assistance with curriculum planning, classroom management, and, of course, occupational guidance. During the 1930s and into the 1940s, school guidance workers often used E. G. Williamson's *directive approach* to counseling, which promoted setting goals, overcoming obstacles, and achieving a satisfactory lifestyle (Schmidt, 2008).

During the 1940s, the directive approach was overshadowed by the *nondirective*, relationship-oriented, humanistic approaches of Carl Rogers and others (Gysbers & Henderson, 2006). The humanistic philosophy was to affect all of counseling, and it soon seeped into the training of school counselors. The days where school counselors were seen as only providing vocational counseling within a directive and didactic framework were clearly gone. Now, within a humanistic framework, they would provide a broad spectrum of counseling services that included mental health counseling, consultation, coordination of services, and, of course, the more traditional guidance functions.

Modern Day School Counseling: Becoming a Profession

Several factors led to the rapid expansion of school counseling and the emergence of school counseling as a recognized profession. The passage of the *George-Barden Act* in 1946 provided federal government funding for the first time to support counseling and guidance in schools (Schmidt, 2008). In 1953, the American School Counselor Association (ASCA) (see www.schoolcounselor.org) became the fifth division of the American Personnel and Guidance Association (today, the American Counseling Association, or ACA). Over the years, ASCA has shaped the direction of school counseling through discussion, debate, conferences, and the publication of role statements, journals, position papers, ethical standards, and more recently, a national model for school counseling (ASCA, 2005a). Also during the 1950s, the Association for Counselor Education and Supervision (ACES) and the National Career Development Association (NCDA), two other ACA divisions, were founded. These associations have significantly contributed to the development of school counseling by highlighting school counseling issues, developing interest networks, establishing accreditation procedures, offering program sessions at conferences, supporting legislative initiatives, and collaborating with ASCA (Baker & Gerler, 2008).

In 1957, the Soviet satellite Sputnik "launched" a new round of Cold War competition between the USA and the USSR. Suddenly, Americans were jolted into believing there was a great need for more trained scientists so we could beat the Soviets to the moon. There was public criticism of education and its failure to supply trained individuals for careers identified as vital to the national well-being. As a direct result, the *National Defense Education Act* (NDEA) of 1958 was passed to help create and define counseling positions within the public schools. This act allocated funds for training institutes to quickly graduate secondary school counselors. Those counselors were then charged with the task of identifying young people who had math and science talent and to encourage these students to pursue further studies in the sciences. Although the goal of the NDEA was to train vocational counselors, the humanistic and mental health orientation of school counseling was firmly embedded into counselor training, and it was not long before these guidance counselors were doing many other things besides vocational counseling.

In the middle and late 1960s, school counseling expanded further with the passage of the *Elementary and Secondary Education Act* and *Vocational Education Act* amendments. These acts focused on the implementation of specialized programs beyond the traditional college-bound and vocationally oriented students to include services for students from families with low income, school dropouts, and those having severe academic problems, as well as promoting elementary school counseling (Herr & Erford, 2011). These acts and others directly stimulated growth in many other areas of the school counseling profession, including performance standards for school counselors, criteria for the

credentialing of school counselors, and the strengthening of accrediting bodies such as those established by state departments of education. All of these developments launched what became known as the new era in the guidance and counseling profession (Gibson & Mitchell, 2008).

During the 1960s, 1970s, and 1980s, the school counseling profession saw a gradual but consistent broadening of the services it provided to students and also the need for attention to cultural competence in designing and delivering services (Baker & Gerler, 2008; Gysbers, 2010). During these decades, graduate programs in counseling, and subsequently school counselors, gave greater attention to developmental theories and how school counselors could have an impact on the predictable stages of development experienced by all students (Havighurst, 1972). Increasingly, school counselors offered comprehensive services within a *preventative* and *developmental* framework from prekindergarten through high school (ASCA, 2005a; Gysbers & Henderson, 2006; Myrick, 2003; Neukrug, Barr, Hoffman, & Kaplan, 1993). This focus included what became known as the *three "Cs"* of school counseling: *counseling* (individual, small group, and large group), *consultation*, and *coordination* of a wide range of activities (ACA, 1990).

Recognizing the evolution of the profession and the proliferation of terms utilized, in 1990 the ASCA Governing Board unanimously voted to call the profession *school counseling* and the programs that school counselors offered *school counseling programs* (ASCA, 2005a). This shift signified the changing direction of school counseling over the years. Although today's school counselor still counsels, consults, and coordinates, he or she also provides a broad range of other services, such as advocacy for equity and social justice, leadership, collaboration with school and community stakeholders, being a systemic change agent, accountability and data-driven school counseling programming, multicultural competence, creating and maintaining safe and welcoming school environments, and use of technology (ASCA, 2010a; Stone & Dahir, 2011; Virginia School Counselor Association, 2008).

Recent History: Transforming School Counseling in the Twenty-First Century

School counselors are currently undergoing a major shift in how they do business (Martin & Robinson, 2011). Comprehensive school counseling programs have been shown to positively affect student achievement, attendance, and behavior as well as school safety and climate in several statewide research studies (Lapan, Carey, Dimmitt, & Gysbers, 2010; Lapan, Gysbers, & Kayson, 2007). This is a result of a number of initiatives that have had a major impact on school counseling, including high stakes testing, the redefinition of school counseling as the result of grants funded by the Education Trust, and a new model for the development and implementation of comprehensive school counseling programs promulgated by ASCA. Let's take a quick look at each of these.

High Stakes Testing and the Achievement Gap

During the 1990s, many states developed learning standards whose purpose was to ensure that all children succeeded in school. These standards, as reflected in children's scores on statewide high stakes testing, were an attempt to make sure that all children were meeting minimum competencies in the schools. Increasingly, school personnel were being

held accountable for the test scores of all of the children in their classes. Although the standards emphasized "all" children, the most significant impact was upon students of color, students from families with low income, English language learners, and children with disabilities, as these children had traditionally done most poorly on standardized tests. This achievement gap needed to be eliminated if children were to succeed.

In 2002, President Bush signed the *No Child Left Behind (NCLB) Act*, which declared that each state needed to have a plan that showed how, by the year 2014, all students will have obtained proficiency in reading/language arts and math as reflected in scores on standardized tests (United States Department of Education, 2001). This federal law brought all states in line with what many had already started on their own when implementing statewide learning standards and competencies and tests to measure student achievement. NCLB placed particular pressure on the lower performing school districts, which tend to be located in poorer neighborhoods (Baker, Robinson, Danner, & Neukrug, 2001; Neukrug & Fawcett, 2010). Today, many school districts in high-poverty areas find themselves struggling to focus limited resources on bringing up achievement test scores while also trying to maintain other needed resources (Holcomb-McCoy, 2007).

How have these laws affected counselors? Increasingly, school counselors are being asked to be an integral part of the educational team to ensure that all students are achieving (Martin & Robinson, 2011). No longer could counselors see themselves as ancillary to the educational process. No longer could they see themselves as separate from teachers and administrators, or as running mini mental health clinics in the schools. Instead, counselors were being asked to demonstrate that the services they provided assisted teachers and students in creating a more effective learning environment—an environment that would allow children to learn in ways that would be reflected on achievement test scores. The results of this emphasis on high stakes testing and its impact on the role of the counselor were big! Soon, new initiatives for school counseling were developed, as reflected by publications and projects sponsored by the Education Trust (2006), the *ASCA National Model* (ASCA, 2005a), the *ASCA School Counselor Competencies* (2008a), and other models for school counseling programs (e.g., see Brown & Trusty, 2005; Galassi & Akos, 2007). Table 16.2 presents this new vision of the school counselor and compares it with the way school counselors have been trained in the past.

What has the impact been on children? Although progress is slow, for the first time in history the "achievement gap" is beginning to lessen (Plucker, Burroughs, & Song, 2010). It is hoped that as NCLB continues to have an impact on the schools, and as school counselors continue to help create a more effective learning environment for all children, this achievement gap will continue to lessen and eventually disappear altogether.

The Education Trust

Arguing that school counselors were not trained for the twenty-first century, during the late 1990s and into the new millennium, the Education Trust (2009) funded major grants to a number of universities across the country to help them develop plans that would transform their school counselor training programs (Guerra, 1998). Their model emphasized training counselors as educational leaders who can become advocates for all students as they focus on fostering academic achievement and career aspirations. In addition, this model saw school counselors as an integral part of the educational system, not an ancillary service, and believed counselors should play a crucial role in helping all students achieve

TABLE 16.2

Transformation of the Role of the Professional School Counselor	
PRESENT FOCUS	NEW VISION
Mental health providers	Academic/student achievement focus
Individual student's concerns/issues	Whole school and system concern/issues
Clinical model focused on student deficits	Academic focus, building on strengths
Providing service, one-on-one and small groups	Leader, planner, program developer
Primary focus on personal/social supporting student success	Focus on academic counseling, learning, and achievement
Ancillary support personnel	Integral members of educational team
Loosely defined role and responsibility	Focusing on mission and role identification
Record keeping	Use of data to effect change
Sorters, selectors in course placement process	Advocating inclusion in rigorous preparation for all, especially students from low-income and minority families
Work in isolation or with other counselors	Teaming and collaboration with all educators in school in resolving issues involving the whole school and community
Guarding the status quo	Acting as a change agent, especially for educational equity for all students
Involvement primarily with students	Involvement with students, parents, educational professionals, community, and community agencies
Little or no accountability	Full accountability for student success, use of data, planning and preparation for access to wide range of post secondary options
Dependence on the system's resources for helping students and families	Brokers of services for parents and students from community resources/agencies as well as the school system's resources
Postsecondary planning with interested students	Creating pathways for all students to achieve high aspirations

Source: Martin, P. J., & Robinson, S. G. (2011). Transforming the school counseling profession. In B. T. Erford (Ed.), *Transforming the school counseling profession* (3rd ed., pp. 1–18). Boston: Pearson, p. 10.

academically. The Education Trust has been a major impetus in transforming the role of school counselors. Their model influenced the development of the ASCA National Model.

The ASCA National Model

Recognizing that school counselors were being left on the sidelines during the discussions of educational reform, ASCA published the *National Standards for School Counseling Programs* (Campbell & Dahir, 1997), which contained the standards and competencies (knowledge, attitudes, and skills) that students were expected to gain in the academic, career, and personal/social domains as a result of participating in a *comprehensive school counseling program*. These standards are currently being revised to more fully incorporate important concepts and constructs such as student motivation, equity, and appreciation of diversity (personal correspondence, ASCA president Patricia Nailor, July, 2, 2010).

ASCA then collaborated with the Education Trust and leaders in the field of school counseling to develop a comprehensive model that all school counselors could use as a framework for designing and implementing a school counseling program. The result was the *ASCA National Model*, first published in 2003 and now in its second edition (ASCA, 2005a). This innovative model has four systems: *foundation, delivery, management,* and *accountability*. Central to each of these systems is the belief that school counselors must be leaders, advocates, collaborators, and systemic change agents (see Figure 16.1). As this model is now central to the what school counselors do, it will be discussed in detail in the next section: Roles and Functions of School Counselors. One of the benefits of the *National Model* is that it clearly focuses on those activities that counselors should be doing while highlighting activities they should not be doing. Thus, many activities with which school counselors have been inappropriately burdened should be lessened as administrators see a clear vision for the school counseling professional (see Box 16.1).

The profession of school counseling has grown and evolved dramatically over the years, from its meager beginnings at the turn of the century, to its slow inclusion in the schools, to its rapid expansion as a result of Sputnik and the NDEA, to its broader humanistic, developmental, and comprehensive focus in recent years, to the widespread implementation of comprehensive school counseling programs (e.g., those using the ASCA's National Model framework).

FIGURE 16.1
The ASCA National Model Graphic

Source: American School Counselor Association. (2005a). *The ASCA national model: A framework for school counseling programs* (2nd ed.). Arlington, VA: Author, p. 20.

BOX 16.1

Comparing Activities

Appropriate Activities for School Counselors

- Individual student academic program planning
- Interpreting cognitive, aptitude, and achievement tests
- Counseling students who are tardy or absent
- Counseling students who have disciplinary problems
- Counseling students about appropriate school dress
- Collaborating with teachers to present guidance curriculum lessons
- Analyzing grade point averages in relationship to achievement
- Interpreting student records
- Providing teachers with suggestions for better study hall management
- Ensuring student records are maintained as per state and federal regulations
- Assisting the school principal with identifying and resolving student needs, issues, and problems
- Working with students to provide small- and large-group counseling services
- Advocating for students at IEP meetings, student study teams, and attendance review boards
- Disaggregated data analysis

Inappropriate Activities for School Counselors

- Registering and scheduling all new students
- Coordinating or administering cognitive, aptitude, and achievement tests
- Signing excuses for students who are tardy or absent
- Performing disciplinary actions
- Sending home students who are not appropriately dressed
- Teaching classes when teachers are absent
- Computing grade point averages
- Maintaining student records
- Supervising study halls
- Clerical record keeping
- Assisting with duties in the principal's office
- Working with one student at a time in a therapeutic, clinical mode
- Preparation of individual education plans, student study teams, and school attendance review boards
- Data entry

SOURCE: American School Counselor Association. (2005). *The ASCA national nodel: A framework for school counseling programs* (2nd ed.). Arlington, VA: Author, p. 56.

Roles and Functions of School Counselors: The ASCA National Model

From its origins in early vocational guidance to *ASCA's National Model*, school counseling has seen dramatic shifts in how it delivers its services. Today, the role and functions of the school counselor are undergoing a paradigm shift as the profession embraces the various components of the ASCA National Model (2005a) and the call to promote equity and social justice in our schools and communities becomes louder (Holcomb-McCoy, 2007; Ratts, DeKruyf, & Chen-Hayes, 2007). The ASCA National Model identifies four elements that are critical to the development and implementation of a comprehensive school counseling program: *foundation, delivery, management,* and *accountability.* Four overarching themes critical to the

implementation of the four systems are also identified and include *leadership, advocacy, collaboration and teaming,* and *systemic change* (see Figure 16.1). The following is a summary of the four elements followed by a summary of the themes. The ASCA National Model, which has received the endorsement of the major players in the school counseling profession, is now being taught in counselor education programs and being adopted by school systems across the nation.

The Four Elements: Foundation, Delivery, Management, and Accountability

Foundation

The foundation of a school counseling program includes three components:

1. *Beliefs and philosophy:* Describes the underlying principles that drive the program.
2. *Mission Statement:* Describes the purposes of the program, advocates for the success of all students, shows system wide linkages, and identifies long-range results.
3. *Standards and competencies:* Defines the specific academic, career, and personal/social knowledge, attitudes, and skills that will be addressed to promote all students' development, learning, and success.

Delivery

"The Delivery System is the vehicle for providing school counseling services to students and stakeholders. . . . Results of school and student data should be used to determine which school counseling services will be delivered" (ASCA, in press). It consists of four components:

1. *Guidance Curriculum:* The school guidance curriculum is intended to be a comprehensive instructional program coordinated by school counselors and collaboratively delivered to students, parents/guardians, and school stakeholders.
2. *Individual Student Planning*: Individual student planning consists of a system of activities to "help all students plan, monitor, and manage their own learning as well as meet competencies in the areas of academic, career, and personal/social development" (ASCA, 2005a, p. 41). It is done collaboratively with students, parents/guardians, and other school personnel.
3. *Responsive Services:* This encompasses the various methods counselors use to respond to student concerns and includes individual and small group counseling, crisis counseling, consultation, referring to other professionals, and other programs or interventions to address student needs (e.g., peer tutoring, mentors).
4. *System Support:* This refers to those activities that support the school counselor in effectively running the program. They include such things as professional development activities, counseling and program supervision, consultation, collaboration and teaming with stakeholders, program management, and assuring that counselors and others do their fair share of the responsibilities needed to run a school effectively.

Management

The Management System "coordinates . . . the activities . . . associated with implementing your school counseling program. After you examine your school's data and consult with stakeholders . . . , (it) helps you organize your plans and establish timelines and responsibilities to meet the identified needs and program goals" (ASCA, in press). It consists of six components:

1. *Management Agreements:* A signed agreement with the supervising administrators stating the school counseling program goals for the year, school counselor responsibilities, distribution of school counselor time, resources, budget, and professional development opportunities.
2. *Advisory Council:* A group that is representative of the school demographics and stakeholders whose purpose is to offer feedback and support regarding "program development and annual goals, examine the data and program audit to review progress . . . support the program via advocacy, public relations, and assistance in accessing . . . resources (and provide a) two-way communication link between the . . . program and the . . . stakeholders" (ASCA, in press).
3. *Use of Data:* "Data collection strategies have three purposes: (1) to monitor student progress and close the achievement gap; (2) to demonstrate school counselor program effectiveness, and (3) to evaluate school counseling programs" (ASCA, in press).
4. *Action Plans:* This involves specific plans for reaching all students and also for closing the achievement gap.
5. *Use of Time:* This describes specific time spent to deliver services for each of the components of the counseling program.
6. *Calendars:* This involves preparing annual and weekly calendars, which can be helpful and effective tools for informing stakeholders and promoting the school counseling program. "The yearly calendar is a way for school counselors to identify the school counseling program priorities and their commitment to them" (ASCA, 2005a, p. 58). A well-developed weekly calendar that is "complete, timely, and colorful can be a powerful public relations booster. . . . An effective calendar invites others to acknowledge and participate in the school counseling program activities" (ASCA, 2005a, p. 57).

Accountability

Accountability addresses "How are students different as a result of the program?" (ASCA, 2005a, p. 23). There are three components of accountability:

1. *Results Reports:* These include evaluation of programs run by school counselors as well as evaluation of changes in students over time throughout the school. Such results are used to make programs more effective and should be shared with stakeholders.
2. *Performance Standards*: This involves evaluating the school counselor through a rating system designed to assess if the counselor has effectively implemented a comprehensive program and met the goals specified in the management agreement. ASCA offers a rubric based on thirteen performance

standards, which may be used for this purpose (ASCA, 2005a). Some suggest adding a multicultural competency performance standard to the thirteen offered by ASCA (Gysbers & Henderson, 2006; Virginia School Counselor Association, 2008).

3. *Program Audit:* This examines the degree of implementation of the various components of a comprehensive school counseling program as well as the program's alignment with the ASCA National Model.

The Themes: Leadership, Advocacy, Collaboration and Teaming, Systemic Change

Leadership

> *Leadership is the art of getting someone else to do something you want done because he [or she] wants to do it.* (Dwight D. Eisenhower)

The effective school counselor is a leader in the schools and embraces qualities such as being collaborative, facilitative, professional, empowering, and encouraging (Snowden & Gorton, 2002). If school counselors want to transform counseling programs into the new paradigm identified in ASCA's National Model, and if they desire to contribute significantly to lessening the achievement gap, they will increasingly have to take on leadership roles in the schools (DeVoss & Andrews, 2006). This involves the orchestration of services as they collaborate with the stakeholders (Holcomb-McCoy, 2007). It means that school counselors can no longer isolate themselves from the mission of the educational system, but instead, must be critical players and voices within that system (Stone & Dahir, 2006). Leadership also involves being multiculturally responsive (Grothaus, Crum, & James, 2010).

Advocacy

Gordon (2006) noted that, "educational opportunity and academic achievement are directly tied to the social divisions associated with race, ethnicity, gender, first language, and social class" (p. 25). In order to counteract this inequitable status quo, being an advocate for student success has been identified as an essential role for school counselors (Howard & Solberg, 2006; McAuliffe, Grothaus, Pare, & Wininger, 2008; Ratts, DeKruyf, & Chen-Hayes, 2007). To paraphrase an old adage: *when we're not engaging in advocacy, we're part of the problem.* School counselors advocate for equity in access, support, and resources to ensure that all students are able to achieve academic success, acquire career and college readiness skills and knowledge, develop desirable personal/social attitudes and skills, and have viable post-secondary options.

Collaboration and Teaming

School counselors collaborate with colleagues and community partners to ensure that all students have access to rigorous academic preparation and receive the support necessary to be successful. "The commitment to working collaboratively with stakeholders inside and outside the school building should be evident in the school mission statement, school policies, the school counseling program mission statement, and school counseling program activities" (ASCA, in press). School counselors should be especially attentive to collaboration with families as research clearly indicates that enhanced family

involvement in schools is related to a host of improvements for students (Bryan & Henry, 2008; Epstein, Sanders, & Sheldon, 2007; Grothaus & Cole, in press; Van Velsor & Orozsco, 2007).

Systemic Change

Due to the fact that they are one of the few individuals in the school to examine system-wide data and because they are collaborators who work with all the stakeholders in the school, school counselors are in a unique and critical position to understand the systemic needs of schools. School counselors are charged with challenging inequitable policies and systems and promoting equity for all students (ASCA, in press; Holcomb-McCoy, 2007).

The Emergent Model

The changes occurring in the roles and functions of the school counselor as the result of the National Model and education reform efforts are huge but they will not occur over-night. The need for progress remains but promising signs are appearing. A recent state-wide study (Center for School Counseling Outcome Research, 2010) found that school counselors were spending their time in portions that closely approximated the ASCA Model recommendations (ASCA, 2005a) but still averaged 18% of their time on non-counseling program-related duties. Meanwhile, over 300 schools have achieved the *Recognized ASCA Model Program* (RAMP) designation since its inception in 2004. This involves completing a rigorous refereed review process to determine whether the school counseling program is comprehensive, data-driven, serves all students, and fully incorporates the four elements and four themes of the ASCA National Model (ASCA, 2010b). In addition, approximately two-thirds of the states and the District of Columbia mandate that school counseling programs be available for students in public schools (ASCA, n.d.). As school systems slowly incorporate these changes, we will begin to see a new image of the school counselor emerge across the American landscape. Box 16.2 offers the perspective of a school counseling district supervisor from an urban school district regarding her vision of the roles and responsibilities of professional school counselors.

Theory and Process of School Counseling

Because the school counselor is involved in such a wide range of tasks, the theories and processes necessary to do the job adequately are many. Thus, school counselors need to have knowledge of a wide range of theories to implement such programs as the ASCA National Model. These include knowledge of *counseling theory, career development theory, human development theory*, and *systems theory*.

Counseling Theory

In Chapter 4, we identified a number of counseling theories, all of which can be used to some degree when working with students. For instance, *humanistic theory* gives the school counselor the counseling skills necessary to understand the inner world of children, and

BOX 16.2

Vanessa: District Supervisor of School Counseling

Image not available due to copyright restrictions

From early on, I've had a love and a passion for helping others. When I was 10, I received a present that helped me realize my love for education—a blackboard and a box of chalk. I spent hours "playing" school. I loved teaching and guiding my students through lessons. I wanted them to be happy and well adjusted.

During that time, I also witnessed the unfair treatment of a student in my class. One boy looked disheveled and hungry most of the time. When he was required to read aloud, he was ridiculed by teachers and students. This seemed to embarrass and hurt him. I would go to bed at night feeling sad and thinking of ways to help him. I realized that I wanted to be a teacher so that I could help others, especially those who were considered outcasts and treated unfairly.

Years later, as a fourth-grade teacher, I discovered that even students who initially struggled could learn and excel when they were shown respect and knew that somebody cared about them and wanted them to do their very best. I taught as many social and personal skills as I did academic skills. This helped me to realize how important relationships are to learning.

In 1985, I was selected to participate in a program that provided training to become a professional school counselor. I loved my time as a school counselor. I had an opportunity to practice both of my passions—teaching and helping others! During the ensuing years, my school district afforded me the opportunity to work at all levels and to coordinate programs at the district level. I organized professional development, coordinated meetings, and supported the school counselors. Gradually, my supervisor gave me more responsibilities and, when she announced her retirement, urged me to apply for her position. I started supervising school counseling and AVID for Newport News Virginia Public Schools in 1997.

As the supervisor of school counseling, I am responsible for providing leadership for the school counseling programs in our district. I support our professional school counselors to serve successfully as educational advocates so that every student can graduate college, career, and citizen ready and prepared to succeed in this global society. I support school counselors in their work to remove barriers that prevent students from succeeding. That support takes the form of professional development, coaching, management, assisting with accountability systems, and providing resources. I work to help school counselors implement best practices that have been proven to impact student success while using the framework of the ASCA National Model.

One of the most meaningful aspects of my job is helping counselors concentrate on issues, strategies, and interventions that will help close achievement and opportunity gaps. I hold them accountable to demonstrate their impact on student achievement and to share the results data with school stakeholders. I look forward to the day when all the administrators, teachers, parents, and community members realize the difference that school counselors can and do make to promote the lifelong success of students.

When empowered professional school counselors collaborate with others and serve as agents of change in the educational system, they can create opportunities for all students to realize their dreams. Then and only then will that passionate, impressionable 10-year old realize her dreams.

cognitive and behavioral theories can be used by counselors who want to set specific goals that are focused on changing behaviors or cognitions. Although school counselors are trained in all of these theoretical approaches, due to time constraints on the job, they tend to practice theoretical approaches that lend themselves to short-term or brief-treatment modalities. Therefore, *behavioral, cognitive, reality therapy, solution-focused,* and *narrative approaches* are often used (Murphy, 2008; Stone & Dahir, 2006, Winslade & Monk, 2007). Although humanistic approaches can be unwieldy because of the amount

of time they take, being empathic, the critical component of humanistic approaches, has been an important tool for building relationships with stakeholders.

Career Development Theory

A number of career development theories can be successfully applied in the schools. However, perhaps the most important approach in this context is the use of a developmental theory such as that of *Super's Lifespan Development Approach*, as it helps the school counselor devise career programs that are appropriate to children's age levels. Once such programs are devised, a number of other theories can be applied, as long as they are appropriate to the age level. For instance, developmental theory is the basis for devising career awareness programs for elementary school children, as this theory reminds us that young children are just beginning to explore the world of work; *trait-and-factor* and *personality theories* can be applied in the middle school as children begin to examine who they are and which talents they possess; and *social cognitive career theory* as well as *constructivist theory* are important to high school students as they begin to examine the realities of work or college and to look at how they understand the world. Infusing multicultural responsiveness into any career theory appears vital, as studies have shown that based on gender, race, or ethnicity, and social class some children begin to foreclose prematurely on career possibilities as early as age six or seven (Jackson & Grant, 2004).

Human Development Theory

Knowledge of theories of normal and of abnormal development are crucial if school counselors are to understand how children develop over their lifespan. Thus, knowledge of *physical development* and *cognitive development* helps school counselors identify those students who may be developmentally delayed or gifted. Knowledge of *moral development* helps school counselors understand the sometimes turbulent world of the developing teen. *Lifespan development approaches*, such as that of Erikson, can help the school counselor determine if a student is progressing normally and can help to identify appropriate interventions if needed. Theories of *personality development* can help a school counselor understand why a student might be exhibiting what some call abnormal behavior. Such theory makes sense out of what sometimes appears to be nonsensical acting out. In addition, Sears (2005) points to the importance of examining *environmental contexts* and the ability of young people to cope and thrive in various settings. She recommends using insights from research on resiliency to complement the developmental focus.

Systems Theory

Section III of this text introduced you to *systems theory* as it applied to family counseling, group counseling, and consultation and supervision. Clearly, knowledge of all three of these systems is a critical piece of the school counselor's job. Knowing how children "fit" into their family and understanding the complex dynamics of the family are basic to working with children and parents/guardians. Being able to work effectively with groups of children and having insight into the sometimes-intricate interactions that can occur is critical if the school counselor is to work effectively in groups. In addition, understanding the complexity of the school system and how to use that knowledge to effectively consult

and advocate are major tasks for school counselors. As Erford, House, and Martin (2007) suggest "An appropriate mantra for professional school counselors might be: 'Fix the system, not the student'" (p. 12). Finally, seeing the importance of participating in administrative supervision from principals, program and counseling supervision with other school counselors, and understanding the importance of supervising others, such as other school counselors or interns, is one more systemic piece for the effective school counselor (Gysbers & Henderson, 2006; Virginia School Counselor Association, 2008).

Settings for School Counselors

Today's school counselors are called to act as leaders, advocates, collaborators, and systemic change agents to ensure equity for all students. In addition, although there is much in common in the training of elementary, middle, and secondary school counselors, there are some differences in what the school counselor actually does as a function of setting. For example, while ASCA recommends that school counselors spend 80% of their time in direct service to students, families, and school personnel, the distribution of a school counselor's time will vary based on school level. To highlight one aspect of service delivery, the ASCA National Model recommends that elementary school counselors devote 35–45% of their time to the Guidance Curriculum component, middle school counselors spend 25–35% of their time for Guidance Curriculum, and high school counselors apportion 15–25% of their time to this area of service delivery (ASCA, 2005a).

As for caseloads, research appears to support lower student-to-school counselor ratios (ASCA recommends 1:250) (ASCA, 2009; Carrell & Carrell, 2006). Despite this, a recent report on school counselor to student ratios ranged from 1:203 in Wyoming to 1:1076 in Illinois with the national average being 1:467 (ASCA, 2008b). Consequently, what the school counselor does is sometimes a function of the number of students he or she has been assigned. The law of parsimony, or how to serve the greatest number of students effectively, often influences the manner in which school counseling services are delivered. With that in mind, let's examine what school counselors do as a function of setting.

Elementary School Counselors

The elementary years of school life comprise the formative phase of child development. During this time, children are building their academic self-concept as they address issues of competence and confidence toward learning. They are also working on decision-making, communication skills, and developing values. In addition, they are beginning to develop social relationships and examine their position in their family. School counseling at this level should be comprehensive, developmental, preventive, multiculturally responsive, and address students' academic, career and personal/social development (ASCA, 2010c). Based on ASCA's National Model, needed services for elementary students are delineated in Box 16.3. Box 16.4 offers the perspective of an elementary school counselor who is being asked to transition to using the ASCA National Model.

BOX 16.3

Sample Elementary School Counseling Program Content

School Guidance Curriculum

1. Academic support, including organizational, study and test-taking skills
2. Goal setting and decision making
3. Career awareness, exploration, and planning
4. Education on understanding self and others
5. Peer relationships, coping strategies and effective social skills
6. Communication, problem solving, and conflict resolution
7. Substance abuse education
8. Multicultural/diversity awareness

Individual Student Planning

1. Academic planning
2. Goal setting/decision making
3. Career planning

4. Education in self-understanding, including strengths and weaknesses
5. Transition plans

Responsive Services

1. Individual and small-group counseling
2. Individual/family/school crisis intervention
3. Conflict resolution
4. Consultation/collaboration
5. Referrals

System Support

1. Professional development
2. Consultation, collaboration, and teaming
3. Program management and operation

SOURCE: American School Counselor Association. (2010). *Why elementary school counselors?* Retrieved from www.schoolcounselor.org/content.asp?contentid=230 (Section, "Elementary school counselors implement . . . ")

BOX 16.4

Kristina: Elementary School Counselor

Edward Neukrug

I have been an elementary school counselor for the past fourteen years. I chose counseling as my profession because of my deep interest in psychology and my desire to understand the inner world of people and how they change and develop. My decision to work as a school counselor came about as a result of becoming a mother and wanting a work schedule that would allow me time with my children.

As a school counselor working with children in pre-kindergarten through grade 5, my days are very busy and my responsibilities are varied. I do individual counseling, small group counseling, and classroom guidance.

I also work with teachers, school administrators, parents, and social service agencies. The goal of all my work is to help children be successful in school. The nature of my role is proactive and preventative in that I help to promote the academic, social, emotional, and career development of each student. Typical issues I deal with include study skills, peer relationships, self-esteem, family changes, behavior problems, school anxiety, feeling awareness, attention difficulties, learning differences, bullying, motivation, conflict mediation, character development, decision making, and problem solving. However, in helping children with such various developmental and situational concerns, working in a school setting requires my overriding focus be on school achievement.

The ASCA National Model has become quite important over the past few years. The Guidance Department

BOX 16.4   *(continued)*

for my school system is working to adopt and implement its philosophy and principles. One way that the model has impacted my role as a school counselor is that there is now a greater emphasis placed on data, accountability, leadership, and systemic change. For example, whereas before I hoped that I was helping children and believed that I was because of their self-reports, as well as feedback from parents and teachers, I now need to show the effectiveness of my role with hard data. However, this can be difficult because of time constraints brought on by being one counselor for 400 to 600 students and because of the very nature of counseling as well as the many variables that affect an individual student's school success. Despite such changes, I love my job and feel energy and fulfillment working with children. As I change and grow along with the field of school counseling, I anticipate becoming more effective and hope to have more positive impact on the children I serve.

Middle School Counselors

As children move into adolescence, they face a multitude of developmental tasks highlighted by a need to understand their interests, their abilities, the world of work, their peer relationships, their sexuality, and a variety of life roles (see Box 16.5). Ultimately, they are beginning to define who they are—beginning to obtain a sense of self and a unique identity. At this point in their lives, they often are relying increasingly on feedback and

BOX 16.5

The Challenges of Middle School

Reggie and Sam, two sixth graders, have come to the counseling office to participate in a conflict mediation session. For the past three months, Sam has been continually teasing Reggie about his size, and Reggie recently started a fight over it. Prior to the meeting, however, the school counselor met with Reggie and Sam's teacher to get an "inside view" of what was going on with them and to find out how they are doing in school. The counselor also examined the test scores and records of Reggie and Sam and noticed that in the past few months Reggie's grades have dropped precipitously.

The counselor facilitates a discussion between the two students, and after 10 minutes, which was more like bantering back and forth, Sam offers an apology to Reggie, and states he won't tease any longer. Shaking his head in disbelief, Reggie says, "You've said this before! What did I ever do to you?" Reggie looks dejected, perhaps on the verge of tears. "What do you think is going on, Sam?" the counselor asks. Slowly, Sam replies, "Kids have been teasing me about being learning disabled, and I can take it, why can't he!" The counselor spends a few moments having Reggie and Sam discuss their feelings, and a resolution occurs when Reggie and Sam shake hands and agree to leave each other alone. The counselor requests two more meetings with Reggie and Sam, which they agree to.

Following the meeting, the counselor decides to conduct a needs assessment of students, teachers, and parents, in order to get a handle on how much bullying is occurring in the school. The counselor will consider conducting psychoeducational groups and other school-wide activities if bullying seems to be a system-wide problem. Also, the counselor will check with the teacher to see if Reggie's test scores begin to improve.

This exchange demonstrates the changes that begin to unfold during the middle school years and how some students respond to them. Faced with many transitions, the middle school years can leave children harboring great feelings of anger and/or hurt. The vignette shows the importance of paying attention to academics, consulting with the teacher, having a systemic perspective, and providing needed preventive measures (e.g., school-wide bullying program) when necessary.

reinforcement from their peers, rather than from parents/guardians. Social relationships become paramount.

As with elementary school counseling, middle school counseling continues to be comprehensive, developmental, preventive, multiculturally alert, and should address students' academic, career, and personal/social development (ASCA, 2010d). Based on ASCA's National Model, needed services for middle school students are delineated in Box 16.6. Box 16.7 offers the perspective of a middle school counselor who is being asked to transition the way he works by using the National Model.

Secondary School Counselors

As students enter high school, they are taking an important step toward adulthood as they aim for career and college readiness and begin to have increased clarity as to how they define themselves. High school students are better able to describe their values, their skills, and their abilities. At the same time, they increasingly are influenced by their peers and they will face important life decisions regarding such things as alcohol and drugs, sexual behavior, and the development of meaningful relationships with others. These students will be facing important decisions about their future. As with elementary and middle school counseling, high school counseling continues to be comprehensive, developmental, preventive, multiculturally sensitive, and should

BOX 16.6

Sample Middle School Counseling Program Content

School Guidance Curriculum

1. Academic skills support
2. Organizational, study, and test-taking skills
3. Education in understanding self and others
4. Coping strategies
5. Peer relationships and effective social skills
6. Communication, problem solving, decision making, and conflict resolution
7. Career awareness, exploration, and planning
8. Substance abuse education
9. Multicultural/diversity awareness

Individual Student Planning

1. Goal setting/decision making
2. Academic planning
3. Career planning
4. Education in understanding of self, including strengths and weaknesses
5. Transition planning

Responsive Services

1. Individual and small-group counseling
2. Individual/family/school crisis intervention
3. Peer facilitation
4. Consultation/collaboration
5. Referrals

System Support

1. Professional development
2. Consultation, collaboration, and teaming
3. Program management and operation

SOURCE: American School Counselor Association. (2010). *Why middle school counselors?* Retrieved from http://www.schoolcounselor.org/content.asp?contentid=231 (Section, "Middle school counselors implement . . . ").

BOX 16.7

Rivers: Middle School Counselor

Edward Neukrug

I always felt like I had a calling—a calling to help others. My father was a minister and my mom was a counselor—not by degree, but because everyone would come to her to talk about their problems. It was an endless stream of people, seeking her out. My mom's two sisters married my dad's two brothers, and we all lived together for a while until everyone could afford to live on their own. That's how my family was—always helping each other. So, with my dad's values, my mom's behaviors, and the constant message that it was important to care for others, there was no choice for me—I had a calling to be there for others.

My calling led me on the path to becoming a math teacher. It was my way of helping others learn. But even as a teacher I found myself counseling—students always came to me, and faculty too sought my advice and counsel. After twelve years of teaching, I knew I had to do more. I considered administration, but ultimately counseling pulled me toward that field. I soon obtained my master's degree in counseling and became a middle school counselor. And that's where I am today—at the same middle school for more than 15 years.

I believe that counseling is a calling—you can have all the book learning in the world, but if somewhere inside you, you don't have that calling, you're not going to be much of a counselor. It's a service and you are looking to the higher good—the best in people. And my calling was to work with children—it seems like the best fit for me.

What do I do? Well, I work on schedules, do individual counseling, and group counseling, including grief groups, groups to assist students academically, first-generation college-bound groups, groups on bullying, and suicide prevention groups. I also do classroom guidance for academic planning, career decision-making, testing, and behavior management. In addition, I coordinate testing programs, deal with attendance and truancy issues, deal with gangs, help students with issues around their sexuality, and more . . .

The ASCA Model and the Education Trust initiatives have certainly put the focus on having ALL children achieving at high levels. However, I feel we have always been proactive in our school. We look at each report card and find students having difficulty with classes. We meet with parents, teachers, and concerned others when students are having academic problems. We coordinate mentor and volunteer mental health programs. We are always trying to make sure that students achieve at their highest level. And, as an African American, I try to make sure that I am reaching out to as many African American students as possible—to act as a mentor and a model. I always try to keep in mind that the next child I touch could be the one who ends up turning his or her life around.

And oh yes, I am a minister also. I run a small church on the side with its focus being to help individuals in the poorest section of the city. My life is pretty full!

address students' academic, career, and personal/social development (ASCA, 2010e). Based on ASCA's National Model, needed services for secondary students are delineated in Box 16.8. Box 16.9 offers the perspective of a relatively new secondary school counselor as she describes her roles, duties, and vision for her profession and position.

Multicultural/Social Justice Focus

Creating a Multicultural School Environment

American schools are becoming increasingly diverse yet our schools still appear to lag in serving students of color, students from families with low income, English language learners, and students receiving special education services (Grothaus, Crum, & James,

BOX 16.8

Sample High School Counseling Program Content

Classroom Guidance

1. Academic skills support
2. Organizational, study, and test-taking skills
3. Post-secondary planning and application process
4. Career planning
5. Education in understanding self and others
6. Coping strategies
7. Peer relationships and effective social skills
8. Communication, problem solving, decision making, conflict resolution, and study skills
9. Career awareness and the world of work
10. Substance abuse education
11. Multicultural/diversity awareness

Individual Student Planning

1. Goal setting
2. Academic plans
3. Career plans

4. Problem solving
5. Education in understanding of self, including strengths and weaknesses
6. Transition plans

Responsive Services

1. Individual and small-group counseling
2. Individual/family/school crisis intervention
3. Peer facilitation
4. Consultation/collaboration
5. Referrals

System Support

1. Professional development
2. Consultation, collaboration, and teaming
3. Program management and operation

SOURCE: ASCA (American School Counselor Association). (2010). *Why secondary school counselors?* Retrieved July 20, 2010, from http://www.schoolcounselor.org/content.asp?contentid=233 (Section, "Secondary school counselors implement . . .").

BOX 16.9

Lauren: High School Counselor

Courtesy of Lauren Lamar

From early on, I knew that I wanted to work with youth. I thought about becoming a teacher, a child psychologist, a social worker, even a family lawyer. In college, I majored in psychology and volunteered in a program working with teenagers facing many challenges, but I still did not know what the right career was for me.

After I graduated from college, I did some research and I learned about the counseling program at a local university.

School counseling appealed to me because we're in the perfect position to help children and youth in a proactive manner. I also liked that school counselors have the opportunity to impact the lives of all students, not just the high achievers or the ones who are getting into trouble. High school students are so multi-dimensional. In many ways they are still children, but they are also coming into their own, becoming adults. As a school counselor, I'm able to play a part in that development.

Every day is different in a high school, which is one of the things that I love about it. Emergencies that require my attention can come up at any time. This can be challenging but I am never bored. A typical day for me begins about 30 minutes before the students arrive. I check my messages and I prepare to see students.

BOX 16.9   *(continued)*

During the day, I meet with students about a variety of topics, including: academic issues, college planning questions, social and personal concerns. I write letters of recommendation, help students with college applications, collaborate and consult with parents, teachers, and administrators. I conduct classroom guidance on academic, career, and personal/social topics and work with students in small groups. I am often involved in child study team and student support team meetings as well as parent-teacher conferences. Additionally, I collect data to track my effectiveness in working with students and see how I'm spending my time. I also coach both swimming and field hockey at my high school. I find that it allows me to get to know students who are not on my caseload and to learn even more about my students outside of my office.

I have been a high school counselor for two and a half years and I absolutely love my job. I work with a tremendous and incredibly supportive group of counselors. Most importantly though, by acting as an advocate I can make an enormous difference in the lives my students. Many of my students come from populations that are typically underserved in the school setting. To work toward closing the achievement gap, I promote enrollment in rigorous courses and arrange for the support students need to succeed. I advocate for the students and their parents with teachers, administrators and even college admissions officers. I see myself as an agent of change. I collaborate with my colleagues to support equity for all students in school and to help all students succeed. At the end of the day, there is nothing more rewarding than knowing that I have been able to have lasting positive impact on the life of a student.

2010; Holcomb-McCoy, 2007). As a result of these changing demographics, and with the increased focus on multiculturalism, equity, and social justice, school counselors will increasingly be challenged to make the schools more responsive to students and stakeholders with diverse constellations of cultural affiliations (Bemak & Chung, 2008; Cholewa & West-Olatunji, 2008; Day-Vines & Terriquez, 2008; Ford, Moore, & Whiting, 2006). School counselors are expected to "specifically address the needs of every student, particularly students of culturally diverse, low social-economic status and other underserved or underperforming populations" (ASCA, 2005a, p. 77). Yet there is some evidence that school counselors have lower expectations for students from some cultural groups (Auwarter & Aruguete, 2008). Improving our own multicultural competence and the cultural responsiveness of our schools and communities is an ongoing journey that can begin with looking within and acknowledging that our "own practices are cultural in origin, rather than the 'only right way to do things'" (Dimmock & Walker, 2005, p. 190). Today's school counselors are called to develop a positive multicultural atmosphere and to promote social justice and equity in many ways, some of which are delineated in Table 16.3.

Assessing Multicultural Competence

One way that school counselors can ensure that they are creating a multicultural environment is to do a systematic analysis of their school. Holcomb-McCoy (2007) offers a checklist of 51 items across nine categories to help the school counselor do this. The categories, which are based on "theme analysis" of multicultural issues in school counseling, are as follows:

1. Multicultural counseling
2. Multicultural consultation
3. Understanding racism and student resistance
4. Multicultural assessment

TABLE 16.3

Elements to Creating a Multicultural Environment and Promoting Social Justice

1. Raising awareness that culture is a powerful and pervasive influence on students, stakeholders, and our own attitudes and behavior.
2. Being actively involved in the community in which your school is located by engaging in networking, advocacy, and knowing available cultural resources (Griffin & Farris, 2010; Vera, Buhin, & Shin, 2006).
3. Participating in and leading multicultural workshops/trainings for the school and community stakeholders.
4. Making the school counseling program accessible, including being available at times that parents/guardians are able to see you. Also, ensuring that your school and school counseling office and materials are accessible for persons with disabilities. Communicating and assessing (through a translator if necessary) with students and stakeholders in their preferred language.
5. Creating a welcoming, inclusive school climate where cultural richness is celebrated.
6. Promoting use of inclusive language and recognition of multiple cultures (e.g., using "humankind" vs. mankind; celebrating various holidays, not just those of Christian or European-American origins; have school décor represent the contributions of multiple cultures).
7. Promoting inclusive curriculum and culturally aware teaching and classroom management strategies that are more salient to students' lives.
8. Working to improve cross-cultural relationships in your school and community, not just between racial/ethnic groups but also with regard to social class, ability/disability, sexual orientation, etc.
9. Broaching the topic of culture when counseling, consulting, doing classroom guidance, and other school counseling practices. This can send a signal that these topics are important and open for discussion if salient.
10. Adapting your counseling and consultation techniques to be culturally sensitive.
11. Helping students to "code switch," to make situationally intelligent decisions about language and behavior for various circumstances (Day-Vines & Day-Hairston, 2005). Also, train faculty and staff to be culturally sensitive and skilled (e.g., not emphasizing the terms "proper" or "correct" English—implying that a student's home language is improper; instead request that students use "school" or "formal" English).
12. Creating a multicultural advisory committee, with representative membership from the school and community, to examine and offer advice on all aspects of the school experience (e.g., curriculum, teaching methods, inclusive climate).
13. Consulting cultural informants—people who are familiar with the cultures represented in your school.
14. Assisting schools in developing mechanisms for hiring individuals from diverse backgrounds.
15. Examining disaggregated school data for evidence of inequity (e.g., disproportionate numbers of some groups of students receiving behavioral referrals, inequitable representation in gifted programs and those receiving special education services, disparate graduation rates for different student groups). Collaborate with stakeholders to change school policies and practices that maintain the inequitable status-quo.
16. Asking questions (Holcomb-McCoy, 2007) about the curriculum, the school climate, faculty/staff attitudes, and actions, such as:
    a. Are adults encouraging all students?
    b. Do we have an accurate and representative curriculum?
    c. Is there equity in access to opportunities, available resources, and teacher quality?
    d. Do we have adult role models for our diverse student body?
    e. Are there student and faculty friendships across racial, ethnic, ability, sexual orientation, & social class groups?
    f. Is the discussion of –isms safe & encouraged?
    g. Who is included in the decision making process?
    h. How can we make a given situation more equitable and democratic?
17. Collaborating with community organizations that promote positive goals for youth and families.
18. Previewing practices, programs, and policies that have been successful elsewhere (e.g., see Education Trust website).
19. Assisting others to be successful self-advocates.
20. Advocating with your federal, state, and local legislators and policy makers.
21. Being persistent. Address the source of peoples' concerns about your ideas/proposals and create allies for positive change.
22. Evaluating in order to improve, celebrate the changes your efforts produce.
23. Recognizing the need for self-care and support in this challenging enterprise.

(Adapted from Virginia School Counselors Association, 2008)

---

5. Understanding racial identity development
6. Multicultural family counseling
7. Social advocacy
8. Developing school–family–community partnerships
9. Understanding cross-cultural interpersonal interactions

Ethical, Professional, and Legal Issues

Select Ethical Issues: ASCA's Code of Ethics

Although a division of ACA, ASCA has moved to become independent of its parent organization and today one can join ASCA without being a member of ACA. This newfound independence is also reflected in the status of its ethical code (ASCA, 2010a). Although ASCA has previously seen its ethical guidelines as an addition to the ACA code, the *ASCA Ethical Standards for School Counselors* are now viewed as a stand-alone code specific to school counselors. Table 16.4 offers a listing of the major headings of the guidelines. See "Legal and Ethical" at http://www.schoolcounselor.org for the full code.

Select Professional Issues in School Counseling

The American School Counseling Association (ASCA)

With more than 28,000 members, ASCA is one of the largest and most active divisions of ACA (www.schoolcounselor.org). Some of the many things that ASCA does include: providing training to implement the ASCA National Model; sponsoring conferences

TABLE 16.4

Summary of Major Headings of ASCAs Ethical Code

Preamble

A. Responsibilities to Students

    1. Confidentiality
    2. Counseling Plans
    3. Academic, Career/College/Post-Secondary Access and Personal/Social Counseling Plans
    4. Dual Relationships
    5. Appropriate Referrals
    6. Group Work
    7. Danger to Self or Others
    8. Student Records
    9. Evaluation, Assessment, and Interpretation
    10. Technology
    11. Student Peer Support Program

B. Responsibilities to Parents/Guardians

    1. Parent Rights and Responsibilities
    2. Parents/Guardians and Confidentiality

C. Responsibilities to Colleagues and Professional Associates

    1. Professional Relationships
    2. Sharing Information with Other Professionals
    3. Collaborating and Educating around the Role of the School Counselor

D. Responsibilities to the School and Community

    1. Responsibilities to the School
    2. Responsibility to the Community

E. Responsibilities to Self

    1. Professional Competence
    2. Multicultural and Social Justice Advocacy and Leadership

F. Responsibilities to the Profession

    1. Professionalism
    2. Contribution to the Profession
    3. Supervision of School Counselor Candidates
    4. Collaboration and Education about School Counselors and School Counseling Programs with other Professionals

G. Maintenance of Standards

    1. Concerns about Ethical Behavior of a Colleague
    2. Forced to Work in Situations that Do Not Reflect Ethics of Profession
    3. Use of Ethical Decision-Making Models

and professional development workshops; developing and maintaining an ethical code and providing for ethical review and guidance; developing position statements on a number of important issues that face school counselors; assisting in accreditation and credentialing initiatives; advocating for legislative initiatives; supporting evaluation and research; sponsoring liability insurance; and publishing a magazine entitled the *ASCA School Counselor* and a refereed journal entitled *The Professional School Counselor*.

ASCA—In or Out of ACA?

During the 1990s, ASCA considered leaving ACA (Hubert, 1995). Some felt that ASCA could better address the unique needs of school counselors as an independent association. As a result, ASCA has moved to a semi-independent division status. Currently, additional points of contention concern ASCA's decision not to sign the *20/20 Vision* document for counseling and their subsequent exclusion from being a full member of the 20/20 commission (see Chapter 1). Today, one joins ASCA separately from ACA. In fact, if you go to ACA's Web site to join ASCA, it will send you to ASCA's Web site. Currently, ASCA and ACA offer deep discounts for student memberships, and we encourage you to join both associations.

Specialty Certification in School Counseling

Although school counseling credentialing (certification or licensure) on the state level has been around longer than any other counselor credential, national certification was not initiated until 1992 when the National Certified School Counselor (NCSC) credential became established (Paisley & Borders, 1995). In 1994, this certification became affiliated with the National Board for Certified Counselors (NBCC). In addition to the NCSC, the National Board for Professional Teaching Standards (NBPTS) has developed a certification process that was finalized in 2004. This certification requires credentialing and three years as a school counselor as well as a two- to three-year performance-based assessment that demonstrates proficiency in a wide range of school counseling skills. Although this certification process is expensive, some states reimburse this cost and offer salary incentives to those who become certified. If you would like to compare these two certification processes, ASCA has developed a chart that highlights their differences (see ASCA, 2005b).

Youth Experiencing Trauma, Mental Health Concerns, Substance Abuse, and other Issues

The shock of hearing about children being shot in schools has awakened us to the problems that many of our youth face today. One result of this new awareness is that school counselors are increasingly being asked to play a role in working with youth dealing with one or more significant concerns (Erford, Lee, Newsome, & Rock, 2011). A few of the many roles that the counselor takes on in this capacity include facilitating resiliency characteristics in students; promoting a welcoming, supportive, culturally responsive, and inclusive school climate; leading the efforts to prevent and manage crisis situations; assessing suicidal ideation and other threats of violence; coordinating with community resource providers; collaborating to develop safety programs in the schools; assisting students in dealing with bullying, abuse or harassment; and doing grief counseling for students, families, and school staff.

Salaries and Job Outlook of School Counselors

Currently, there are about 275,800 educational, vocational, and school counselors, and employment of school counselors in the near future is expected to grow "faster than average," according to the Occupational Outlook Handbook (U.S. Department of Labor, 2010). The increased need for school counselors is the result of more states mandating school counselors, increased enrollments in the schools, and expanded roles of school counselors. Salaries of school counselors are almost always based on the salaries of teachers who have master's degrees. The median salary of school counselors as of May 2008 was $57,800.

Select Legal Issues in School Counseling

Confidentiality, Privileged Communication, and the Law

Generally, school counselors do not have *privileged communication*, which is the legal right to keep information confidential from the courts. Therefore, if they are requested to reveal such information by the courts, they must comply. Although it is important to have a healthy respect for one's ethical guidelines, remember that the "law takes precedence over your ethical code and employer policies. Violating the law, even with the best intentions, or even if directed to do so by a superior, is a criminal act" (Tompkins & Mehring, 1993, p. 340). Ultimately, if the counselor is considering breaking confidentiality, he or she must make a wise decision and take into account the client's situation, the work situation, the ethical guidelines, and the legal system (Isaacs & Stone, 2003).

Child's Right to Confidentiality/Parents' Rights to Confidential Information

Although ethical guidelines generally support a student's right to confidential counseling, the law has not (Attorney C. Borstein, personal communication, July 20, 2010; Davis & Mickelson, 1994; Hubert, 1996; Isaacs & Stone, 2003; Lawrence & Kurpius, 2000). Even though some states partially or fully protect student disclosure to counselors (Glosoff & Pate, 2003; Swenson, 1997), generally it is the counselor's legal obligation to reveal information about counseling sessions if a parent or guardian requests such information. However, when and how to reveal such information is often tricky (see Box 16.10). Whenever reasonable and possible, school counselors are urged to collaborate with parents/guardians regarding the delivery of counseling services (Glosoff & Pate, 2003). Generally, most parents/guardians will respect the confidentiality of the counseling relationship if they are assured that the counselor is looking out for the best interests of the child and the family.

Public Law 94-142, IDEA, Section 504, RTI, and the ADA

Passed in 1975, *PL94-142*, along with the recent reauthorizations and expansions of the law referred to as the *Individuals with Disabilities Education Act* (IDEA), has greatly affected the role of the school counselor. These laws ensure the right of students to be assessed, at the school system's expense, if the student is suspected of having a disability that interferes with learning. In addition, they assert that schools must make accommodations, within the least restrictive environment, for any student from age of

Student Sues School System for Revealing Sexual Orientation to Parents

A federal judge in Santa Ana, California, ruled that a lesbian high school student could move forward on her suit against the school district that she attends because the principal had allegedly broken her privacy rights and revealed to the student's mother that she was lesbian. Apparently, the principal and others had witnessed the student hugging and kissing her girlfriend on numerous occasions. The student had been disciplined for this behavior and the lawsuit also claims discrimination as heterosexual couples had apparently not been disciplined. In terms of confidentiality, and parents' rights to information, the outcome of this lawsuit should be interesting and could affect the role of the counselor. ("Girl can sue. . .," 2005)

3 through age 21 who qualifies in one of the 13 categories for receiving special education services; that is, students must be taught in regular classrooms whenever possible and reasonable (Havey, 2003). The importance of knowledge in this area should not be underestimated, and most school counseling programs now require coursework in understanding how to work with students with disabilities (Milsom & Akos, 2003). School counselors are also involved with *Response to Intervention* (RTI), a data-driven and multiple level approach to help students struggling with academics (ASCA, 2008c).

School counselors play an active role in the implementation of these laws by referring students for testing, consulting with parents and teachers, and advocating and consulting with special education and RTI teams. These teams can develop RTI plans, *individual education plans* (IEPs) specific to the educational goals of the student, and *504 plans* to ensure access to education when it may otherwise be limited due to physical or mental impairment. PL94-142, the IDEA, along with section 504 of the *1973 Rehabilitation Act* and parts of the *Americans with Disabilities Act* (ADA) are all important laws that aid children with disabilities to gain an education within the least restrictive environment.

Parental Rights to School Records (FERPA)

The *Family Educational Rights and Privacy Act* (FERPA), passed in the mid-1970s, allows parents access to the educational records of their children. Although under specified conditions FERPA excludes counseling notes from the category of educational records (Glosoff & Pate, 2003), Remley, Hermann, & Huey (2003) suggest that school counselors keep case notes in their offices and not allow other school personnel access to those notes if school counselors are to abide by FERPA regulations. Additionally, counselors need to be aware that their confidential notes can be subpoenaed, and they may have to reveal their notes and/or testify about them in court if requested by the court to do so.

Suspected Child Abuse

With close to 900,000 substantiated cases of child abuse being reported every year, and with some school counselors assessing the possible abuse of dozens of children a year, reporting suspected child abuse is clearly an important issue for school counselors (Bryant & Milsom, 2005). Today, all states require school counselors and teachers to report suspected child abuse (Davis & Ritchie, 2003). Each counselor needs to be aware of the specific procedures for reporting suspected child abuse in his or her state.

The Hatch and Grassley Amendments

Originally known as the *Hatch Amendment* and then later replaced by the *Grassley Amendment*, this law states that children in federally funded programs cannot participate in surveys, analysis, or evaluation projects without the consent of their parents or legal guardians (Sealander, Schwiebert, Oren, & Weekley, 2003). In essence, it is attempting to protect children from revealing information about themselves or from participating in experimental programs without their parents giving consent.

◼ *The School Counselor in Process: Adapting to the Twenty-First Century*

Without that commitment *to the process of change, a school counselor will not be able to effectively serve as a catalyst in student lives and a significant change agent in the educational community*

(Allen, as cited in Hopkins, 2005)

The evolution of school counseling has been dramatic. We've moved from a vocational guidance focus to an emphasis on developing and implementing comprehensive developmental school counseling programs while advocating and collaborating to ensure equity for all students. School counseling today covers a wide range of services (ASCA, 2005a). The school counselor of tomorrow is expected to see even more changes. Increased interactions with culturally diverse students, greater emphasis on the use of data, greater use of technology, increased career options for students, and increased involvement of families are a few of the opportunities and challenges facing the school counselor of tomorrow. Thus, counselors will need to become increasingly adaptable as their roles and functions continue to change and expand. This will require each counselor to examine what he or she is doing and how he or she can respond to the everyday needs of students, parents/guardians, teachers, administrators, and community stakeholders while proactively providing prevention programming and being able to handle crises that will occur on a frequent basis. The counselor who is comfortable with change will survive and flourish.

■ *Summary*

This chapter discussed the unique specialty area of school counseling. We began by briefly defining school counseling, noting that its purpose is to offer a comprehensive school counseling program that promotes and enhances student achievement for all students by assisting them with their academic, personal/social, and career development. We noted that today's school counseling is developmental and preventative and that the services the school counselor offers are interwoven throughout the school's total educational program.

We offered some background information on the emergence of school counseling, noting that its origins date back to the beginning of the twentieth century when there was an increasing need for vocational guidance. Frank Parsons and others were highlighted as instrumental in defining vocational guidance. Although the school counseling profession was initially slow to expand, during the 1930s, with influences from such individuals as E. G. Williamson and John Brewer, the profession diversified and began to define itself more clearly. During the 1940s, the humanistic psychology and education movement shifted the focus of school counseling from a directive, didactic approach to an approach that focused more on the importance of the relationship between the student and counselor and was more facilitative than directive. In addition, school counseling at this time took on a greater mental health focus.

The decade of the 1950s, with the launch of Sputnik and the subsequent passage of the *National Defense Education Act* (NDEA), saw a great increase in the need for school counselors. The 1960s saw continued expansion of school counseling and an increased focus on comprehensive, developmental school counseling programs. Increased professionalism and diversity were the major thrusts of school counseling in the 1970s and 1980s; and, as we moved into the 1990s, school counseling expanded its comprehensive developmental and preventative focus and also emphasized cultural competence and advocacy for equity and success for all students.

As the chapter continued, we noted that high-stakes testing, such as those that resulted from state learning standards as well as the federal *No Child Left Behind (NCLB) Act*, demanded that all students must meet minimum educational competencies. Such testing has challenged the traditional role of the school counselor, who tended to be seen as someone delivering an ancillary service that did not directly address students' educational concerns. We also noted that such testing, as well as grants from the Education Trust, led to a new paradigm in counselor training that was epitomized by ASCA's National Model. This model is now being taught throughout the country in counselor education programs and has been adopted by many school systems.

Subsequently, we briefly defined ASCA's National Model, which identifies four elements that are critical to the development of a school counseling program: foundation, delivery, management, and accountability. Four overarching themes crucial to the implementation of the four systems were also identified: leadership, advocacy, collaboration and teaming, and systemic change. We also highlighted the importance of a number of theories to the practice of school counseling. We briefly discussed how counseling theory,

theories of human development, career development theory, and systems theory are all used in multiple ways when working with children.

Some of the roles and functions of elementary, middle, and secondary school counselors were discussed. We also offered a window into the life of an elementary, middle, and secondary school counselor as well as a school district director of school counseling. We highlighted some of the challenges and opportunities facing school counseling as we become more responsive to multicultural issues. We suggested that school counselors should particularly focus on lessening the achievement gap, reducing barriers to success, advocating for equity for all students, sensitizing the total school community to multicultural issues, ensuring that educational materials are not biased, striving to understand how students interpret their environment, and establishing a comprehensive developmental counseling program.

As the chapter neared its conclusion, we featured a number of ethical, professional, and legal issues. We pointed out that as ASCA has become increasingly independent from ACA, it has relied more on its own code of ethics. We outlined some of the points covered in ASCA's ethical code and encouraged you to examine the full code. We then discussed a number of important professional issues, including a brief description of ASCA, the independence of ASCA from ACA, the specialty certifications in school counseling offered by NBCC and NBPTS, the importance of working with youth experiencing any number of serious concerns, and the salary average and the job outlook for school counselors.

Next, we highlighted how the following legal and practice issues have affected the role of the school counselor: privileged communication; children's and parents' rights to confidential information; PL94-142, the IDEA, section 504 of the *Rehabilitation Act*, the ADA, Response to Intervention, FERPA, child abuse laws, and the Hatch and Grassley Amendments. Finally, we ended the chapter by stressing the need for school counselors to remain flexible in the face of the many changes that will occur in the schools as we move forward.

References

American Counseling Association. (1990). *The practice of guidance and counseling by school counselors: ASCA role statement*. Alexandria, VA: Author.

American School Counselor Association. (In Press). *The ASCA national model workbook* (2nd ed.). Alexandria, VA: Author.

American School Counselor Association. (n.d.). *State school counseling mandates*. Retrieved, from http://www.schoolcounselor.org/content.asp?pl=325&sl=133&contentid=424

American School Counselor Association. (2005a). *The ASCA National Model: A framework for school counseling programs* (2nd ed.). Arlington, VA: Author.

American School Counselor Association. (2005b). *NBCC and NBPTS: Comparison of costs and benefits*. Retrieved from http://www.schoolcounselor.org/files/SC_MA05_NBCC_NBPTS_CertChart.pdf

American School Counselor Association. (2008a). *School counselor competencies*. Retrieved from http://www.schoolcounselor.org/files/SCCompetencies.pdf

American School Counselor Association. (2008b). *Student-to-counselor ratios*. Retrieved from http://www.schoolcounselor.org/content.asp?pl=328&sl=460&contentid=460

American School Counselor Association. (2008c). *The professional school counselor and response to intervention*. Retrieved from http://asca2.timberlakepublishing.com//files/PS_Intervention.pdf

American School Counselor Association. (2009). *The role of the professional school counselor*. Retrieved from http://www.schoolcounselor.org/content.asp?pl=325&sl=133&contentid=240

American School Counselor Association. (2010a). *Ethical standards for school counselors. Retrieved from http://www.schoolcounselor.org/files/EthicalStandards2010.pdf*

American School Counselor Association. (2010b). *RAMP application guide*. Retrieved from http://www.ascanationalmodel.org/content.asp?pl=11&sl=38&contentid=38

American School Counselor Association. (2010c). *Why elementary school counselors?* Retrieved from http://www.schoolcounselor.org/content.asp?contentid=230.

American School Counselor Association. (2010d). *Why middle school counselors?* Retrieved from http://www.schoolcounselor.org/content.asp?contentid=231.

American School Counselor Association. (2010e). *Why secondary school counselors?* Retrieved from http://www.schoolcounselor.org/content.asp?contentid=233

Auwarter, A. E., & Aruguete, M. S. (2008). Counselor perceptions of students who vary in gender and socioeconomic status. *Social Psychology of Education*, *11*, 389–395. Doi: 10.1007/s11218-008-9056-0

Baker, S. B., & Gerler Jr., E. R. (2008). *School counseling for the twenty-first century* (5th ed.). Upper Saddle River, NJ: Pearson.

Baker, S. R., Robinson, J. E., Danner, M. J. E., & Neukrug, E. (2001). *Community social disorganization theory applied to adolescent academic achievement*. Retrieved from ERIC database. (ED453301)

Bemak, F., & Chung, R. C. (2008). New professional roles and advocacy strategies for school counselors: A multicultural/social justice perspective to move beyond the nice counselor syndrome. *Journal of Counseling and Development*, 86, 372–382.

Brewer, J. M. (1932). *Education as guidance*. New York: Macmillan.

Brown, D., & Trusty, J. (2005). *Designing and leading comprehensive school counseling programs: Promoting student competence and meeting student needs*. Belmont, CA: Brooks/Cole.

Bryan, J., & Henry, L. (2008). Strengths-based partnerships: A school-family-community partnership approach to empowering students. *Professional School Counseling, 12*(2), 149–156.

Bryant, J., & Milsom, A. (2005). Child abuse reporting by school counselors. *Professional School Counseling, 9*(1), 63–71.

Campbell, C. A., & Dahir, C. A. (1997). *Sharing the vision: The national standards for school counseling programs*. Alexandria, VA: American School Counselor Association.

Carrell, S. E., & Carrell, S. A. (2006). Do lower student to counselor ratios reduce school disciplinary problems? *The B. E. Journal of Economic Analysis and Policy, 4(5),* Retrieved from http://www.bepress.com/bejeap/contributions/vol5/iss1/art11

Center for School Counseling Outcome Research. (2010). *Nebraska school counseling state evaluation*. Retrieved from www.education.ne.gov/CARED.

Cholewa, V., & West-Olatunji, C. (2008). Exploring the relationship among cultural discontinuity, psychological distress, and academic achievement outcomes for low-income, culturally diverse students. *Professional School Counseling, 12*, 54–61.

Davis, J. L., & Mickelson, D. J. (1994). School counselors: Are you aware of ethical and legal aspects of counseling? *School Counselor, 42*(1), 5–13.

Davis, T., & Ritchie, M. (2003). Confidentiality and the school counselor: A challenge for the 1990s. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues*

in school counseling (2nd ed., pp. 197–207). Alexandria, VA: American School Counselor Association.

Day-Vines, N. L., & Day-Hairston, B. O. (2005). Culturally congruent strategies for addressing the behavioral needs of urban, African American male adolescents. *Professional School Counseling, 8,* 236–243.

Day-Vines, N. L., & Terriquez, V. (2008). A strength-based approach to promoting prosocial behavior among African-American and Latino students. *Professional School Counseling, 12,* 170–175.

DeVoss, J. A., & Andrews, M. F. (2006). *School counselors as educational leaders.* Boston: Lahaska Press.

Dimmock, C., & Walker, A. (2005). *Educational leadership: Culture and diversity.* Thousand Oaks, CA: Sage.

Education Trust. (2006). *Yes we can: Telling truths and dispelling myths about race and education in America.* Washington, DC: Author.

Education Trust. (2009). *About the Education Trust.* Retrieved from http://www.edtrust.org/dc/about

Epstein, J. L., Sanders, M. G., & Sheldon, S. B. (2007). *Family and community involvement: Achievement effects.* Retrieved from http://www.csos.jhu.edu/p2000/pdf/NICHD%20Progress%20Report%20Summary%2007.pdf

Erford, B. T., House, R. M., & Martin, P. J. (2007). Transforming the school counseling profession. In B. T. Erford (Ed.), *Transforming the school counseling profession* (2nd ed., pp. 1–12). Upper Saddle River, NJ: Pearson.

Erford, B. T., Lee, V. V., Newsome, D. W., & Rock, E. (2011). Systematic approaches to counseling students experiencing complex and specialized problems. In B. T. Erford (Ed.), *Transforming the school counseling profession* (3rd ed., pp. 288–313). Boston: Pearson.

Ford, D. Y., Moore, J. L. III, & Whiting, G. W. (2006). Eliminating deficit orientations: Creating classrooms and curricula for gifted students from diverse cultural backgrounds. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings* (pp. 173–193). Hoboken, NJ: John Wiley & Sons.

Galassi, J. P., & Akos, P. (2007). *Strengths-based school counseling: Promoting student development and achievement.* New York: Lawrence Erlbaum Associates.

Gibson, R., & Mitchell, M. (2008). *Introduction to counseling and guidance* (7th ed.). Upper Saddle River, NJ: Merrill.

Girl can sue for telling mom she's gay: Federal judge allows violation of privacy case to proceed to California (2005, December 4). Retrieved from http://msnbc.msn.com/id/10299356/from/ET/

Glosoff, H. L., & Pate, R. H. (2003). Privacy and confidentiality in school counseling. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 164–178). Alexandria, VA: American School Counselor Association.

Gordon, E. W. (2006). Establishing a system of public education in which all children achieve at high levels and reach their full potential. In T. Smiley (Ed.), *The covenant with Black America* (pp. 23–45). Chicago: Third World Press.

Griffin, D., & Farris, A. (2010). School counselors and collaboration: Finding resources through community mapping. *Professional School Counseling, 13,* 248–256.

Grothaus, T., & Cole, R. (2010). Meeting the challenges together: School counselors collaborating with students and families with low income. *Journal of School Counseling, 8*(27). Retrieved from http://www.jsc.montana.edu/articles/v8n27.pdf

Grothaus, T., Crum, K.S., & James, A.B. (2010). Effective leadership in a culturally diverse learning environment. *International Journal of Urban Educational Leadership 4*(1), 111–125.

Guerra, P. (1998, February). Revamping school counselor education: The Dewitt Wallace-Reader's Digest Fund. *Counseling Today, 19*, 36.

Gysbers, N. C. (2010, July). *Remembering the past, shaping the future*. Keynote presented at the annual conference of the American School Counselor Association, Boston, MA.

Gysbers, N. C., & Henderson, P. (2006). *Developing and managing your school guidance and counseling program* (4th ed.). Alexandria, VA: American Counseling Association.

Havey, J. M. (2003). Inclusion, the law and placement decisions: Implications for school psychologists. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 412–423). Alexandria, VA: American School Counselor Association.

Havighurst, R. J. (1972). *Developmental tasks and education* (3rd ed.). New York: David McKay.

Herr, E. L., & Erford, B. T. (2011). Historical roots and future issues. In B. T. Erford (Ed.), *Transforming the school counseling profession* (3rd ed., pp. 19–43). Boston: Pearson.

Holcomb-McCoy, C. (2007). *School counseling to close the achievement gap: A social justice framework for success*. Thousand Oaks, CA: Corwin.

Hopkins, G. (2005). School counselors reflective on what makes them effective. *Education World*. Retrieved from http://www.educationworld.com/a_curr/curr198.shtml

Howard, K. A. S., & Solberg, V. S. H. (2006). School-based social justice: The achieving success identity pathways program. *Professional School Counseling, 9*, 278–287.

Hubert, M. (1995, December). Disaffiliation: An ethical consideration. *The ASCA Counselor*. Alexandria, VA: Author.

Hubert, M. (1996). Confidentiality and the minor student. *The ASCA Counselor*. Alexandria, VA: Author.

Isaacs, M. L., & Stone, C. (2003). School counselors and confidentiality: Factors affecting professional choices. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 179–196). Alexandria, VA: American School Counselor Association.

Jackson, M., & Grant, G. (2004). Equity, access, and career development: Contextual conflicts. In R. Perusse, & G. E. Goodnough (Eds.), *Leadership, advocacy and direct service strategies for professional school counselors* (pp. 125–153) Belmont, CA: Brooks/Cole.

Lapan, R. T., Carey, J., Dimmitt, C., & Gysbers, N. C. (2010). *And the studies say . . .* Paper presented at the annual conference of the American School Counselor Association, Boston, MA.

Lapan, R. T., Gysbers, N. C., & Kayson, M. A. (2007). *Missouri school counselors benefit all students*. Jefferson City, MO: Missouri Department of Elementary and Secondary Education.

Lawrence, G., & Kurpius, S. E. R. (2000). Legal and ethical issues involved when counseling minors in nonschool settings. *Journal of Counseling and Development, 78*, 130–136.

Lee, C. (2001). Culturally responsive school counselors and programs: Addressing the needs of all students. *Professional School Counseling, 4*, 163–171.

Martin, P. J., & Robinson, S. G. (2011). Transforming the school counseling profession. In B. T. Erford (Ed.), *Transforming the school counseling profession* (3rd ed., pp. 1–18). Boston: Pearson.

McAuliffe, G., Grothaus, T., Pare, D., & Wininger, A. (2007). The practice of culturally alert counseling. In G. McAuliffe (Ed.), *Culturally alert counseling: A comprehensive introduction* (pp. 570–631). Thousand Oaks, CA: Sage.

Milsom, A., & Akos, P. (2003). Preparing school counselors to work with students with disabilities. *Counselor Education and Supervision, 43*, 86–95.

Murphy, J. J. (2008). *Solution-focused counseling in schools* (2nd ed.). Alexandria, VA: American Counseling Association.

Myrick, R. D. (2003). *Developmental guidance and counseling: A practical approach* (4th ed.). Minneapolis: Educational Media Corporation.

Neukrug, E. S., Barr, C. G., Hoffman, L. R., & Kaplan, L. S. (1993). Developmental counseling and guidance: A model for use in your school. *The School Counselor, 40*, 356–362.

Neukrug, E. S., & Fawcett, R. C. (2010). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (2nd ed.). Belmont, Ca: Brooks/Cole.

Paisley, P. O., & Borders, L. (1995). School counseling: An evolving specialty. *Journal of Counseling and Development, 74*, 150–153.

Parsons, F. (1909). *Choosing a vocation.* Boston: Houghton Mifflin.

Pope, M., & Sveinsdottir, M. (2005). Frank, we hardly knew ye: The very personal side of Frank Parsons. *Journal of Counseling and Development, 83*, 105–115.

Plucker, J. A., Burroughs, N., Song, R. (2010). *Mind the (other) gap!: The growing excellence gap in k-12 education.* Bloomington, IN: Center for Evaluation and Education Policy. Retrieved from https://www.iub.edu/~ceep/Gap/excellence/ExcellenceGapBrief.pdf

Ratts, M. J., DeKruyf, L., & Chen-Hayes, S. F. (2007). The ACA Advocacy Competencies: A social justice advocacy framework for professional school counselors. *Professional School Counseling, 11*, 90–97.

Remley, T. P., Hermann, W. C., & Huey, W. C. (2003). Chapter 5: Records. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 223–225). Alexandria, VA: American School Counselor Association.

Sandhu, D. S. (2000). Alienated students: Counseling strategies to curb school violence. *Professional School Counseling, 4*, 81–85.

Schmidt, J. J. (2008). *Counseling in schools: Comprehensive programs of responsive services for all students* (5th ed.). Boston: Pearson.

Sealander, K. A., Schwiebert, V. L., Oren, T. A., & Weekley, J. L. (2003). Confidentiality and the law. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.), *Ethical and legal issues in school counseling* (2nd ed., pp. 208–218). Alexandria, VA: American School Counselor Association.

Sears, S. (2005). Large group guidance: Curriculum development and instruction. In C. Sink (Ed.) *Contemporary counseling: Theory, research, and practice* (pp. 189–213). Boston: Lahaska Press.

Snowden, P. E., & Gorton, R. A. (2002). School leadership and administration: Important concepts, case studies, and simulations. New York: McGraw-Hill.

Stone, C. B. & Dahir, C. A. (2006). *The transformed school counselor.* Boston, MA: Houghton Mifflin Company.

Stone, C. B., & Dahir, C. A. (2011). *School counselor accountability: A MEASURE of student success* (3rd ed.). Upper Saddle River, NJ: Pearson Education, Inc.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Tompkins, L., & Mehring, T. (1993). Client privacy and the school counselor: Privilege, ethics, and employer practices. *The School Counselor, 40*, 335–342.

United States Department of Education. (2001). *Elementary and secondary education act* (No Child Left Behind"). Retrieved from http://www2.ed.gov/policy/elsec/leg/esea02/beginning.html#sec1

United States Department of Labor. (2010). *Occupational outlook handbook, 2010–11 edition.* Retrieved from http://www.bls.gov/oco/ocos067.htm

Van Velsor, P., & Orozco, G. L. (2007). Involving low-income parents in the schools: Community centric strategies for school counselors. *Professional School Counseling, 11*(1), 17–24.

Vera, E. M., Buhin, L. & Shin, R. Q. (2006). The pursuit of social justice and the elimination of racism. In M. G. Constantine & D. W. Sue (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings* (pp. 87–103). Hoboken, NJ: Wiley.

Virginia School Counselor Association. (2008). *Virginia professional school counseling program manual*. Yorktown, VA: Author.

Winslade, J. M., & Monk, G. D. (2007). *Narrative counseling in schools: Powerful and brief* (2nd ed.). Thousand Oaks, CA: Corwin Press.

Clinical Mental Health Counseling[1]

I'm working at a crisis center, and a client tells me he's being followed by the Mob. They want to kill him, he states. He asks me what he should do, and I say, "Why don't you call the FBI, or the State Police?" He calls the State Police, and they want to see him. I drive him out to the State Police barracks, thinking along the way, "This guy is paranoid." We get there. The cops talk with him for half an hour. They come out and tell him to lie down in the back of my car so no one will see him. My heart drops. "He's not paranoid?" I think, "Oh my God!" They tell me to take the back roads back to the crisis center!

I'm working at a mental health center with a client who had been hospitalized for depression a few years back. I've been seeing her for a few months and have built a fairly solid relationship with her. At the end of the session she tells me, "You know, when I was hospitalized, one of the staff molested me."

I'm at the same mental health center. I've been seeing a client for about a year. She's been psychotic, on and off, for a number of years and is pretty stiff in the way she interacts with people. She's on some heavy-duty antipsychotic medication. She sees me once every three weeks for a check-in. Suddenly, at the end of a session, she looks at me and tells me she had an abortion ten years ago. Her psychotic episodes started about ten years back. This certainly seems to be an interesting coincidence. I decide to see her weekly. She begins to share her guilt about the abortion, and within a couple of months, she's practically off her medication. Now, I wouldn't have said she was back to normal, but she certainly was doing better! What a success! A month later, she dies in the middle of the night!

I'm in private practice, and it's a Friday afternoon. I'm seeing one of my last clients of the day, looking forward to going away on a weekend trip to the country. He's a 15-year-old I've been seeing for a while. At the end of the session, he blurts out that he was molested when on a recent vacation. There goes my weekend trip, as I have to deal with his parents, the law, and him.

My girlfriend and I have just broken up. It's my birthday. I'm very depressed. I go to my part-time job at a small counseling center. A new client walks in. She immediately tells me it's her birthday and that she and her husband have just split up. Is this a coincidence, or what? I wonder if I can get through the session. *Ed Neukrug*

---

[1] This chapter was co-written by Ed Neukrug and Kathleen Levingston.

So, you want to work as a mental health counselor? It can be fun. It can be boring. It can be scary. It can be sad, and it can be exhilarating. It's the best of jobs and the worst of jobs. Let's see what it's all about.

This chapter is about working in *clinical mental health counseling*. We'll start by defining this counseling arena. Then we'll offer a brief overview of the history of this specialty area. This will be followed by an overview of some of the places you can find clinical mental health counselors. We will examine some of the theories used by counselors in these settings and some typical roles and functions of the clinical mental health counselor. We'll present some special issues currently impinging on the clinical mental health counselor and offer information on current salary ranges. As we near the end of the chapter we will examine some multicultural and social justice issues, as well as some ethical, professional, and legal issues in the area of mental health counseling. We'll conclude the chapter with some thoughts about the changing nature of mental health counseling.

What Is Clinical Mental Health Counseling?

Probably, the best place to start in describing *clinical mental health counseling* is to examine the course content and field placements needed in such programs. Today, all counseling programs accredited by the Commission for the Accreditation of Counseling and Related Programs (CACREP) must provide content knowledge in eight areas: 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. In addition, clinical mental health counseling programs must also offer course content in psychopathology, diagnosis, assessment psychopharmacology, treatment planning, crisis counseling and trauma, psychosocial history, report writing, marriage and family, program development, addictions, case conceptualization, evidence-based treatment, and more! In addition, a 100-hour practicum and 600-hour internship are also required.

Until recently, *community counseling* (aka *agency counseling*) and clinical mental health counseling were seen as similar programs that had different accreditation processes by CACREP, with community counseling programs requiring a minimum of 48 credit hours and clinical mental health counseling programs requiring 60 credit hours. However, with most states requiring 60 credits for licensure, and with differences between the two degrees seeming relatively minor, the 2009 CACREP standards have done away with the community counseling degree. To help programs adjust to these changes, the 2009 CACREP standards currently require any new programs in clinical mental health counseling to have a minimum of 54 credits, and after July 1, 2013, all new programs in this specialty area will be required to have 60 credit hours (CACREP, 2010).

Over the years, changes such as those just noted have been many in the field of counseling and may even be described as a bit of a roller coaster ride. Despite the fact that the clinical mental health counseling degree is generally viewed as the specialty area most appropriate for becoming a Licensed Professional Counselor (LPC), in most states today one can become a Licensed Professional Counselor regardless of specialty area (see Box 17.1). Although it hasn't been a straight path to get where we are today, the field of counseling is stronger than ever. It will be interesting to see where we are in 2025.

BOX 17.1

What a Long Strange Road It's Been

I received my master's degree in 1974 with a focus on counseling in higher education settings. My internship was at a college-affiliated crisis center. Subsequent to obtaining my master's degree, I worked at a drug and alcohol abuse funded storefront crisis center. A couple of years later, I obtained a job as an outpatient therapist at a community mental health center. After obtaining my doctorate in counselor education, I taught counseling and later worked part-time as an associate school psychologist and as a school counselor in New Hampshire. During this time, I received clinical supervision and eventually obtained licensure as a psychologist in Massachusetts and New Hampshire. Moving to Virginia, I applied for licensure as a psychologist. The psychology licensure board denied me, saying my field was counseling and not psychology. I then applied for and obtained licensure as a professional counselor. Thus, despite my original degree in college student development counseling, I was able, with some additional training, to freely move into a number of different settings and obtain a variety of different credentials. Although it has become increasingly more difficult to obtain certification and licensure in closely related fields like psychology or school psychology, it is still true today that with some additional training, one can move fairly easily from one counseling specialty area to another. *Ed Neukrug*

A History of Clinical Mental Health Counseling

The Beginning of the Mental Health Movement

As noted in Chapter 2, the fields of psychiatry and clinical psychology arose around the turn of the twentieth century. It was at that time that one's emotional state was seen as having "psychological origins" in contrast to physical or demonic ones. *Freud's psychoanalytic approach* was one major impetus for this new way of viewing emotional problems that drastically changed the manner in which mental disorders were conceptualized and treated. It was also during this period that sanitariums began to experiment with more humane methods of hospitalization (Smith & Robinson, 1995).

The early 1900s saw the beginning of *vocational guidance*. This movement, along with the development of the first *assessment instruments*, was to have an impact on the eventual role of counseling in the mental health field. Besides being a natural fit, vocational guidance and testing shared something else in common: they both were concerned about differences in people, and highlighting differences (uniqueness!) was soon to become the hallmark of counseling and psychotherapy in general.

During the 1930s, the federal government began to earmark small amounts of money for mental health treatment, especially for research in mental health. As the decade continued, one could see a new mindset sprouting in America. Influenced by psychoanalysis, vocational guidance, an increasingly humane attitude toward mental illness, and *existential philosophers and psychologists* (some of whom emigrated from Europe), America was now beginning to accept the concept that mental health services were a necessary and important aspect of living in a civilized world. However, traditional psychoanalysis was seen as too long-term and mostly used by the rich; vocational guidance was too limited, too short-term, and too directive in its approach; and existential philosophy was viewed as too ethereal. However, a merging of these three approaches seemed just right.

As the 1940s neared, a new approach to counseling and psychotherapy evolved, one that encapsulated many of the precepts of psychoanalysis, counseling, existentialism, and American take-charge philosophy. This approach was optimistic and relatively short-term as compared to psychoanalysis and was founded on the belief that if people worked hard enough, they could change. Not surprisingly, it was during this time that we saw the beginnings of *self-help groups* like Alcoholics Anonymous and groups to assist new immigrants adjusting to American life, groups that affirmed the idea that individuals can change.

As a byproduct of the Second World War, evaluation techniques to determine who was emotionally fit to enter the military became much more sophisticated. In addition, the recovery rates of individuals who had emotional problems that resulted from the war were very high. Mental health providers were suddenly becoming more assured about their ability to treat individuals (Hershenson, Power, & Waldo, 2003). It was on the heels of these successes that the *National Mental Health Act* was passed in 1946, which gave states funds for research, training, prevention, diagnosis, and treatment of mental health disorders.

During the late 1940s, the National Institute of Mental Health (NIMH) was created by Congress. NIMH supported increased research and training in the mental health field and was the impetus for the 1955 *Mental Health Study Act*. This act established the Joint Commission on Mental Illness and Health, which made a number of far-reaching recommendations around increased funding and services for mental health and mental illness. Partly as a result of this act, the 1950s saw the expansion and acceptance of mental health services around the country. It was also at this time that we began to see the widespread use of psychotropic medication. During the late 1950s and continuing into the 1960s a number of new, and at the time revolutionary, approaches to counseling began to take shape.

Expansion of Mental Health Services

The 1960s saw great upheaval in American society. There was unrest in the ghettos and a country in bitter turmoil over the Vietnam War. The civil rights movement was growing in momentum. Out of this turmoil came landmark civil rights, economic, and social legislation (Kaplan & Cuciti, 1986). One such legislative initiative was the *1963 Community Mental Health Centers Act*, which funded the establishment of mental health centers in communities throughout the nation. These centers would provide short-term inpatient care, outpatient care, partial hospitalization, emergency services, and consultation and education services. This made it possible for individuals with a wide range of mental health concerns to obtain free or low-cost mental health services. In fact, approximately 600 community-based mental health centers could trace their origins to this act (Burger, 2010).

The late 1960s and early 1970s saw a number of federal laws passed that expanded the scope of community mental health centers and funded substance abuse treatment. In 1975, the Supreme Court decision in *Donaldson v. O'Connor* led to the deinstitutionalization of tens of thousands of state mental hospital patients who had been hospitalized against their will and who were not in danger of harming themselves or others (see Chapter 2, Box 2.3). Many of these former patients would receive services at the newly established local community mental health centers. The 1970s also saw the passage of a

number of important legislative acts that would have a direct impact on individuals with disabilities. One major legislative initiative was the *Rehabilitation Act of 1973*, which ensured access to vocational rehabilitation services for adults if they met three conditions: having a severe physical or mental disability, having a disability that interfered with their ability to obtain or maintain a job, and having feasibility of employment with their disability. This act increased the need for highly trained rehabilitation counselors.

With the election of President Carter in 1976, there was an increased focus on the importance of mental health treatment. In the late 1970s, President Carter authorized the expansion of mental health services. Near the end of this decade, we saw the establishment of the American Mental Health Counseling Association (AMHCA), the first division of the American Counseling Association (ACA) to be focused solely on mental health counseling and mental health concerns. Although legislative actions of the 1970s brought with them increased diversification of the counseling field and resulted in large numbers of counselors settling into a variety of community counseling agencies, the boom period of the 1970s was soon to end with the election of Ronald Reagan.

Carter's defeat by Reagan in 1980 led to the elimination and reduction of some mental health programs and a move toward federal *block grants*. Block grants had the effect of allowing the states to decide which programs to fund and resulted in less money for some programs, particularly mental health centers (Hershenson et al., 2003). Despite this temporary setback, the 1980s and 1990s saw a slow but steady expansion and diversification in the field of counseling and a settling-in phase in our profession. Counselors during these decades could be found in almost any mental health setting. In addition, it was during these decades that we began to see counselors working in settings where they had not been found before, such as family service agencies, prisons, gerontological settings, hospitals, business, and industry.

Beginning in the 1990s and into the twenty-first century we have seen dramatic changes in the delivery of mental health services as *health maintenance organizations* (HMOs) increasingly became the primary health insurance providers (Danzinger & Welfel, 2001; Grey House Staff, 2010; Kongstvedt, 2007). Previously, clients who had medical insurance generally had choice as to the type of counseling services they desired as well as to which licensed professional they could see. However, in an effort to save money, HMOs carefully monitored which services would be allowable and oversaw which providers a client could see (Huber, 1997; Walsh & Dasenbrook, 2005).

Recent Events

In 2009, every state in the country had finally passed a counselor licensure law (Shallcross, 2009). With licensure being the first important step toward counselors becoming *independent providers* and obtaining *third-party reimbursement*, this was no small step. Today, most mental health counselors can complete separate applications to become providers for the vast array of managed care and health insurance companies (Walsh & Dasenbrook, 2010). With the passage of the *Patient Protection and Affordable Care Act* (PPACA) in 2010, mental health benefits have become a part of the packages offered by state insurance exchanges, which will hopefully continue to broaden the eligible services mental health counselors may provide such as being included as Medicare providers (AMHCA, 2010a). Along these lines, ACA, AMHCA, and the National Board for Certified Counselors (NBCC) are often seen successfully advocating for the inclusion of clinical mental health

counselors in a wide variety of insurance plans, such as TRICARE, the large health care organization for our military families (Institute of Medicine, 2010; NBCC, 2010a). Although mental health services fulfill an important need in American society, it has become clear that where, when, and from whom one seeks specific counseling-related services is often not under the control of the consumer.

Somewhat related to the increased oversight of mental health services by HMOs and other insurance providers has been the gradual acceptance of the importance of diagnosis and the use of psychotropic drugs. With HMOs and other insurance providers insisting on a DSM-IV-TR (soon to be DSM-5) diagnosis if a client is to obtain services, clinical mental health counselors must know how to diagnose. Although there are benefits and drawbacks to the diagnostic and statistical manual (see Table 17.1; also see Table 10.2), it is clear that mental health counselors need a working knowledge of this classification system if they are to work side-by-side with other professionals. Whereas counseling programs had traditionally played down the importance of diagnosis (Patureau-Hatchett, 2009), this attitude is changing as counselors have become providers for most insurance companies and HMOs.

Closely related to the use of DSM is an increased willingness on the part of counselors to refer clients for *psychotropic medication*. With persuasive evidence that some emotional disorders are genetically linked (Douthit, 2006; Holloway, 2004; Neukrug, 2001), and with research now showing that the treatment of some problems, such as depression, is best facilitated through a combination of therapy and psychotropic medication, it is becoming evident that counselors will need to learn how to use such medications (Kalat, 2008; Kuat & Dickinson, 2007; Lewis, 2006; Manber et al., 2008; Paradise & Kirby, 2005; Schatzberg & Nemeroff, 2009). To not do so will undoubtedly find the counselor out of sync with the rest of the mental health field. In addition, it may leave the counselor open to ethical misconduct charges and possible malpractice suits, as in some cases not to use medication may be viewed as practicing incompetent therapy.

As community counseling agencies have become more prevalent and as licensure has taken hold in every state, the number of counseling programs that offer degrees in

TABLE 17.1

Drawbacks and Benefits of a Diagnostic and Statistical Manual Diagnosis	
DRAWBACKS	BENEFITS
• Objectifies and depersonalizes the person, as we view him or her in a dispassionate manner, much like watching a rat in a maze. • Labeling can lead to a self-fulfilling prophecy whereby the individual is seen as the diagnosis, is treated in a manner consistent with that diagnosis, and therefore is reinforced for that diagnostic label. • Provides clinicians with a common language that enables them to discuss clients as if they were not real people with real concerns. • Creates artificial categories that we "buy into," and thus we believe such diagnoses exist. In fact, such diagnoses are a social construction and are thus a function of the values of society.	• Offers us a way of understanding the person more deeply, as we are challenged to make a thorough assessment of the client. • By understanding the diagnostic label and by knowing the research in the field, we can better match treatment plans and use of medication with the diagnosis, thus leading to better therapeutic outcomes. • Offers clinicians a common language by which they can consult with one another and jointly come up with more effective treatment decisions. • Provides clear-cut diagnostic categories from which research designs can be generated and new treatments found.

clinical mental health counseling has increased. Whereas most students in counseling programs used to specialize in school counseling, students are now evenly split between school counseling and clinical mental health counseling (about 36% in each) (Clawson et al., 2008). Today, students who specialize in community agency counseling and clinical mental health counseling, respectively, find jobs in one or more of the following settings: agencies, 67% and 65%; managed care, 14% and 19%; private practice, 11% and 12%; elementary schools, 11% and 10%; middle schools, 7% and 19%; secondary schools, 9% and 15%; and higher education, 6% and 19%. Approximately 12% and 11%, respectively, go on to pursue an advanced degree. It is clear that clinical mental health counseling has become one of the major specializations in the counseling profession.

Roles and Functions of the Clinical Mental Health Counselor

In view of the diversity of agencies in which clinical mental health counselors are found, it is clear that they can play roles that vary dramatically. Let's attempt, however, to generate a list of roles common to most mental health counselors.

Case Manager

All clinical mental health counselors are involved in some kind of case management. Whether working in a mental health center, residential treatment center, or religiously-affiliated counseling setting, the counselor has the responsibility to understand client needs, create treatment plans, and follow through on treatment goals. And, along with these tasks comes a wide range of mundane activities related to case management, including paperwork, evaluation, follow-up, billing, time management, and so forth.

Appraiser of Client Needs

Whether it is through a formal clinical interview, the use of the DSM, the use of tests, or an informal session with a new client, the clinical mental health counselor is assessing client needs and making some kind of determination about the disposition of the case.

Counselor

All clinical mental health counselors, of course, do counseling. Although some counselors may use brief-treatment approaches while others are doing long-term therapy, and some conduct individual or group counseling while others practice family counseling, there is little question that the major role of the mental health counselor is to assist the client through the counseling process.

Consultant

One of the most important roles of the clinical mental health counselor is that of consultant. As discussed in Chapter 8, consultation for the mental health counselor can be consulting outward or inward. The focus of outward consultation is on assisting individuals

who have some mental health concerns but are not clients directly involved with the agency, such as the parents and teachers of a client. Inward consultation happens when the counselor works to assist the agency in the successful functioning of that agency and ultimately the effective treatment of its clients. Consulting with other clinicians about a client would be an example of inward consultation.

Crisis Responder

With terrorist acts such as 9/11, natural disasters such as Hurricane Katrina, and school shootings such as those at Columbine and Virginia Tech, mental health counselors have increasingly become the first line of defense to assist in crisis management. Counselors assess the situation, provide information, offer support, and assist clients in developing coping skills. In addition, counselors serve as critical incident stress debriefers to address reactions of the other helpers (medical personnel, police officers, firefighters) who may be adversely affected while helping those in crisis.

Supervisor and Supervisee

You might remember from Chapter 8 that supervision is crucial to a client's growth, as it is designed to optimize the therapeutic competence of the counselor (Bernard & Goodyear, 2008; Campbell & Herlihy, 2006). From a practical standpoint, supervision is also important because most states require a minimum of two years of clinical supervision as one aspect of obtaining licensure as a professional counselor.

A Professional Who Is Accountable

These days, accountability is a major requirement for all counselors. One way of showing accountability is through good record keeping. For instance, all counselors should be taking case notes, almost all counselors will be writing intake interviews and/or intermittent summary reports, and most counselors will be filling out paperwork for insurance companies or funding sources. Counselors are also accountable in other ways, such as when they complete needs assessments of their client population and when they evaluate the success of the counseling they do and the programs they run.

Other Roles

Some other roles you sometimes find mental health counselors taking on include (Neukrug, 2007; Southern Regional Educational Board, 1969; Taylor, Bradley, & Warren, 1996):

- *Outreach worker*, such as the counselor who goes on home visits to ensure the well-being of his or her clients
- *Broker/Networker*, such as the counselor who assists his or her clients in using other social service resources
- *Advocate*, such as the counselor who champions and defends clients' causes and clients' rights and who organizes client and community support in order to provide needed services
- *Teacher/educator*, such as the counselor who tutors, mentors, and models new behaviors for clients

- *Community planner*, such as the counselor who works with community members in designing, implementing, and organizing new programs
- *Administrator*, such as the counselor who runs, manages, and supervises community service programs
- *Clinical assistant,* such as the counselor who works closely with and may be supervised by more highly trained professionals in an effort to assist in client growth (Neukrug, 2007; SREB, 1969)

Finally, Gladding and Newsome (2009) offer another method of categorizing the work of mental health counselors. They suggest that the counselor distinguish whether his or her role is one of *primary prevention, secondary prevention*, or *tertiary prevention*. Those who focus on primary prevention concentrate on prevention of emotional problems and the promotion of a wellness outlook. Secondary prevention focuses on the control of non-severe mental health problems, while tertiary prevention concentrates on the control of serious mental health problems. A continuum exists whereby those who practice primary prevention focus less on assessment and diagnosis and more on presenting educationally oriented materials to ward off potential problems. Those involved with secondary and tertiary prevention respectively become increasingly involved in diagnosis, long-term treatment, and working with psychopathology (see Figure 17.1). Gladding and Newsome (2009) suggest that it is important for all counselors to spend some time focusing on primary prevention in order to ward off potential client problems.

Theory and Process of Clinical Mental Health Counseling

Because there are so many different settings, roles, and functions of mental health counselors, it is not a simple process to talk about a theoretical orientation for this kind of counselor. In fact, sometimes a counselor's theoretical approach is driven by the type of agency in which he or she works. For instance, if a counselor works in an agency that mandates a maximum of 10 sessions per client, he or she must resort to brief-treatment modalities. This leaves the counselor with a handful of theoretical approaches from which to choose. The counselor who works mostly with families must obviously have training in couples

FIGURE 17.1
Comparison of Primary, Secondary, or Tertiary Prevention

	Primary	Secondary	Tertiary	
Short Term	→	→	→	Long Term
Modifying Behavior	→	→	→	Personality Reconstruction
Wellness Focus	→	→	→	Focus on Pathology
Before Problems Occur	→	→	→	After Problems Occur
Preventive	→	→	→	Restorative
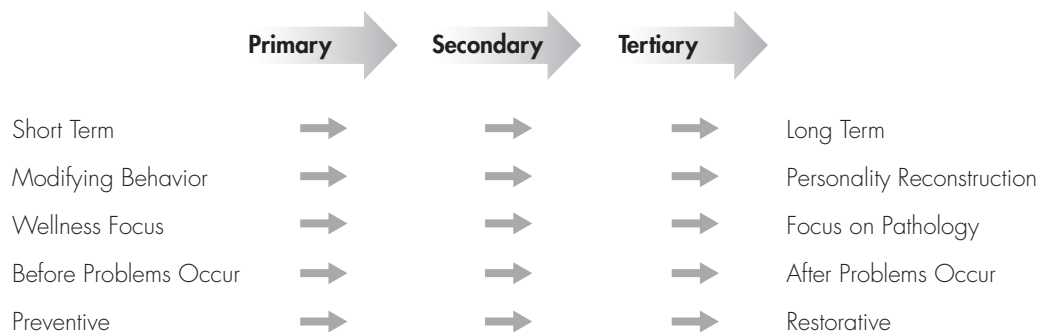
and family work; and, again, this counselor must choose from the existing family therapy approaches. Similarly, the rehabilitation counselor who mostly conducts career counseling must choose from the career development approaches. Therefore, to define a general theoretical approach taken by most mental health counselors would be impossible.

Although we might not be able to identify a general theoretical approach, there are some broad principles that are common to many counselors who work in these settings. For instance, Hershenson and colleagues (2003) suggest that the following seven principles govern the ways in which counselors deliver services at all agencies:

1. Respecting the client
2. Providing a facilitative environment that fosters client progress
3. Helping clients actively define goals in order to promote growth and development
4. Empowering clients and helping them understand that counseling is an educational process that involves client learning
5. Focusing on client strengths, not weaknesses
6. Focusing on both the person and the context (environment)
7. Using techniques that have been shown to be valid through prior research

Settings Where You Find Mental Health Counselors

With the spread of the community mental health movement, many agencies and settings have arisen that offer mental health services and provide employment for clinical mental health counselors (Burger & Youkeles, 2010; Gladding & Newsome, 2009). Although some counselors obtain related degrees (e.g., rehabilitation counseling, career counseling, gerontological counseling) the following settings represent the places where you are most likely to find the clinical mental health counselor.

Career and Employment Agencies

Counselors today can be found at college counseling or college career management centers, state employment offices, vocational-rehabilitation offices, and private agencies that offer career and employment counseling (Ferguson's Careers in Focus, 2008). Such counselors typically will assist individuals in "choosing an occupation, changing a career, or adjusting to a work environment" (Helwig, 1996, p. 75). Usually, such work involves assessing clients' interests and aptitudes and helping to bring self-knowledge to clients concerning their career development process. In addition to AMHCA (see www.amhca.org), one of the largest divisions of ACA, individuals who work in these settings often join one or both of the following ACA divisions: the National Career Development Association (NCDA, see www.ncda.org) and the National Employment Counseling Association (NECA, see www.employmentcounseling.org).

Community Mental Health Centers

Counselors have been working in mental health centers since they were first established more than 40 years ago (Garner, 2008; West, Hosie, & Mackey, 1987). Although a major function of the mental health center is to assist individuals with severe emotional

problems, the kinds of services they offer vary greatly. Today, many community mental health centers provide twelve types of services, and counselors can be found working in any of these service areas. They include:

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 older persons
8. Preinstitutional court screening
9. Follow-up care for mental hospitals
10. Transitional care from mental hospitals
11. Alcoholism services
12. Drug abuse services

Because community mental health centers offer such a wide range of services, they often employ hundreds of clinicians, including psychiatrists, psychologists, counselors, social workers, psychiatric nurses, and human service professionals (Garner, 2008). The responsibilities of clinicians at mental health centers vary and include such activities as clinical assessment; consultation; education; prevention; referral; retention and education, individual, group, couples, and family counseling; and much more. Because there are a variety of different kinds of clinicians at mental health centers, it is not unusual for clinicians to work as a team (Ferguson's Careers in Focus, 2008; Gladding & Newsome, 2009). For instance, for a new client who enters the system, one clinician might conduct the intake interview, the psychiatrist might meet with the client for a medication assessment, and the case might be presented at a team meeting in order to determine which clinician might work best with this particular client.

As federal money for mental health centers has dried up, mental health centers have had to go elsewhere to secure funding. Thus, we see mental health centers obtaining grants from organizations like the United Way, and we have seen them increasingly rely on third-party billing for reimbursement of services. Because licensing is generally needed for insurance reimbursement, mental health centers have increasingly hired individuals who are licensed and who are eligible to receive third-party reimbursements.

Although clinical mental health counselors may be members of a variety of professional associations, many counselors who are employed at mental health centers belong to AMHCA, which is one of the largest divisions of ACA. AMHCA has a long history of advocacy for mental health issues and legislation (see www.amhca.org).

Correctional Facilities

In 2008, approximately 7.3 million Americans were in jail, on probation, or on parole—about 1 in every 198 United States adult residents—and of these, an extremely large number were minority males (Bureau of Justice Statistics, 2008a, 2008b). With most prisoners being undereducated, abused as children, abusers of drugs and alcohol, and coming from dysfunctional families, the need for counseling is paramount. It is not surprising that counselors today find themselves performing multiple functions when working with those who are incarcerated. Some of these functions include counseling, assessment,

crisis intervention, consultation, vocational training, assisting with day-to-day adjustment problems, and making referrals to outside agencies when the incarcerated individual is released from prison (Crighton & Towl, 2008; Helwig, 1996; Hershenson et al., 2003).

With so many incarcerated individuals having been found to be addicted to drugs and alcohol, it is no wonder that in addition to AMHCA, many correctional counselors join the International Association of Addictions and Offender Counselors (IAAOC), a division of ACA (see www.iaaoc.org).

Family Service Agencies

Because of a historically strong emphasis on family issues and community advocacy in the social work profession, many family service agencies were originally established by social workers. This resulted in social workers being the clinicians of choice for many family service agencies, and these agencies continue to be one of the largest employers of social workers (Ritter, Vakalahi, & Kiernan-Stern, 2009). However, as counselors began to include couples and family counseling in their repertoire of skills, they have increasingly been hired by such agencies. These agencies often receive partial funding through such organizations as United Way and through government grants. In addition, these agencies also receive payments via clients' insurance companies or directly from clients on a fee-for-service basis. Although many of these agencies have a religious affiliation (e.g., Catholic or Jewish Family Services), religion usually does not play a major role in acceptance of clients for counseling (Male, 1996). Counselors who work in such agencies have a full range of responsibilities, including conducting intake interviews, providing case management, offering consultation and education, and providing individual, group, and family counseling. In addition to AMHCA, individuals who work for family service agencies are often members of the International Association of Marriage and Family Counselors (IAMFC, see www.iamfconline.org), a division of ACA, and/or the American Association of Marriage and Family Therapy (AAMFT; see www.aamft.org).

Gerontological Settings

As the population of individuals over 60 years old continues to rise (United States Census Bureau, 2010), so does their need for mental health services (Gibson & Mitchell, 2007; Goodman, Schlossberg, & Anderson, 2006; Schwiebert, Myers, & Dice, 2000; Walsh, Currier, Shah, Lyness, & Friedman, 2008). Whereas older persons have traditionally been less amenable to counseling than younger people, as the baby boomers age, this trend is likely to end (Maples & Abney, 2006). It is, therefore, not surprising that across the country we have seen an increase in day-treatment programs for older persons at community mental health centers, long-term care facilities such as nursing homes, housing settings that are specifically geared toward older persons, senior centers, and programs for older persons offered through religious organizations and social services agencies (Ritter, Vakalahi, & Kiernan-Stern, 2009).

When working with older persons, both prevention and treatment become important, and counselors will often be found assisting older persons with developmental challenges and with situational crises such as loss of a spouse (Ferguson's Careers in Focus, 2008; Gladding & Newsome, 2009; Walsh et al., 2008). Counselors often have to assist older persons in dealing with the negative stereotypes placed on them by society as well as the psychological and physiological changes they face as a result of aging. Issues of loneliness, physical illnesses, loss and bereavement, and expected developmental changes of growing older are some of the things that counselors will face when working with older

BOX 17.2

The Needs of Older Americans

In an effort to understand some of the needs of older Americans, I visited a local community center that had organized senior services. This included meals at reduced prices; educational activities, such as guest speakers on a variety of topics; and social activities, such as movies, travel to local theater productions, and so forth. At the Center, I had lunch with Irving, Lasard, Izzi, Jeanette, Max, Joe, and some other senior citizens, with their average age being about 80 years old. We had an informal discussion about a number of issues facing older Americans. Although there was some debate concerning the amount of federal subsidies that should be given to seniors, some of their major issues seemed clear. For instance, all felt that seniors were entitled to safe and secure housing, access to good medical care, having their transportation needs met, having access to healthy meals, and having federal assistance in the delivery and implementation of these programs. Most of this group felt that they had spent a lifetime of hard work and now deserved something back in return.

Finally, it was clear that many of these seniors were dealing with losses in their lives—losses of spouses, of friends, and relatives. This psychological component, clearly, was not being attended to by any of the existing available services. *Ed Neukrug*

clients (see Box 17.2). Although both individual and family counseling can be means of treatment, some suggest that group counseling may be particularly effective when working with older persons (Gladding & Newsome, 2009; Thomas & Martin, 2006).

With some graduate programs offering emphasis areas in the counseling of older persons (Clawson et al., 2008), it is clear that this area of counseling has gained quite a bit of importance. In addition to AMHCA, individuals who have an interest in gerontological settings often join the division of ACA known as the Association for Adult Development and Aging (AADA, see www.aadaweb.org).

HMOs, PPOs, and EAPs

Ironically, although *Health Maintenance Organizations* (HMOs) and *Employee Assistance Programs* (EAPs) have cut into the ability of private practitioners to make a living (see discussion in "Private Practice" section), they have provided another possible place of employment for clinical mental health counselors (Clawson et al., 2008; Hayes & Paisley, 1996; Ritter, Vakalahi, & Kiernan-Stern, 2009). For instance, some HMOs have designated clinicians for whom they provide office space, and subscribers must see one of these clinicians unless they receive special authorization to see someone else. HMOs such as these will often hire master's-level counselors. Other HMOs will select specific private practices to which they will refer, and counselors are often one of the many kinds of clinicians that may be found in these practices. Finally, due to the overseeing of clinicians' work that generally is handled by HMOs, some will hire counselors to review the casework of other clinicians.

Preferred Provider Organizations (PPOs), which are a type of HMO, are another source of employment for counselors. PPOs are organized to provide discounted rates to members. With PPOs there are gatekeepers who will refer clients to designated providers, although a client can go outside the PPO with the PPO paying for a portion of the services.

Some businesses now hire counselors as part of their employee assistance programs (EAPs). EAP counselors provide education and prevention on such topics as substance abuse and stress reduction, do assessment of employee problems, and sometimes provide short-term counseling. EAP counselors will often provide referrals to a wide range of

community services such as mental health centers, substance abuse agencies, lawyers, and private practice clinicians (Hayes & Paisley, 1996; Gladding & Newsome, 2009). Counselors who work for HMOs, PPOs, and EAPs will often join AMHCA (see www.amhca.org).

The Military and Government

The military and government are unique work settings that offer a wide range of counseling opportunities. One primary role of this counselor is to assist military or government personnel with the identification of educational or training programs that will offer opportunities for advancement within the military or government or help people transition to a new career (Helwig, 1996). In addition, military and government counselors are often found providing primary prevention and psychoeducational programs. Some military and government counselors conduct individual, group, and family counseling for military or government employees or their dependents. Such counselors sometimes work for a military family service center or an outpatient department of a military hospital or clinic, or serve as an in-house government employee, somewhat similar to an EAP counselor (see Box 17.3). With an increased awareness and focus on mental health

BOX 17.3

Meichell: A Military Counselor

Courtesy of Meichell Worthing

I was raised in what some might call a typical military family. We moved every couple of years, changing schools 13 times in a 12-year period. I always loved school and am fond of the adventure of moving to different places and experiencing different cultures. However, for every place that I was able to thrive in military life, my two brothers suffered educationally and emotionally, both dropping out in early high school. Both received special education services, but something was missing. No one was dealing with what it meant for them to be military kids. Many marriages also succumb to the pressures and end in divorce, which was the case with my parent's marriage.

There is a special shell type of emotional exterior that military families create around themselves in order to withstand the many losses they endure. Every deployment is a loss of time, memories, shared joys, and pains, between husband and wife, parent and child, and general family wholeness. This often makes it hard to understand what is happening in the inner lives of these families. It takes special care and understanding of this organism that is its own culture.

I started out as a special education major in undergrad hoping to help children like my brothers. However, something was missing for me, and I made a drastic change to psychology my senior year. While exploring graduate studies, I met my husband, a Navy Sailor, and found myself marrying into the Navy (ironically, something I said I would not do!). I began work on a graduate degree in counseling while my husband left for his first 1-year tour in the Middle East. After receiving my license, I opened my private practice. It was around this time that I was introduced to a consultant program sponsored by the Department of Defense. I serve as a contracted counselor to provide extra support on various military installations to both military personnel and their families. I also see military families in my private practice. It is rewarding to serve in this capacity having been raised in the military lifestyle/culture and continuing in this culture as the wife of a serviceman.

Why do I counsel military families? It is essential that these families have people in their communities that care about their struggles, are clinically trained, easily accessible, and willing to help them maintain strong families in the midst of constant change. Service men and woman deserve the best care and the secure knowledge that their families are emotionally cared for while they risk everything for the greater good of their country.

concerns of military members and their families by the Department of Defense Task Force on Mental Health (2007) and the recent approval for TRICARE reimbursement (see earlier discussion in "Recent Events" section), career opportunities to work with this particular population may increase in the future. In addition to AMHCA, counselors who work for the military or government often join the Association for Counseling and Education in Government (ACEG), which initially was called Military Educators and Counselors Association (MECA). ACEG is a division of ACA (see www.dantes.doded.mil/dantes_web/organizations/aceg/index.htm).

Pastoral, Religious, and Spiritual Counseling Agencies

Some counselors who obtain a degree in mental health counseling are interested in working in settings that have a religious and/or a spiritual orientation. In fact, spirituality seems to be an increasingly important aspect of counseling for many counselors (Morrison, Clutter, Pritchett, & Demmit, 2009; Stanard, Sandhu, & Painter, 2000; Young, Wiggins-Frame, & Cashwell, 2007).

Some who do pastoral counseling are ministers who may have had some coursework in counseling and sometimes pursue a master's degree in counseling. Others who have a strong religious orientation will obtain a degree in counseling and then seek out employment in a setting that fosters their particular point of view (e.g., Christian counseling agencies). These individuals tend to integrate the basic precepts of their religious viewpoints with what they've learned in graduate school (see Box 17.4). Obviously, at times, this makes for some interesting ethical dilemmas, such as the pro-life Christian counselor whose counselor education training has taught him or her to respect the client's right to make decisions for him- or herself, including those clients who might want to have an abortion. Besides pastoral and religious counselors, an increasing number of counselors have integrated a spiritual viewpoint into their counseling orientation. These counselors tend not to be driven by religious convictions but believe that spiritual issues are primary to understanding one's search for meaning in life.

Pastoral counselors who are affiliated with a church, synagogue, temple, or mosque can often be found ministering at these settings. Religious counselors are often found in private practice groups that offer their particular religious bent, while counselors with a spiritual orientation can be found in all kinds of agency/mental health settings. In addition to AMHCA, pastoral counselors or counselors with a spiritual orientation might join the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC; see www.aservic.org) and/or the American Association of Pastoral Counselors (AAPC; see www.aapc.org).

Private Practice Settings

Now that every state has a licensing law, there has been and will continue to be a rise in the number of counselors who are in private practice. Today, many private practice counselors can be found conducting individual, group, couples, and family counseling for individuals with developmental concerns and "normal" life problems (primary and secondary prevention). However, private practice counselors can also be found working with those who are seriously impaired (tertiary prevention), although additional training in

BOX 17.4

Kevin: A Christian Counselor

Image not available due to copyright restrictions

Let me start by saying that what I am doing as a vocation now was never considered in my earlier years. After a stint in the Navy in the late 70's, I went into the ship repair industry and worked successfully in the field of electrical engineering for over 14 years. Subsequently, in the early 90's, I went through a bitter divorce. Broken at a soul level, very alone and in deep despair, I sought out counsel with the minister at my church. Disappointed in his response, I went to a "Christian Counselor." Even though I brought up my spirituality, I was dealt with very clinically—no prayer, no reference to Biblical context, and no mention of Jesus as Healer, which are part of my core Christian beliefs. At that moment, a seed was planted to do something about this for others who might face a similar situation. I prayed long and hard and found

what I consider to be my calling by God: I wanted to help broken and shattered people by becoming a Christian counselor. I walked away from my prestigious career and simply followed this path. My quest led me to receive my master's degree in counseling, become an ordained minister, and obtain my license as a professional counselor, which allowed me to be employed as a Pastoral Counselor with a local church.

For the past 5 years I was on staff with a large private Christian agency providing clinical counseling, within a Christian framework, to individuals, couples, and families who desire this perspective. Currently, I have opened a private practice of my own. By "Christian-based," I mean that I operate from a Christian worldview and recognize that the broken and shattered are all spiritual beings created to be in a relationship with God and with each other. By "clinically sound," I mean that I strive to constantly learn more in our field of expertise, counseling. This is partly why I am a member of the American Association of Christian Counselors and the International Society for the Study of Trauma and Dissociation. I diligently pursue knowledge on an ongoing basis to advance my deeper understanding of others so that I can provide effective interventions filtered through the Spirit of God.

psychopathology, psychopharmacology, and assessment is sometimes needed to work with this population.

With the cost of mental health services skyrocketing, insurance companies have increasingly cut back on the mental health services they provide (Allen, 2000; Fraser & Solovey, 2007; Huber, 1997). Also, many employers now provide medical coverage through the use of managed health programs such as HMOs and EAPs (Grey House Staff, 2009; Walsh & Dasenbrook, 2009). Such managed programs maintain low costs by referring only to providers who agree to the terms of the program, by providing peer review of proposed treatment plans, through early detection and treatment, by preauthorization for admissions to hospitals, and by overseeing case management of clinicians (Gladding & Newsome, 2009). This kind of oversight of practice, as well as the increased amount of resulting paperwork, has added additional work and stress to the private practitioner and has cut into his or her ability to make a living (Daniels, 2001; Hunt, 2005; Janesick & Goldsmith, 2000). As a result, many private practice clinicians may also be found doing such things as marital and divorce mediation, parent education, consultation to business and industry, stress management and biofeedback, educationally oriented workshops, supervision, evaluations for adoption and custody, and professional

BOX 17.5

Chevette: A Nationally Certified and Licensed Professional Counselor

Courtesy of Chevette Alston

There is no magical story as to how I became a counselor; I am one of those rare people who knew from an early age that the mental health field was my area of interest. And perhaps like many in our profession, my path has taken some twists and turns.

I first worked with minority clients as a university counselor. I quickly realized that the word minority was inclusive of a number of areas, including ethnicity, culture, gender, socioeconomic status, and more. As a relatively young counselor, I tended to use one theoretical approach with all my clients. It didn't yet occur to me to vary my approach based on the unique needs of the individuals with whom I was working.

My next job was at a local community college where I worked for a federally funded student support program called the Open Door Project whose purpose was to provide academic and counseling services to help students stay in college. Here I saw a variety of clients, some struggling with financial issues, which at times took priority over the desire to stay in college. Others were first generation

college students who struggled partly because there was no "culture of college" in their family of origins, and they did not have the advantage of family members that understood their experience or could give them helpful advice on how to study, testing skills, or other tips that would lend to successful college completion. It was here that I began to change my "generic" approach to counseling and learned to meet the client "where he or she was."

Today, I am in private practice. As I've grown as a counselor and professional, I've moved toward the idea that it is critical to have a broad base of knowledge and apply theories and techniques based on client needs and available resources. For example, clearly a middle class minority has different needs and resources from a minority who lives in subsidized housing. Although on the surface they may come from the same minority group, their backgrounds and available resources are dramatically different. To treat them the same would make little sense. And of course, all persons, regardless of where they come from, have their own unique concerns that are important to them and that are critical for me to understand.

As I look over my life as a counselor I can see how my approach to counseling has changed as I have held various jobs and as I have matured as a professional. I am excited to see where I will be in the next ten years.

writing (Bertram, 1996; Walsh & Dasenbrook, 2007). Private practice counselors often join AMHCA (www.amhca.org) (see Box 17.5).

Rehabilitation Agencies

In the United States today, close to 41.3 million (15%) Americans five years of age and older have a disability such as mental retardation, learning disabilities, emotional problems, speech impairment, hearing impairment, visual impairment, orthopedic impairment, multiple disabilities, or other health impairments (United States Census Bureau, 2006). These individuals are often counseled by rehabilitation counselors at one of three rehabilitation agencies: state departments of vocational rehabilitation, Veterans Administration (VA) hospitals, and private rehabilitation agencies (Fabian & MacDonald-Wilson, 2005; Ferguson's Careers in Focus, 2008; Matkin, 1997). Whereas state vocational rehabilitation agencies and VA hospitals obtain federal and/or state funding, private agencies mostly rely on insurance reimbursement, worker's compensation, and other client-related

methods of payment. At these settings, rehabilitation counselors often provide a wide range of services for their clients. For instance, they may

- help people deal with the personal, social, and vocational effects of disabilities;
- counsel people with disabilities resulting from birth defects, illness or disease, accidents, or the stress of daily life;
- evaluate the strengths and limitations of individuals, provide personal and vocational counseling, and arrange for medical care, vocational training, and job placement;
- interview both individuals with disabilities and their families, evaluate school and medical reports, and confer and plan with physicians, psychologists, occupational therapists, and employers to determine the capabilities and skills of the individual;
- develop a rehabilitation program that often includes training to help the person develop job skills;
- recognize and help remove environmental and attitudinal barriers;
- work toward increasing the client's capacity to live independently. (United States Department of Labor, 2010–2011a, "nature of work," para. 8)

In providing these services, the rehabilitation counselor often employs individual and group counseling techniques, and coordinates community services for clients (Ferguson's Careers in Focus, 2008; Garfield & Beaman, 1996; Garner, 2008; Leahy, Muenzen, Saunders, & Strauser, 2009). Because of the wide range of disabilities with which the rehabilitation counselor works, it is often important that a team approach be taken when working with clients.

As new medical procedures make it possible for individuals to live longer with disabling and chronic health conditions, it is likely that we will see an increase in the number of individuals with disabilities. This will result in the need for additional services in which we will likely find the rehabilitation counselor taking an active role (Garner, 2008).

The rehabilitation counselor straddles two professional associations: the American Rehabilitation Counseling Association (ARCA, see www.arcaweb.org), which is a division of ACA, and the National Rehabilitation Counseling Association (NRCA; see http://nrca-net.org). Like many of ACA's divisions, ARCA has moved to a semi-independent state from its parent association, and one can now either join ARCA on its own or in conjunction with joining ACA.

Residential Treatment Centers

Increasingly, we are finding counselors working in residential treatment centers. Such centers tend to have a rehabilitative focus, provide a live-in setting for the duration of treatment, and provide counseling services. Today, residential treatment centers service many different people, including those who are incarcerated, individuals with physical disabilities, individuals with mental illness, the developmentally delayed, substance abusers, delinquent youths, and individuals with eating disorders, to name just a few (Lynch & Lynch, 1996).

Services provided in such settings vary but often include individual and group counseling, vocational counseling, assistance with reentry into the community, and consultation and referral to other professionals when the individual is ready to reenter

BOX 17.6

Don—A Counselor At a Residential Treatment Center

Courtesy of Don Macauley

I have always been interested in what makes people tick, which made a career in counseling a natural fit for me. Fresh out of getting my undergraduate degree in sociology, I volunteered as a co-facilitator of poly-substance abuse groups. Running these groups allowed me to develop basic group facilitation skills in an often challenging and intimidating environment. Empowered by my developing skills, I packed my bags and headed into the woods as a group leader in a youth wilderness program. I lived alongside troubled adolescents in the sweltering heat of summer and bitter cold of winter. This allowed me to not only appreciate but also experience many of the struggles the residents were facing being away from home, battling the elements, and processing difficult emotions.

After leaving the wilderness program, I worked as a unit staff member in a residential treatment facility while returning to school to earn my master's degree in community agency counseling. I completed my internship in the university's counseling center, where I was exposed to a diverse student population presenting a wide variety of issues that required me to be aware of my own cultural beliefs, attitudes, and perspectives. Upon graduation, I became a case manager for a local youth shelter where I learned about family struggles and how different household roles influence family dynamics. I became increasingly interested in understanding the intricacies of youth and family issues. After becoming a Licensed Professional Counselor (LPC), I became an in-home clinician and had the unique opportunity of viewing families from within their own surroundings. Seeing some of the decrepit environmental conditions was an integral piece in identifying and understanding the stressors leading to family dysfunction.

In my current position at a residential treatment center for at-risk youth, I have been able to draw on my previous counseling experiences and thoroughly develop my counseling skills. This experience continues to teach me the value of empathy and unconditional positive regard as well as the importance of maintaining a family systems perspective when working with at-risk youth.

the community. Because of the wide range of clients who may be served in residential treatment centers, as with vocational rehabilitation settings, a team approach involving a number of specialists and group treatment planning is often used. In addition to joining AMHCA, counselors who work at residential treatment centers often join the professional association that is most similar to the focus of the clientele with whom the counselor works (e.g., counselors who work at residential centers for those with disabilities might join NRCA [see http://nrca-net.org] or ARCA [www.arcaweb.org]) (see Box 17.6).

Substance Abuse Settings

The substance abuse statistics in the United States are staggering (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). For instance, for individuals aged 12 and older, in 2008 it was found that:

- 22.2 million (8.9%) were abusing or dependent on alcohol or drugs
- 15.2 million (6.5%) were dependent on or abused alcohol
- 20.1 million (8%) were actively using illicit drugs
- 129 million (51.6%) drank alcohol
- 17.3 million Americans (6.9%) were heavy drinkers

- 58.1 million (23.3%) had participated in binge drinking once or more in the past 30 days
- 23.1 million (9.2%) received treatment for a substance abuse problem

Drug and alcohol abuse today can be found in the inner cities and in middle-class America. It not only affects the users but also has a great impact on family members and on society (Fisher & Harrison, 2009; Woititz, 2002). There is little question that substance abuse is related to many of the problems facing our nation, including violent crime, problems on the job, and changing morals. Thus, the widespread abuse of substances, unfortunately, provides an array of places for counselors including hospital detoxification (detox) units, halfway houses, and drug and alcohol treatment centers (Gladding & Newsome, 2009; SAMSHA, 2008; Wischnitzer & Wischnitzer, 2005).

Counselors who work in substance abuse treatment centers provide individual counseling, group counseling, and periodic couples and family counseling (Ferguson's Careers in Focus, 2008). In addition, educational programs may be a part of this counselor's role as he or she attempts to bring increased awareness to the client and his or her family concerning the role that drugs and alcohol may play in their lives. In addition to joining AMHCA, many individuals with a focus on substance abuse will join the International Association of Addictions and Offender Counselors (IAAOC; see www.iaaoc.org), a division of ACA.

Youth Services Agencies

Today many state-assisted youth services programs employ master's-level counselors. Employment opportunities in such programs range from counselors who work with foster children, to counselors who work in residential treatment centers for delinquent youth, to those who are employed in state correctional systems with juvenile offenders. Youth counselors provide a full range of services, including intake interviewing, assessment, guidance activities, consultation and referral with other mental health professionals, and individual, group, couples, and family counseling (Helwig, 1996; Thompson & Henderson, 2010). With the tragic recent rash of youth violence in the schools and the increased recognition of youth mental health needs, the importance of providing counseling services to youth has become clear (McAuliffe, 2001; McGowan, 2004; McWhirter et al., 2007; Mellin, 2009). Because of its focus on children, some counselors who work with youth are members of the American School Counselors Association (ASCA; see www.schoolcounselor.org), while many simply decide to join AMHCA (www.amhca.org).

Counselors in Other Settings

In addition to the settings listed above, counselors can be found at many other community agencies, including crisis centers, psychiatric hospitals, hospices, group homes, women's shelters, and departments of social services, to name just a few (see Baxter, Toch, & Perry, 1997; Collison & Garfield, 1996; Ferguson's Careers in Focus, 2008; Garner, 2008). A degree in counseling is versatile and provides the counselor with a wide range of opportunities for employment. In fact, one might find the counselor in any setting where helping others is crucial. If you are considering a job in counseling, review the agencies listed above, but keep your options open.

◼ Multicultural/Social Justice Focus

Broad Issues Hindering Multicultural Mental Health Counseling

Relative to multicultural counseling, clinical mental health counselors face a number of primary issues, including the following (Atkinson, 2004; D'Andrea & Heckman, 2008; Gladding & Newsome, 2009; Phelps, Taylor, & Gerard, 2001; Sue & Sue, 2008):

1. Clients from nondominant groups are underrepresented at mental health centers.
2. Clients from nondominant groups are frequently misunderstood, misdiagnosed, find therapy not helpful, attend therapy at lower rates, and are more likely to terminate therapy.
3. Clients from cultural backgrounds different from that of their counselor may experience the helping relationship more negatively than if the helper is of the same culture.
4. Most counseling theories are Western-based and might be dissonant with some minority cultures' values and attitudes.
5. Some community agency and mental health counselors may not have the sensitivity or the training necessary to work with diverse clients.
6. Some community agency and mental health counselors have an ethnocentric worldview.

Clinical mental health counselors must take heed of these concerns if they are to work effectively with the increasingly large numbers of clients from nondominant groups who will require services in the decades to come.

Assessment of Clients at Mental Health Agencies

When assessing clients through testing, it is of particular importance to understand the nature of bias in tests and to remember that a counselor's bias can lead to misinterpretation of tests, even when they are designed to be cross-culturally fair (Neukrug & Fawcett, 2010). Similarly, when assessing a client for a clinical diagnosis, counselors should consider the possibility that a diagnosis may be culturally predisposed, thus leading to the likelihood that individuals from some cultures will be misdiagnosed (Eriksen & Kress, 2005; 2006; 2008; Halstead, 2007; Kress, Eriksen, Rayle, & Ford, 2005; Horwitz, 2002). To a limited degree, DSM-IV-TR attempts to control for this by noting when cross-cultural issues may impact a diagnosis and by listing approximately 25 "culture-bound syndromes." These syndromes may represent normal behavior within the culture or abnormal behavior that is specific to the culture and for which there is no corresponding DSM classification. For instance, some African Americans and European Americans from the South may undergo what is called a "spell," in which they communicate with deceased loved ones or spirits while undergoing dramatic personality shifts, which may be misconstrued as a psychotic episode (American Psychiatric Association [APA], 2000). Clearly, when conducting a clinical assessment counselors must be extra careful to eliminate cultural bias.

Limited Numbers of Counselors from Diverse Cultures

One problem that has an impact on all of us is the limited number of individuals from diverse backgrounds who become counselors (see ACA, 2009). If agencies are to offer services to clients from nondominant groups, it is clear that more counselors from diverse cultures are needed, for research shows that minority clients sometimes work best with minority counselors (D'Andrea & Heckman, 2008; McKenzie, 1999; Phelps et al., 2001). It is all of our responsibility to encourage agency administrators to hire counselors from diverse cultures and to ensure that clients from nondominant groups are treated with respect and in culturally sensitive ways. Of course, counselor education programs need to take strong steps to increase the numbers of graduate students from culturally diverse groups who enter their programs.

Ethical, Professional, and Legal Issues

Ethical Issue: Ethical Complaints and Ethical Concerns

One manner in which we can assess the kinds of ethical difficulties mental health counselors may be facing is by examining the kinds of ethical complaints made against Licensed Professional Counselors. Although many mental health counselors are not LPCs, it is likely that most face similar ethical dilemmas to LPCs. In surveying 45 licensing boards Neukrug, Milliken, and Walden (2001) found that 24% of complaints were made for inappropriate dual relationship; 17% for incompetence in the facilitation of a counseling relationship; 8% for practicing without a license or other misrepresentation of qualifications; 7% for having a sexual relationship with a client; 5% for breach of confidentiality; 4% for inappropriate fee assessment; 1% for failure to inform clients about goals, techniques, rules, and limitations of the counseling relationship; and 1% for failure to report abuse. Another 33% of the ethical complaints were listed in an "other" category, with many boards indicating that drug abuse and felony or misdemeanor conviction was the cause. Although ethical complaints do not necessarily translate into ethical violations, it is likely that trends in ethical violations can be deduced from these data.

Table 3.2 in Chapter 3 (page 73) examines further research by Neukrug and Milliken (2011) which identifies behaviors about which counselors have little agreement regarding whether or not they are ethical (see further discussion in Chapter 3). To assess counselor responses, a random sample of ACA members, most of whom were mental health counselors, were pooled. The items in this table are grouped by logical categories. You may want to discuss these behaviors in class.

Professional Issues

AMHCA: The American Mental Health Counselors Association

Because mental health counseling covers a wide spectrum of counselors who work in many different types of settings, there is no one "perfect" professional association to meet the needs of its entire constituency (Hershenson & Berger, 2001). However, probably the association that comes closest is the American Mental Health Counselors Association (AMHCA).

The mission of AMHCA is "To enhance the profession of mental health counseling through licensing, advocacy, education and professional development" (AMHCA, 2010c, para. 2), and its vision is "To be the national organization representing licensed mental health counselors and state chapters, with consistent standards of education, training, licensing, practice, advocacy and ethics" (AMHCA, 2010c, para. 3). A few of the many activities that AMHCA conducts include advocating for licensed counselors, providing workshops and conferences, offering malpractice insurance, providing a code of ethics, providing job links, helping consumers find counselors, and publishing a journal.

As with ASCA, AMHCA felt that they could better address some of the unique needs of mental health counselors with their own separate association and has also moved to a semi-independent division status with ACA. Today, one can join AMHCA separately from ACA. If you want to join AMHCA, membership is rather inexpensive, especially considering the benefits. As you continue on your journey in the counseling profession, consider which organizations work best for you.

Credentialing

Many clinical mental health counselors are interested in becoming a National Certified Counselor (NCC) through the National Board of Certified Counselors (NBCC). In addition, many obtain additional certifications through NBCC as Certified Clinical Mental Health Counselors (CCMHC) or Master Addiction Counselors (MAC) (NBCC, 2010b, 2010c). Of course, many community agency and mental health counselors also want to become Licensed Professional Counselors (LPCs), as this will allow them to obtain third-party reimbursement. Most states require a master's degree and 60 credits in designated curriculum areas to become licensed—but check your state to know the exact requirements. Usually, if your master's degree is less than 60 credits, you will need to pick up the additional credits. In addition, a minimum of two years of post-master's supervision and the passing of a licensing exam are generally required. While some states use the NCC or CCMHC for their licensure exam, other states have devised a separate licensing exam.

Of course, one can obtain other credentials depending on your area of specialization. For instance, on the national level, one can become a certified rehabilitation counselor, addiction counselor, art therapist, play therapist, or pastoral clinical supervisor. Increasingly, as other specialty areas become more popular, we will see additional certifications arise. Finally, you may want to find out if any specialty certifications exist in your state.

Salaries of Mental Health Counselors

As you can see, the settings in which you find the clinical mental health counselor vary dramatically. Generally, employment prospects for counselors are expected to be strong, as reported by the *Occupational Outlook Handbook* (United States Department of Labor, 2010–2011b). Although salaries might vary as a function of the setting or the region in which you live, generally, entry-level salaries for mental health counselors are between $25,000 and $40,000, with most counselors starting in upper 20s or low 30s. Because advancement in many of these agencies is possible, counselors can often earn up to $50,000 or $60,000. Counselors in private practice who are well networked and established can earn up to $100,000 or more (Baxter et al., 1997; Collison & Garfield, 1996; Ferguson's Careers in Focus, 2008).

Select Legal Issues

A number of legal issues that have a direct impact on clinical mental health counseling have been discussed throughout this text. Although we cannot highlight all of them, the following discussion identifies a few that seem to have been particularly important in recent years.

HIPAA

The passage of the *Health Insurance Portability and Accountability Act* (HIPAA) ensures the privacy of client records and adherence to rules concerning the sharing of such information (Zuckerman, 2008). In general, HIPAA restricts the amount of information that can be shared without client consent and allows for clients to have access to their records, except for process notes used in counseling (United States Department of Health and Human Services, 2010). In fact, HIPAA requires agencies to show how they have complied with this act. As a result of HIPAA, mental health professionals will generally have to do the following:

- Provide information to patients about their privacy rights and how that information can be used.
- Adopt clear privacy procedures for their practices.
- Train employees so that they understand the privacy procedures.
- Designate an individual to be responsible for seeing that privacy procedures are adopted and followed.
- Secure patient records. (APA Practice Organization, 2009, p. 3)

Confidentiality of Records

In addition to HIPAA, confidentiality of records continues to be a critical issue for clinical mental health counselors. As discussed throughout this text, a number of laws protect patients' rights to confidentiality. In terms of federal law, the *Freedom of Information Act* of 1974 allows individuals access to any records maintained by a federal agency that contain personal information about the individual, and every state has followed along with similar laws governing state agencies (National Security Archive, 2009). Similarly, the *Family Education Rights and Privacy Act* (FERPA), ensures parents the right to access their minor children's educational records, although this does not apply to case notes (United States Department of Education, 2010). Also, clients probably have a legal right to view their counseling records, and increasingly they have been exercising these rights (Swenson, 1997). Relative to children, although ethical guidelines usually support a child's right to confidential counseling, it has generally been assumed that parents have the right to view records of their children (Attorney C. Borstein, personal communication, May 24, 2010; Remley & Herlihy, 2009). Of course, specific local and state laws may vary, and each counselor should become aware of how local laws apply.

Confidentiality and Privileged Communication

In Chapters 4 and 5, we distinguished between the ethical obligation one holds toward *confidentiality* and the legal right clients hold toward *privileged communication* (Glosoff, Herlihy, & Spence, 2000). As a reminder, privileged communication is a conversation

conducted with someone that the law (state or federal statute) delineates as a person with whom conversations may be privileged (i.e., attorney–client, doctor–patient, therapist–patient, clergy–penitent, husband–wife, and the like). Because privileged communication is generally only given to clients of licensed practitioners, this raises issues for mental health counselors who are not licensed as they cannot guarantee confidentiality to their clients should a court decide to subpoena the counselor.

Confinement Against One's Will

Earlier in this chapter and in Chapter 2, we discussed the case of Kenneth Donaldson, who had sued the state mental hospital in Florida for confining him against his will (see *Donaldson v. O'Connor*, 1975) (see Box 2.3). 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). As a result of this decision, every state in the country now prohibits long-term confinement of clients against their will unless there is a clear indication that they are a danger to self or others. And, even in these cases, a court hearing to show cause is generally necessary. This law has had a dramatic affect on how clinical mental health counselors work with clients and the kinds of decisions they make concerning those clients who may not be quite ill enough to be committed, but are also not well enough to adequately care for themselves. At times, clients such as these are cause for great concern among mental health counselors.

The Clinical Mental Health Counselor in Process: Growing, Changing, Accepting

The field of mental health counseling has undergone dramatic changes in recent years, and it is likely to continue do so in the foreseeable future (Cannon & Cooper, 2010). The ever-increasing acceptance of diagnostic tools such as DSM, the dramatic shifts in the health care delivery system, the increase in the kinds of counseling services offered, the ever-expanding knowledge of multicultural issues and their effects on client treatment, and the development of new ways of treating individuals with various emotional problems are just a few of the many issues that currently face the clinical mental health counselor. Thus, the clinical mental health counselor must not hide his or her head in the sand and continue to operate as usual. He or she must change with the times, attend conferences and participate in continuing education opportunities, and be flexible enough to adapt to new ways of working with clients from all backgrounds.

Summary

In this chapter, we examined the unique characteristics of the clinical mental health counselor. We discussed the transition of merging community counseling into the clinical mental health counseling degree program. Then while exploring the history of mental

health counseling, we noted that this counseling specialty area had its origins with the development of psychoanalysis, the testing movement, and vocational guidance at the turn of the century. Over the years, the field was greatly influenced by existentialists from Europe and the Western philosophy of taking charge of one's life. The profession was launched into modern-day America through a series of legislative acts in the 1940s, 1950s, and 1960s. As a result of this legislation, research uncovered innovative therapeutic treatment modalities and new psychotropic medications that were to vastly change the way counseling was delivered. In addition, this legislation funded mental health centers and other counseling-related services, and soon counseling became more acceptable in America.

The growth of different types of agencies that offered various counseling services was rapid during the 1960s and 1970s. Very quickly we began to see mental health centers emerge in almost every community in America. In addition, other agencies, such as substance abuse centers, family service agencies, and vocational rehabilitation agencies, became part of the American landscape. Today, we see counselors working in just about every agency where counseling services are offered. We highlighted how all 50 states have passed a counselor licensure law and how our professional organizations continue to advocate for mental health counselors to be providers for a range of insurance companies (e.g., Medicare, TRICARE, etc.). We particularly noted how managed care, diagnosis, and the use of medications have recently affected the role of the clinical mental health counselor.

Although we noted that the roles and functions of clinical mental health counselors vary dramatically based on the setting, we did highlight some of the more common ones. These include the roles of case manager, appraiser of client needs, counselor, consultant, crisis debriefer, supervisee and supervisor, and a professional who is accountable. In addition, we highlighted other roles taken on by many clinical mental health counselors. These included the roles of outreach worker, broker/networker, advocate, teacher/educator, community planner, administrator, and clinical assistant. We also noted that roles may vary based on whether the clinical mental health counselor practices primary, secondary, or tertiary prevention.

Because there are so many different settings, roles, and functions of a clinical mental health counselor, the theories used by such counselors vary dramatically. However, we were able to identify some broad principles that underlie the counseling process of mental health counselors. These included respect for the client, creating a facilitative environment for client growth, helping clients define goals, empowering clients and helping them view counseling as a process that involves client learning, focusing on the strengths of the client, understanding the client within his or her environment or context, and using up-to-date techniques.

Because counselors can be found in just about every setting where counseling takes place, it would be impossible to list every agency where we might find clinical mental health counselors today. However, some of the more common settings we highlighted included career and employment agencies; community mental health centers; correctional facilities; family service agencies; gerontological settings; HMOs, PPOs, EAPs; the military and government; pastoral, spiritual, and religious counseling agencies; private practice settings; rehabilitation agencies; residential treatment centers; substance abuse settings; and youth service programs.

Within this chapter, we examined some primary issues related to multicultural counseling and the clinical mental health counselor. We noted that most counseling

theories are Western-based and may not be effective with some clients, that some clinical mental health counselors may have little sensitivity or training in working with diverse clients and may have an ethnocentric world view. We also stressed that the clinical mental health counselor needs to be aware of bias in testing and problems with diagnosing clients from diverse cultures. Finally, we stated the importance of having more counselors of color in mental health settings.

Examining some of the more prevalent ethical, professional, and legal issues, we noted some ethical concerns that are likely to be impinging on clinical mental health counselors. Specifically, we reported that ethical complaints were more likely to be made for inappropriate dual relationship, incompetence in the facilitation of a counseling relationship, practicing without a license or other misrepresentation of qualifications, or having a sexual relationship with a client. Other complaints were made for breach of confidentiality; inappropriate fee assessment; failure to inform clients about goals, techniques, rules, and limitations of the counseling relationship; failure to report abuse; drug abuse; or having a misdemeanor or felony charge. We also highlighted a recent study that explored a number of behaviors that mental health counselors tend to struggle with in the ethical decision-making process.

We stated that many clinical mental health counselors belong to AMHCA, and those who are rehabilitation counselors usually join ARCA or NRCA. However, we also noted that because of the varied types of clinical mental health counselors, there are many professional association which they can join. We stated that many clinical mental health counselors obtain an NCC, with some subsequently acquiring the CCMHC and/or licensure as professional counselors. We also noted that there are other certifications for clinical mental health counselors, with two of the more popular ones being Certified Rehabilitation Counselor (CRC) and Master Addiction Counselor (MAC). Next, we highlighted some of the salaries one might expect from employment in this specialty area.

Some select legal issues we discussed included the passage of the Health Insurance Portability and Accountability Act (HIPAA), which addresses the privacy of clients; the Freedom of Information Act and FERPA, which asserts the right of individuals to obtain their confidential records; the difference between confidentiality and privileged communication; and how "Donaldson v. O'Connor" asserted the rights of individuals to not be confined against their will unless they are in danger of harming themselves or others.

The chapter concluded by noting that clinical mental health counseling has undergone dramatic changes in recent years and that the astute counselor must keep up with these changes if he or she is to work effectively with all clients.

◼ *References*

Allen, A. (2000). Impact of capitation on clinical judgment in suicide risk assessment. *Dissertation Abstracts International*, 60, 8-B, AAG9944227.

American Counseling Association. (2005). *Code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Counseling Association. (2009, August 1). *Membership report*. Alexandria, VA: Author.

American Mental Health Counselors Association. (2010a). *With health reform passage, AMHCA continues LMHC Medicare fight*. Retrieved from https://www.amhca.org/news/detail.aspx?ArticleId=132

American Mental Health Counselors Association. (2010b). *Code of ethics*. Retrieved from https://www.amhca.org/assets/news/AMHCA_Code_of_Ethics_2010_w_pagination_cx_51110.pdf

American Mental Health Counselors Association. (2010c). *About AMHCA*. Retrieved from https://www.amhca.org/about/default.aspx

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

APA Practice Organization. (2009). *HIPAA: What you need to know now: The privacy rule: A primer for psychologists*. Retrieved from http://www.apapracticecentral.org/business/hipaa/2009-privacy.pdf

Baxter, N. J., Toch, M. U., & Perry, P. A. (1997). *Opportunities in counseling and development careers* (rev. ed.). Lincolnwood: IL: BGM Career Horizons.

Bernard, J. M. & Goodyear, R. K. (2008). *Fundamentals of clinical supervision* (4th ed.). Boston: Allyn & Bacon.

Bertram, B. (1996). Careers in private practice. In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 65–72). Washington, DC: Taylor & Francis.

Bureau of Justice Statistics. (2008a). *Prisoners in 2008*. Retrieved from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1763

Bureau of Justice Statistics. (2008b). *Probation and parole in the United States, 2008*. Retrieved from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1764

Burger, W. (2010). *Human services in contemporary America* (8th ed.). Belmont, Ca: Brooks/Cole.

Campbell, J. M., & Herlihy, B. (2006). *Essentials of clinical supervision*. Hoboken, NJ: John Wiley & Sons.

Cannon, E., & Cooper, J. (2010). Clinical mental health counseling: A national survey of counselor educators. *Journal of Mental Health Counseling, 32,* 236–246.

Clawson, T., Henderson, D. A., Schweiger, W. K., & Collins, D. R. (2008). *Counselor Preparation: Programs, faculty, trends* (12th ed.). New York: Brunner-Routledge.

Collison, B. B., & N. J. Garfield (Eds.). (1996). *Careers in counseling and human services* (2nd ed.). Washington, DC: Taylor & Francis.

Council for the Accreditation of Counseling and Related Educational Programs. (2010). *2009 Standards*. Retrieved from http://cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Crighton, D. A. & Towl, G. J. (2008). *Psychology in Prisons* (2nd ed.). Malden, MA: Blackwell.

D'Andrea, M., & Heckman, E. (2008). A 40-year review of multicultural counseling outcome research: Outlining a future research agenda for the multicultural counseling movement. *Journal of Counseling & Development*, 86(3), 356–363.

Daniels, J. A. (2001). Managed care, ethics, and counseling. *Journal of Counseling and Development, 79,* 119–122.

Danzinger, P. R., & Welfel, E. R. (2001). The impact of managed care on mental health counselors: A survey of perceptions, practices, and compliance with ethical standards. *Journal of Mental Health Counseling, 23,* 137–150.

Department of Defense Task Force on Mental Health. (2007). *An achievable vision: Report of the Department of Defense task force on mental health*. Falls Church, VA: Defense Board.

Douthit, K. (2006). The convergence of counseling and psychiatric genetics: An essential role for counselors. *Journal of Counseling and Development, 84*(1), 16–28.

Eriksen, K., & Kress, V. (2008). Gender and diagnosis: Struggles and suggestions for counselors. *Journal of Counseling and Development, 86,* 152–162.

Eriksen, K., & Kress, V. (2006). The *DSM* and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28,* 202–217.

Eriksen, K., & Kress, V. (2005). *Beyond the DSM Story: Ethical quandaries, challenges, and best practices*. Thousand Oaks: Sage.

Fabian, E. S., & MacDonald-Wilson, K. L. (2005). Professional practice in rehabilitation service delivery systems and related system resources. In R. M. Parker, E. M. Szymanski, & J. B. Patterson (Eds.), *Rehabilitation counseling: Basics and beyond* (4th ed., pp. 55–88). Austin, TX: PRO-ED.

Ferguson Publishing. (2008). *Careers in focus: Therapists* (2nd ed). New York, NY: Ferguson.

Fisher, G. L., & Harrison, T. C. (2009). *Substance abuse: Information for school counselors, social workers, therapists, and counselors.* Boston: Pearson.

Fraser, J. S., & Solovey, A. D. (2007). *Second-order change in psychotherapy: The golden thread that unifies effective treatments.* Washington, DC: American Psychological Association.

Garfield, N. J., & Beaman. J. (1996). Careers in health care facilities. In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 95–110). Washington, DC: Taylor & Francis.

Garner, G. O. (2008). *Careers in social and rehabilitation services* (3rd ed.). New York: Wiley.

Gibson, R., & Mitchell, M. (2007). *Introduction to counseling and guidance* (7th ed). Upper Saddle River, NJ: Merrill.

Gladding, S., & Newsome. D. W. (2009). *Clinical mental health counseling in community and agency settings.* Upper Saddle River, NJ: Pearson Education.

Glosoff, H. L., Herihy, B., & Spence, B. E. (2000). Privileged communication in the counselor–client relationship. *Journal of Counseling and Development, 78*(4), 454–462.

Good, B. J. (1997). Studying mental illness in context: Local, global, or universal. *Ethos, 25*(2), 230–248. doi:10.1525/eth.1997.25.2.230

Goodman, J., Schlossberg, N. K., & Anderson, M. L. (2006). *Counseling adults in transition: Linking practice with theory* (3rd ed.). New York: Springer Pub.

Grey House Staff. (2009). *HMO/PPO directory, 2010: Detailed profiles of U.S. managed healthcare organizations and key decision makers* (22nd ed.). Millerton, NY: Author.

Halstead, R. W. (2007). *Assessment of client core issues.* Alexandria, VA: American Counseling Association.

Hayes, B., & Paisley, P. O. (1996). In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 53–64). Washington, DC: Taylor & Francis.

Helwig, A. A. (1996). Careers in federal and state agencies. In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 91–103). Washington, D.C.: Taylor & Francis.

Hershenson, D. B., & Berger, G. P. (2001). The state of community counseling: A survey of directors of CACREP-accredited programs. *Journal of Counseling and Development, 79*, 188–193.

Hershenson, D. B., Power, P.W., & Waldo, M. (2003). *Community counseling: Contemporary theory and practice.* Long Grove, IL: Waveland Press.

Holloway, J. D. (2004, April). Genes and disease: More knowledge can equal more fear. *APA Monitor, 35*(4), 52.

Horwitz, A. V. (2002). *The social control of mental illness.* Clinton Corners, NY: Percheron Press.

Huber, C. (1997). Time-limited counseling, invisible rationing, and informed consent. *Family Journal, 5*(4), 325–327. doi:10.1177/1066480797054008

Hunt, H. A. (2005). *Essentials of private practice: Streamlining costs, procedures, and policies for less stress.* New York: Norton.

Institute of Medicine. (2010). *Provision of mental health counseling services under TRICARE.* Retrieved from http://www.iom.edu/Reports/2010/Provision-of-Mental-Health Counseling-Services-Under-TRICARE.aspx

Janesick, B. J., & Goldsmith, K. L. (2000). *Managed dying.* Philadelphia: Xlibris Corporation.

Kalat, J. W. (2008). *Biological psychology* (10th ed.). Belmont, Ca: Wadsworth.

Kaplan, M., & Cuciti, P. L. (Eds.) (1986). *The Great Society and its legacy: Twenty years of U.S. social policy.* Durham, NC: Duke University Press.

Kongstvedt, P. R. (2007). *Essentials of managed health care* (5th ed.). Sudbury, MA: Jones and Bartlett.

Kuat, K. P. & Dickinson, J. A. (2007). The mental health practitioner and psychopharmacology. *Journal of Mental Health Counseling, 29*(3), 204–225.

Kress, V., Eriksen, K., Rayle, A., & Ford, S. (2005). The DSM-IV-TR and culture: Considerations for counselors. *Journal of Counseling and Development, 83*(1), 97–104.

Leahy, M., Muenzen, P., Saunders, J., & Strauser, D. (2009). Essential knowledge domains underlying effective rehabilitation counseling practice. *Rehabilitation Counseling Bulletin, 2*(2), 95–106. doi:10.1177/0034355208323646

Lewis, B. (2006). *Moving beyond Prozac, DSM, and the new psychiatry: The birth of postpsychiatry.* Ann Arbor: University of Michigan Press.

Lynch, R. T., & Lynch, R. K. (1996). Careers in residential treatment centers and community based support programs. In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 111–121). Washington, DC: Taylor & Francis.

Male, R. A. (1996). Careers in public and private agencies. In B. B. Collison & N. J. Garfield (Eds.), *Careers in counseling and human services* (2nd ed., pp. 81–89). Washington, DC: Taylor & Francis.

Manber, R., Kraemer, H., Arnow, B., Trevedi, M. H., Rush, A. J., Thase, M. . . . Keller, M. E. (2008). Faster remission of chronic depression with combined psychotherapy and medication than with each therapy alone. *Journal of Consulting and Clinical Psychology, 76*(3), 459 467. doi:10.1037/0012-006X.76.3.459

Maples, M., & Abney, P. (2006). Baby boomers mature and gerontological counseling comes of age. *Journal of Counseling and Development, 84*(1), 3–9.

Matkin, R. E. (1997). Public and private rehabilitation counseling practices. In D. R. Maki & T. R. Rigger (Eds.), *Rehabilitation counseling: Profession and Practice* (pp. 139–150). New York: Springer.

McAuliffe, G. (Ed.). (2001). *Working with troubled youth in schools: A guide for all school staff.* Westport, CT: Bergin & Garvey.

McGowan, A. S. (Ed.). (2004). Special section on school violence. *Journal of Counseling and Development, 82*(3), 259–312.

McKenzie, K. (1999). Moving the misdiagnosis debate forward. *International Review of Psychiatry, 11*(2–3), 153–161. doi:10.1080/09540269974320

McWhirter, J. J., McWhirter, B. T., McWhirter, E. H., & McWhirter, R. J. (2007). *At-risk youth: A comprehensive response for counselors, teachers, psychologists, and human service professionals.* Belmont, CA: Thomson Brooks/Cole.

Mellin, E. (2009). Responding to the crisis in children's mental health: Potential roles for the counseling profession. *Journal of Counseling and Development, 87*(4), 501–506.

Morrison, J., Clutter, S., Pritchett, E., & Demmitt, A. (2009). Perceptions of clients and counseling professionals regarding spirituality in counseling. *Counseling and Values, 53*(3), 183–194.

National Security Archive (2009). *FOIA Basics.* Retrieved from http://www.gwu.edu/~nsarchiv/nsa/foia/guide.html

National Board for Certified Counselors. (2010a). *NBCC/ACA/AMHCA alert: Senate introduces TRICARE mental health care access act.* Retrieved from http://www.nbcc.org/advocacy/Updates.aspx

National Board for Certified Counselors. (2010b). CCHC: *The certified clinical mental health counselor credential.* Retrieved from http://www.nbcc.org/certifications/ccmhc/Default.aspx

National Board for Certified Counselors. (2010c). MAC: *The master addictions counselor credential.* Retrieved from http://www.nbcc.org/certifications/mac/Default.aspx

Neukrug, E. (2001). Medical breakthroughs: Genetic research and genetic counseling, psychotropic medications, and the mind-body connection. In T. McClam & M. Woodside (Eds.), *Human service challenges in the twenty-first century* (pp. 115–132). Birmingham, AL: Ebsco Media.

Neukrug, E. (2007). *Theory, practice and trends in human services: An introduction to an emerging profession* (4th ed.). Pacific Grove, CA: Brooks Cole.

Neukrug, E., & Fawcett, R. C. (2010). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists.* Pacific Grove, CA: Brooks Cole.

Neukrug, E., & Milliken, T. (2011). *Counselors perceptions of ethical behavior. Journal of Counseling and Development, 89,* 206–216.

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical practices of credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41*(1), 57–70.

Paradise, L. V. & Kirby, P. (2005). The treatment and prevention of depression: Implications for counseling and counselor training. *Journal of Counseling and Development, 83,* 116–119.

Patureau-Hatchett, M. (2009). Counselors' perceptions of training, theoretical orientation, cultural and gender bias, and use of the "Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision." *Dissertation Abstracts International, 69,* 10A.

Phelps, R. E., Taylor, J. D., & Gerard, P. A. (2001). Cultural mistrust, ethnic identity, racial identity, and self-esteem among ethnically diverse black university students. *Journal of Counseling and Development, 79,* 209–216.

Remley, T. P., & Herlihy, B. (2009). *Ethical, legal, and professional issues in counseling* (3rd ed.). Columbus, OH: Prentice Hall.

Ritter, J.A., Vakalahi, H. F. O., & Kiernan-Stern, M. (2009). *101 careers in social work.* New York: Springer Pub.

Schatzberg, A. F. & Nemeroff, C. B. (2009). *The American Psychiatric Publishing textbook of psychopharmacology* (4th ed.). Washington, DC: American Psychiatric Press.

Schwiebert, V. L., Myers, J. E., & Dice, C. (2000). Ethical guidelines for counselors working with older adults. *Journal of Counseling and Development, 78,* 123–129.

Shallcross, L. (2009, November). Counseling profession reaches the big 50. *Counseling Today.* Retrieved from http://www.counseling.org/Publications/CounselingTodayArticles.aspx?AGuid=aab6f2 8-77ab-4826-b573-03b6288f200b

Smith, H. B., & Robinson, G. (1995). Mental health counseling: past, present, and future. *Journal of Counseling and Development, 74*(2), 158–162.

Southern Regional Educational Board. (1969). *Roles and functions for different levels of mental health workers.* Atlanta, GA: Author.

Stanard, R. P., Sandhu, D. S., & Painter, L. C. (2000). Assessment of spirituality in counseling. *Journal of Counseling and Development, 78,* 204–210.

Substance Abuse and Mental Health Services Administration. (2008). *National survey of substance abuse treatment services (N-SSATS): 2007.* Data on Substance Abuse Treatment Facilities. OAS Series #S-44, DHHS Publication No. (SMA) 08-4343, Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 national survey on drug use and health: National findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: John Wiley & Sons.

Taylor, M., Bradley, V., Warren, R. (Eds.). (1996). *The community support skill standards: Tools for managing change and achievement outcomes: Skill standards for direct service workers in human services.* Cambridge, MA: Human Services Research Institute.

Thomas, C. M., & Martin, V. (2006). Group work: Elderly people and their caregivers. In D. Capuzzi & D. R. Gross (Eds.), *Introduction to group work* (4th ed., pp. 483–513). Denver, CO: Love.

Thompson, C. L., & Henderson, D. A. (2010). *Counseling children* (8th ed.). Pacific Grove, CA: Brooks/Cole.

United States Census Bureau. (2006). *Evaluation report covering disabilities.* Retrieved from http://www.census.gov/hhes/www/disability/GQdisability.pdf

United States Census Bureau. (2010). *The 2010 statistical abstract. Section 1: Population.* Retrieved from http://www.census.gov/prod/2009pubs/10statab/pop.pdf

United States Department of Education. (2010). *Family Education Rights and Privacy Act (FERPA).* Retrieved from http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

United States Department of Health and Human Services. (2010). *Health information privacy.* Retrieved from http://www.hhs.gov/ocr/privacy

United States Department of Labor. (2010–2011a). *Occupational Outlook Handbook: Counselors: nature of work*. Retrieved from http://www.bls.gov/oco/ocos067.htm#nature

United States Department of Labor. (2010–2011b). *Occupational Outlook Handbook: Counselors*. Retrieved from http://www.bls.gov/oco/ocos067.htm#nature

Walsh, P. G., Currier, G., Shah, M. N., Lyness, J. M., & Friedman, B. (2008). Psychiatric emergency services for the U. S. elderly: 2008 and beyond. *The American Journal of Geriatric Psychiatry, 16*(9), 706–707. doi:10.1097/JGP.0b013e31817e73c7

Walsh, R., & Dasenbrook, N. (2005). Navigating the managed care maze. *Counseling Today, 48*(5), 60.

Walsh, R., & Dasenbrook, N. (2007). *The complete guide to private practice for licensed mental health professionals* (4th ed.). Rockford, IL: Crysand Press.

Walsh, R. & Dasenbrook, N. (2009). Contracting strategies with managed care and other agencies. In I. Marini & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (pp. 79–87). New York: Springer.

Walsh, R., & Dasenbrook, N. (2010). Managed care update. *Counseling Today, 52*(9), 16–17.

West, J. D., Hosie, T. W., & Mackey, J. A. (1987). Employment and roles of counselors in mental health agencies. *Journal of Counseling and Development, 66*, 135–138.

Wischnitzer, S., & Wischnitzer, E. (2005). *Top 100 health-care careers: Your complete guidebook to training and jobs in allied health, nursing, medicine, and more*. Indianapolis, IN: JIST Works.

Woititz, J. G. (2002). *The complete ACOA sourcebook: Adult children of alcoholics at home, at work, and in love*. Deerfield Beach, FL: Health Communications.

Young, J. S., Wiggins-Frame, M., & Cashwell, C. S. (2007). Spirituality and counselor competence: A national survey of American Counseling Association members. *Journal of Counseling and Development, 85*, 47–52.

Zuckerman, E. L. (2008). *The paper office: Forms, guidelines, and resources to make your practice work ethically, legally, and profitably* (4th ed.). New York: Guilford Press.

Student Affairs and College Counseling[1]

*I*t was 1974, and I was obtaining my master's degree in counseling, thinking I would eventually work in an agency setting. Somehow, in my ignorance, I found myself in a counseling program that stressed counseling in higher education settings. Up until being admitted to that program, I had wrongly believed that the attainment of a counseling degree meant that you became a school counselor or an agency counselor. I had a lot to learn.

As I went through the program, it didn't take long for me to realize that the college experience was crucial in the development of the individual. In fact, I realized that I had gone through many changes in my own life as I had pursued my bachelor's degree. Suddenly, I was rather interested in learning about student affairs and the impact a student affairs practitioner could have on the development of the college student. I began to see this as an option for my career.

I learned, through my program, that the history of student affairs practices is long and illustrious, and that student affairs practitioners (e.g., college counselors, career counselors, directors of multicultural centers, etc.) are critical to the development of college students. Today, it is common to find student affairs practitioners working in a variety of campus settings that focus on student development. *Ed Neukrug*

*I*n this chapter, we will discuss the history of student affairs practice, including college counseling, and the various ways in which student affairs has affected the development of the emerging adult. We will explore models and theories of student development, the roles and functions of the student affairs practitioner, the settings in which we find student affairs counselors, and the unique multicultural, ethical, professional, and legal issues that impinge on the work of the counselor in higher education settings. But first let us find out what this specialty area is all about.

---

[1] This chapter was co-written by Ed Neukrug and Hannah Bayne.

■ What Is Student Affairs?

There are a lot of names for this specialty area. It can be called student affairs, student affairs practices, college student development, college counseling, student development in higher education, and I've probably left out a few. So bear with me if throughout this chapter I use all of these names at different times.

Student affairs entails a broad range of services that includes, but is not limited to, recruitment activities, admissions, registration, orientation, residence life, counseling, and advising. Ideally, offices of student affairs provide programs and services to enhance the college experience of all students, whether they are the 18-year-old first attending college, the 35-year-old married father of two returning to college, the 60-year-old grandmother attending college for the first time, the international student challenged by language and cultural differences, or the veteran pursing an education after returning from combat. Student affairs practitioners help to facilitate students' learning and knowledge of self by offering services directly to students, collaborating with faculty and administration, and being proactive in making changes in the institution.

Student affairs practitioners are found working in a wide variety of settings in higher education, many of which we will describe later in this chapter. The most recent CACREP accreditation standards identify this specialty area as *student affairs and college counseling*, although college counseling is actually under the broader umbrella of student affairs (CACREP, 2009).

■ The History of Student Affairs

The Beginning

Student affairs practices have a long history dating back to some of the earliest American colleges in the 1700s (Rentz, 2004). These colleges were almost exclusively religiously affiliated and had as their major goal the development of moral men for the clergy. Early college faculty believed that students were immature and in need of guidance if they were to develop morally. Not surprisingly, at this time, student affairs practices were governed by the philosophy of *in loco parentis*, or the concept that college faculty would take on the role of parenting and guiding students (Bowden, 2007). During these early years, the faculty took on most of the roles in which we find student development specialists today. For instance, it was usual at that time to find faculty doing informal counseling, being involved in the discipline of students, assisting with admissions and registration, and serving as moral and religious mentors for students. During these times, the educator was charged with developing the intellectual, personal, physical, and spiritual aspects of the student.

The Expansion of Student Affairs Practices

During the early part of the nineteenth century, there was a movement away from faculty being involved with the moral and religious development of students and more toward an academically oriented relationship (Bowden, 2007; Gerda, 2006). In the latter part of the nineteenth century, perhaps as a backlash to a century in which there was little concern

about the emotional and spiritual aspects of students, there was a shift back to an emphasis on the personal development of students. It was at this time that many colleges began to hire deans of students who were charged with overseeing a broad range of student development concerns such as enrollment, admissions, and the moral development of students (Gerda, 2006). In addition, this part of the century saw the first campus mental health services being organized, under the direction of psychiatrists, to address the emotional development of students and prevent personal concerns from impacting academic success (Kraft, 2009).

As with community agencies and schools, the emergence of *psychoanalysis*, *testing*, and the *vocational guidance* movement at the beginning of the twentieth century had an impact on the role that colleges played in the development of the student. Thus, the early part of the century saw a psychological and humanitarian focus toward students, as well as the use of intelligence and aptitude testing for both vocational guidance and the provision of psychological services. At this time some of the first student affairs associations were developed, including the National Association of Women Deans and Counselors (NAWDAC), the National Association of Student Personnel Administrators (NASPA), and the College Student Educators International, also known as the American College Personnel Association (ACPA; see www.myacpa.org).

The Depression of the late 1920s and the 1930s brought cutbacks in counseling, guidance, and other support services. With declining college enrollment, administrators viewed student affairs as an unnecessary expense (Carpenter, 2004). However, as the country moved out of the Depression and into the 1940s, there was a resurgence of student affairs practices with what became known as the *student personnel point of view* (Rentz, 2004). This development was largely fueled by the GI bill at the end of World War II, which gave financial assistance to veterans to attend college. Thus, this era saw extremely large numbers of individuals going to college, many of whom needed academic guidance and personal support services. This trend continued well into the 1950s.

The 1960s brought with it civil rights rallies and antiwar protests on college campuses. As one might expect, it was during this period that the concept of in loco parentis changed, as students increasingly insisted that they were not to be controlled by individuals in positions of authority (Bowden, 2007). During the late 1960s, there was more federal aid for students and an increasingly diverse campus environment. *Theories of development* that focused on identity issues were introduced during the 1960s and increasingly applied during the 1970s, as student development specialists attempted to offer educationally oriented activities focused on supporting developmental changes. This decade also saw a rise in proactive interventions on campus, such as the establishment of crisis centers, women's centers, and substance abuse centers. The decades of the 1960s and 1970s also saw growth in the popularity of counseling centers that offered a wide range of counseling-related services.

Recent Trends

The 1980s brought increased refinement and application of developmental theories, as well as the emergence of student services that offered assistance to individuals with disabilities, minorities, women, nontraditional students, and other students with special needs. This broadening of services was ironically happening during the same decade that funding cutbacks became more prevalent, thus forcing many student services offices to downsize. This decade also saw a number of legislative initiatives that

affected the implementation of student services, such as affirmative action, laws concerning sexual harassment, and laws affecting the rights of students (e.g., freedom of speech).

The early 1990s saw continued state and federal cutbacks to colleges, which often resulted in reduced services for students. Increasingly, colleges attempted to maintain academic programs while trying to reduce the cost of student services without eliminating them totally. It was also during this period that we saw a call within the profession to examine the effectiveness of student development theory. As the second half of the 1990s saw an economic upswing in the country, colleges and universities began to feel more solvent, and the place of student services was once again secure.

The late 90s and early years of the 21st century impacted student affairs with advances in *technology* that changed how students and student affairs professionals interacted. In addition, *campus violence* became an added issue of concern, as high-profile incidents changed the way campuses regarded student safety and prevention.

Current Practices

Today, student affairs professionals have been challenged to respond to the impact of the economic downturn that began in 2007. These challenges include cutbacks in funding to higher education, tuition increases while families experience job loss, and decreased availability of student loans. In addition to helping students navigate these financial difficulties, student affairs practitioners must also address other student needs (e.g., creating a multicultural environment, ensuring a safe and secure campus, reducing the risk of drugs and alcohol, etc.). Also, with the spread of technology and the rise of distance learning, student affairs practitioners have needed to re-think how to address student needs when students may not be learning at the main campus. This has led to some creative ways of reaching out to the new nontraditional student. Amidst these challenges, student affairs continues to grow as an integral part of the college organizational structure, and the services offered have an impact on every college student.

The student affairs practitioner of today often has a degree in counseling, although some will have a degree in higher education or in student affairs administration. As you might expect, those with a degree in higher education or in student affairs administration are less likely to be found in settings where counseling or a more traditional helping role is needed. The settings we will discuss later in the chapter generally hire individuals with a counseling degree, although there is no hard and fast rule to this. Of those who obtain degrees in counseling, approximately 10% specialize in student affairs or in college counseling (Schweiger, Henderson, Clawson, Collins, & Nuckolls, 2008).

Roles and Functions of Student Affairs Specialists

As you might expect, the roles and functions of the student development practitioner will vary dramatically depending on the setting and the kind of job within that setting. Despite this wide variance, Delworth and Hanson (1991) define four major roles of the student affairs practitioner (also see Komives & Woodward, 2003). They include the counselor, who guides, supports, and advises students; the educator, who fosters intellectual and

personal growth; the campus ecology manager, who creates a climate on campus for successful student development; and the administrator, who designs and manages programs. Let's take a brief look at each of these roles.

The Counselor: Guiding, Supporting, and Advising Students

Well-developed skills and extensive knowledge in interpersonal
helping are essential tools in student affairs professionals' reper-
toire of responses and interventions, no matter what their primary
position or responsibilities. (Winston, 2003, p. 504)

Although trained as counselors, not all student development practitioners with a counseling degree do counseling. However, they are all committed to a counseling approach of working with students, which includes the following beliefs (Forrest, 1991):

1. An effective student affairs program will address the needs of the "whole" student, including emotional, physical, spiritual, and interpersonal aspects.
2. Each student is unique.
3. The affective domain is integral to the student's development.
4. A developmental perspective is necessary for understanding the needs of students.
5. The personal characteristics of the helper play a part in facilitating student growth.
6. Counseling can be of value to students and ultimately to universities.

In the role of counselor, the student affairs practitioner will be a role model to students, provide direct support to students, develop and provide preventive psychological programs, facilitate groups, make referrals to mental health experts, request psychological expertise from clinicians, and advocate for change in the system to foster student growth (Brandel & Yarris, 2004; Winston, 2003).

The Educator: Fostering Intellectual and Personal Growth

The central mission of higher education is to enhance learning.
Both faculty and student affairs staff should be able to articulate
their educational purposes and to offer a rationale for the strate-
gies they design to accomplish these ends. (King, 2003, p. 234)

Many student affairs practitioners find themselves in the role of educator, fostering both the intellectual and personal growth of the student (Brown, 1991; Hunter & Murray, 2007). This is a natural shift for practitioners who have been trained in counseling. In fostering student growth, the practitioner, as educator, may *advise, mentor, build curriculum, instruct, evaluate-assess*, and be a *scholar-researcher*.

Advisor

As an advisor, the student affairs practitioner is able to understand the developmental needs of the student and recommend a course of academic and personal growth that will

meet those needs. Student affairs professionals may also choose to serve as advisors for student organizations, helping students learn how to take on leadership roles, create a sense of community, and develop personal responsibility (Fochtman, 2006).

Mentor

As a mentor, the practitioner advises, counsels, models for, and guides students. He or she is involved in ongoing relationships with students that can be transforming experiences for them. More experienced student affairs practitioners are often mentors to new professionals to help them navigate the various roles and responsibilities of the profession (Fochtman, 2006).

Curriculum Builder/Instructor

As a curriculum builder/instructor, the student affairs practitioner can assist faculty in developing coursework that fosters personal and intellectual growth, may teach courses through departments (e.g., interpersonal skills), may offer workshops throughout the university (e.g., men's and women's groups; the first year experience; study skills), and may refer students and others to educational workshops in the community that have an impact on the whole person. The rise of learning communities on college campuses has presented additional opportunities for student affairs professionals to play a role in curriculum and instruction (Ellertson & Thoennes, 2007; Hunter & Murray, 2007). Learning communities allow students to interact with peers who have similar academic or extracurricular interests, and typically include targeted instruction geared toward community learning goals, such as leadership or international relations. Student affairs practitioners in these settings are free to design service-learning projects, academic coursework, and programs that meet the specific needs of each group.

Evaluator–Assessor

As an evaluator–assessor, the student affairs practitioner assesses students' progress toward stated goals and offers feedback to students on how successful they have been at reaching their goals. Evaluation may also occur within supervisory roles, and involve assessment of student employees or leaders of student organizations (Fochtman, 2006).

Scholar–Researcher

As a scholar and researcher, the student development practitioner is willing to pursue research ideas and disseminate the results of research on innovative programs (Steenbarger & Smith, 1996). Areas of research could include studying student environments, student needs and concerns, utilization of current services, and program outcomes (Hadley, 1999).

The Campus Ecology Manager: Creating a Successful Student Development Climate

As manager of the campus environment, the student development practitioner focuses on how the campus can be structured to meet the physical, emotional, spiritual, and educational needs of the student (Hamrick, Evans, & Schuh, 2002; Manning, 2009; Strange, 2003). This approach examines four components: the *physical setting*,

the *human aggregate*, *organizational structure and dynamics*, and *perceptual or constructed environments*.

Physical Setting

The physical setting includes such things as the architecture of the buildings, the terrain, the layout of the campus, the setting of the campus, physical space, and so forth. Student affairs practitioners can offer feedback as to what kinds of physical setting might be most conducive to creating a psychologically and physically safe environment for all students. For instance, after the tragic events at Virginia Tech where 32 students and faculty were killed, student affairs practitioners across the country played a vital role in assessing the kinds of changes that can be made on a campus to ensure physical safety. Professionals are also intent on providing psychological safety to students by creating an environment that feels secure, comfortable, and supportive.

Human Aggregates

Students can be identified by the groups that they affiliate with, such as gender, ethnicity, sexual orientation, age, academic performance, and so forth. The student affairs practitioner has the expertise to help ensure that all students feel a sense of "fit" to the higher education setting. Practitioners can recognize and address the needs of students who might feel left out. For example, a woman who is attending an engineering program with mostly men may feel intimidated. Similarly, international students who see little of their culture reflected in the school are less likely to feel welcomed. Additionally, African-American students may have negative experiences due to stereotypes or racial tensions on campus (Ancis, Sedlacek, & Mohr, 2000).

Organizational Structure and Dynamics

Due to their training in systems and communication theory, student affairs practitioners have the background to help assess the organizational climate of the higher education setting. Good organizational structure and good communication skills result in a higher education setting that demonstrates appreciation of different values, involvement among stakeholders, collaboration, clear lines of communication, openness, and the ability to try out new behaviors.

Perceptual or Constructed Environments

The student affairs practitioner is particularly trained in assessing students' perceptions of their environment. Despite the good efforts of administrators to create a comfortable environment, the setting the student perceives may not meet his or her needs. Thus, assessing student perceptions and offering feedback to administrators is critical to making needed changes in the environment.

The Administrator: Designing and Managing Programs

Sometimes the student affairs practitioner finds him- or herself in the role of administrator. Good administrators sometimes need to be in control, impose structure, and set goals. However, the trend in leadership is to have administrators who are systemic

thinkers—creative, out-of-the-box leaders who can collaborate with others and pull together people and services from throughout the university (Ahren, 2008; Rogers, 2003). In their role as administrators, student affairs practitioners *attend to students, services and programs, structure, staff,* and *sources* (Ambler, 1991).

Students

In their role as administrators, student affairs practitioners need to make sure that student services are enhancing the educational, psychological, and physical well-being of students. Often, this is accomplished by collaborating with key stakeholders (e.g., faculty, staff, other student services offices), developing needs assessments, suggesting new programs, evaluating existing programs, and supervising others. As administrators, student affairs practitioners sometimes have to walk a precarious balance between meeting student needs and meeting the needs of the institution, which may be in conflict under certain circumstances, such as when a financial crisis causes a reduction in student services.

Services and Programs

Based on needs assessments, evaluation of existing programs, and collaboration with others, student affairs practitioners revise old services and programs and develop new ones.

Structure

For student services to function effectively, there must be an organizational structure that allows for clear lines of communication within and between each student service office. Student affairs practitioners can make needed changes to ensure that communication is occurring.

Staff

Effective programming requires well-trained and satisfied staff who have clearly defined roles and functions. Student affairs practitioners are responsible for ensuring that job descriptions are clear and for monitoring the working relationships among staff.

Sources

Whether it involves working with funding sources or identifying ways of obtaining free resources (e.g., interns working at a counseling center), student service practitioners must be able to handle budgets and resources to ensure the successful functioning of student service offices.

Theories of Student Development

Developmental Theory

The driving force behind student affairs is the concept that as students attend college and graduate school they develop in predictable ways, and that student affairs practitioners can develop interventions that move students toward greater cognitive complexity

(Pascarella & Terenzini, 2005). Many of the theories used by student practitioners to help us understand development and devise interventions have already been discussed in Chapter 9. For instance, they might rely on theories of moral development as noted by Kohlberg (1969) and Gilligan (1982), lifespan development as noted by Erikson (1963, 1968) and Levinson (1978, 1996), constructive/cognitive development as noted by Kegan (1982), psychosexual development (e.g., Freud, 1969/1940), and faith development (e.g., Fowler, 1995). In addition, recently student affairs practitioners have used racial/cultural and White identity development models, discussed in Chapter 14, to help understand an individual's development (e.g., Atkinson, 2004c; Carter, Helms, & Juby, 2004; D'Andrea & Daniels, 1999). Finally, person–environment models, or models that attempt to examine how the environment affects the behavior of the changing adult, have taken on some prominence lately (Pascarella & Terenzini, 2005).

Although a chapter such as this cannot touch on all of the developmental theories that may have an impact on students, two that have been consistently used to describe changes in students over time are Chickering's seven vectors model (Chickering, 1969; Chickering & Reisser, 1993), and Perry's (1970) scheme of intellectual and ethical development (Pascarella & Terenzini, 2005).

Chickering's Seven Vectors of Student Development

In 1969, Chickering identified seven vectors that he believed were crucial in the development of college students. These vectors have become the standard model used in understanding college student development, particularly the development of the traditional-aged college student (18 to 22 years old). Chickering postulated that students can mature along each vector, increasingly developing a more complex identity, and that, through knowledge of these vectors, student affairs specialists can foster student development. The vectors include the following:

1. *Achieving competence*. Chickering believed that each student's ability to successfully develop his or her intellectual, physical, and interpersonal competence is crucial during the college years and that such growth ultimately leads one to a sense of self-worth.
2. *Managing emotions*. As students develop into adulthood they increasingly struggle with finding ways of managing emotions, especially anger and emotions related to their sexuality, both of which become ever more salient in the college years. The task for students is to establish new, more mature ways of managing all of their emotions.
3. *Developing autonomy*. The developing college student is increasingly faced with issues of autonomy as he or she disengages from his or her family of origin and develops a separate sense of self.
4. *Establishing identity*. As students become autonomous, self-sufficient adults, they are better able to understand their intellectual, physical, and interpersonal competence and strive to more effectively manage their emotions. In this process students begin to examine who they are within these domains and establish a sense of identity.
5. *Forming interpersonal relationships*. As individuals increasingly become more aware of their own identity, they are better able to form relationships with others and ultimately become more tolerant of differences.

6. *Developing purpose.* Perhaps one of the most important vectors, developing purpose relates to how individuals make meaning out of their lives. Deciding what is worth striving for can only be accomplished if an individual has a clear sense of who he or she is.

7. *Developing integrity.* This last vector has to do with one's ability to develop a value system governed by a well-thought-out belief system. Such a value system is the basis for moral action in the developing adult.

The challenge for student affairs specialists is to find ways to stimulate and facilitate growth along each of these vectors and thus assist college students in the healthy development of identity.

Perry's Scheme of Intellectual and Ethical Development

Perry's cognitive development scheme asserts that there are developmental stages that reflect a logical and sequential manner in which students develop their cognitive processes (Hofer, 2002). Thus, for the student affairs practitioner, it would be crucial to identify the probable stage of development from which most students operate in order to understand how they make meaning of the world. Equipped with such knowledge, interventions could be designed that would facilitate higher-level meaning making. Although we have discussed Perry in previous chapters, below is a brief recap of his theory. Perry set forth a theory that identified nine positions interspersed through three stages. Below are descriptions of the three stages.

1. *Dualism.* Students who are dualists tend to view truth categorically, as right or wrong, and have little tolerance for ambiguity (Moore, 2002). Such students might see the professor, professional documents, texts, and the like as holding the truth to knowledge in their field. They believe that there is one right answer to questions and have difficulty with uncertainty, ambiguity, or the unknown. These students want to be told "the truth" and will regurgitate such knowledge in class, on an exam, or in conversation. As students reach the latter position in dualism, they approach what some call multiplicity or transition (Magolda & Porterfield, 1988; Moore, 2002), in which a beginning recognition of the limits of authority occurs. These students are moving toward relativism.

2. *Relativism.* Relativists are able to think more abstractly and allow for differing opinions. In relativism, a student comes to understand that there may be many ways of constructing reality and of defining truth. They become more comfortable with ambiguity and realize that knowledge is relative and that there are limits to what we know. They are more comfortable sharing information and thoughts with one another and value not only the knowledge of experts, but also the knowledge of their peers.

3. *Commitment to Relativism.* Generally this stage is only reached by individuals who are older (have lived life) and who have a number of years of education behind them (Lovell, 1990). Individuals who have reached this stage have the capacity to maintain their relativistic outlook and are also able to commit themselves to specific behaviors and values (Moore, 2002). For example, the committed relativist may make a specific religious or job commitment while at the same time recognizing the possibility that new information may modify that choice (Widick, 1977). Although most adults do not reach the higher levels of this development (Lovell, 1990), these models suggest that if afforded the right opportunities, most can do so.

Although students develop intellectually, interpersonally, spiritually, and even physically in college, few would dispute that the most important aspect of the college experience is the development of one's cognitive processes. This is why Perry's scheme has been given particular attention over the years.

◾ *Settings Where You Find Student Affairs Specialists*

In their first year after graduating, most students who obtain their degrees in college counseling or in student affairs are able to find employment in higher education. Schweiger and associates (2008) found that 69% of those who obtained their degrees in college counseling and 75% of those who obtained their degree in student affairs worked in higher education during their first year after graduation. This is a significant increase in student affairs employment of recent counseling graduates, up from 21% and 41%, respectfully, in 2004 (Clawson, Schweiger, & Collins, 2004). Other college counseling and student affairs graduates go on to attend an advanced graduate program or work in a variety of other settings, including managed care, private practice, agencies, or k-12 schools.

There are many career options in student affairs settings, as well as opportunities for progression within each division, all of which offer a positive employment outlook for students interested in this specialty area (Garner, 2008). Although the majority of counselors have the expectation of doing counseling once they obtain their degree, many settings within the postsecondary environment exist where the counselor can find work doing advising, consulting, supervising, and offering preventive educational workshops. The following discussion describes some of the many places where you might find the student affairs specialist.

Academic Support Services

The purpose of *academic support services* is to assist students in reaching their academic goals (Dungy, 2003). A wide range of academic support services are offered at many colleges and universities these days, and it is common to find a counselor working in many of these settings. Some of them include academic advising, administering learning resource centers for students with special needs, and coordinating tutoring services. The kinds of services offered to students at these centers include assistance with scheduling, time management, study skills, stress reduction, and consulting with faculty concerning the special needs of these students. Counselors at community colleges spend a good deal of their time providing these services to students, as well as offering personal and career counseling.

Career Development Services

Almost all colleges have an office that provides *career development services*. Although some of these offices are part of the counseling center, today they are more frequently found separate from it. Career development services tend to include a wide range of activities (Dungy, 2003), including individual counseling related to career choice, testing and assessment for purposes of career decision making, access to career resource materials, computerized career development programs to assist in choice of major, and internship and job placement. In addition, most career development centers provide assistance with résumé writing, job interviewing skills, cooperative education programs (e.g., internships),

finding employment, and obtaining graduate assistantships. Professionals in career services may be responsible for organizing job fairs, as well as developing and maintaining relationships with major employers.

Counseling Centers

Today, most colleges and universities have *counseling centers* staffed by counselors and/or psychologists (see Box 18.1) (Dungy, 2003). Increasingly, counselors at large universities are required to have a doctorate in counseling or psychology, while smaller colleges and community colleges will often hire master's-level counselors. Less frequently, social workers

BOX 18.1

Lenora: Director of a University Counseling Service

Chrikstine Stringfield-Rick

Helping others has always been a significant component of my life. As the oldest of five children, and the only daughter, I learned early in life how to help provide for others what they needed both physically and emotionally.

I was raised in Paterson, New Jersey by parents who were determined to provide their children with a solid foundation of love, strength, support, and encouragement. As an African-American child growing up in an urban environment and a society that did not embrace me, my gifts, or my abilities, it was my family who gave me their wisdom, determination, perseverance, and the knowledge that only I am in control of my destiny.

After surviving an urban mis-educational system and being told by my White high school counselor that I should not attend college but pursue a job where I would work with my hands, I left Paterson to attend Shaw University in Raleigh, North Carolina. I knew I wanted to help make a difference in the lives of those I left behind, and I initially thought that teaching would be the best way to give back to the community. However, after gaining practical experience in elementary and junior high schools, I realized that teaching on those levels was not my calling. I therefore decided teacher training would be a better way to bring my goal to fruition, so I completed a graduate program in urban teacher education and obtained a position at the University of Massachusetts. This work was more fulfilling but not as satisfying as I expected.

Throughout this career exploration process I realized that I was spending a great deal of time supporting my family, friends, and co-workers during their times of emotional upheaval. I would listen, ask critical questions, and help them develop a plan or strategy to ameliorate or change their particular life circumstance. These individuals would later call or write me to say how helpful our discussions had been in making changes in their lives.

From these experiences my life's career path was established. I completed my doctoral degree in Humanistic Applications of the Behavioral Sciences (Counseling Psychology) with the goal of assisting adults with their mild to moderate mental health concerns.

The majority of my early clinical experiences were within a university environment, and these experiences, along with my life experiences and training, established a foundation for my current position as the director of a comprehensive urban university counseling service. In that capacity I manage the daily functions of the office, manage the budget, recruit, hire, and supervise clinical staff and graduate students, facilitate seminars and psycho-educational workshops, provide consultation to the university community for mental health concerns, and of course, I carry a small clinical load. In addition, I sometimes find time to teach undergraduate and graduate courses. I find my career to be invigorating as I engage in a wide range of activities. Although my path has been a little circuitous in getting here, I'm glad I am where I am.

may also be found at these centers. Counselors at counseling centers work with students who are experiencing adjustment problems and normal developmental concerns. In addition, staff often will provide remedial and preventive assistance by offering workshops, courses, or support groups on campus. Often, such centers offer testing as an adjunct to counseling. Some college counselors may work with students who are struggling with severe problems, while others are likely to refer such students to private practitioners or community agencies. Counselors work with students on a wide range of issues, such as concerns over academic success, self-esteem, relationship problems, test anxiety, stress, sexuality and sexual concerns, depression, suicidal thoughts, substance abuse, eating disorders, and career development concerns (Collison & Garfield, 1996; Vespia, 2007). Increasingly, students are entering college with a history of mental health treatment, and many are on medication to help manage a range of mild to more severe mental health issues (Prescott, 2008; Vespia, 2007). Counselors may additionally need to address post-traumatic stress in veterans returning to college after combat, suicidal ideation as students face competitive programs and an unstable job market, or students suffering from the aftermath of sexual assault. Now, and in the coming years, counseling center staff will be challenged to find ways to respond to the increasing mental health needs of the college student population.

Disability Services (Office of Educational Accessibility)

Counselors who work for *disability services*, now sometimes called the *office of educational accessibility*, provide a wide range of services that support students with disabilities (Dungy, 2003). For instance, they can be found conducting short-term counseling, running support groups, ensuring compliance of the university with the *Americans with Disabilities Act* and other state and federal laws, assessing students for disabilities, assisting faculty in understanding how they can support individuals with disabilities in their academic pursuits, arranging transportation when appropriate, and assisting individuals with disabilities with campus housing. The range of disabilities with which the counselor works varies greatly. Some of the more common disabilities include the physically challenged, learning disabled, hearing impaired, and visually impaired.

Health Services

Many universities have their own *health services* that provide health care and preventive educational programs to students, faculty, staff, and administrators (Dungy, 2003). These health services are generally run by physicians, nurses, nurse practitioners, and physicians' assistants, and some may also offer counseling services, generally staffed by master's or doctoral level counselors. In addition, counselors will often be hired by health services to offer educational and preventive programs on such things as AIDS awareness, stress management, and living a healthy lifestyle. Some universities utilize student affairs professionals to organize student peer educator groups that work to promote healthy lifestyles or safe sex practices on campus.

Human Resources

The *office of human resources* is involved with overseeing benefit packages for faculty, administrators, and staff and running preventive educational programs such as workshops on drug and alcohol abuse, stress management, communication skills, and financial

management. Some human resource staff may be involved with hiring staff and assisting new faculty in their transition to the university, or helping faculty who are leaving the university find new jobs and/or move to a new area of the country. Some staff may also be involved in providing workshops and advice on sexual harassment issues and on affirmative action laws. In addition, human resource offices may house employee assistance programs that provide educational workshops, crisis intervention, short-term counseling, and referral to community agencies. Individuals who work for a human resource office may hold a degree in counseling or student affairs.

Multicultural Student Services

Today, most colleges and universities have an *office of multicultural and multiracial student services* that focuses on issues unique to ethnic minorities, women, men, religious groups, and sexual minority students (Dungy, 2003; Lopez-Mulnix & Mulnix, 2006; Wong & Buckner, 2008). Staff who work in such offices will often have a degree in counseling or in student affairs and will provide a variety of services such as offering workshops for campus administrators, faculty, and staff to educate them on diversity issues; providing a supportive office where students from diverse backgrounds can feel welcome; assisting in providing a safe and accepting campus-wide atmosphere; serving as advocates for individuals from diverse backgrounds; and educating the campus community on relevant laws (see Box 18.2). Some universities with high international student enrollment may have a separate office to support the needs of these students. This office may handle orientation, federal paperwork, and ongoing cultural exchange programs.

Residence Life and Housing Services

The *office of residence life and housing services* generally provides a wide range of services related to student living (Dungy, 2003). Some residence life staff will live in student housing, oversee the day-to-day living of students, and assist with any housing-related problems that may arise. Other staff will assist students with their educational, social, and developmental concerns and may conduct preventive workshops on topics such as stress management, time management, communication skills, diversity issues, and other concerns. In addition, staff will often be found assisting students who are having problems adjusting to college, struggling with personal problems, or dealing with interpersonal concerns with roommates and other students. Although staff who work in residence life may have a variety of degrees related to student affairs, clearly a master's in counseling is ideal, as many of the issues that face such staff are of a personal nature (see box 18.3).

Student Activities Services

Often administered by the office of the dean of students, the *office of student activities services* is responsible for ensuring the smooth functioning of student organizations, advising student government, advising and coordinating sorority and fraternity chapters, scheduling campus activities, publishing student handbooks, enforcing student regulations, supervising student media (e.g., newspaper and radio), running intramural and recreational activities, and organizing social, cultural, and educational activities (Dungy, 2003). As with many student affairs offices, a degree in counseling or student affairs is often needed to obtain a position with student services (see box 18.4).

BOX 18.2

Carretta: Assistant to the Vice President, Student Affairs

Courtesy of Carretta Cooke

I was always curious. I also wondered about people, and I grew up in a city where race, ethnicity, and class defined who you were. A wonderfully ethnic place, Detroit had kosher delis, Black Muslims, Polish bakeries, Italian and Soul food restaurants, and world-famous museums.

Emigrating from the South, my father, a Korean War veteran, finished mortuary science school, married my mom, and settled in Detroit. I was lucky—my parents were able to afford me a life that was rare for an African American child growing up during the civil rights era. Ballet, voice, and piano lessons, dressup social occasions, and private education were experiences that might have left me unaware of the fast-changing world around me. However, my parents helped educate me. At a time when Black history was a paragraph in history books about Lincoln freeing the slaves, I was being told about Denmark Vesey, Nat Turner, Harriet Tubman, and the contributions that African Americans made and were making in this country. I was a small child during the March on Washington but vividly remember the pride on my father's face as I sat on his lap and we watched it on television. I also remember not being able to use the bathroom in Tennessee, and looking at the signs that said "White Only" in Maryland as we drove to visit my relatives in the South. I guess that's why we always drove from Detroit to Sumter, South Carolina, in a day! I find it an honor to be part of a people who have endured and survived.

As an International Relations major in college, I was determined to be the first African American and female ambassador to China. I thought I would go on to law school. However, as an intern in the admissions office in college, I was fascinated by work in student services. Besides, my older sister was studying for the bar exam, and it scared the hell out of me! So, upon graduating I began work as a financial aid counselor at a small Catholic college that had a diverse student body. I loved the college environment and decided China could wait—for a while anyway.

I came to multicultural student services still searching for my career in international relations. Accepting a position as Assistant Director for Minority Student Services at a large university near Washington, DC, I thought I could obtain a job at an international agency and move closer toward my goal of becoming a diplomat. However, I soon realized that I loved the work I was doing. After a racial incident on campus, I started pulling people together to have frank discussions about difference, "isms," to share perceptions. I found myself energized.

Now it is more than 30 years since my graduation, and I'm not the ambassador to China, but I have served more diverse groups than a career diplomat. I have served as executive director of a multicultural student affairs department that has more than four cultural units at a major selective university in the Midwest until recently. In my current position, I am still able to foment change as a senior level administrator and a campus expert on inclusion and diversity. I love working with the student community around issues of diversity. I love meeting people who have issues about race, ethnicity, and difference. I try to help them to better understand themselves and ultimately to heal.

I want to finish my doctorate and move into a position of greater authority and impact, possibly a vice president of student affairs. But, I will always be committed to diversity in the higher education setting. Whether it be speaking about the impact of diversity on college campuses, working with my faculty colleagues to infuse diversity issues into the curriculum, helping administrative staff deal with changing demographics, or helping people heal, I will never stop being that curious child—wanting to know the how and why of it all and, along the way, helping others and learning about myself.

BOX 18.3

Tamekia: Area Coordinator for Residence Life

In my opinion, there is no greater experience than working in residence life. I learned so much living with college students on a 24-hour basis for four years. From something as "simple" as roommate conflicts, to 3 a.m. fire alarms, to binge drinking, to students who have to go to the emergency room, to the many parent calls, residence life taught me how to manage and deal with difficult and complex issues. My journey to residence life was entirely coincidental. I was weeks away from graduating with my bachelor's in psychology and was planning to move to Tennessee to start my master's degree in counseling. I was moving to a new area where I had no family or friends, and I needed a job and a place to live. Thankfully, the person who interviewed me told me about a graduate assistantship in residence life. It seemed like a win-win situation. My out-of-state tuition would be waived and I would have a place to live. I applied, interviewed, and got the job.

I had no idea what I was getting myself into. I have worked in residence life for the past four years, spending three of those years as a resident director and a year as an area coordinator. In these roles, I learned so much about college student development and definitely put my counseling skills to good use. I also learned about crisis response and time management, how to be an effective supervisor, the importance of documentation, how to train staff, and many more transferable skills. There are aspects of residence life that I didn't like—like the numerous early morning calls I received—but, overall, I enjoyed my experience. The good definitely outweighed the bad.

College students are an amazing population of individuals to work with. It was amazing to see how they evolved throughout their college years. I was able to see my residents graduate and develop into successful, productive individuals. I recently resigned from my residence life position to pursue a doctorate in counseling. The reactions I received from residents upon my departure were just amazing. I had no idea that I impacted their lives so much. I enjoyed what I did and cared about them, which was reflected during every interaction I had with my residents. As I continue my doctoral studies, I bring each of my valuable learning experiences with me in the work that I do. My residence life experience was a worthwhile, valuable experience that I wouldn't take back for the world!

Courtesy of Tamekia Bell

Other Student Services Offices

The degree in counseling with a specialty in student services is versatile, and such individuals can be found in almost any setting on a college campus. Besides the ones listed above, some of the more prevalent offices include the *admissions office, office of assessment and evaluation, financial aid office, commuter services, distance learning site directors, women's/ men's centers,* and *the office of the registrar* (Dungy, 2003). Although traditional counseling is rarely offered at these offices, individuals with a background in counseling are often hired because of the heavy emphasis on advising, as counselors make excellent advisors. In addition, many graduates will obtain jobs in these offices as a stepping-stone to other student services positions, positions that might have a more involved counseling role, more status, and better pay.

BOX 18.4

Joe: Director of Student Activities

Courtesy of Joe Lowder

I often say that I did not grow up wanting to be a student affairs administrator. It is not a career that comes to mind until you are impacted by someone or something that shifts your perspective and direction. I grew up in a rural area of Mississippi, and my main goal was to push myself to graduate from college. My father dropped out of school in the eighth grade because of frequent moves. However, after a long road, he attained his GED and an associate's degree to better our family. My father's persistence helped me to truly understand the value of an education.

At first, I attended a small, residential community college in my hometown where I was heavily involved on campus and thrived. Later, I transferred to a four-year college in Alabama where I lived and worked off-campus. My grades dropped dramatically and I found myself dissatisfied with the university. I decided to transfer back home to the large state land-grant university in Mississippi. There, I got involved in a campus organization and soon the organization's advisor suggested I examine a career in student affairs. Luckily, one of the master's degrees offered there was in counselor education. Although I took a number of common core classes with family and school counseling students, my emphasis was in student affairs in higher education. My master's degree helped me realize that I wasn't dissatisfied with the four-year university I had been at, but rather with the experience that I had created for myself while there. This revelation is why I now have such a passion for student activities.

I consider myself lucky that I fell into a counseling degree, because counseling is the fundamental base of the work I do every day in student activities. My job is much more than planning events; it consists of mentoring, navigating conflict, team building, active listening, goal setting, informal career counseling, and asking students tough questions. I have learned that the one-on-one meetings are one of the most powerful tools I have to inspire and challenge students and staff to become well-rounded individuals.

Looking back, my educational journey has come full circle. I have my father and my student organization advisor to thank for shifting my perspective and helping me to find my direction. I did not realize until after I was in my current career that my father's path was also shifted by a college administrator at my small-hometown community college. It was the Dean of students at this college who encouraged my father to attain his GED and gave him a small loan so he could work fewer hours and focus on the degree. For a long time, my father did not understand exactly what I did in student affairs, and always told his friends, "he teaches at the university or something." However, after hearing about his Dean of students, I told my father that this type of guidance and nurturing is exactly what I strive to give my students. My dad now finally understands why I work in student affairs, and he has never been more proud of me!

Multicultural/Social Justice Focus

Students who attend racially diverse institutions and are engaged in educationally purposeful activities that involve interactions with peers from different racial/ethnic backgrounds come to enjoy cognitive, psychosocial, and inter-personal gains that are useful during and after college. (Harper & Hurtado, 2007, p.14)

With up to one-third of all college students being identified as racial/cultural minorities in the twenty-first century, multicultural issues are playing an increasingly important role in student affairs practices. Although offices of multicultural student services can be traced back to the 1960s, as more students of color and women attend colleges addressing multicultural issues can no longer be the sole responsibility of multicultural student services. All student services offices and student affairs practitioners will need to learn how to effectively deliver services to this increasingly diverse population (Kezar & Eckel, 2007; MacKinnon, Broido, & Wilson, 2004; Pascarella & Terenzini, 2005; Shuford & Palmer, 2004; Stage & Downey, 1999; Talbot, 2003; Valverde & Castenell, 1998). The following discussion summarizes some of these ways.

Applying Student Development Theory to Students from Diverse Backgrounds

Student affairs practitioners must ensure that the theories they use are cross-culturally appropriate. In addition, all student affairs practitioners should be current on racial/cultural identity models if they are to work effectively with students from diverse backgrounds (see Chapter 14). Students must see the university making deliberate and continual commitment to improving the college experience of the students from nondominant groups, rather than merely paying lip service to diversity without following through with targeted initiatives (Harper & Hurtado, 2007; Lopez-Mulnix & Mulnix, 2006). Additionally, practitioners must work to understand the nuances of culture for students of biracial or multiracial backgrounds. For instance, restricting recruitment and programming to monoracial groups may cause students with multiple cultural identities to feel excluded (Kellogg & Niskode, 2008).

Implementing a Cultural Environment Transitions Model

All student affairs practitioners must take part in helping universities transform their total university environment into one that embraces diversity. It is crucial that student affairs practitioners jointly develop a model that will assist universities that operate mostly from a White Eurocentric perspective transition to one that embraces all cultures (Lopez-Mulnix & Mulnix, 2006). A number of ways to make this transition have been identified in recent years (Valverde, 1998; Talbot, 2003), one of which is described in Table 18.1.

Becoming a Cultural Broker

Student affairs practitioners can actively assist all parts of the university in implementing specific changes that can move the university toward increased cultural sensitivity. Examples might include the following:

1. Helping administrators see how the use of culture-specific terms such as "Christmas vacation" might be offensive to some non-Christians and to some cross-culturally sensitive Christians.
2. Helping orientation leaders assess the needs of minority students in order to better address their specific issues during orientation.
3. Assisting in the recruitment of staff that better reflects the diversity on campus.
4. Encouraging the use of nonsexist and nonculturally biased language by the campuswide community.

TABLE 18.1

Stages in Multiculturing a Campus					
STAGES:	ONE	TWO	THREE	FOUR	FIVE
Type	Monocultural campus	Ethnocentric campus	Accommodating campus	Transitional campus	Transformed campus
Characteristic	Devoid of minority traits	Dominant white culture, which admits minority	Personnel and policies modified to accommodate people of color	Limited pluralism	Multicultural in all aspects

Source: Valverde (1998), p. 22

5. Offering diversity workshops for students, staff, faculty, and administrators.
6. Providing assistance, such as scholarships, to encourage minority students to enroll.
7. Supporting the development of cultural student groups on campus.
8. Advocating for groups that have been traditionally oppressed and offering them a "voice" on campus.

Removing the Barriers to Academic Excellence of Underrepresented Students

Rapidly increasing numbers of diverse college students have led to an artificial barrier between these new students and faculty members, the majority of which are older White males (Broido, 2004; Gordon, 2007; Valverde & Castenell, 1998). Differences in language, ways of meaning making, perceptions of racial and ethnic conflict, sexual orientation, and general cultural differences have made it difficult for underrepresented students to adjust to and achieve in college (Ancis, Sedlacek, & Mohr, 2000; Broido, 2004; Harper & Hurtado, 2007). One role of the student affairs practitioner is to lessen the gap between students and faculty so that all students will have an equal opportunity to achieve in all majors. This may mean working with faculty members to understand cultural or social barriers that may be impacting their students and helping faculty to devise strategies so that they can better relate to all students (Gordon, 2007; Harper & Hurtado, 2007).

Creating a Social Justice Environment

One role of the student affairs practitioner is to create an environment in which all students, particularly those who come from underrepresented groups, feel welcomed, uplifted, and empowered. Mackinnon and associates (2004) suggest three ways of advancing this mission:

1. Provide support for students from diverse backgrounds, especially those who have been disenfranchised and poor.
2. Educate students about oppression and privilege, and create an environment that affirms other values and advocates for liberation of those who are oppressed.
3. Work to change policies and institutional structures that foster oppression.

Ethical, Professional, and Legal Issues

Ethical Concerns

Ethical Guidelines

College Student Educators International, formerly the American College Personnel Association, still uses its acronym of ACPA and offers ethical principles for student affairs practitioners (see ACPA, 2006). In addition, the American College Counseling Association (ACCA), a division of the American Counseling Association (ACA), applies the ACA ethical code to student affairs practitioners (see ACA, 2005). Although the ACPA ethical principles are more specific to higher education settings, both guidelines are important for addressing ethical issues.

Confidentiality and Duty to Warn

Although confidentiality is an issue that faces all counselors, it has been particularly focused upon in college settings following a landmark case that resulted in what has become known as the *Tarasoff rule* (Corey, Corey, & Callanan, 2011; Swenson, 1997) (see Chapter 4, Box 4.9). This case, which examined the liability the university holds when an individual is in danger of harming another, has far-reaching implications for counselors who work in a college setting. Confidentiality is an important professional standard. However, in light of acts of campus violence, student affairs professionals may be called to take potential safety risks more seriously and thus limit the extent of confidentiality offered to each student (Fisher, 2007).

Confidentiality, Informed Consent, and the Breaking of Rules

Because student affairs specialists are working for both students and the institution, they are sometimes faced with the dilemma of deciding to whom they owe their allegiance (Winston, 2003). Thus, students will sometimes come to student affairs practitioners with confidential information that the practitioner may be obligated to pass on to the institution. An example of this might be a student revealing to an advisor that he or she has cheated on an examination or knows of someone who has cheated. Thus, the student affairs practitioner must be clear on the limits of confidentiality when working with students and must obtain informed consent from the student for any advising or counseling that will take place under the limitations.

Professional Issues

Professional Associations

The sheer number of professional associations reflects the broad diversity in the field of student affairs. Today, the American College Counseling Association (ACCA; www.collegecounseling.org), which is a division of ACA, and the College Student Educators International (ACPA; www.myacpa.org) are the two associations joined most frequently by counselors who work in student affairs. ACPA typically attracts those who identify with student affairs in general, while individuals who work in a counseling capacity in higher education generally join ACCA. Another important association is the National

Association of Student Personnel Administrators (NASPA, www.naspa.org), which focuses on concerns of administrators in higher education. Also, many who work in student development offices will join associations specific to their field of interest. For instance, we often find those working in career services joining the National Career Development Association (NCDA, www.ncda.org) and those working in counseling centers joining the American Mental Health Counselors Association (AMHCA, www.amhca.org).

Technology and Student Affairs

Technology has greatly affected how some students learn, and it has increasingly become commonplace to find students learning via live TV or audio transmission, live online courses, or pre-packaged online courses (Pullan, 2010). As accreditation bodies have increasingly accepted this new way of teaching (see CACREP, 2009a), student affairs practitioners have had to devise new ways of meeting the needs of these new non-traditional students. Today, colleges and universities have placed student affairs practitioners at distant sites and have found creative ways to reach students who are not located on the main campus, such as offering online counseling, online remediation of writing, and intensive short-term institutes on campus where students can have their college needs addressed.

Even on campus, advances in technology have made it necessary for student affairs professionals to be proficient in the technologies available to students. Professionals may need to engage in online communication, create online social communities, and provide constant access to up-to-date information (Kleinglass, 2005). Additionally, many professionals may struggle with ensuring confidentiality across various media. Student affairs professionals unfamiliar with current technology will need to receive regular training to keep up with students' ever-changing online habits. The need to be constantly available in a time of instant communication and continuous access to information will likely remain a challenge for the field of student affairs.

Salaries of Student Affairs Practitioners

Because of the diversity of student affairs practitioners on college campuses, salaries vary considerably within any one institution. In addition, colleges and universities vary dramatically on how much they pay student affairs practitioners. This tends to be a function of the geographical location of the college, whether it is a private or public institution, the financial stability of the institution, and the value the institution places on the specific student affairs job. For instance, the median salary for college counselors is about $50,000 at junior colleges and about $44,000 at four year colleges (United States Department of Labor, 2010–2011a), and median salaries for some select student service practitioners are approximately: $55,000 for directors of student activities, $74,000 for directors of student financial aid, and $88,000 for deans of students (United States Department of Labor, 2010–2011b). Please note, however, that salaries at some institutions can be quite a bit higher.

Legal Issues

Campus Safety

With the tragedy of 32 students and faculty being murdered at Virginia Tech, as well as violence on campus at numerous other universities, ensuring campus safety has become

a major concern for student services. Indeed, nearly every student affairs office has been impacted by the creation of policies and procedures to minimize risks and identify threats while protecting individual rights. Among these policies are methods to alert students to potential dangers, as well as identify worrisome student behaviors to prevent future violence. Many universities have adopted crisis alerts that can instantly notify students via text or email if there is a situation on or near campus. Heightened security in campus buildings has also been widely adopted following recent acts of violence (Rasmussen & Johnson, 2008). Additionally, student affairs professionals in various offices have the added responsibility of gatekeeping and referral.

Most colleges and universities now have threat assessment teams that work to identify potentially problematic students. Student affairs professionals and faculty members contact the team with any evidence that a student is exhibiting any abnormal or threatening behaviors. These students are then frequently referred to the counseling center for assessment and may be referred again to an outside agency if the concerns are severe (McBain, 2008). Counseling center staff may also be asked to disclose information on students to the threat assessment team, thus complicating the practice of confidentiality. Whatever the individual school's policy, staff from across all departments of student affairs must work together to protect campus safety, while also maintaining an environment that is supportive of students with mental health needs.

Liability Concerns

Student affairs practitioners face liability concerns that many other counselors do not. Some of the more common liability concerns are described below.

In Loco Parentis: In recent years, a number of student-initiated lawsuits have suggested that colleges may have a duty to protect students from physical harm that might occur through such things as sexual attacks, psychological problems such as suicidal ideation, sports-related injuries, and substance abuse (Barr, 2003; Bowden, 2007; LaCroix, 2008; White, 2007). Whereas *in loco parentis* was formerly seen as protecting student moral development, this new in loco parentis suggests that there is a duty of colleges to protect students from harm. Student affairs practitioners will need to pay special attention to these and other issues in the decades to come.

Alcohol Abuse: When a university has condoned the use of alcohol, which subsequently becomes the reason for an accident or death, the university may be found to be at fault (Barr, 2003; Black, 2007). For example, not being vigilant about addressing underage drinking or allowing alcohol at events, both of which could result in a car accident, could lead to legal action. Campuses have responded to this threat very differently. Some campuses are designated as "dry campuses," meaning alcohol is not allowed anywhere on school grounds and students may be penalized for being caught under the influence. Other campuses are "wet campuses," which allow students to drink in designated locations and under certain guidelines. Regardless of the approach, colleges and universities must continually balance student safety and legal considerations when making and enforcing alcohol-related policies (Scribner et al., 2009).

Defamation and Libel: When written or oral materials are used with the intention of defaming a person, a university may be held liable (Barr, 2003). Thus, student affairs specialists who work with student organizations or media (e.g., student newspaper) on campus must be knowledgeable about how such organizations might defame a person.

Civil Rights Liability: A number of civil rights laws have been passed over the years, which prohibit discrimination of protected classes of individuals (e.g., minorities). In addition, universities today are increasingly being challenged to protect the civil rights of all people (Barr, 2003; Fagin, 2005). Thus, when rights are in some way violated, the university may be held liable.

Contract Liability: Numerous publications are initiated by a university, many of which are viewed as a contract (e.g., the university catalog) (Barr, 2003; Palfreyman, 2003). Thus, student affairs specialists who are involved in the development of such publications must be keenly aware of potential liability concerns.

The Right to Records: The Family Educational Rights and Privacy Act (FERPA) ensures that all individuals have the right to inspect their educational records and to request a formal hearing if they believe the record to be false (Barr, 2003; White, 2007). Parents do not have rights to student records at postsecondary institutions unless their child is a dependent according to the tax code, or if the student signs a release of information. Thus, student affairs practitioners need to know when and how to disperse requested records to students. It should be noted that if certain conditions are followed, FERPA excludes counseling notes from the category of educational records (Glosoff & Pate, 2003).

The Counselor in Process: The Student Affairs Practitioner

Colleges and universities have historically been on the cutting edge; they are our nation's laboratories, where we experiment for the future. They exist to provide and expand our knowledge base. Any individual who wants to work at such an institution must be a forward thinker who is willing to take risks, test out new paradigms, and provide new ways of offering services. The student affairs practitioner must be willing to move forward with the changes that will inevitably take place in our universities and later be reflected in society. Whether it is women's centers, multiculturalism, political correctness, or new student development models to be tested, the realm of the student affairs practitioner is ever moving and ever changing. As Rentz (2004) succinctly stated:

> *The role, mission, and goals of student affairs have never been, and hopefully never will be, static. For it is in the dynamic tension that resides within and between the field and higher education's changing institutions that the seeds of our power and value can be found.* (p. 54)

Summary

This chapter began by highlighting the fact that the main purpose of the student affairs practitioner is to help facilitate the learning and self-knowledge of all students by offering services directly to students, collaborating with faculty and administration, and by being proactive in making changes in the institution.

The history of student services, we noted, dates back to the early colleges, which were mostly religiously oriented, had as their purpose the development of moral persons,

and stressed the concept of in loco parentis, in which faculty often filled the role that is today taken by student affairs practitioners. We noted that at the end of the nineteenth century there was a shift toward addressing the needs of the whole person.

During the early years of the twentieth century student services became firmly established, and with an exception during the Depression, the focus generally remained on the whole person. The end of World War II saw extremely large increases in the number of college students and a concomitant rise in student affairs practices. This trend continued well into the 1950s. The 1960s ushered in the "modern-day era" of student affairs, which saw an increased emphasis on the application of developmental theories. The 1970s saw an expansion of student affairs practices that leveled off during the 1980s. The 1980s brought increased refinement and application of developmental theories and an increased focus on nontraditional and minority students, while the 1990s saw an increased emphasis on promoting academic success and an attempt to find ways of reducing the cost of student services.

We pointed out that the latter part of the 1990s brought increased economic solvency on the part of student services. More recently, we have seen a focus on the importance of creating a multicultural environment on campus, having a safe and secure campus, reducing the use of drugs and alcohol, and dealing with the spread of technology and the rise of distance learning.

We noted that the development of the student affairs profession was reflected in the establishment of a number of professional associations over the years, including the American College Counseling Association (ACCA), which is a division of ACA; the American College Personnel Association, now called the College Students Educators International (keeping the acronym ACPA); and the National Association of Student Personnel Administrators (NASPA).

As the chapter continued, we noted that despite the fact that there is great variability in the roles and functions of the student affairs practitioner, it is likely that he or she will find him- or herself in one or more of four major roles: the counselor who guides, supports, and advises students; the specialist who fosters intellectual and personal growth; the campus ecology manager who creates a climate for successful student development, and the administrator, who designs and manages programs.

Within this chapter we noted that developmental theories are a driving force behind student affairs practice. We pointed out that many of the developmental theories discussed in Chapter 9 guide student affairs practice, and that two theories in particular, Chickering's seven vectors model and Perry's scheme of intellectual and ethical development, have been relied upon by student affairs practitioners. We noted that Chickering believed that students mature along seven vectors, which include achieving competence, managing emotions, developing autonomy, establishing identity, forming mature interpersonal relationships, developing purpose, and developing integrity. Perry, on the other hand, examined changes in cognitive development as a function of college experience, noting that individuals tend to move from a dualistic, rigid way of viewing the world to a relativistic, more open mode of understanding.

As the chapter continued, we identified some of the student affairs offices where one is likely to find individuals who hold a degree in counseling. These include academic support services, career development centers, counseling centers, disability services (office of educational accessibility), health services, human resources, multicultural student services, residence life and housing services, and student activities services. We also noted

that there are many other student services offices staffed by individuals with counseling degrees.

Relative to multicultural and social justice issues, we noted that college campuses are becoming increasingly diverse and we highlighted a few issues that student affairs practitioners should address. They included the importance of ensuring that the theories they use are cross-culturally appropriate and that they have knowledge of racial/cultural identity development models; helping universities transform their environment to one that embraces diversity; acting as a cultural broker by being a consultant to others in helping to make university-wide culturally sensitive changes; helping to remove barriers to academic excellence for minority students; and helping to create a social justice environment where equality of all individuals is stressed.

Two major ethical issues we identified included concerns over confidentiality, especially in reference to our responsibility toward an individual who may be in danger of harm (e.g., the Tarasoff rule), and the conflict that sometimes exists between confidential information we receive from students and our responsibility to report such information to our supervisors or the institution at large.

Relative to professional issues, we highlighted three associations in this field: the American College Counseling Association (ACCA), which tends to focus on counseling issues; the College Students Educators International (ACPA), which generally attracts those who identify with student affairs in general; and the National Association of Student Personnel Administrators (NASPA), which focuses on concerns of administrators. Also relative to professional issues, we pointed out that technology and distance learning have greatly affected how student affairs practitioners reach students, and we discussed the importance of finding creative ways of addressing the needs of these new non-traditional students. We noted that because there are so many types of student affairs practitioners, the salaries of such staff can vary dramatically. However, we were able to identify entry-level salaries as often starting in the mid-40s and directorships in some offices going well above $88,000.

As the chapter neared its conclusion, we discussed a number of legal issues impacting the student affairs practitioner. First, we highlighted how policies and procedures have changed to better ensure campus safety. Then, we examined a number of liability issues, including: in loco parentis to ensure that students are protected from harm; keeping students safe from the effects of alcohol abuse; ensuring that students aren't defamed or libeled; ensuring the civil rights of students; contract liability, or ensuring that publications are accurate (e.g., the catalog); and the rights of students to their records as stated by FERPA. Finally, we concluded the chapter by noting that the student affairs practitioner of today must be willing to move forward in response to the changes that will inevitably take place in our universities and later be reflected in society.

References

Ahren, C. (2008). Closing the gap with student affairs staff: From margin to mainstream. *New Directions for Higher Education, 143*, 83–91. DOI: 10.1002/he.316

Ambler, D. A. (1991). Designing and managing programs: The administrator role. In U. Delworth & G. Hanson (Eds.), *Student services* (2nd ed., pp. 247–264). San Francisco: Jossey-Bass.

American College Personnel Association. (2006). *Statement of ethical principles and standards*. Retrieved from http://www2.myacpa.org/ethics/statement.php

American Counseling Association. (2005). *ACA code of ethics*. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Mental Health Counselors Association. (2010). *About AMHCA*. Retrieved from http://www.amhca.org/about/

Ancis, J. R., Sedlacek, W. E., & Mohr, J. J. (2000). Student perceptions of campus cultural climate by race. *Journal of Counseling and Development, 78*, 180–185.

Atkinson, D. R. (2004c). Within-group differences among ethnic minorities. In D. R. Atkinson (Ed.), *Counseling American minorities* (6th ed., pp. 27–56). New York: McGraw-Hill.

Barr, M. J. (2003). Legal foundations of student affairs practice. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 128–150). San Francisco: Jossey-Bass.

Black, D. (2007). Laying down the law: Addressing alcohol liability. *Student Affairs Leader, 35*(9), 4–6.

Bowden, R. (2007). Evolution of responsibility: from "in loco parentis" to "ad meliora vertamur." *Education, 127* (4), 480–489.

Brandel, I. W., & Yarris, E. (2004). Counseling centers. In F. J. D. MacKinnon (Ed.), *Rentz' Student affairs practice in higher education* (3rd ed., pp. 144–177). Springfield, IL: Charles C. Thomas.

Broido, E.M. (2004). Understanding diversity in millennial students. *New Directions for Student Services, 106*, 73–85. doi:10.1002/ss.126

Brown, R. R. (1991). Fostering intellectual and personal growth: The student development role. In U. Delworth & G. Hanson (Eds.), *Student services* (2nd ed., pp. 284–303). San Francisco: Jossey-Bass.

Council on the Accreditation of Counseling and Related Educational Programs. (2009). *Standards*. Retrieved from http://www.cacrep.org/doc/2009%20Standards%20with%20cover.pdf

Carpenter, S. (2004). The philosophical heritage of student affairs. In F. J. D. MacKinnon (Ed.), *Rentz' Student affairs practice in higher education* (3rd ed., pp. 3–26). Springfield, IL: Charles C. Thomas.

Carter, R. T., Helms, J. E., & Juby, H. L. (2004). The relationship between racism and racial identity for White Americans: A profile analysis. *Journal of Multicultural Counseling and Development, 31*(2), 2–17.

Chickering, A. W. (1969). *Education and identity*. San Francisco: Jossey-Bass.

Chickering, A. W., & Reisser, L. (1993). *Education and identity* (2nd ed.). San Francisco: Jossey-Bass.

Clawson, T., Henderson, D. A., Schweiger, W. K., & Collins, D. R. (2004). *Counselor Preparation: Programs, faculty, trends* (11th ed.). New York: Brunner-Routledge.

Collison, B. B., & Garfield, N. J. (Eds.). (1996). *Careers in counseling and human development* (2nd ed.). Washington, DC: Taylor & Francis.

Corey, G., Corey, M. S., Callanan, P. (2011). *Issues and ethics in the helping professions* (8th ed.). Belmont, CA: Brooks/Cole.

D'Andrea, M., & Daniels, J. (1999). Exploring the psychology of White racism through naturalistic inquiry. *Journal of Counseling and Development, 77*(1), 93–101.

Delworth, U., & Hanson, G. (Eds.). (1991). *Student services* (2nd ed.). San Francisco: Jossey-Bass.

Dungy, G. J. (2003). Organization and functions of student affairs. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 339–357). San Francisco: Jossey-Bass.

Ellertson, S. & Thoennes, K.V. (2007). Reframing teaching and learning: Lessons from learning communities for student affairs. *New Directions for Student Services, 117.* 35–46. doi: 10.1002/ss.231

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

Fagin, J.A. (2005). Chairs can help minimize institutions' legal liability by understanding personnel laws, policies. *Academic Leader, 21*(12), 4–8.

Fisher, K. (2007). Report on Virginia Tech shootings urges clarification of privacy laws. *Chronicle of Higher Education, 53*(42), A30-A30 ½.

Fochtman, M.M. (2006). Managing, supervising, advising, and mentoring: each requires a unique hat for the professional. *Campus Activities Programming, 38*(7), 47–52.

Forrest, L. (1991). Guiding, supporting, and advising students: The counselor role. In U. Delworth & G. Hanson (Eds.), *Student services* (2nd ed., pp. 265–283). San Francisco: Jossey-Bass.

Fowler, J. W. (1995). *Stages of faith: The psychology of human development and the quest for meaning.* New York: Harper & Row. (Original work published 1981)

Freud, S. (1969*). An outline of psycho-analysis* (rev. ed.). (J. Strachey, trans.). New York: Norton. (Original work published 1940)

Garner, G. O. (2008). *Careers in social and rehabilitation* services (3rd ed.). New York: McGraw-Hill.

Gerda, J. (2006). Gathering together: A view of the earliest student affairs professional organizations. *NASPA Journal, 43*(4), 147–163.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Glosoff, H. L., & Pate, R. H. (2003). Privacy and confidentiality in school counseling. In T. P. Remley, M. A. Hermann, & W. C. Huey (Eds.). *Ethical and legal issues in school counseling* (2nd ed., pp. 164–178). Alexandria, VA: American School Counselor Association.

Gordon, J. (2007). What can White faculty do? *Teaching in Higher Education, 12*(3), 337–347. doi:10.1080/13562510701278682

Hadley, T. D. (1999). Student affairs researcher: Information broker. *New Directions for Student Services, 85,* 83–91. doi:10.1002/ss.8508

Hamrick, F. A., Evans, N. J., & Schuh, J. H. (2002). *Foundations of student affairs practice.* San Francisco: Jossey-Bass.

Harper, S., & Hurtado, S. (2007). Nine themes in campus racial climates and implications for institutional transformation. *New Directions for Student Services, 120,* 7–24.

Hunter, M. S. & Murray, K. A. (2007). New frontiers for student affairs professionals: teaching and the first-year experience. *New Directions for Student Services, 117,* 25–34. doi:10.1002/ss.230

Hofer, B. K. (2002). Personal epistemology as a psychological and educational construct: An Introduction. In B. Hofer & P. Pintrich, P. (Eds.), *Personal epistemology: The psychology of beliefs about knowledge and knowing* (pp. 3–14). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Kegan, R. (1982). *The evolving self.* Cambridge, MA: Harvard University Press.

Kellogg, A. & Niskode, A. S. (2008). Student affairs and higher education policy issues related to multicultural students. *New Directions for Student Services, 123,* 93–102. doi: 10.1002/ss.290

Kezar, A., & Eckel, P. (2007). Learning to ensure the success of students of color: A systematic approach to effecting change. *Change, 39*(4), 18–21. doi:10.3200/CHNG.39.4.18–25

King, P. M. (2003). Student learning in higher education. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 234–268). San Francisco: Jossey-Bass.

Kleinglass, N. (2005). Who is driving the changing landscape in student affairs? *New Directions for student services, 112,* 25–38. doi:10.1002/ss.182

Kohlberg, L. (1969). *Stages in the development of moral thought and action.* New York: Holt, Rinehart & Winston.

Komives, S. R., & Woodward, D. B. (2003). Part five: Essential competencies and techniques. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 421–422). San Francisco: Jossey-Bass.

Kraft, D. P. (2009). Mens sana: The growth of mental health in the American College Health Association. *Journal of American College Health, 58*(3), 267–275.

LaCroix, T. (2008). Student drug testing: The blinding appeal of in loco parentis and the importance of state protection of student privacy. *Brigham Young University Education and Law Journal, 2*, 251–279.

Levinson, D. (1978). *The seasons of a man's life*. New York: Knopf.

Levinson, D. (1996). *The seasons of a woman's life*. New York: Knopf.

Lopez-Mulnix, E., & Mulnix, M. (2006). Models of excellence in multicultural colleges and universities. *Journal of Hispanic Higher Education, 5*(1), 4–21.

Lovell, C. W. (1990, October). *Cognitive development (Perry scheme) in students of counseling: The national sample*. Paper presented at the annual meeting of the Southern Association for Counselor Education and Supervision, Norfolk, VA.

MacKinnon, F. J. D., Broido, E. M., & Wilson, M. E. (2004). Issues in student affairs. In F. J. D. (Ed.), *Rentz' Student affairs practice in higher education* (3rd ed., pp. 387–402). Springfield, IL: Charles C. Thomas.

Magolda, M. B., & Porterfield, W. D. (1988). *Assessing intellectual development: The link between theory and practice*. Alexandria, VA: American College Personnel Association.

Manning, K. (2009). Placemaking in student affairs. *Student Affairs Leader, 37*(7), 6–8.

McBain, L. (2008, Winter). Balancing student privacy, campus security, and public safety: Issues for campus leaders. *Perspectives,* 1–22.

Moore, W. S. (2002). Understanding learning in a postmodern world: Reconsidering the Perry scheme of intellectual and ethical development. In B. Hofer & P. Pintrich, P. (Eds.), *Personal epistemology: The psychology of beliefs about knowledge and knowing* (pp. 17–36). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

National Career Development Association. (2003). *Ethical standards*. Retrieved from http://www.ncda.org/pdf/EthicalStandards.pdf

Palfreyman, D. (2003). Phelps . . . Clark . . . and now Rycotewood? Disappointment damages for breach of contract to educate. *Education and the Law, 15*(4), 237–247.

Pascarella, E. T., & Terenzini, P. T. (2005). *How college affects students: A third decade of research* (vol. 2). San Francisco: Jossey-Bass.

Perry, W. G. (1970*). Forms of intellectual and ethical development in the college years: A scheme*. New York: Holt, Rinehart, & Winston.

Prescott, H. M. (2008). College mental health since the early twentieth century. *Harvard Review of Psychiatry, 16*(4), 258–266. doi: 10.1080/10673220802277771

Pullan, M. (2010). Student support services for millennial undergraduates. *Journal of Educational Technology Systems, 38*(2), 235–251. doi:10.2190/ET.38.2.k

Rasmussen, C., & Johnson, G. (2008, May). *The ripple effect of Virginia Tech: Assessing the nationwide impact on campus safety and security policy and practice*. Minneapolis, MN: Midwestern Higher Education Compact.

Rentz, A. L. (2004). Student affairs: An historical perspective. In F. J. D. MacKinnon (Ed.), *Rentz' Student affairs practice in higher education* (3rd ed., pp.27–57). Springfield, IL: Charles C. Thomas.

Rogers, J. L. (2003). Leadership. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 447–465). San Francisco: Jossey-Bass.

Schweiger, W. K., Henderson, D., Clawson, T., Collins, D., & Nuckolls, M. (2008). *Counselor Preparation: Programs, faculty, trends*. (12th ed.) New York: Routledge.

Scribner, R., Ackleh, A.S., Fitzpatrick, B.G., Jacquez, G., Thibodeaux, J.J., Rommel, R., & Simonsen, N. (2009). A systems approach to college drinking: Development of a deterministic model for testing alcohol control policies. *Journal of Studies on Alcohol and Drugs, 70*(5), 805–821.

Shuford, B., & Palmer, C. J., (2004). Multicultural affairs. In F. J. D. MacKinnon (Ed.), *Rentz' student affairs practice in higher education* (3rd ed., pp. 218–238). Springfield, IL: Charles C. Thomas.

Stage, F. K., Downey, J. P. (1999). Hate crimes and violence on college and university campuses. *Journal of College Student Development, 40*, 3–9.

Steenbarger, B. N., & Smith, H. B. (1996). Assessing the quality of counseling services: Developing accountable helping systems. *Journal of Counseling and Development, 75,* 145–150.

Strange, C. C. (2003). Dynamics of campus environments. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 297–316). San Francisco: Jossey-Bass.

Swenson, L. C. (1997). *Psychology and law for the helping professions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Talbot, D. M. (2003). Multiculturalism. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 423–446). San Francisco: Jossey-Bass.

United States Department of Labor. (2010–2011a). *Occupational Outlook Handbook: Counselors.* Retrieved from http://www.bls.gov/oco/ocos067.htm

United States Department of Labor. (2010–2011b). *Occupational Outlook Handbook: Education Administrators.* Retrieved from http://www.bls.gov/oco/ocos007.htm

Valverde, L. A. (1998). Future strategies and actions: Creating multicultural higher education campuses. In L. A. Valverde & L. A. Castenell, (Eds.), *The multicultural campus: Strategies for transforming higher education* (pp. 19–30). Walnut Creek, CA: AltaMira.

Valverde, L., & Castenell, L. (1998). *The multicultural campus: Strategies for transforming higher education.* Walnut Creek, CA: AltaMira.

Vespia, K. M. (2007). A national survey of small college counseling centers: Successes, issues, and challenges. *Journal of College Student Psychotherapy, 22*(1), 17–40. doi:10.1300/J035v22n01_03

White, B. (2007). Student rights: From in loco parentis to sine parentibus and back again? Understanding the Family Education Rights and Privacy Act in higher education. *Brigham Young University Education and Law Journal, 2,* 321–350.

Widick, C. (1977). The Perry scheme: A foundation for developmental practice. *The Counseling Psychologist, 6*(4), 35–38. doi:10.1177/001100007700600415

Winston, R. B. (2003). Counseling and helping skills. In S. R. Komives & D. B. Woodward (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 484–506). San Francisco: Jossey-Bass.

Wong, P., & Buckner, J. (2008). Multiracial student services come of age: The state of multiracial student services in higher education in the United States. *New Directions for Student Services, 123,* 43–41. doi: 10.1002/ss

Afterword

A Look Toward Your Future:
Applying for Graduate Programs
and Finding a Job

My path toward the attainment of a master's and doctoral degree in counselor education was, by no means, direct. At first, majoring in biology, counseling hardly seemed like the career I would end up choosing. During the 1970s, career counselors were not as aware of these degrees as they are now. Thus, when I went to my career counseling center to seek help in deciding my future, it was not the best experience for me. In addition, sourcebooks with information about the field of counseling or specifics about where to apply for a graduate degree were not readily available. And, of course, there was no Internet. Today, the degree is often sought after, and it is now much easier to find out about various programs.

I've had many jobs over the years. How I learned about these jobs and each of their application processes differed. I've also been on the other end of the application process where I reviewed materials and assisted in making decisions about whether or not an applicant should be admitted to a graduate program or recommended for a job. As an interviewee, I've made some mistakes. And as a reviewer of applicants' materials, I've seen mistakes made.

With my experience over the years, I humbly believe that I might be able to help others by identifying resources and by offering some helpful "tips" for those considering a master's or doctorate in counseling and for those applying for a job. This afterword is intended to help you in that process.

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 pinpoint some critical elements. For instance, when making an informed decision about going on to graduate school, one should probably consider the following:

1. Whether or not 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

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 that 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. Make sure that your application "speaks to" the school or job to which you are applying.
4. Be prepared for and take any necessary tests (e.g., GREs for graduate schools, personality tests for some jobs).
5. Write a great essay or statement of philosophy.
6. Find out if an interview is required and if so, 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 asked for. Some general guidelines when developing your résumé include:

1. Make it readable, attractive, grammatically correct, and to the point.
2. Do not use gender bias 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 that it is not hard on the eyes of the reader.
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 have you eliminated from the selection process. For instance, sometimes individuals include a career goal that is 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 they were not in the counseling field. Don't forget that all experience is good experience and that jobs have transferrable 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 *Amazing Résumés* (Bright & Earl, 2009) or *Best Résumés for College Students and New Grads* (Kursmark, 2006). In addition, today, there are some great Web sites to help you build a terrific résumé.

The Portfolio

In addition to a résumé, a portfolio may increase your chance of being admitted to graduate school or obtaining a job (Cobia, 2005). Portfolios include 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., 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, students who have 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), 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, letters of recommendation, and a project that shows how the student would build a comprehensive school counseling program. Although portfolios have been, in the past, a "paper" project, today's portfolios are often placed on a CD or online (Barnes, Clark, & Thull, 2003).

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 a graduate school (see Baxter et al., 1997; Collison & Garfield, 1996; Garner, 2001). 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 Street, Suite 510
  Alexandria, VA 22314
  Phone: 703.535.5990
  Web site: www.cacrep.org
  Related association: American Counseling Association

  Counselor Preparation: Programs, Faculty, Trends (12th ed.) (2008).
  Authors: Schweiger, W., Henderson, D., Clawson, T., Collins, D., & Nuckolls,
      New York: Taylor & Francis Group.
  7625 Empire Drive
  Florence, Kentucky 41042-2919
  Phone: 800.634.7064
  Web site: http://www.routledge.com/
  Email: orders@taylorandfrancis.com

- *Doctoral programs in counseling and clinical psychology:*

  American Psychological Association (APA)
  750 First Street NE
  Washington, DC 20002
  Graduate and Postdoctoral Education
  Phone: 202.336.5979
  Web site: www.apa.org/education/grad/index.aspx
  Related association: American Psychological Association (www.apa.org)

- *Master's programs in rehabilitation counseling:*

  Council on Rehabilitation Education
  1699 Woodfield Rd., Suite 300
  Schaumburg, IL 60173
  Phone: 847.944.1345
  Email: sdenys@cpcredentialing.com
  Web site: www.core-rehab.org
  Related association: 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 Street,
  Alexandria, VA 22314-3061
  Phone: 703.838.9808
  Web site: http://www.aamft.org/about/COAMFTE/index_nm.asp
  Related association: American Association for Marriage and Family Therapy
    (www.aamft.org)

- *Clinical pastoral programs:*

  Association for Clinical Pastoral Education, Inc.
  1549 Clairmont Road, Suite 103
  Decatur, GA 30033
  Phone: 404.320.1472
  Web site: www.acpe.edu

- *Master's programs in social work:*

  Council on Social Work Education
  1725 Duke St., Suite 500
  Alexandria, VA 22314
  Phone: 703.683.8080
  Web site: http://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
  225 North Fairfax Street
  Alexandria, VA 22314
  Phone: 888.290.0878
  Web site: http://www.americanarttherapyassociation.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 wanted to get a head start on the process, you would have joined 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 Afterword, Box 1)!

AFTERWORD, BOX 1

Networking

Randy was a former student of mine who was enthusiastic about the counseling field. He joined his professional associations, he worked with me on research, and he 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 then and there.

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 sometimes, 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 American Counseling Association (ACA) periodical, lists a variety of counseling-related jobs throughout the country. So does the APA newspaper, *The Monitor*. Similarly, the *Chronicle of Higher Education* lists jobs nationally, although most of the listed jobs are confined to the area of student affairs or are 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 a prospective employer 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 a listing of local community agencies that can be helpful when conducting a job search. Sometimes these placement services will have job listings and 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 generally 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 a great 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 chosen graduate program or job.

In Process and Moving Forward

Change can be painful. It requires giving up a former way of living in the world and accommodating to a new way. Even when the past way is not working, it is our security blanket. It is what we know, and often it feels safer to stick with the familiar than take the risk of moving into unknown territory. After all, if people weren't afraid of change, they would hardly need counselors.

There is something to be said for sticking with what has worked. It's like our favorite old armchair. We can rely on it to be comfortable and faithful to us. We can always fall back on it. However, there is something exhilarating about taking risks. Like rollerblading for the first time, it's exciting and you may fall down, but generally you end up on your feet.

As you move into your career as a counselor, are you feeling comfy in your armchair or are you going rollerblading? Consider your choices and think about your future. If you get too comfy, then move on for a doctorate or get a new job—but whatever you do, get up on those rollerblades and keep moving.

References

Barnes, P., Clark, P., & Thull, B. (2003, November). Web-based digital portfolios and counselor supervision. *Journal of Technology in Counseling, 3*(1). Retrieved from http://jtc.colstate.edu/vol3_1/Barnes/Barnes.htm

Baxter, N. J., Toch, M. U., & Perry, P. A. (1997). *Opportunities in counseling and development careers* (rev. ed.). Lincolnwood, IL: VGM Career Horizons.

Bright, J., & Earl, J. (2009). *Amazing resumes: What employers want to see—and how to say it* (2nd ed.). Indianapolis, IN: JIST works.

Cobia, C. D., Carney, J. S., Buckhalt, J. A., Middleton, R. A., Shannon, D. M., Trippany, R., & Kunkel, E. (2005). The doctoral portfolio: Centerpiece of a comprehensive system of evaluation. *Counselor Education and Supervision, 44*(4), 242–254

Collison, B. B., & Garfield, N. J. (Eds.) (1996). *Careers in counseling and human development* (2nd ed.). Washington, DC: Taylor & Francis.

Garner, G. O. (2001). *Careers in social and rehabilitation* services (2nd ed.). Lincolnwood, IL: VGM Career Horizons.

Kursmark, L. M. (2006). *Best resumes for college students and new grads: Jump-start your career* (2nd ed.). Indianapolis, IN: JIST Works.

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 non racist 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 the 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 on 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.amcdaca .org/amcd/competencies.pdf

Advocacy Competencies

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 multi-media 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/Resources/Competencies/Advocacy_Competencies.pdf

Assessment of Your Theoretical and Conceptual Orientations

The following offers you a way to determine the theory of counseling and the broad conceptual perspective with which you are most affiliated. If you prefer, a similar scale that is somewhat more user-friendly can be found at http://www.odu.edu/~eneukrug/therapists/survey.html.

  To discover your theoretical and conceptual orientations, read each of the following items, and using the scale below, write in the spaces provided how strongly you feel about each item (write in a 1, 2, 3, 4, or 5).

I Don't Believe This   1   2   3   4   5   I Feel Extremely Certain
Statement at All   That This Statement Is True

_____ 1. Instincts (e.g., hunger, thirst, survival, sex, and aggression) are very strong motivators of behavior.

_____ 2. Psychological symptoms represent a desire to regain repressed parts of ourselves as well as parts of self that have never been revealed to consciousness.

_____ 3. Environmental influences on the child can lead to the development of a neurotic character, but through education and therapy, the person can change.

_____ 4. Children learn behaviors through conditioning (e.g., positive reinforcement, punishment).

_____ 5. We are born with the potential for rational or irrational thinking.

_____ 6. We are born with a predisposition toward certain disorders that could reveal itself under stressful conditions.

_____ 7. We are born with five needs: survival, love and belonging, power, freedom, and fun.

_____ 8. We are born into a world that has no inherent meaning or purpose, and we subsequently create our own meaning and purpose.

_____ 9. An inborn actualizing tendency lends direction toward reaching our full potential.

_____ 10. We are born with the capacity to embrace an infinite number of personality dimensions.

_____ 11. Reality is created through interactions or discussions within one's social circle.

_____ 12. Change can occur in fewer than six sessions. Extended therapy is often detrimental.

_____ 13. Deciding how to satisfy instincts (e.g., hunger, thirst, survival, sex, and aggression) occurs mostly unconsciously.

_____ 14. Revealing unconscious material to consciousness allows for an integrated "whole" person.

_____ 15. We all are striving for perfection in our effort to be whole and complete.

_____ 16. Past and present conditioning makes us who we are.

_____ 17. Irrational thinking leads to emotional distress, dysfunctional behaviors, and criticism of self and others.

_____ 18. By understanding one's cognitive processes (thinking), one can manage and change the way one lives.

_____ 19. We all have a quality world containing mental pictures of the people, things, and beliefs most important in meeting our unique needs.

_____ 20. We all struggle with the basic questions of what it is to be human.

_____ 21. Children continually assess whether interactions are positive or negative to their actualizing process, or way of living in the world.

_____ 22. The mind, body, and soul operate in unison; they cannot be separated.

_____ 23. Values held by those in power are disseminated through language and become the norms against which we compare ourselves.

_____ 24. Individuals can find exceptions to their problems and build on those exceptions to find new ways of living in the world.

_____ 25. Our personality is framed at a very young age and is quite difficult to change.

_____ 26. Primordial images that we all have interact with repressed material to create psychological complexes (e.g., mother complex; Peter Pan complex).

_____ 27. Children's experiences by age 5 years, and memories of those experiences, are critical factors in personality development.

_____ 28. Behaviors are generally conditioned and learned in very complex and subtle ways.

_____ 29. Although learning and biological factors influence the development of rational or irrational thinking, it is the individual who sustains his or her type of thinking.

_____ 30. Core beliefs (underlying beliefs that map our world) are the basis for a person's feelings, behaviors, and physiological responses.

_____ 31. We can only choose our actions and thoughts; our feelings and our physiology result from those choices.

_____ 32. We are born alone, will die alone, and except for periodic moments when we encounter another person deeply, we live alone.

_____ 33. The "self" has a need to be regarded positively by significant others.

_____ 34. From birth, the individual is in a constant state of self-regulation through a process of need identification and need fulfillment.

_____ 35. Psychopathology (mental disorders) is a social construction. There is no separate reality that supports its existence.

_____ 36. Although many therapies describe structures that affect functioning (e.g., id, ego, self-actualizing tendency), there is no objective reality proving their existence.

_____ 37. The development of defense mechanisms (repression, denial, projection) are ways of managing instincts.

_____ 38. Archetypes, or inherited unconscious primordial images, provide the psyche with its tendency to perceive the world in certain ways that we identify as human.

_____ 39. As children, how we learn to cope with inevitable feelings of inferiority affects our personality development.

_____ 40. Conditioning (e.g., positive reinforcement, punishment) can lead to a multitude of personality characteristics.

_____ 41. When our cognitive processes result in irrational thinking, we will tend to have self-defeating emotions and exhibit dysfunctional behaviors.

_____ 42. Genetics, biological factors, and experiences combine to produce specific core beliefs that affect how we behave and feel.

_____ 43. At any point in one's life, one can evaluate one's behaviors, thoughts, feelings, and physiology, and make new choices that better meet one's needs.

_____ 44. Meaningfulness, as well as a limited sense of freedom, comes through consciousness and the choices we make.

_____ 45. Because they want to be loved, children will often act in ways that significant others want them to act instead of acting in a manner that is real or congruent with themselves.

_____ 46. Parental dictates, social mores, and peer norms can prevent a person from attaining satisfaction of a need. This unsatisfied need can affect us in ways we are unaware.

_____ 47. Constant discourse and interactions with others within one's social milieu lead to the development of a sense of self.

_____ 48. Language endemic in culture, society, and the individual's social sphere determines the nature of reality.

_____ 49. Because we spend the majority of our time unconsciously struggling to satisfy our unmet needs, happiness is an elusive feeling experienced infrequently.

_____ 50. We are born with the mental functions of sensation–intuition and thinking–feeling, which affect our perceptions. Their relative strengths are affected by how we were raised.

_____ 51. At an early age, we develop a private logic that moves us toward dysfunctional behaviors or towards wholeness.

_____ 52. By carefully analyzing how behaviors are conditioned, one can understand why an individual exhibits his or her current behavioral repertoire.

_____ 53. It is not events that cause negative emotions, but the belief about the events.

_____ 54. We all have automatic thoughts (fleeting thoughts about what we are perceiving and experiencing) that result in a set of behaviors, feelings, and physiological responses.

_____ 55. When language shows caring and the taking of responsibility, good choices are made. When language is blaming, critical, and judgmental, poor choices are made.

_____ 56. We sometimes avoid living authentically and experiencing life fully because we are afraid to look squarely at how we are making meaning in our lives.

_____ 57. Anxiety, and related symptoms, can be conceptualized as a signal to the individual that he or she is acting in a nongenuine way and not living fully.

_____ 58. Breaking free from defenses (e.g., repression) allows one to fully experience the present and live a saner life.

_____ 59. Reality is a social construction, and each person's reality is organized and maintained through his or her narrative and discourse with others.

_____ 60. Pathology, for all practical purposes, does not exist and is not inherently found within the person.

_____ 61. Early child-rearing practices are largely responsible for our personality development.

_____ 62. People are born with a tendency to be either extraverted (e.g., being outgoing) or introverted (e.g., being an observer, looking inward).

_____ 63. Child experiences, and the memories of them, impact each of our unique abilities and characteristics integral to the development of our character or personality.

_____ 64. By identifying what behaviors have been conditioned, one can eliminate undesirable behaviors and set goals to acquire more functional ways of acting.

_____ 65. The depth at which and length of time for which one experiences a self-defeating emotion is related to one's beliefs about an event, not to the event directly.

_____ 66. Automatic thoughts (fleeting thoughts about what we are perceiving) reinforce core beliefs we have about the world.

_____ 67. Needs can only be satisfied in the present, so focusing on how past needs were not met is useless.

_____ 68. People can gain a personally meaningful and authentic existence by making new choices that involve facing life's struggles honestly and directly.

_____ 69. Being around people who are real, empathic, and show positive regard results in the individual's becoming more real.

_____ 70. The ultimate way of living involves allowing oneself access to all of what is available to one's experience. Essentially, Now = Awareness = Reality.

_____ 71. Problems individuals have are a function of their problem-saturated stories or narratives. However, new preferred stories can be generated.

_____ 72. Problems are the result of language passed down by families, culture, and society, and dialogues between people.

SCORING

Scoring I: Place the numbers you chose across from the respective item. In each column, add up your score for each theory and divide the total by 30. That will give you the percentage score for that approach. Place your percentage in the parentheses. For the "psychodynamic score," add the total scores from each of the bottom rows and place it in the far right column. Divide that score by 90, and that will give you the percentage score for psychodynamic therapy. Place that percentage in the parentheses next to *psychodynamic*.

PSYCHOANALYSIS ( )	ANALYTICAL ( )	INDIVIDUAL PSYCHOLOGY ( )	SCORE FOR PSYCHODYNAMIC ( )
1 ___	2 ___	3 ___	
13 ___	14 ___	15 ___	
25 ___	26 ___	27 ___	
37 ___	38 ___	39 ___	
49 ___	50 ___	51 ___	
61 ___	62 ___	63 ___	
TOTAL: ___	___	___	___

Scoring II: Place the numbers you chose across from the respective item. In each column, add up your score for each theory and divide the total by 30. That will give you the percentage score for that approach. Place your percentage in the parentheses. For the "existential–humanistic score," add the total scores from each of the bottom rows and place it in the far right column. Divide that score by 90, and that will give you the percentage score for existential–humanistic therapy. Place that percentage in the parentheses next to *existential–humanistic*.

EXISTENTIAL ( )	PERSON-CENTERED ( )	GESTALT ( )	SCORE FOR EXISTENTIAL– HUMANISTIC ( )
8 ___	9 ___	10 ___	
20 ___	21 ___	22 ___	
32 ___	33 ___	34 ___	
44 ___	45 ___	46 ___	
56 ___	57 ___	58 ___	
68 ___	69 ___	70 ___	
TOTAL: ___	___	___	___

Scoring III: Place the numbers you chose across from the respective item. In each column, add up your score for each theory and divide the total by 30. That will give you the percentage score for that approach. Place your percentage in the parentheses. For the "cognitive–behavioral score," add the total scores from each of the bottom rows and place it in the far right column. Divide that score by 120, and that will give you the percentage score for cognitive–behavioral therapy. Place that percentage in the parentheses next to *cognitive–behavioral*.

BEHAVIORAL ( )	REBT ( )	COGNITIVE – BEHAVIORAL ( )	REALITY THERAPY( )	SCORE FOR COGNITIVE– BEHAVIORAL ( )
4 __	5 __	6 __	7 __	
16 __	17 __	18 __	19 __	
28 __	29 __	30 __	31 __	
40 __	41 __	42 __	43 __	
52 __	53 __	54 __	55 __	
64 __	65 __	66 __	67 __	
TOTAL: __	__	__	__	__

Scoring IV: Place the numbers you chose across from the respective item. In each column, add up your score for each theory and divide the total by 30. That will give you the percentage score for that approach. Place your percentage in the parentheses. For the "post-modern score," add the total scores from each of the bottom rows and place it in the far right column. Divide that score by 60, and that will give you the percentage score for post-modern therapy. Place that percentage in the parentheses next to *post-modern*.

NARRATIVE ( )	SOLUTION-FOCUSED ( )	SCORE FOR POST–MODERN ( )
11 __	12 __	
23 __	24 __	
35 __	36 __	
47 __	48 __	
59 __	60 __	
71 __	72 __	
TOTAL: __	__	__

RESULTS

Your scores represent the percent of items you endorsed in each theoretical area as well as the percent of items you endorsed for the combined theories in a specific conceptual orientation (psychodynamic, existential–humanistic, cognitive–behavioral, and postmodern).

Descriptions of Theoretical Orientations

PSYCHOANALYSIS   Developed by Sigmund Freud, psychoanalysis suggests that instincts, such as hunger, thirst, survival, aggression, and sex, are very strong motivators of behavior. The satisfaction of instincts is mostly an unconscious process, and defense mechanisms are developed to help manage our instincts. Because we are in a constant and mostly unconscious struggle to satisfy our instincts, psychoanalysts believe that happiness is elusive. Early child-rearing practices are responsible for how we manage our defenses and for normal or abnormal personality development. The fact that early childhood experiences forms personality and that our behaviors are mostly dictated by the unconscious lends a sense of determinism to this approach.

ANALYTICAL PSYCHOLOGY   Analytical psychology was developed by Carl Jung, who believed that psychological symptoms represent a desire to regain lost parts of self, as well as parts that have never been revealed to consciousness, so that the person can become whole. Analytical therapists believe that we have primitive or primordial images that interact with repressed material to cause "complexes." We inherit these images, or archetypes, and they provide the psyche with its tendency to perceive the world in certain ways that we identify as human. In addition, we are born with the mental functions of sensation–intuition and thinking–feeling, which affect our perceptions and whose relative strengths are affected by child-rearing patterns. We are also born with a tendency to be extraverted (outgoing) or introverted (observer; inward).

INDIVIDUAL PSYCHOLOGY   Developed by Alfred Adler, individual psychology suggests that early childhood experiences, and the memories of those experiences, result in our character or personality. If early experiences, and the memories of them, enhance our innate abilities and characteristics, we will have a tendency to move toward wholeness, completion, and perfection. However, a person's response to early feelings of inferiority can result in the creation of private logic and compensatory behaviors that lead toward maladaptive or neurotic behaviors. Although early experiences influence the development of personality, education and therapy can be effective in helping a person change.

BEHAVIOR THERAPY   Developed by B. F. Skinner, John Wolpe, Albert Bandura, Ivan Pavlov, and others, behavior therapy is based on classical conditioning, operant conditioning, and social learning (or modeling), which suggest that how individuals are conditioned affects their personality development. They believe that conditioning is very complex and can happen in subtle ways. By carefully analyzing how behaviors are conditioned, one can understand why an individual exhibits certain behaviors and develop goals to eliminate undesirable behaviors while reinforcing new desirable behaviors.

RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT)   Developed by Albert Ellis, REBT suggests that 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, not the event itself. Beliefs about an event can be rational or irrational, with irrational thinking leading to emotional distress, dysfunctional behaviors, and criticism of self and others. Although individuals have a tendency to sustain the type of thinking they previously learned, irrational thinking can be challenged and individuals can adopt rational thinking if given the opportunity through counseling.

COGNITIVE THERAPY   Developed by Aaron "Tim" Beck, cognitive therapy suggests that we are born with a predisposition toward certain emotional disorders that reveals itself under stressful conditions. Cognitive therapists also believe that genetics, biological factors, and experiences combine to produce specific core beliefs that are responsible for automatic thoughts (fleeting thoughts about what we perceive and experience), which result in a set of behaviors, feelings, and physiological responses. By understanding one's cognitive processes (e.g., core beliefs, automatic thoughts), one can address and change automatic thoughts and core beliefs that lead to dysfunctional behaviors and distressful feelings.

REALITY THERAPY   Developed by William Glasser, reality therapy suggests that we are born with five needs—survival, love and belonging, power, freedom, and fun—which can only be satisfied in the present. Reality therapists believe that we have a "quality world" that contains pictures in our mind of the people, things, and beliefs most important to meeting our needs. We make choices based on these pictures, although we can only choose actions and thoughts; feelings and our physiology result from those choices. At any point in one's life, one can evaluate one's behaviors, thoughts, feelings, and physiology, and make new choices. Language we use reflects the kinds of choices we have made.

EXISTENTIAL THERAPY   Developed by Viktor Frankl, Rollo May, and others, existential therapy states that we are born into a world that has no inherent meaning or purpose, that we all struggle with the basic questions of what it is to be human, and that we alone can create our own meaning and purpose. Existential therapists believe that we all have the ability to live authentically and experience fully, but sometimes avoid such an existence out of our fears of looking squarely at how we are making meaning in our lives. They state that meaningfulness, as well as a limited sense of freedom, comes through consciousness and the choices we make.

PERSON-CENTERED COUNSELING   Carl Rogers founded this approach, which states that we have an inborn actualizing tendency that lends direction to our lives as we attempt to reach our full potential. However, this tendency is sometimes thwarted as individuals act in ways that significant others want them to act due to the individual's desire to be loved and regarded by those significant others. This results in the creation of an incongruent self. Anxiety and related symptoms are a signal that the person is acting in a nongenuine way and not living fully. Being around people who are real, empathic, and show positive regard can help individuals become real.

GESTALT THERAPY   Founded by Fritz Perls, Gestalt therapy suggests that we are born with the capacity to embrace an infinite number of personality dimensions. With the mind, body, and soul operating in unison, from birth, the individual is in a constant state of need identification and need fulfillment. However, parental dictates, social mores, and peer norms can prevent a person from attaining a need and results in defenses that block the experiencing of needs. Gestalt therapy highlights the importance of accessing one's experience because the "now" of experience = awareness = reality. Experiencing allows one to break free from defenses and live a saner life.

NARRATIVE THERAPY   Narrative therapy, developed by Michael White, suggests that reality is a social construction and that each person's reality is organized and maintained through his or her narrative or language discourse. Within this context, values held by those in power are often disseminated through language and become the norms against which individuals compare themselves. Therefore, problems individuals have, including mental disorders, are a function of problem-saturated stories or narratives people have in their lives, and these are created through the individual's social discourse. However, new, preferred stories can be generated.

SOLUTION-FOCUSED BRIEF THERAPY   Steve de Shazer and Insoo Kim Berg, two founders of solution-focused brief therapy, suggested that problems are the result of language passed down by families, culture, and society, and dialogues between people. Therefore, pathology, for all practical purposes, is not inherently found within the person, as is professed by many therapies that describe structures that affect functioning (e.g., id, ego, self-actualizing tendency). Believing there is no objective reality, they suggest that individuals can find exceptions to their problems and build on those exceptions to find new ways of living in the world. They suggest that change can occur in fewer than six sessions, and that extended therapy is often detrimental.

Description of Broad Conceptual Orientations

PSYCHODYNAMIC APPROACHES (PSYCHOANALYSIS, ANALYTICAL THERAPY, AND INDIVIDUAL PSYCHOLOGY)   Developed near the beginning of the twentieth century but maintaining widespread popularity today, psychodynamic approaches vary considerably but contain some common elements. For instance, they all suggest that an unconscious and a conscious affect the functioning of the person in some deeply personal and "dynamic" ways. They all look at early child-rearing practices as being important in the development of personality. They all believe that examining the past, and the dynamic interaction of the past with conscious and unconscious factors, are important in the therapeutic process. Although these approaches have tended to be long-term, in recent years, some have been adapted and used in relatively brief treatment modality formats.

COGNITIVE–BEHAVIORAL APPROACHES (BEHAVIOR THERAPY, RATIONAL EMOTIVE BEHAVIOR THERAPY (REBT), COGNITIVE THERAPY, AND REALITY THERAPY)   Cognitive–behavioral approaches look at how cognitions and/or behaviors affect personality development, behaviors, and emotional states. All of these approaches believe that cognitions and/or behaviors have been learned and can be relearned. They tend to spend a limited amount of time examining the past, as they focus more on how present cognitions and

behaviors affect the individual's feelings, thoughts, actions, and physiological responses. They all believe that after identifying problematic behaviors and/or cognitions, one can choose, replace, or reinforce new cognitions and behaviors that result in more effective functioning. These approaches tend to be shorter than the psychodynamic or existential–humanistic approaches.

EXISTENTIAL–HUMANISTIC APPROACHES (EXISTENTIAL THERAPY, GESTALT THERAPY, AND PERSON-CENTERED COUNSELING)   Loosely based on the philosophies of existentialism and phenomenology, these approaches were particularly prevalent during the latter part of the twentieth century but continue to be widely used today. Existentialism examines the kinds of choices one makes to develop meaning and purpose in life, and, from a psychotherapeutic perspective, suggests that people can choose new ways of living at any point in their lives. Phenomenology is the belief that each person's reality is unique and that to understand the person, you must hear how that person has come to make sense of his or her world. These approaches tend to focus on the "here and now" and gently challenge clients to make new choices in their lives. Although generally shorter-term than the psychodynamic approaches, these therapies tend to be longer-term than the cognitive–behavioral approaches.

POST-MODERN APPROACHES (NARRATIVE THERAPY AND SOLUTION-FOCUSED BRIEF THERAPY)   Narrative therapy and solution-focused brief therapy are recent additions to the therapeutic milieu and are based on the philosophies of social constructivism and post-modernism. Social constructivism suggests that individuals construct meaning in their lives from the discourses they have with others and the language that is used in their culture and in society. Post-modernism suggests that all reality should be questioned. Those with this philosophy even doubt many of the basic assumptions of past popular therapies, which suggest that certain structures cause mental health problems (id, ego, superego, core beliefs, lack of internal locus of control, etc.). Rather than harp on past problems that tend to be embedded in oppressive belief systems, post-modern approaches suggest that clients can find exceptions to their problems and develop creative solutions. Post-modern approaches tend to be short-term therapies, with solution-focused brief therapy being considered a particularly brief approach, sometimes lasting fewer than five sessions.

Author Index

Subject Index