Counseling as a profession has an interesting history and encompasses a number of basic premises and foundational perspectives in which the counselor needs to be educated. This section provides the beginning counseling student with an overview of both the historical context of counseling and the philosophical basis on which the counselor operates. It introduces the counseling student to not only the process of counselor–client interaction, the helping relationship, but also information dealing with diversity issues in counseling and with ethical and legal considerations. It also provides the student with important information on research and writing in counseling, as well as on technology and counseling.

The development of counseling as a distinct profession is outlined in Chapter 1, “The Counseling Profession: Historical Perspectives and Current Issues and Trends.” It traces the roots of counseling from the vocational guidance movement at the beginning of the 20th century to the current status of professional associations, legislation, certification, licensure, accreditation, and current issues and trends related to counseling.

Chapter 2, “The Helping Relationship,” presents to students the characteristics and qualities that distinguish helping professionals. Essential components of the helping relationship and personal qualities that effective helpers possess are described, as well as basic and advanced skills and concepts pertinent to the development of a safe and productive counseling relationship. These core skills—and the corresponding integration of case study material—provide a foundation for the beginning counselor to both understand the counseling process and become more self-aware about his or her own interpersonal interactions.

Most counselors, regardless of their particular work setting or client population, will need to confront the issue of effective multicultural counseling. Chapter 3, “Counseling People of Color,” presents a 21st-century paradigm for responding to the challenges and opportunities in counseling people of color. Demographics, history, race and ethnicity, an exploration of the “cross-cultural zone,” ethical considerations, and guidelines for ethnically responsive counseling are discussed to provide the beginning professional with an excellent introduction to the topic.

The relationship between the client and the counselor does not exist in a vacuum; rather, it is ingrained in the personal, legal, and ethical context of our society.
Counselors are often called upon to make decisions regarding clients when the “correct” mode of action may not be immediately clear. There may be two contradictory obligations—for example, the obligation to respect the confidentiality of a client and the obligation to protect that client from self-harm or from harming others. When faced with situations such as this, the counselor cannot rely simply on personal judgment but, instead, needs to act on the basis of the professional guidelines and codes of ethics of the counseling and human development professions. Chapter 4, “Ethics and the Beginning Counselor: Being Ethical Right from the Start,” provides an overview of the ethical and legal guidelines on which counselors must base their decisions. It discusses the role of personal values versus professional ethics, the question of counselor competence, clients’ rights, confidentiality (including HIPAA and the “Privacy Rule”) and informed consent, and the practicalities of dealing with legal issues and client-related litigation. The chapter also reflects the increasing commitment among members of the profession to respect the diversity of our clientele. Such concepts are essential for the beginning counselor to understand and incorporate in gaining a sense of the professional status of the counselor.

Research and writing are major components of the experience of counselor education students in graduate programs all over the country. The fifth chapter in this text, “Research and Writing in Counseling,” provides the beginning student with invaluable information about the integration of research, practice, and theory; the definition of research; how to access databases; the differences between and value of both quantitative and qualitative research; guidelines for writing a term paper and developing thesis and dissertation proposals; and the ethics of writing and conducting research. This chapter is critical to the future success of all those working toward the completion of an advanced degree.

The use of technology in counseling and the possibilities for information retrieval presented by the World Wide Web is a topic of growing importance to counselors in all settings. Chapter 6, “Technology and Counseling,” overviews information related to technology and its applications to counseling. Cybercounseling and distance counseling, computer-assisted counseling, technology in assessment and diagnosis, technological aids for client interventions, technologically based resources for counselors and clients, using technology for client–therapist referrals, technology in counselor supervision, technology and continuing education units, technology-aided counselor communication, and the paperwork and scheduling applications are all discussed. The content of this chapter underscores the importance of technology to the success of the counseling practitioner; it also addresses positives, negatives, and ethical issues connected with the counseling applications of technology.
CHAPTER 1

The Counseling Profession: Historical Perspectives and Current Issues and Trends

HARRIET L. GLOSOFF, PhD

University of Virginia

Historical and Formative Factors

If one assumes that counseling is advising, counselors have existed since people appeared on earth. Mothers, fathers, friends, lovers, clergy, and social leaders all provide such counsel—whether sought after or not. The idea of a professionally trained counselor is relatively new. This idea did not, however, emerge because of the recognition of a “deep need within human development” (Stripling, 1983, p. 206). The counseling profession evolved in response to the demands made by the industrialization and urbanization of the United States. At the turn of the 20th century, America faced a confluence of social and economic problems, such as the proper distribution of a growing workforce, an increasingly educated population, the needs of immigrants, and the preservation of social values as family connections were weakened (Aubrey, 1982; Herr, 1985).

A representative democracy demands an educated citizenry taking responsibility for the government itself. As the new democracy developed, so did the ideal of education for all citizens. Toward the end of the 19th century, the curriculum of schools began to change, and choices among school subjects became available. Help with such choices was necessary. Jessie Davis, one of the pioneers in counseling, declared in his autobiography that he had graduated from school “fairly well prepared to live in the

I would like to extend my gratitude and appreciation to Perry Rockwell Jr., PhD, professor emeritus of Counselor Education at the University of Wisconsin at Platteville. His pioneer work in the historical underpinning of guidance and counseling in the United States formed the bases for the first edition of this chapter. I also would like to thank Scott Barstow, director of public policy for the American Counseling Association, for information on federal legislation enacted since the last edition of this chapter.
Middle Ages” (Davis, 1956, p. 57). His experiences led directly to the establishment of guidance and counseling services in schools. Other factors were providing pressures that made the evolution of professionally training individuals to help people make choices inevitable. The industrial revolution and its attendant job specialization and technologic advances were some of those pressures. There was also an increase in democracy after the Civil War ended in 1865. If the United States had continued to exist as a slave society or a closed class society, there probably would have been little need for the development of counseling services.

The population of the country was on the increase, and the census of 1890 revealed that the frontier was essentially closed. Larger cities were growing increasingly more crowded, and immigrants to the United States and other citizens could no longer move westward without regard for others. “Free” land was all but gone. It became necessary to remain near the cities to work, to live, and to get along with one’s neighbors. Providing assistance in the choices necessary to live in the large industrially based cities became necessary.

During the 20th century, the development of professional counseling in the United States was influenced by a variety of factors. The newly developed science of psychology began, and continued, studying the differences among individuals. Instruments for appraising people were in their infancy but were known to pioneers in the field, who noted the need for counseling services. As these tools developed more sophistication, they were adapted and/or adopted by counselors. Other factors contributing to the evolution of counseling included the work of leaders of the early settlement house movement and other social reformers; the mental hygiene movement; the extent to which Americans value personal success; the emphasis placed on the awareness and use of one’s talents, interests, and abilities; the ongoing industrialization of the country; the continued growth of career education and career guidance; the development of psychology as a profession; and the rapid changes in all fields due to the increased availability of technology (Shertzer & Stone, 1986).

Pressures from various socioeconomic factors also led to the kaleidoscope we know as counseling today. The history of counseling has continued the thread of individual choice in a society that prizes freedom to choose as an ideal. Like a kaleidoscope, the form, emphasis, and brightness of various aspects of counseling have changed as society changes. This chapter examines the following select facets of that kaleidoscope that have shaped the counseling profession:

- The vocational guidance movement
- The mental health counseling movement
- The development of professional identity
- The influence of federal legislation
- The history of the American Counseling Association
- Credentialing and the “professionalization” of counseling

The chapter concludes with a brief review of current issues and trends in the counseling profession.
Beginnings of the Vocational Guidance Movement

Perhaps the earliest notion of professional counseling in response to societal pressures was that of Lysander S. Richards. In 1881, Richards published a slim volume titled *Vocophy*. He considered vocophy to be a “new profession, a system enabling a person to name the calling or vocation one is best suited to follow” (Richards, 1881). His work has been dismissed because there is no documented proof that he actually established the services he advocated. Nevertheless, his ideas foreshadowed what was to come. He called his counselors “vocophers” and urged that they study occupations and the people they counseled.

Richards (1881) included letters from various famous people of the day in his book *Vocophy*. He believed that aspirants to particular occupations should consider what successful people had to say about the qualifications for success in that field. Letters from Grant, Longfellow, Westinghouse, and others, which described the ingredients for success in their occupations, were included in the book.

Later, a series of pamphlets published by the Metropolitan Life Insurance Company in the 1960s and used widely by school counselors asked the question, “Should your child be a ———?” A famous person in a field would describe what was necessary for success in that field. Using successful people to provide career information is a technique employed by counselors today as well.

Richards also seemed advanced for his time regarding his views of women and youth and their work. He said that if a woman could do the work “though at present solely followed by man, there can be no objections, whether normally or religiously considered, to her following it” (Richards, 1881, preface). He deplored the drifting of youth from job to job without consideration of what would be best for them and for society.

Whether Richards influenced those who followed is speculative. Influence is the quicksilver of history. He was active in the literary societies in the Boston area, as was Frank Parsons. Did they meet? Did they debate? Richards’s *Vocophy* was in the Harvard Library in the 1890s. In an article published in the later 1890s, Parsons (1894) expressed ideas similar to those of Richards. Brewer (1942) noted that Meyer Bloomfield, a colleague of Parsons at the Breadwinners Institute, mentioned Richards in his Harvard courses, as did Henry C. Metcalf of Tufts and Frank Locke of the YMCA in Boston.

Frank Parsons

Regardless of who influenced whom, the need for counseling about vocational choice seems to have permeated American society of the late 19th and early 20th centuries. There is no question of the credit given to Frank Parsons for leading the way to vocational guidance. Parsons had a long history of concern for economic and political reforms that would benefit people. He published books and articles on a wide variety of topics, including taxation, women’s suffrage, and education for all people. Of all his endeavors, Parsons was most interested in social reform and especially in assisting people to make sound occupational choices. Other pioneers in the field credited him...
with being the first counselor (Davis, 1914; Reed, 1944), and he has often been referred to as the “father of guidance.” Parsons alone, of those individuals who had some direct connection with the organization and extension of guidance services, had a definite, well-thought-out, and organized social philosophy, which he articulated often and at length (Rockwell, 1958).

Parsons was one of the many in the late 19th and early 20th centuries who were striving to make the world a better place in which to live. These people saw in the growth of large private fortunes, based on industrial might and the resultant political power, a clear danger to the realization of a more perfect society based on the brotherhood of all humankind. They were humanitarian s all, each seeking the good things in life for the individual within society. Parsons found himself in the company of such notables of this movement as Henry D. Lloyd, Edward Bellamy, Phillip Brooks, and Benjamin O. Flower (Rockwell, 1958). Parsons believed it was better to select a vocation scientifically than to drift through a variety of vocations, perhaps never finding one that would be best for the person and, thus, make society better. Meyer Bloomfield, director of the Civic Service House in Boston, asked Parsons to establish such a service within the Civic Service House. Thus, Parsons became director of what was called the Breadwinners Institute from 1905 through 1907 (Brewer, 1942). Parsons developed a plan for individualized counseling and opened the Vocational Bureau of Boston in January 1908. He served as its director and vocational counselor. The primary goal of the bureau was to develop the potential of Boston’s growing immigrant population. Although Parsons was but one of many who were seeking social reforms at this time, he was able to secure the support of the leaders of powerful groups in business, labor, education, and politics. His report to the members of the board controlling the Vocational Bureau was the first recorded instance of the use of the term vocational guidance. (Brewer, in 1942, published the report as an appendix to his History.) Parsons’s report emphasized that counseling was not designed to make decisions for counselees. “No attempt is made, of course, to decide FOR [sic] the applicant what his calling should be; but the Bureau tries to help him arrive at a wise, well-founded conclusion for himself” (Brewer, 1942, p. 304). According to Williamson (1965), this was consistent with the moral and intellectual atmosphere of that time. He traced the growth of counseling before Parsons’s work to the concept of “vocational freedom of choice” (p. 3). He noted that the climate of the late 1800s stimulated practical application of vocational choice or individuals’ freedom to pursue choice in personal development.

Parsons also developed a plan for the education of counselors. His plan was outlined in his book Choosing a Vocation (1909), published posthumously. Parsons’s prescriptions for how counselees should examine themselves and their lives reflected his political and social philosophy (Rockwell, 1958, pp. 74–130).

**Early Ties Between Vocational Guidance and School Counseling**

Many see educational settings as the first homes to the profession of counseling, especially in terms of vocational guidance. In 1898, at about the same time that Parsons
opened the Vocational Bureau, Jesse Davis began advising students about educational and vocational matters (Aubrey, 1982). Jessie B. Davis had been unsure of what he wanted to do with his life throughout his educational career. He was questioned thoroughly by Charles Thurber, one of his professors at Cornell University, and that left a lasting impression on him. He began to use the professor’s methods in his work with students at the Central High School in Detroit and attempted to incorporate guidance into the normal educational experience of students. In 1907, Davis became principal of the Grand Rapids, Michigan, Central School and was able to implement his ideas of self-study, occupational study, and examination of self in relation to the chosen occupation throughout the 7th through 12th grades (Brewer, 1942). This was done primarily through essays written in English classes. Essay topics varied from self-examination of values and ideals to the selection of a vocation by the 12th grade. Throughout the topics, social and civic ethics were emphasized (Davis, 1914). Just five years later (1912), Grand Rapids established a citywide guidance department.

Grand Rapids was not the only city in the early 1900s that housed newly developed vocational guidance services. Both Anna Y. Reed in Seattle and Eli Weaver in New York established counseling services based on Social Darwinian concepts (Rockwell, 1958). Similar to Darwin’s biological theory of “survival of the fittest,” Social Darwinism contends that certain groups in a society become powerful because they have adapted best to the evolving requirements of that society. Reed decided that counseling services were needed for America’s youth through her study of newsboys, penal institutions, and charity schools. She emphasized that business people were the most successful and that counseling should be designed to help youth emulate them. She equated morality and business ideals and was much concerned that whatever course of action was taken on any social question should be taken on the basis of social research, of economy, and of how it would be accepted by the business world. Reed urged that schools keep children focused on the potential for making money, which she believed every pupil could understand (Reed, 1916).

The guidance services that Reed developed were similar to those of modern placement agencies that focus on an individual’s acceptability to employers. Other programs, she said, “savored too much of a philanthropic or social service proposition and too little of a practical commercial venture” (Reed, 1920, p. 62).

Eli Weaver also believed in working within the framework of the existing society and looked on counseling as a means of keeping the wheels of the machinery well oiled. He was chairman of the Students’ Aid Committee of the High School Teachers’ Association of New York in 1905. In developing the work of his committee, Weaver concluded that the students were in need of advice and counsel before their entrance into the workaday world. He had no funds or active help from school authorities but was able to secure the volunteer services of teachers to work with young people in New York. By 1910, he was able to report teachers actively attempting to aid boys and girls discover what they could do best and how to secure a job in which their abilities could be used to the fullest advantage (Brewer, 1942; Rockwell, 1958).

Counselors in the school systems of Boston and New York during the 1920s were expected to assist students in making educational and vocational choices. It was during the 1920s that the certification of school counselors began in these two cities.
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It was also during that decade that the Strong Vocational Interest Inventory was first published (1928) and used by counselors, setting the stage for future directions in career counseling (Shertzer & Stone, 1986).

The Creation of the National Vocational Guidance Association

The early pioneers in counseling clearly reflected society’s need for workers who were skilled and happy in what they did. A distinct influence in early counseling was the vocational education movement. In 1906, the National Society for the Promotion of Industrial Education (NSPIE) was formed. Advocates of vocational counseling served on its board and later on the board of the Vocation Bureau established by Parsons. Ralph Albertson, an employment supervisor at William Filene’s Sons Company and confidant of Frank Parsons, became secretary of the board of trustees of the Vocation Bureau (Stephens, 1970). Frank Snedden, a vocational educator from Massachusetts, is given credit for suggesting that a vocational guidance conference separate from the NSPIE be held (Brewer, 1942). Such conferences were held in 1911 and 1912.

At a third national conference in 1913, the National Vocational Guidance Association (NVGA) was formed in Grand Rapids, Michigan (Norris, 1954). Frank Leavitt became the first president and noted the economic, educational, and social demands for guidance and the counseling it entailed. He also felt that it was necessary “for the very preservation of society itself” (Norris, 1954, p. 17). Counseling in regard to career choice remained an integral part of the movement.

Beginnings of the Mental Health Counseling Movement

The economic, educational, and social reform forces that led to the organization of NVGA also led to other movements, which were later incorporated into the kaleidoscope we call counseling today. In the early 1800s, American reformers such as Dorothea Dix advocated for the establishment of institutions that would treat people with emotional disorders in a humane manner. Although these reformers made great strides in accomplishing their goals, following the Civil War there was a rapid decline in the conditions related to the humane treatment of institutionalized individuals (Palmo & Weikel, 1986).

Clifford Beers, who had suffered harsh treatment for mental illness in several psychiatric institutions, published *A Mind That Found Itself*, an autobiography about his experience (Beers, 1908). Publication of this book served as a catalyst for the mental hygiene movement and studies of people with emotional and behavior problems. Early studies of children with emotional problems supported the concept of providing counseling for all children in schools. Beginning at about the same time as vocational guidance, the mental hygiene movement and the field of psychology have had equally strong influences on the development of professional counseling. In 1908, the same year Frank Parsons opened the Vocational Bureau, William Healy, a physician, established the first community psychiatric clinic. The Juvenile Psychopathic Institute was founded to provide services to young people in Chicago who were having problems. The institute
used testing, modified psychoanalysis, and involvement of family members. In 1909, leaders of Cook County, Illinois, deciding that counseling services would benefit children, established countywide child guidance clinics. In this same year, the U.S. Congress founded the National Committee on Mental Hygiene.

Early Psychologists

Wilhelm Wundt must be credited with establishing, in the late 1870s in Germany, the first experimental psychology laboratory. One way that Wundt endeavored to study how the mind is structured was by using a form of introspection or asking subjects to use self-reflection and to verbalize what they were experiencing (Belkin, 1988).

In the United States, William James modified Wundt's approach and tried to discover the functions of the mind, rather than focusing primarily on its structure. James believed that individuals function as holistic beings who used thoughts, reasoning, emotions, and behaviors. James and his followers are referred to as “functionalists,” and they developed experimental designs to facilitate understanding why human beings' minds function as they do (Belkin, 1988). James's interest in the ideas of “adaptive functioning,” “free will,” and the conscious functioning of individuals is clearly pertinent to the development of the counseling profession. A scientific approach to social problems had become popular in the late 19th and early 20th centuries. Granville Stanley Hall founded what many consider the first psychology laboratory in the United States in 1883 at Johns Hopkins University, where he focused on collecting data on the mental characteristics of children (Belkin, 1988). His study of the development of children's mental and physical abilities continued under his tenure as president of Clark University, where he emphasized graduate study and research. The scientific approach to social problems was based on the assumption that the answer to a social problem could be discovered through objective research. Many consider G. Stanley Hall the “father of American psychology” (Belkin, 1988, p. 15). Even though his work itself has not endured, in addition to founding one of the first psychology departments, G. Stanley Hall was also the primary person to organize the American Psychological Association (APA), and he bestowed the first doctorates in the field of psychology. Of course, the early behaviorists, such as John Watson and B. F. Skinner, and experimental psychologists, such as Max Weber and Wolfgang Kohler, are also associated with the development of the field of psychology.

David Spence Hill, who organized the first guidance and counseling services in New Orleans, was a graduate of Clark University during the presidency of G. Stanley Hall. As director of research for the New Orleans schools, he discovered a need for guidance while researching whether there was a need for a vocational school in his district (Rockwell, 1958). He concluded that there was a need for such a high school, and he also believed it necessary to assist youth in assessing their abilities and in learning about the opportunities that would best help them use those skills. He was aware of Binet's appraisal work and attempted to use the Binet tasks in helping the students in the New Orleans schools. He realized the need for counseling because of his belief that the education of an individual must be of the highest order. Counseling based on scientific research would help secure the best education for each pupil. If counselors were to help youth know themselves and match their characteristics with qualifications
for jobs, some means of measuring individual characteristics was necessary. Counselors relied a great deal on questioning youth about their abilities and their desires, with the implicit assumption that counselees know themselves and can reason about their reported skills and their qualifications for jobs. A counselor’s task was to help them in this process by using greater maturity and objective judgment. The development of tests and appraisal instruments lent a scientific air to the process.

During the late 1800s and early 1900s, the testing movement was also taking hold. In the 1890s, James Cattell was the first person in this country to focus on ways to measure intelligence. In 1894, he introduced the first mental abilities test, which was administered to freshmen entering Columbia University (Goldenberg, 1973).

In 1905, the Binet-Simon Test was introduced in France. In 1916, L. M. Terman of Stanford University released a revised version of the Binet-Simon Test he had developed, titled the Stanford-Binet Test. With the release of the Stanford-Binet Test, the term *intelligence quotient* or *IQ* was first used. Although the development of the Stanford-Binet certainly helped spearhead the testing movement in the United States, it was World War I that truly gave flight to the development and use of standardized instruments (Baruth & Robinson, 1987).

**Influences of World War I and the Development of Testing**

World War I influenced the counseling profession’s roots in both the vocational guidance and mental health arenas. The Army, in order to screen personnel, commissioned the development of psychological instruments, including the Army Alpha and Beta IQ tests of intelligence. In the period following World War I, the number and variety of such instruments proliferated, and even though counselors were not the major creators of the instruments, they became users. Counselors began to use standardized instruments as tools for use in military, educational, and clinical settings. These screening tools also supported the development of aptitude and interest tests used by counselors in business and educational settings (Aubrey, 1982). Quantifying a person’s intelligence, aptitude, achievement, interest, and personality gave a great deal of credibility to a counselor’s judgment about the person (Ginzberg, 1971).

After World War I, psychological testing became pervasive in industrial personnel classification, in education, and in counseling offices. Knowledge about and skill in using standardized tests became part of the education of a counselor. Data derived from appraisal instruments were used to make better judgments about counselees and to advise them about what decision was the wisest to make. Large commercial producers of psychometric devices emerged. The process of developing and marketing tests to industry, education, government, and counselors in private practice became quite sophisticated. Counselors were expected to be experts in selecting and using appropriate instruments from a myriad of those offered. Their use in the counseling process became such that testing and counseling were often considered synonymous.

The practice of using tests in counseling was not without controversy. Criteria for psychometric instruments used in decision making were not published until 1954, with the publication of the American Psychological Association’s *Technical Recommendations*...
for Psychological Tests and Diagnostic Techniques (Stephens, 1954). Publications such as Testing, Testing, Testing (Joint Committee on Testing, 1962), The Educational Decision-Makers (Cicourel & Kitsuse, 1963), and The Brain Watchers (Gross, 1962) are examples of many voices questioning counselors and others’ reliance on test data.

Beginnings of Professional Identity

The Great Depression and the Continuation of the Career Guidance Movement

There was continued progress in the development of career counseling during the 1930s. The Great Depression, with its loss of employment for millions of people, demonstrated the need for career counseling to assist adults as well as youth to identify, develop, and learn to market new vocational skills (Ohlsen, 1983). At the University of Minnesota, E. G. Williamson and colleagues modified the work of Frank Parsons and employed it in working with students. Their work is considered by some to be the first theory of career counseling, and it emphasized a directive, counselor-centered approach known as the “Minnesota point of view.” Williamson’s approach continued to emphasize matching individuals’ traits with those of various jobs and dominated counseling during most of the 1930s and 1940s. The publication of the Dictionary of Occupational Titles in 1938 provided counselors with a basic resource to match people with occupations for which they were theoretically well suited (Shertzer & Stone, 1986).

The concept that society would be better if individuals and their occupations were matched for greater efficiency and satisfaction continued to shape the vocational guidance movement. There was a plethora of organizations dedicated to this end. In 1934, a number of them met to form the American Council of Guidance and Personnel Associations, or ACGPA (Brewer, 1942, p. 152), including the American College Personnel Association, the National Association of Deans of Women, the National Federation of Bureau of Occupations, the National Vocational Guidance Association, the Personnel Research Foundation, and the Teachers’ College Personnel Association. By 1939, the name was changed to the Council of Guidance and Personnel Associations (CGPA), and other groups were added: the Alliance for the Guidance of Rural Youth, the International Association of Altrusa Clubs, the National Federation of Business and Professional Women’s Clubs, the Western Personnel Service, the American Association of Collegiate Registrars (withdrew in 1941), the Institute of Women’s Professional Relations, the Kiwanis International, and the Association of YMCA Secretaries met with the group from time to time.

Brewer (1942) stated that the October 1938 issue of Occupations, the publication of the NVGA, listed 96 organizations interested in furthering vocational guidance among the young people of the nation. Counseling per se was coming to the forefront of concerns within the vocational guidance movement. All groups seemed dedicated to placing “square pegs in square holes” through the use of tests.

During the 1950s, the U.S. government was particularly interested in issues related to vocational guidance or career guidance. In response to the Soviet Union’s successful space program (for example, the launching of Sputnik), the government became concerned with identifying young people with scientific and mathematical talent. To this end, they passed the National Defense Education Act (NDEA) in 1958.
Some contend that the impact of NDEA goes well beyond funding of vocational guidance programs. Hoyt stated that NDEA “had a greater impact on counselor education than any other single force” (1974, p. 504). NDEA funded the training of guidance counselors at both the elementary and secondary levels, and NDEA training programs were established to produce counselors qualified for public schools (Herr, 1985). Although the legislation established counselor education programs specifically to train professionals to identify bright children and steer them into technical fields, these counselors were also trained in other domains of counseling as well.

Influence of World War II

World War II strongly influenced the confluence of the vocational guidance and mental health movements, along with that of rehabilitation counseling. The U.S. government continued to rely on standardized instruments and classification systems during World War II. The government requested that psychologists and counselors aid in selecting and training specialists for the military and industry (Ohlsen, 1983). Before and during World War II, millions of men and women were tested and assigned to particular duties according to their test scores and their requests. The armed forces stationed counselors and psychologists at many induction and separation centers. Picchioni and Bonk (1983) quote Mitchell Dreese of the adjutant general’s office as saying that counseling “is essentially the same whether it be in the home, the church, the school, industry, business or the Army” (p. 54). The process was certainly an extensive use of the scientific approach to counseling. Society, through its representatives in government, had become embroiled in what counseling should be and what it should become. Society has not relinquished that sense of involvement through all the forms, shapes, and colors of the kaleidoscope counseling had become.

The use of standardized tests is not the only reason World War II had a tremendous influence on the counseling profession. Personnel were also needed on the front lines and in aid stations to help soldiers deal with “battle neuroses.” This was accomplished through minimum training and what seemed to be an “overnight” credentialing of new medical school graduates and research-oriented clinical psychologists. Even though minimally trained, their interventions resulted in a significant reduction of chronic battle neuroses (Cummings, 1990).

In 1944, the War Department established the Army Separation-Classification and Counseling Program in response to the emotional and vocational needs of returning soldiers. The Veterans Administration (VA) also established counseling centers within their hospitals (Shertzer & Stone, 1986). The VA coined the term counseling psychology and established counseling psychology positions and training programs to fill these positions. The National Institute of Mental Health (NIMH) was established just after World War II and established a series of training stipends for graduate programs in professional psychology. NIMH reinforced the VA’s standard of the doctorate being the entry level into professional psychology by setting up PhD training stipends. The American Psychological Association (APA) was asked to set standards of training for the new programs in university graduate schools. Although the goal of the VA and NIMH was to train counseling psychologists for the public sector, more and more trained psychologists chose to enter private practice.
In addition, during the 1940s a trend toward working with the psychological problems of “normal people” emerged. In reaction to the Nazi movement and World War II, humanistic psychologists and psychiatrists came from Europe to the United States. Their work gradually influenced the strong quantitative leanings in counseling and contributed to the work of well-known psychologists such as Rollo May, Abraham Maslow, and Carl Rogers.

Carl Rogers and the Continuation of the Mental Health Movement

In reviewing a history of what has happened, it is often difficult to know whether events have shaped a leader of an era or whether a person has influenced events. There seems little doubt that Carl R. Rogers, his ideas, and his disciples affected counseling from its core outward. Rogers’s idea was that individuals had the capacity to explore themselves and to make decisions without an authoritative judgment from a counselor. He saw little need to make diagnoses of client problems or to provide information or direction to those he called clients. He emphasized the importance of the relationship between the counselor and client. In his system, the client rather than the counselor was the most important factor. Because no advice was given or persuasion used to follow a particular course, Rogers’s system became known as nondirective counseling. Rogers became interested in the process of counseling and pioneered the electronic recording and filming of counseling sessions, an unheard-of idea at that time. Working in the academic environment of Ohio State University and the University of Chicago, Rogers published his ideas in Counseling and Psychotherapy: Newer Concepts in Practice in 1942 and Client-Centered Therapy in 1951.

It is not the purpose of this chapter to delineate all the postulates of what became known as client-centered counseling and, later, person-centered counseling. It is important to note, however, the impact that approach had on counseling has continued to the present day. The rise to prominence of Carl Rogers’s theory was the first major challenge to the tenets of the Minnesota point of view. In fact, many programs at counseling conventions debated the issue of client-centered versus trait-factored counseling.

Rogers himself remained within the scientific approach to counseling. His concern was to learn what went on in the counseling process, to learn what worked (for him) and what did not. His was a search for necessary and sufficient conditions under which effective counseling could take place. Whenever research about client-centered counseling was reported by Rogers, it was supported by psychometric data. Certainly one of the effects of Rogers on the profession was to emphasize understanding the counseling process and the need for research. The ensuing debates about the primacy of feeling or rationality as a proper basis of counseling stimulated professional counselors to research their processes and techniques. Theories were refined, and new instruments for determining their efficacy were developed. Counselors in training became as familiar with recording devices as they were with textbooks.

Aubrey (1982) noted that “without doubt, the most profound influence in changing the course and direction of the entire guidance movement in the mid and late 1940s was Carl Rogers” (p. 202). Rogers built on the humanistic and individualistic
foundations of the education guidance movement in which he was trained at Columbia
University by formulating the nondirective client-centered approach to counseling.
He brought a psychologically oriented counseling theory into the guidance move-
ment, thus grounding the counseling profession in the broad disciplines of education
and psychology (Weikel & Palmo, 1989).

Federal Legislation and Its Influence
on the Counseling Profession

The Great Depression prompted the development of government-sponsored programs
that included a counseling component with an emphasis on classification. Both the Civil-
ian Conservation Corps (CCC) and the National Youth Administration (NYA) attempted
to help youth find themselves in the occupational scene of the 1930s (Miller, 1971). In
1938, the George-Dean Act had appropriated $14 million for vocational education, and
by 1938 the Occupational Information and Guidance Services was established. The fed-
eral government became influential in the field of counseling and remains so today.

The following list exemplifies how the federal government has influenced the
development of the counseling profession by offering examples of governmental
actions and legislation. Primary sources of this information include American Coun-
seling Association legislative briefing papers available from the ACA Office of Public
Policy and Information, S. Barstow (personal communication, August 25, 2003; May
15 and June 15, 2007), Baruth and Robinson (1987), and Vacc and Loesch (1994). This
is not an exhaustive list of all legislation that has influenced professional counseling
and counseling services. In addition, many of these acts (e.g., Rehabilitation Act, No
Child Left Behind) must be reauthorized on a regular basis. I have noted only major
revisions to the original bills enacted, rather than listing each reauthorization.

1917  The Smith-Hughes Act created federal grants to support a nationwide
      vocational education program.
1933  The Wagner-Peyser Act established the U.S. Employment Services.
1936  The George-Dean Act continued the support established by the Smith-
      Hughes Act.
1938  The U.S. Office of Education established the Occupational and Informa-
      tion Guidance Services Bureau that, among other things, conducted
      research on vocational guidance issues. Its publications stressed the need
      for school counseling.
1944  The Veterans Administration established a nationwide network of guid-
      ance services to assist veterans. The services included vocational rehabili-
      tation, counseling, training, and advisement.
1944  The U.S. Employment Service was begun under the influence of the War
      Manpower Commission. Fifteen hundred offices were established, and
      employment “counselors” were used.
1946  The George-Barden Act provided government support for establishing
      training programs for counselors. The emphasis was on vocational guid-
      ance and established a precedent for funding training for counselors.
1946  The National Institute of Mental Health (NIMH) was established just after World War II, and the National Mental Health Act passed in 1946 authorized funds for research, demonstration, training, and assistance to states in the use of effective methods of prevention, diagnosis, and treatment of people with mental health disorders.

1954  *The Vocational Rehabilitation Act* (VRA) recognized the needs of people with disabilities. The VRA was a revision of earlier vocational rehabilitation acts and was prompted, in part, by the government’s attempts to meet the needs of World War II veterans. It mandated the development of counselors who specialized in assisting persons with disabilities and allocated funds for training these counselors.

1955  *The Mental Health Study Act* of 1955 established the Joint Commission on Mental Illness and Health.

1958  As noted previously, the emphasis of the National Defense Education Act (NDEA) was on improving math and science performance in our public schools; counseling in the schools was seen as an important function in helping students explore their abilities, options, and interests in relation to career development. Title V of this act specifically addressed counseling through grants to schools to carry out counseling activities. Title V-D authorized contracts to institutions of higher education to improve the training of counselors in the schools.

1962  *The Manpower Development Training Act* established guidance services to individuals who were underemployed and/or economically disadvantaged.

1963  *The Community Mental Health Centers Act*, an outgrowth of the Mental Health Study Act, is considered by many to be one of the most crucial laws dealing with mental health that has been enacted in the United States. The act mandated the creation of more than 2,000 mental health centers and provided direct counseling services to people in the community as well as outreach and coordination of other services. The Community Mental Health Centers Act also provided opportunities for counselors to be employed outside educational settings.

1964  *The Amendment to the National Defense Education Act* of 1958 continued to affect counseling through the addition of counselors in the public schools, especially elementary schools, aimed at reducing the counselor–student ratio.

1965  *The Elementary and Secondary Education Act* (ESEA) did much to develop and expand the role of the elementary school counseling program and the services provided by the elementary school counselor.

1972  Title IX of the Education Amendments to the 1964 Civil Rights Act mandated that no one be discriminated against or excluded from participating in any federally funded educational program or activity on the basis of sex. It also prohibited sex-biased appraisal and sex-biased appraisal instruments.

1975  *Public Law (P.L.) 94-142*, also known as the Education for All Handicapped Children Act, mandated guidelines for the education of exceptional children in public schools. It declared that all children, regardless
of their disabilities, were entitled to an appropriate free public education. Counselors became instrumental in designing, implementing, and evaluating the individualized education plans that were required for each student with special needs.

1976  
*P.L. 94-482* extended and revised the Vocational Education Act of 1963 and its 1968 amendments. It directed states to develop and implement programs of vocational education specifically to provide equal education opportunities to both sexes and to overcome sex bias and stereotyping. It also specified that funds must be used in vocational education for individuals who are disadvantaged, had limited English proficiency, and/or had handicapping conditions.

1977  
Sections 503 and 504 were added to the civil rights law typically known as the Rehabilitation Act of 1973. Section 503 mandates all employers conducting business with the federal government (meeting specific criteria) to take affirmative action in the recruitment, hiring, advancement, and treatment of qualified persons with disabilities. Section 504 notes that no qualified person (spanning all age ranges) who is disabled may be discriminated against in any federally assisted program.

1977  
President Carter established the President’s Commission on Mental Health.

1979  
The Veterans’ Health Care Amendments called for the provision of readjustment counseling and related mental health services to Vietnam-era veterans.

1980  
The Mental Health Systems Act stressed the need for balancing services in both preventive and remedial mental health programs. The act required the development of new services for children, youth, minority populations, older people, and people with chronic mental illness. The act was repealed during the same year it was passed because of the severe federal budget cuts for social programs during the first year of President Reagan’s term in office.

1981  
The Older Americans Act was enacted to improve the quality of life for many individuals who are 60 years old or older by authorizing a comprehensive social services program. The act provides assistance for creation and implementation of services, including counseling.

1984  
The Carl D. Perkins Vocational Education Act amended the Vocational Education Act of 1963. Its primary purpose was to help the states develop, expand, and improve vocational education programs. The act sought to include previously underserved people, such as those with disabilities, adults in need of training or retraining, and single parents. The legislation indicated that career guidance and counseling functions should be performed by professionally trained counselors. In addition, the entire act was filled with language that showed how important legislators believed counseling and career development services to be.

1990  
The Americans with Disabilities Act (ADA) prohibited job discrimination against people with disabilities. It also mandated that individuals with disabilities have the same access to goods, services, facilities, and accommodations afforded to all others.
1990 *The Carl D. Perkins Vocational Education Act* was reauthorized, setting directions for state and local agencies to develop vocational and applied education programs. It targeted single parents, displaced homemakers, and single pregnant women and noted that states were to use a certain percentage of their funds to provide basic academic and occupational skills and materials in preparation for vocational education and training to provide these people with marketable skills. In addition, states were required to use funds to promote sex equity by providing programs, services, and comprehensive career guidance, support services, and preparatory services for girls and women.

1994 *The School-to-Work Opportunities Act* set up partnerships among educators, businesses, and employers to facilitate the transition of students who plan on moving directly to the world of work from high school.

1995 *The Elementary School Counseling Demonstration Act* allocated $2 million in grant money for schools to develop comprehensive elementary school counseling programs.

1996 *The Mental Health Insurance Parity Act* (enacted in 1996 and effective January 1, 1998) prevents health plans that cover mental health services from placing unequal caps on the dollar amount covered (either annually or on a lifetime basis) for the provision of mental health services if these same caps are not placed on the coverage of other medical services. Although this act has several limitations, it was a major step toward parity of insurance coverage for mental health services. Some of these limitations include that health plans are not required to provide mental health benefits. Additionally, it does not prohibit health plans from requiring higher deductibles and copayments for mental health services or from placing strict limits on the number of days of treatment covered for mental health conditions. Further, health plans that experience a 1% increase in premiums as a result of the parity provision, as well as businesses with fewer than 50 employees, are exempt from the provision (ACA Office of Public Policy and Information, 1996).

1996 *The Health Insurance Portability and Accountability Act* (HIPAA, P.L. 104-191) included language to promote “administrative simplification” in the administration of health care benefits by establishing national standards for the electronic transmission of health information, for the use and disclosure of personally identifiable health information, and for the security of information. Although the standards do not contain any counselor-specific provisions, they have an impact on all counselors, both as providers of mental health services and as health care consumers.

1997 *The Balanced Budget Act* included provisions that prohibit Medicaid managed care plans from discrimination against providers on the basis of the type of license they hold. This did not extend to fee-for-service plans administered through Medicaid.

1998 *Higher Education Act Amendments* reauthorized higher education programs into law for another 5 years. In addition to dropping student loan
interest rates and increasing Pell Grant awards, the act created the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR-UP), which provides grants for establishing partnerships between colleges, schools, and community organizations. The provisions included payment for counseling services to certain at-risk and low-income students and other elementary, middle, and secondary school students. These services were specified to include counseling on financial aid, college admissions and achievement tests, college application procedures, and efforts to foster parental encouragement of students' interest in college education. In addition, the amendments allow for personal counseling, family counseling, and home visits for students with limited English proficiency. The act also sent a clear message against the use of drugs. It declared that students who are convicted of any state or federal offense for the possession or sale of a controlled substance will not be eligible to receive any grant, loan, or work assistance under the Higher Education bill (ACA Office of Public Policy and Information, 1998a).

1998 *The Health Professions Education Partnerships Act (HPEPA)* is a landmark piece of legislation. It recognizes professional counselors under health professional training programs. Specifically, education programs, counseling students and graduates, and counselor educators are eligible for a wide range of programs operated by the federal Health Resources and Services Administration (HRSA) and the federal Center for Mental Health Service (CMHS) to the same extent as other master's-level mental health professions. Where the term “graduate programs in behavioral and mental health practice” is referenced in these programs, the provisions passed in HPEPA include graduate programs in counseling (ACA Office of Public Policy and Information, 1998b).

1998 *The Workforce Investment Act (WIA)* revamped all job training programs in the country and reauthorized the Rehabilitation Act. According to the ACA Office of Public Policy and Information (1998c), the WIA streamlined requirements for the major federal grant programs that support training and related services for adults, dislocated workers, and disadvantaged youth. Under the WIA, all adults, regardless of income or employment status, became eligible for core services including skills assessments, job search assistance, and information on educational and employment opportunities.

The WIA mandated that states and local governments set up and maintain networks of “one-stop centers” in which consumers are afforded a single point of entry to federal job training and education programs, job market information, unemployment insurance, and other federal and state services and programs. The WIA required that training services for adults be delivered through vouchers. In addition, the programs are to be administered at the state level by a board. These boards, in turn, designate local service areas. The provisions call for existing JTPA (Job Training Partnership Act) service delivery areas with populations greater than 200,000 to be designated as service areas (as long as they met JTPA performance standards during the previous 2 years).
1998 Reauthorization of the Rehabilitation Act. As noted, the WIA reauthorized the Rehabilitation Act for another 5 years. The act funds state-administered vocational rehabilitation services for people with disabilities. In addition, the act funds research on rehabilitation and disabilities, training for rehabilitation counselors, independent living centers, advocacy services, and other initiatives that facilitate the employment of individuals with disabilities. The act upheld previous requirements that state agency professionals meet state or national certification or licensure requirements. This means that professional rehabilitation counselors need to hold a master's degree in rehabilitation counseling or a closely related field. The act extended this requirement to private contractors with state agencies. In addition, the act renamed Individualized Written Rehabilitation Plans as Individual Plans for Employment and expanded consumer choice and participation in these plans (ACA Office of Public Policy and Information, 1998c).

1999 The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (P.L. 106-554) included a section requiring the Medicare Payment Advisory Commission (MedPAC) to conduct a study on the appropriateness of establishing Medicare coverage of licensed professional counselors and other nonphysician providers, including marriage and family therapists and pastoral counselors. MedPAC issued a weakly written report recommending against covering licensed professional counselors, marriage and family therapists, and pastoral counselors in June 2002. Although MedPAC came to a negative conclusion, the language in P.L. 106-554 calling for the report marked the first time that Congress and the president had enacted legislation referencing licensed professional counselors with respect to Medicare.

1999 The Elementary School Counseling Demonstration Act was approved as part of the Omnibus Spending Package for fiscal year 2000. The act allocated $20 million for schools to hire qualified school counselors for school districts that are awarded 3-year grants by the Department of Education (ACA, 1999a).

1999 The Work Incentives Improvement Act (WIIA) may be the most significant federal law enacted for people with disabilities since the Americans with Disabilities Act passed in 1990 (ACA, 1999b). The WIIA removed many of the financial disincentives that prevented millions of people with disabilities from working. For example, it changed outdated rules that end Medicaid and Medicare coverage when people with disabilities enter or reenter the workplace. Among several provisions, the WIIA allowed people to buy into Medicaid when their jobs pay more than low wages but they may not have access to private health insurance. It also allowed people with disabilities to keep their Medicaid coverage even though their medical condition improved as a result of the medical coverage. In addition, it extended Medicare Part A coverage for people on Social Security disability insurance who return to work for another 4 and a half years. This results in a difference between monthly premiums of almost $350 (the cost of purchasing Part A and B coverage) and $45.50.
The WIAA also made major changes in the employment services systems for people with disabilities. People receiving SSI or SSDI benefits were allowed to choose among participating public and private providers of vocational rehabilitation and employment services who were paid a portion of the SSI or SSDI benefits if the person went to work and achieved “substantial earnings” (to be further determined through regulations not yet promulgated at the time this chapter was written).

2001 *Department of Defense Authorization Act* (P.L. 106-398) included language requiring the Tricare Management Authority to conduct a demonstration project allowing mental health counselors to practice independently, without physician referral and supervision. Licensed professional counselors are the only nationally recognized mental health professionals that Tricare requires to operate under physician referral and supervision. The demonstration project was expected to be concluded at the end of 2003, with a report to Congress by the Department of Defense to follow. Physician referral and supervision requirements for both marriage and family therapists and clinical social workers were removed by Congress following similar demonstration projects.

2001 *No Child Left Behind Act* (NCLB, P.L. 107-110) was a massive reauthorization of the federal education programs contained in the Elementary and Secondary Education Act and included language renaming the Elementary School Counseling Demonstration Program as the Elementary and Secondary School Counseling Program (ESSCP). This language both removed the “demonstration” tag from the program and expanded it to secondary schools. Under the NCLB language, the first $40 million appropriated for the program in any year must be devoted to supporting counseling programs and services in elementary schools.

2006 *The Veterans Benefits, Healthcare, and Information Technology Act* (P.L. 109-461) includes language establishing explicit recognition of licensed mental health counselors as health care professionals within the Department of Veterans Affairs (VA) health care programs. In addition to allowing the hiring of licensed professional counselors in clinical and supervisory positions with VA health care facilities, enactment of this provision should lead to the development of a position description for counselors by the Federal Office of Personnel Management, which would be applicable to all federal agencies.

**Continuing Development of Professional Identity**

**History of the American Counseling Association**

Vacc and Loesch (1994) noted that one way to understand the evolution of a profession is to study the history of a representative professional organization. The American
Counseling Association (ACA) has a rich history that exemplifies its representation of professional counselors. The philosophical development of the counseling profession can be seen by reviewing the three names by which ACA has been known, along with the times those name changes occurred. From its founding in 1952 until 1983, ACA was known as the American Personnel and Guidance Association (APGA). From 1983 until 1992, it was called the American Association for Counseling and Development (AACD). In 1992, the governing body of the association renamed it the American Counseling Association. For purposes of simplicity, the association will be referred to as ACA regardless of the time reference.

Although its official inception is noted as 1952, ACA can trace its organizational beginnings to the turn of the 20th century with the formation of one of its founding divisions, then the National Vocational Guidance Association. Its roots in vocational guidance, education, and psychology have made for an interesting, rich, and often rocky evolution of counseling as a profession unto itself, even before the founding of ACA. The NVGA had considered changing its name at least five times between 1922 and 1948 to better reflect the concern members had about the total adjustment of their clients (Norris, 1954). Members of the American Council of Guidance and Personnel Associations, a federation of associations, were also considering whether it was wise or efficient to attempt to belong to several organizations doing essentially the same thing. Groups belonging to the federation had the practice of meeting in conventions at the same time and place. By the late 1940s, groups had established their identities in work settings, and members had begun to see commonalities of purpose and function. The name of the federation had changed from the American Council of Guidance and Personnel Associations (ACGPA) to the Council of Guidance and Personnel Associations (CGPA) in 1939, so there was a precedent for a name change.

In 1948 Daniel Feder, as chair of CGPA and president of NVGA, urged forming a national organization to include individuals as well as associations. A committee on unification was appointed to develop a plan for such an organization. Its plan was presented at the 1950 convention and forwarded to the organizations concerned (McDaniels, 1964). Both the NVGA and the American College Personnel Association approved the plan and arranged their constitutions to join the new organization as divisions in 1951. At this time the Personnel and Guidance Association (PGA) was born. The following year, 1952, PGA changed its name to the American Personnel and Guidance Association (APGA) to avoid confusion with the Professional Golfers Association (PGA). APGA is now known as the American Counseling Association (ACA). Table 1.1 presents highlights of the ACA's development since its founding.

Professionalism: A Developmental Perspective

The mission of the American Counseling Association is “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, 2003). A review of Table 1.1 indicates not only the developmental nature of the ACA but also the evolving diversity of its
### TABLE 1.1 Organizational Chronology of the American Counseling Association

<table>
<thead>
<tr>
<th>Year</th>
<th>Division Name</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>PGA</td>
<td>The Personnel and Guidance Association was formed.</td>
</tr>
<tr>
<td>1952</td>
<td>APGA</td>
<td>American Personnel and Guidance Association became the new name for PGA.</td>
</tr>
</tbody>
</table>

The following divisions became founding partners of APGA:

- 1952 SPATE Student Personnel Association for Teacher Education.

The following divisions became part of ACA or changed their names:

- 1953 ASCA  American School Counselors Association became a division.
- 1958 DRC  ACA added the Division of Rehabilitation Counseling.
- 1961 ACES  Association for Counselor Education and Supervision replaced the former NAGSCT.
- 1962 ARCA  American Rehabilitation Counseling Association became the new name for the former DRC.
- 1965 AMEG  Association for Measurement and Evaluation in Guidance was established.
- 1966 NECA  National Employment Counselors Association became a division.
- 1972 ANWIC  Association for Non-White Concerns in Personnel and Guidance was formed.
- 1973 ASGW  Association for Specialists in Group Work was established.
- 1974 NCGC  National Catholic Guidance Conference became a division.
- 1974 POCA  Public Offender Counselor Association was established.
- 1975 AHEAD  Association for Humanistic Education and Development replaced the former SPATE.
- 1977 ARVIC  Association for Religious Values in Counseling replaced what had been known as NCGC.
- 1978 AMHCA  American Mental Health Counselors Association became a division.
- 1983 Aacd  American Association for Counseling and Development became the new name for what had been called APGA.
- 1984 AMECD  Association for Measurement and Evaluation in Counseling became the new name for the former AMEG.
- 1984 NCDA  National Career Development Association became the new name of the former NVGA.
- 1984 AMCD  Association for Multicultural Counseling and Development replaced the former Association for Non-White Concerns in Personnel and Guidance.
- 1984 MECA  Military Educators and Counselors Association became an organization affiliate of Aacd.
- 1986 AADA  Association for Adult Development and Aging was formed.
## CHAPTER ONE / The Counseling Profession

**1989 IAMFC**  
International Association of Marriage and Family Counselors was established.

**1990 IAAOC**  
Association of Addiction and Offender Counselors replaced the former POCA.

**1991 ACCA**  
American College Counselors Association was formed to replace ACPA, which was in the process of withdrawing from ACA.

**1992 ACPA**  
American College Personnel Association disaffiliated from ACA. Association for Assessment in Counseling became the new name for AMECD.

**1993 ASERVIC**  
Association for Spiritual, Ethical and Religious Values in Counseling became the new name for ARVIC.

**1995 ACEG**  
Association for Counselors and Educators in Government became the new name for MECA.

**1996 AGLBIC**  
Association of Gay, Lesbian, and Bisexual Issues in Counseling became an organizational affiliate.

**1997 AGLBIC**  
AGLBIC achieved division status.

**1998 ACEG**  
ACEG became a division.

**1999 CSJ**  
Counselors for Social Justice became an organizational affiliate.

**C-AHEAD**  
AHEAD changed its name to the Counseling Association for Humanistic Education and Development.

**2002 CSJ**  
CSJ became a division.

**2004 ACC**  
Association for Creativity in Counseling became a division.

**2003 AACE**  
AAC changed its name to the Association for Assessment in Counseling and Education.

**2007 ALGBTIC**  
AGLBIC changed its name to the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling.

The concept of unification was a common theme in this country in the 1950s (Vacc & Loesch, 1994). This trend may have influenced the four independent founding organizations—NVGA (now NCDA), American College Personnel Association (replaced as an ACA division now by ACCA), the National Association of Guidance and Counselor Trainers (NAGSCT, now ACES), and SPATE (now C-AHEAD)—to come together and work as one federation. The basic format of autonomous divisions working within an umbrella organization has continued to the present time. Divisions have been added as members’ interests or counselor work settings changed because of changes in the socioeconomic milieu. Table 1.2 shows the divisional structure of ACA as of June 2007.

Change is very much reflected in the chronological evolution of ACA. For example, the parent organization, APGA, changed its name twice over a 40-year period. Before 1983, APGA began to feel pressures from its membership for a name change that would accurately reflect the purposes and work activities of its members. The terms *guidance* and *personnel* were onerous to some members. In addition to describing the profession better, the term *counseling* was more prestigious and better understood by the public. By 1983, several of the divisions already recognized the terms *counseling* or *counselor* in their titles (ASCA, ARCA, ACES, ARVIC, POCA,
NECA, and AMHCA). To appease its growing and diverse membership, to have a clearer identity with counseling, and to attract new members in a changing society, APGA became the American Association for Counseling and Development (AACD). Nine years later in 1992, the name was again changed to the American Counseling Association, removing the word development from its title.

Such change was not limited to the parent organization. As can be seen in Table 1.1, six divisions (NVGA, SPATE, NAGSCT, ANWIC, POCA, and MECA) changed their names at least once and two divisions (AMEG and NCGC) changed their names twice since they were formed. Such changes not only reflected the changing nature of the work of the divisions and their members but also brought the divisions’ names more in line with the name changes that had occurred within the parent organization.

Beginning in 1952 with four divisions, the first new division to join the parent organization was the American School Counselors Association (ASCA) in 1953, which quickly became one of the two largest ACA divisions. After World War II, there was a

### TABLE 1.2 Divisions of the American Counseling Association as of June 2007

<table>
<thead>
<tr>
<th>Division Acronym</th>
<th>Division Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AACE</td>
<td>Association for Assessment in Counseling and Education**</td>
</tr>
<tr>
<td>AADA</td>
<td>Association for Adult Development and Aging***</td>
</tr>
<tr>
<td>ACC</td>
<td>Association for Creativity in Counseling</td>
</tr>
<tr>
<td>ACCA</td>
<td>American College Counseling Association**</td>
</tr>
<tr>
<td>ACEG</td>
<td>Association for Counselors and Educators in Government</td>
</tr>
<tr>
<td>ACES</td>
<td>Association for Counselor Education and Supervision</td>
</tr>
<tr>
<td>ALGBTIC</td>
<td>Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling</td>
</tr>
<tr>
<td>AMCD</td>
<td>Association for Multicultural Counseling and Development</td>
</tr>
<tr>
<td>AMHCA</td>
<td>American Mental Health Counselors Association**</td>
</tr>
<tr>
<td>ARCA</td>
<td>American Rehabilitation Counseling Association**</td>
</tr>
<tr>
<td>ASCA</td>
<td>American School Counselors Association**</td>
</tr>
<tr>
<td>ASERVIC</td>
<td>Association for Spiritual, Ethical and Religious Values in Counseling</td>
</tr>
<tr>
<td>ASGW</td>
<td>Association for Specialists in Group Work</td>
</tr>
<tr>
<td>C-AHEAD</td>
<td>Counseling Association for Humanistic Education and Development</td>
</tr>
<tr>
<td>CSJ</td>
<td>Counselors for Social Justice</td>
</tr>
<tr>
<td>IAACOC</td>
<td>International Association of Addictions and Offenders Counselors***</td>
</tr>
<tr>
<td>IAMFCC</td>
<td>Internal Association of Marriage and Family Counselors**</td>
</tr>
<tr>
<td>NCDA</td>
<td>National Career Development Association*</td>
</tr>
<tr>
<td>NECA</td>
<td>National Employment Counseling Association**</td>
</tr>
</tbody>
</table>

*ACA membership is required for professional members only (not required for affiliate, regular student, and/or retired members of these groups).

**ACA membership is not required for members of these groups.

***AADA requires ACA membership for all but “regular” members; IAACOC requires ACA membership for all except retired members.
growing recognition in America that people with disabilities had counseling needs. At the same time that the Veterans Administration was attempting to meet the needs of returning World War II servicemen and women, a number of ACA members were becoming involved in rehabilitation counseling. These factors resulted in the organization of the second new division to join ACA, the American Rehabilitation Counseling Association (ARCA) in 1957 (known as the Division of Rehabilitation Counseling from 1957 to 1962).

Seven years passed before the addition of two new divisions. In 1965, professionals who used psychometric instruments in their settings needed an organization to help them improve the use of such instruments and to communicate among themselves. The Association for Measurement and Evaluation in Guidance (AMEG) was organized to serve this purpose, although not until 1968 was it formally incorporated as an ACA division. The continued interest in vocational counseling at that same time is evident in the formation of the National Employment Counselors Association (NECA) in 1966. NECA members, who came from both the private and public sectors of counseling, had a strong interest on vocational counseling and focused specifically on employment counseling.

The number of divisions in ACA again remained static for seven years, but the 1970s saw the formation and acceptance of several new divisions. There was increasing concern about minority representation with the structure of ACA. That concern, along with the general social consciousness movement in the 1960s and early 1970s, prompted the development of an interest-based division entitled the Association for Non-White Concerns in Personnel and Guidance (ANWIC), which was added in 1972.

In 1973, based on the growing use of groups as a form of counseling intervention, the Association for Specialists in Group Work (ASGW) became the tenth division of ACA. The following year, 1974, the National Catholic Guidance Conference (NCGC) became the 11th division of ACA and brought to the parent association its first division with a strong religious orientation. During the last few decades, the focus of this division changed from that of a Catholic-based organization to a broader examination of spirituality, religious values, and ethical considerations in the field of counseling. This shift in focus is reflected in NCGC changing its name to the Association for Religious Values in Counseling (ARVIC) in 1977 and later (1993) to the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC).

In 1974, the Public Offender Counselor Association (POCA) became the 12th division and brought into the organization people involved with juvenile and adult probation and those who worked with or within our prison systems. The creation of POCA is one example of how responsive the counseling profession has been to the complex social problems faced by our society. During the 1980s, the correlation between addictive and criminal behaviors became quite clear. Many POCA members became interested in broadening the focus of POCA, and it became the International Association of Addictions and Offenders Counselors (IAAOC) in 1990.

As the demand for school counselors diminished in the early and mid-1970s, a need for counselors in a variety of community agencies developed, and counselors found themselves in a variety of noneducational work settings. More nonprofit organizations and services such as crisis centers, hotlines, drop-in clinics, shelters for battered women,
rape counseling centers, and clinics for runaway youth emerged. More agencies began to be funded by local governments and hire people with master's degrees and experience to run these centers. The profession responded, and in 1978 the American Mental Health Counselors Association (AMHCA) became the 13th division of ACA. Between 1976 and the early 1980s, AMHCA's membership expanded more quickly than probably any other mental health organization's (Weikel, 1985). It became the largest division within ACA and, along with ASCA, remains one of the two largest groups affiliated with ACA.

As noted previously, it was in 1983 that APGA changed its name to the American Association for Counseling and Development (AACD). The change symbolized the evolving professional orientation among the association's members, the fact that these members were being found more and more in noneducational work settings, and the concept that what members “did was counseling, not guidance” (Herr, 1985, p. 395).

In 1986, as a reflection of an increasingly larger aging population and the problems of growing older in a youth-oriented society, the Association for Adult Development and Aging (AADA) became the 14th division of what was now called the American Association for Counseling and Development. The strongest emphasis of AADA has been on gerontological counseling, midlife development, and preretirement planning, but its members have broadened their focus to include the counseling needs of persons across the adult life span.

In 1989, based on the growing emphasis on marriage and family counseling and the fact that many ACA members provided marriage and family counseling, the International Association of Marriage and Family Counselors (IAMFC) became the 15th ACA division.

Later in the 1980s, ACPA members who served a wide variety of student development needs on college campuses became unhappy with the increasing de-emphasis of guidance and personnel issues in ACA and began movement to disaffiliate from ACA. The withdrawal of ACPA in 1992 led to the formation of its successor, the American College Counseling Association, with a more focused emphasis on counseling college students. At this time AACD became the American Counseling Association.

Members of ACA, recognizing the growing numbers of counselors who serve clients dealing with issues associated with their sexual orientation, lobbied for a specialty division that would focus on the needs of these clients and counselors. In April 1996, the Association of Gay, Lesbian, and Bisexual Issues in Counseling (AGBLIC) became an organizational affiliate of ACA. An organizational affiliate was defined before 1998 as an interest group with fewer than 1,000 members. In March 1998, the ACA Governing Council voted to amend the ACA bylaws to require 500 or more members to achieve or maintain division status and, in March 2003, to reduce that number to 400. AGBLIC's membership quickly grew, and it achieved status as a division in 1997. As of June 2007, there were more than 775 members of AGLBIC. The AGLBIC board voted in 2007 to change its name to the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC).

In 1998, the Association for Counselors and Educators in Government (ACEG) became a division of ACA. This professional group was originally formed as an organizational affiliate in 1984 under the title of Military Educators and Counselors Association.
Members of this division have primary professional affiliations to some branch of the military establishment or various levels of government.

Counselors for Social Justice (CSJ) was formed as an organizational affiliate in 1999 to address issues related to social justice, oppression, and human rights within the counseling profession and the community at large. CSJ became an ACA division in 2002.

Finally, in 2004, the Association for Creativity in Counseling (ACC) was established to provide a forum for counselors, counselor educators, and counseling students interested in creative, diverse, and relational approaches to counseling. An additional goal of this division is to “develop, implement, and foster interest in counseling-related charitable, scientific, and educational programs designed to further creativity, diversity, and relatedness in the work and lives of counselors, clients and communities” (ACC, 2007).

The American Counseling Association is much more than a collection of divisions. There is also a geographical regional structure: (1) North Atlantic (Connecticut, Delaware, the District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and the Virgin Islands); (2) Southern (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia); (3) Midwest (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin); and (4) Western (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Nevada, Montana, New Mexico, Oregon, Washington, Wyoming, and Utah). Each region, representing ACA state branches, was established to provide leadership training, professional development, and continuing education of branch members following the strategic plan adopted by the association.

Through its ACA Press, the association provides its membership with a plethora of books, scholarly journals, and monographs on topics of interest to counselors. Its workshop and home study program and regional and national conventions provide intensive training opportunities that keep members up-to-date and provide the continuing education units necessary to maintain licensure or certification. Its Code of Ethics (ACA, 2005) provides members and the public with both professional direction and guidance. Its legislative arm not only alerts members to current legislation that is either helpful or harmful to counseling but also gives members a voice in policy development at the federal, state, and local levels.

In 2007, with 19 national divisions, 56 state and territorial branches, 4 regional assemblies, a myriad of divisional affiliates in each of the branches, and a membership of approximately 41,000, the American Counseling Association remains the strongest organization representing counselors on the national scene. It is not, however, without problems. ACA developed from a “group of groups” and has been faced with ongoing organizational challenges that stem from the groups continued desire to have independence while working under an umbrella structure. In October 1997, the governing council voted to amend the ACA bylaws so that, effective July 1, 1998, ACA members were no longer required to also belong to a division and division members were no longer required to also belong to ACA. This freedom of choice for members has led to
some interesting developments. As of December 1999, 14 of the then 18 divisions (77.8%) opted to require their professional members (typically defined as members with a master's degree in counseling) to belong to ACA in addition to their division. As of June 2007, only 12 of the divisions (63.2%) required professional members to also join ACA, and 7 divisions (AACE, ACCA, AMHCA, ARCA, ASCA, IAMFC, NECA) (36.8%) did not require ACA membership for any category of division membership. Membership for all groups except for AMHCA and ASCA are processed through ACA. AMHCA and ASCA collect their own fees.

It is difficult to discern how policy makers (e.g., legislators) view the structure of ACA. To date, a “strength in numbers” philosophy has facilitated passage of legislation that has been important to the provision of counseling services and the recognition of professional counselors. It seems that all ACA entities, regardless of whether ACA membership is required, have managed to work together to have a positive influence on the passage of some key pieces of legislation since 1997. It is not clear, however, if ACA's current governing structure is the most effective or efficient way to advance public policy or to serve the “parent organization” and the divisions. Different strategies to reorganize ACA have been reviewed and rejected by its governing council, but this has not yet been resolved. As of June 2007, the members of the governing council were considering new categories and packages of membership (e.g., a reduced rate if individuals join ACA and their state branch, or if they join ACA and at least one division, and so on) that might best serve ACA, ACA divisions, and all members.

Issues related to divisional and ACA membership may certainly be influenced by finances and what counselors can afford to pay for association membership. It may, however, also be indicative of ongoing problems with professional identity. Do members consider themselves professional counselors first and specialists second or the other way around? The struggle of coming from a group of groups appears to remain in issues related to professional identity and to the governance of the profession.

Credititng and the “Professionalization” of Counseling

The most commonly noted criteria used to evaluate whether an occupation has evolved to the status of a profession include (1) a specialized body of knowledge and theory-driven research, (2) the establishment of a professional society or association, (3) control of training programs, (4) a code of ethics to guide professional behavior, and (5) standards for admitting and policing practitioners (Caplow, 1966; Glosoff, 1993). Given these criteria, no historical perspective of the counseling profession can be considered complete without a discussion of the development of standards related to the preparation and practice of professional counselors.

The counseling profession has met the majority of conditions just noted. There is an evolving body of knowledge and systematic theories and a body of literature to provide a forum for such information. ACA serves as the primary professional association for counselors. There are standards for training programs, professional preparation and ethical behavior (see Chapter 4). Accredited counselor-training programs
have been established, and credentials are granted to individuals demonstrating professional competencies (Glossoff, 1993; Remley, 1991). Great progress has been made in establishing licensure and certification regulations, legally validating the profession. The term **credentialing** was created to represent a broad array of activities pertaining to the establishment of professional training standards and regulations for practice (Bradley, 1991). This term most typically covers three major professional activities: academic program accreditation, certification, and licensure (Loesch, 1984).

**Accreditation**

Accreditation is one means of providing accountability. The licensed professions in this country began the process of regulation and quality control by developing standards for training programs. One definition of **accreditation** is provided by Altekruse and Wittmer (1991) as follows:

>a process by which an association or agency grants public recognition to a school, institute, college, university, or specialized program of study that has met certain established qualifications or standards as determined through initial and periodic evaluations. (p. 53)

The development of standards of preparation for counselors began approximately 40 years ago when a joint committee of the ACES and ASCA, divisions of ACA, began two major studies in 1960. More than 700 counselor educators and supervisors and 2,500 practicing counselors participated in the studies over a 5-year period (Altekruse & Wittmer, 1991). The results facilitated the creation of the “Standards for Counselor Education in the Preparation of Secondary School Counselors,” the first set of standards sanctioned for counselor education, in 1964. After a 3-year trial, they were officially adopted by ACES in 1967 (Association for Counselor Education and Supervision, 1967). Shortly thereafter, “Standards for Preparation of Elementary School Counselors” (APGA, 1968) and “Guidelines for Graduate Programs in the Preparation of Student Personnel Workers in Higher Education” (APGA, 1969) were established.

The Council on Rehabilitation Education (CORE), incorporated as a specialized accrediting body with a focus on rehabilitation counseling in 1972, was a forerunner in setting educational standards and graduate program accreditation in counseling (Sweeney, 1991). The leaders responsible for the creation of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) used CORE as a model. Both councils require similar generic counseling curricula (not focused on specialties) and standards. In addition, CORE focuses on rehabilitation counselor education (RCE) curricula while CACREP addresses program area curricula and standards in other specialty areas but does not include specific RCE curricula.

**Council on Rehabilitation Education (CORE)**

In addition to ARCA, the following four professional organizations were represented on the first CORE board: Council of Rehabilitation Educators (now the National
Council on Rehabilitation Education, NCRE), Council of State Administrators of Vocational Rehabilitation (CSAVR), International Association of Rehabilitation Facilities (now American Rehabilitation Association, ARA), and the National Rehabilitation Counseling Association (NRCA). CORE’s current membership has two public members, the chair of the Commission on Standards and Accreditation, and individuals appointed from the following sponsoring organizations: NRCA, ARCA, NCRE, CSAVR, and the National Council of State Agencies for the Blind (NCSAB).

As of June 2007, CORE had accredited 102 master’s programs offering a degree in rehabilitation counseling, with 7 programs in “candidacy” status (Marv Kuehn, CORE staff, personal communication, June 13, 2007). Since its creation, CORE has reviewed and revised the standards for the accreditation of master’s programs in rehabilitation counselor education on a regular basis. The first major standards revisions in 1981 were followed by revisions in 1988, 1997, and 2004. The most recent revisions in the CORE standards can be reviewed on the CORE Web site (www.core-rehab.org). The 2004 standards present some significant changes from the 1997 standards in the language and format used to describe curricular areas and outcomes required. Based on the 1997 CORE Manual (1997), all CORE-accredited programs were expected to include courses in the following areas of study: foundations of rehabilitation counseling, counseling services, case management, vocational and career development, assessment, job development and placement, and research. Effective August 2004, all CORE-accredited programs are expected to address the following 10 curricular areas of study: professional identity; social and cultural diversity issues; human growth and development; employment and career development; counseling and consultation; group work; assessment; research and program evaluation; medical, functional, environmental, and psychosocial aspects of disability; and rehabilitation services and resources (CORE, 2007). Supervised practicum and internship experiences are required under both the 1997 and 2004 standards. These experiences are very similar to the current (2001) CACREP standards.

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

According to Altekruse and Wittmer (1991), ACES developed “Standards for Entry Preparation of Counselors and Other Personnel-Service Specialists” in 1973. This document, which merged earlier guidelines, was officially adopted by the ACA governing body in 1979. At that time, ACES was the only association accrediting body using the standards of training. Not until 1981 did ACA’s board of directors adopt a resolution to formally oversee the responsibilities of the ACES National Committee on Accreditation. This led to the establishment of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which was formed as an independently incorporated accrediting body, separate from ACA but sponsored by ACA and several divisions (CACREP, 1987). Since its inception, CACREP has conducted reviews of its accreditation standards. After the initial flurry of changes to the 1981 standards, CACREP declared a 5-year time period during which only minor changes would be allowed (Altekruse & Wittmer, 1991). There have been three
significant revisions made to the 1981 standards adopted by CACREP, in 1988, 1994, and 2001. These revisions are necessary to keep up with the continually evolving field of counseling, and CACREP was in the process of revising the 2001 standards when this book went to press.

In addition to providing for accreditation of doctoral-level programs in counselor education and supervision, the 1994 CACREP standards provided for accreditation of master's degree programs in community counseling, with and without specialization in career counseling or gerontological counseling, marriage and family counseling/therapy, mental health counseling, school counseling, student affairs practice in higher education (with college counseling or professional practice emphases), and doctoral degree programs in counselor education and supervision (CACREP, 1994). The current CACREP standards (CACREP, 2001) accredit doctoral programs in counselor education and supervision and master's degree programs in the following specialty areas: career counseling (separate from community counseling); college counseling (no longer listed as an emphasis area under student affairs); community counseling; gerontological counseling (accredited separately from community counseling); marital, couple, and family counseling/therapy (instead of “marriage and family counseling/therapy”); mental health counseling; school counseling; and student affairs.

As of June 2007, CACREP had 500 accredited programs (Jenny Gunderman, CACREP staff, personal communication, June 13, 2007). Of these 500 programs, 49 are doctoral level, and 451 are master’s programs in 208 institutions. The majority of the master’s programs are in the areas of school counseling (179) and community counseling (149). In addition, there were 47 accredited mental health counseling programs, 37 accredited in college counseling or student affairs programs (11 accredited under the 2001 standards as “college counseling” programs, 11 in student affairs with an emphasis in college counseling, and 15 in student affairs with an emphasis in professional practice, administrative, or developmental emphases), 29 accredited marriage and family counseling/therapy programs, 8 accredited career counseling programs, and 2 accredited gerontological counseling programs (Jenny Gunderman).

All academic programs accredited by CACREP, regardless of specialty designation, share a common core of curricular requirements. According to the 2001 CACREP Accreditation Procedures Manual (CACREP, 2001), all accredited programs must address the following eight curricular areas: professional identity, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation. Supervised practica and internships also are required across all program areas. In addition to these common core areas, CACREP-accredited programs must also offer specific types of curricular experiences related to the specialty accreditation, such as community counseling, school counseling, and mental health counseling.

As previously noted, CACREP was in the process of revising the 2001 standards at the time this chapter was written. The CACREP board appointed a standards revision committee and released the first draft of the proposed 2008 standards for public comment in October 2005. The second draft was released in May 2006, and CACREP again solicited comments (until December 15, 2006). The third draft was posted
on-line from June through November 2007. Members of the Standards Revision Committee held forums at several conferences (e.g., ACA, the 2007 ACES conference, the five regional ACES conferences held in fall 2006, ASCA, AMHCA, and the American Association of State Counseling Boards). The proposed drafts represent a significant shift from knowledge-based to outcome- or performance-based standards. Students will need to demonstrate the ability to implement their knowledge in the core and specialty domains, and programs will need to document these outcomes. Another major proposed change is that new full-time faculty hired after 2013 will be required to have earned a doctoral degree in counselor education (rather than counseling psychology or other related fields) if they have not already taught in counselor education programs. Further major revisions in the drafts include combining the current college counseling and student affairs standards into one college student development and counseling program area and revisions to the community and mental health counseling specialties.

Along with the feedback that the Standards Revision Committee received from individuals and professional groups, two things caused CACREP to extend the timeline for the next standards to 2009. First, CACREP was awarded a grant though the Department of Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, to investigate how to best include training standards related to disasters and emergency response preparedness. Second, at the request of the CACREP Board, the Standards Revision Committee included a draft of standards for the proposed new specialty area of addictions counseling in the third draft of the proposed standards. CACREP staff anticipates having the final standards approved and posted online by mid-August 2008 and available in hardcopy as part of a new manual in January 2009.

Another professional organization that accredits counseling-related programs is the American Association for Marriage and Family Therapy (AAMFT). Along with CACREP, AAMFT accredits counselor education programs that emphasize marriage and family therapy. Unlike CACREP, however, AAMFT also accredits academic programs in departments of social work and home economics, as well as nonacademic programs such as agency-based training programs (Hollis, 2000).

Certification

Certification is one of the most confusing of the credentialing terms (Brown & Srebalus, 1988). It is used in reference to (1) the process of becoming qualified to practice in public schools, (2) state laws passed in the same ways as licensure laws, and (3) recognition bestowed on individuals by their professional peers (such as certified public accountants).

Certification is often referred to as a “title control” process because it grants recognition of competence by a professional group or governmental unit but does not confer authority to the holder to practice a profession (Forrest & Stone, 1991; Loesch, 1984). As befits the confusing nature of the term certification, there is one exception to this rule. A designated state agency, most typically a state department of education, certifies school personnel. Professional counselors holding positions as public school counselors must be certified by the state to do so. Therefore, school counselor
certification regulations are actually practice acts, because they control who may and may not practice as a school counselor (Loesch, 1984).

**Types and Purposes of Certification**

**Certification in Schools.** As noted, state boards or departments of education, by authority of state legislatures, establish certification standards for teachers, counselors, administrators, and other school personnel. Certification of school counselors first began in Boston and New York in the 1920s, but not until the National Defense Education Act (NDEA) was passed in 1958 did this type of certification take hold nationwide. By 1967 more than 24,000 guidance counselors were trained under NDEA funding. The NDEA also mandated the establishment of criteria that would qualify schools to receive funds for the services of school counselors, which led to the rapid growth of certification (Sweeney, 1991).

**National Board Certification.** Many professional groups have initiated credentialing efforts at the national and the state levels to encourage excellence by promoting high standards of training, knowledge, and supervised experience. These standards promulgated by professional organizations may or may not be considered by governmental agencies, such as state departments of education or mental health, in relation to hiring and promotion requirements (Sweeney, 1991).

The first counseling-related national certification addressed the specialty of rehabilitation counseling. During the late 1960s, rehabilitation counselors belonging to the National Rehabilitation Counselors Association and American Rehabilitation Counselors Association (an ACA division) began to work together toward establishing certification for rehabilitation counseling specialists (Forrest & Stone, 1991). Their efforts came to fruition in 1973, when the Commission on Rehabilitation Counselor Certification, known as CRCC, began to certify rehabilitation counselors (Forrest & Stone, 1991; Sweeney, 1991). More than 15,580 rehabilitation counselors were designated as CRCs as of June 2007. Until recently, in addition to the general certification in rehabilitation counseling (CRC), CRCC offered specialty certification in addictions counseling and in clinical supervision. CRCC is no longer accepting new applications for certification in these specialties; however, individuals currently certified in these specialties who meet the continuing education requirements may apply for certification renewal.

CRCC divides the criteria for certification as a CRC into several categories. Depending on the category under which the applicant is seeking certification, requirements include either a minimum of a master's degree in counseling (nonspecified) or a master's degree specifically in rehabilitation counseling. In addition to the requirement of a master's, CRCs are required to have relevant supervised professional experience as a rehabilitation counselor (if the applicant did not graduate from a CORE-accredited program) and successful completion of the CRCC examination (CRCC, 2007). The supervised experience requirement varies, depending on the type of degree earned by the applicant.

As noted, graduates of CORE-accredited programs are not required to have postmaster's employment experience before applying to become a CRC. They do, however, need to complete an internship of 600 clock hours supervised by an on-site
CRC or a faculty member who is a CRC. The internship must have been in rehabilitation counseling. Those who graduate with a master's in rehabilitation counseling from a non-CORE-accredited program must demonstrate the completion of an internship comparable to that in CORE-accredited programs and must have 12 months of acceptable employment experience under the supervision of a CRC (or complete a provisional contract). If applicants have a degree in rehabilitation counseling but do not have 600 hours of internship in rehabilitation counseling, they must have 24 months of acceptable employment experience, including a minimum of 12 months under the supervision of a CRC; if lacking the supervision by a CRC, they must complete a provisional contract (CRCC, 2007).

There also are eligibility criteria for individuals with master's degrees in counseling with an emphasis other than rehabilitation counseling who have had a minimum of one graduate course with a primary focus on theories and techniques of counseling. CRCC staff reviews applicants’ transcripts to determine that they have had required courses. The employment requirements vary for these applicants, depending on the number of required courses they have taken. For example, applicants who have had one graduate course in counseling theories and at least one course in assessment, occupational information, medical or psychosocial and cultural aspects of disabilities, and community resources or delivery of rehabilitation services must also have 36 months of acceptable employment experience, including 12 months under the supervision of a CRC. A person who has had a theories and technique course and only one course in medical or psychosocial and cultural aspects of disability and one graduate course in the other three areas previously noted is required to have 48 months of acceptable employment experience with a minimum of 12 months under the supervision of a CRC. Finally, applicants who have had a theories and technique course and only one course in medical or psychosocial and cultural aspects of disabilities must demonstrate 60 months of acceptable employment experience, including a minimum of 12 months under the supervision of a CRC.

CRCC also offers certification to graduates of doctoral programs offering degrees in counseling or rehabilitation counseling. The doctoral transcript must include a minimum of one graduate-level course in theories and techniques of counseling, one graduate-level course on medical or psychosocial and cultural aspects of disabilities, and 600 hours of internship at the doctoral level in a rehabilitation setting supervised by a CRC or 12 months of acceptable employment experience under the supervision of a CRC. In all these situations (master's and doctoral level), if applicants meet the employment criteria but lack supervision by a CRC, they must complete a provisional contract (CRCC, 2007).

In 1979, the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) was the next national counselor certifying body to be established. The NACCMHC merged with the National Board for Certified Counselors (NBCC) in 1992. Basic requirements to become a Certified Clinical Mental Health Counselor (CCMHC) include (1) completion of a minimum of 60 graduate semester hours, (2) graduation with a master's or higher degree from an accredited counselor-preparation program encompassing at least 2 years of postmaster's professional work experience that included a minimum of 3000 client-contact hours and 100 clock hours of individual supervision by a CCMHC or a professional who holds an equivalent
credential, (3) submission of an audiotape or videotape of a counseling session, and (4) successful completion of the CCMHC’s Mental Health Counselor Examination for Specialization in Clinical Counseling (NBCC, 1995). Weikel and Palmo (1989) noted that the stringent requirements to become a CCMHC may be one reason that there were only slightly more than 1000 National Certified Clinical Mental Health Counselors (NCCMHCS) in 1985.

NBCC is probably the most visible and largest national counselor-certifying body (Sweeney, 1991). As of June 2007, NBCC certified 41,022 National Certified Counselors, or NCCs (NBCC, 2007c). The founding of NBCC offered the public a way to identify professional counselors who meet knowledge and skills criteria set forth by the counseling profession in the general practice of counseling. This was especially important given the paucity of counselor licensure laws at that time. The concept of a general practice of counseling is in line with CACREP’s belief that there is a common core of knowledge that is shared by all professional counselors, regardless of any specific area of specialization. It is assumed that all counselors, regardless of their specialty area(s), must have a shared knowledge base and be able to perform some of the same activities (Forrest & Stone, 1991).

To be certified by NBCC as a National Certified Counselor (NCC), applicants who are not licensed by a state as a professional counselor (or equivalent title), must (1) hold a master’s degree or higher with major study in counseling, including a minimum of 48 semester hours or 72 quarter hours in graduate coursework; (2) demonstrate that their graduate coursework was from a regionally accredited institution and includes at least one course (carrying at least two semester/three quarter hours) in each of the core curriculum areas delineated in the CACREP accreditation standards; (3) have successfully completed two academic terms of supervised field experience in a counseling setting or 1 year with an additional year of postmaster’s supervised experience (1,500 additional hours of counseling experience including 50 extra hours of face-to-face supervision) beyond the required 2 years of postmaster’s supervised experience; (4) provide two professional endorsements; and (5) pass the National Counselor Examination (NCE). Counselors who have not graduated from a CACREP-accredited program must also document the completion of a minimum of 3,000 hours of work as a counselor over at least 24 months since the date an advanced degree with a major study in counseling was conferred. In addition, these individuals need to document that they received at least 100 hours of face-to-face counseling supervision over a minimum of 2 years, provided by a supervisor who holds an advanced degree in counseling or a closely related field (social work, psychology, or marriage and family therapy) (NBCC, 2007a).

Once counselors have earned the designation of NCC, they can then qualify for specialty certification as an Approved Clinical Supervisor (ACS, through the Center for Credentialing & Education, a corporate affiliate of the National Board for Certified Counselors), National Certified School Counselor (NCSC), Certified Clinical Mental Health Counselor (CCMHC), Masters Addiction Counselor (MAC), and/or National Certified Career Counselor (NCCC). There are currently 2212 NCSCs, 1160 NCMHCS, 667 MACs, 577 NCCGs, and 157 NCGCs (NBCC, 2007c). The NBCC board of directors decided in 1999 to stop taking new applications for the NCGC and the NCCC specialization areas because of the low number of people who had pursued the credential (Schmitt, 1999).
NBCC and CRCC are not, however, the only bodies that certify specialists in counseling and counseling-related specialties. For example, the National Board for Professional Teaching Standards (NBPTS) offers certification in school counseling in addition to teaching. NBCC participated in negotiations with NBPTS for quite some time to arrive at joint standards (similar to the MAC standards adopted by both NBCC and the National Association of Alcoholism and Drug Abuse Counselors). Negotiations apparently broke down, and NBPTS moved forward with plans. One major problem in developing mutually agreed upon standards was that the NBPTS had proposed certifying school counselors who do not hold a master's degree in counseling. This has been a core criterion for all NBCC credentials. As of June 2007, NBPTS has certified 964 school counselors at the early childhood/young adult level (Shannon Fox, director of Knowledge Management, NBPTS, personal communication, June 15, 2007). It is unclear what this may mean for how school counselors perceive themselves in regard to being counselors or educators first and how having national certification offered by both NCCC and NBPTS will influence the public's perceptions of counselors.

School counseling is not the only specialty area in which organizations other than NBCC and CRCC offer certification. In addition to being an ACA division, IAMFC is an affiliate of the National Academy for Certified Family Therapists, which offers five options for certification of family therapists. The option most relevant for professional counselors requires professionals who are already NCCs or licensed as professional counselors to document professional training, supervision, and experience in working with couples and families (Smith, Carlson, Stevens-Smith, & Dennison, 1995). The American Association of Marriage and Family Therapy (AAMFT) also certifies its own members who meet certain criteria and has done so since the 1970s (Everett, 1990). AAMFT’s credential is granted to members who have clinical member status. The International Certification Reciprocity Consortium (ICRC), NAADAC, NBCC, and the CRCC (as previously noted) all offer specialty addictions certification. Finally, professionals specializing in the treatment of sexual dysfunction can be certified by the American Association of Sex Educators, Counselors and Therapists. Having multiple certifications offered by different associations in the same specialty areas may prove confusing for both professionals and consumers of mental health services.

Licensure

Brown and Srebalus (1988) define a license as “a credential authorized by a state legislature that regulates either the title, practice, or both of an occupational group” (p. 232). Although states enact licensure laws as a means to protect the public from incompetent practitioners, such laws also provide benefits for the profession being regulated. The very fact that a state considers a profession important enough to regulate may lead to an enhanced public image and increased recognition for that profession. Among several types of credentials presented to 1604 professional counselors surveyed, a license as a professional counselor (or similar title) was considered the most important to hold (Glossoff, 1993). Likewise, licensure has often been espoused as the most desirable of the different types of credentials in regard to securing recognition by insurance companies, government and private mental health programs, and consumers; being
given preferred status in job hiring; and adding to the qualifications necessary to be seen as an expert witness (Foos, Ottens, & Hills, 1991; Glosoff, 1993; Remley, 1991; Sweeney, 1991; Throckmorton, 1992).

Just as certification can be confusing, so, too, can the concept of licensure. Because licensure laws typically delineate a “scope of practice” connected with the profession, licensing acts are often known as “practice acts” (Shimberg, 1982). States with such laws in place require people to be licensed or to meet criteria for exemption from licensing noted in those laws to engage in specified counseling activities. There are, however, licensing laws that dictate who may identify themselves as “licensed counselors” or use other counseling-related titles but do not regulate people who are not licensed. These laws are typically referred to as “title acts.” Sweeney (1991) pointed out that it is essential to examine specific state laws and their accompanying regulations to determine the implications for practice. ACA assists counselors in this process by providing information about licensure requirements in each state and the District of Columbia on its Website (http://www.counseling.org). ACA also typically publishes an annual list of counseling regulatory boards in the November–December issue of the Journal of Counseling and Development. In addition to using the resources provided by ACA, I strongly encourage practitioners in those states with counselor licensure laws to ask the regulatory boards if they need a license to practice and what they may and may not call themselves.

Licensure of counseling practitioners, separate from psychologists, can be traced to the early 1970s. Before 1976, no state law defined or regulated the general profession of counseling. This left the profession in a state of legal limbo—although counseling was not expressly forbidden (except where the laws regulating psychology specifically limited activities of professional counselors), it was not legally recognized as a profession, either (Brooks, 1986). At that time, the American Psychological Association began to call for stringent psychology licensure laws that would preclude other professionals from rendering any form of “psychological” services. In Virginia, this resulted in a cease-and-desist order being served to John Weldon, a counselor in private practice in 1972 (Hosie, 1991; Sweeney, 1991). The Virginia State Board of Psychologist Examiners obtained a court order restraining Weldon from rendering private practice services in career counseling (Weldon v. Virginia State Board of Psychologist Examiners, 1972). The board claimed that Weldon was in fact practicing psychology, even though he presented himself as providing guidance and counseling services. In October 1972, Weldon was found to be practicing outside the law, but the court also ruled that the Virginia legislature had created the problem by violating his right to practice his chosen profession of counseling. The court proclaimed that personnel and guidance was a profession separate from psychology and should be recognized and regulated as such (Hosie, 1991). In response to the Weldon case, the Virginia legislature passed a bill certifying personnel and guidance counselors for private practice in March 1975 (Swanson, 1988). This law was amended by the Virginia legislature in 1976 and became the first general practice act for professional counselors.

At about the same time, Culbreth Cook, an Ohio counselor, faced a challenge similar to that of Weldon. Cook, well known and respected in his community, was employed at a 2-year college and provided private educational assessment on a part-time basis. Cook’s education and training qualified him to offer the assessment services he rendered, but he was arrested on the felony charge of practicing psychology without a license (Hosie, 1991; Swanson, 1988). Carl Swanson, an attorney, counselor educator, and ACA
Licensure Committee cochair testified on Cook’s behalf (Sweeney, 1991). The Cleveland Municipal Court judge refused to provide a restraining order against Cook, noting that even attorneys used the tools of psychology (City of Cleveland, Ohio v. Cook, 1975).

ACA has focused on licensure since the 1970s. In 1973, the first ACA licensure committee was created by the Southern Association for Counselor Education and Supervision (Hosie, 1991; Sweeney, 1991). The next year ACA published a position statement on counselor licensure and, in 1975, appointed a special licensure commission. The commission distributed an action packet in 1976, including information about counselor licensure, the fourth draft of model state legislation, and strategies to pursue licensing (APGA, 1976).

Model legislation offers a prototype for counselors in states that do not have licensure laws, in states that are in the process of revising their current laws, and where credentialing laws face sunset or legislative review (Glosoff, Benshoff, Hosie, & Maki, 1995). It also facilitates the development of uniform standards for the preparation and practice of professional counselors across the United States.

Since the first model legislation for licensed professional counselors was created, ACA has revisited and amended its model to reflect changes in standards within the profession and experiences in states that have implemented counselor licensure laws. An underlying philosophy of ACA’s model legislation is that state licensure laws legalize the general practice of counseling within each state, whereas the credentialing of counseling specialists remains under the purview of professional credentialing organizations such as CRCC and NBCC.

The rate of licensure for counselors during the two decades between the time Virginia passed the first counselor licensure law and the endorsement of ACA’s 1994 model legislation is seen by some to be painstakingly slow and by others as quite rapid. Brooks (1986) noted that “legislative successes were distressingly slow in the years following 1974” (p. 253). During the early 1980s, licensure took off when 15 states passed some form of credentialing acts between 1981 and 1986, 14 passed laws between 1987 and 1989; and 7 passed laws between 1990 and 1994 (Glosoff, 1993; Glosoff et al., 1995). Having counseling licensure laws enacted at that rate of progress is exceptional when compared with the 20 years it took the first 18 state psychology laws to be passed (Brooks, 1988). Since 1994, licensure has been achieved in the remainder of all states except California, and a number of states passed amendments that brought existing credentialing laws more into line with ACA’s model legislation (for example, changing title acts to practice laws, expanding the scope of practice of professional counselors to include diagnosis and treatment of people with mental disorders, and increasing educational and experience requirements).

Current Issues and Trends in Counseling

Counselors continue to respond to pressures from various socioeconomic factors—some of which led to the kaleidoscope we know as counseling today and others that will shape the future of the profession. These pressures cut across the various specialty areas of counseling and cannot be categorized or delineated as neatly as in a historical
review of the profession. To illustrate these pressures, the following areas have been selected: diverse clientele, multicultural counseling and social justice issues, licensure, recognition and reimbursement of professional counselors, and legislation (Health Professions Education Partnerships Act, Medicare and the Federal Employees Benefits Program, Tricare, Veterans Affairs, and Medicaid). Current issues and trends in technology are discussed in Chapter 6; issues and trends in private practice and managed care are discussed in Chapter 16.

Diverse Clientele

Counselors are employed in a wide variety of work settings. They provide services to people who exhibit a full range of functioning from healthy adaptation to pathology—from those seeking assistance with self-exploration to those individuals who are dysfunctional enough to require hospitalization. There is not enough space to comprehensively explore all of those work settings and types of services, but I will attempt to briefly review some of the major trends related to types of clients being served by counselors in a variety of work settings. The types of clients served by professional counselors are as diverse as the work settings in which counselors are employed. Following are a few examples of the types of clients receiving increasing attention from professional counselors.

The frequency of abuse of all kinds in our country is astounding. Today’s counselors are increasingly serving individuals who are abused, including very young children, adolescents, adults, and elderly clients—both men and women across all racial, ethnic, and socioeconomic groups. In addition, there has been a greater focus of late on treatment of the abuser. This often involves working with people who have been incarcerated for sexual assault, domestic violence, or pedophilia or those who are on parole. Professional counselors also serve individuals who have been incarcerated for other reasons.

According to the U.S. Department of Justice (Bureau of Justice Statistics, 2005), of the more than 2.1 million individuals incarcerated in state and local facilities in the United States, approximately 16% have a mental illness. It seems that our jails and prisons often are alternatives to mental health facilities for people who are homeless and have mental disorders and that individuals with substance abuse disorders are being incarcerated rather than treated in the community. Mental health services clearly are needed in our jails and prisons. In addition, there are often significant implications for the children and other family members of persons who have been incarcerated. Counselors have been active in providing these services as well as advocating for effective treatment for many years (note the IAAOC was established in 1974).

Another subset of clientele groups receiving increased attention from mental health professionals, including counselors, are people who are HIV positive or have AIDS. There is probably not a community in the country that has gone untouched by the AIDS epidemic. Fear of people with HIV or AIDS may lead them to feel a strong sense of isolation, increasing the already difficult task of living with a life-threatening or terminal illness. Counselors are needed to help ease this difficulty, but many may
not have the training needed to specialize in assisting people with chronic and terminal diseases. This is an issue for counselor education programs.

A similar training issue exists in regard to counselors being adequately prepared to provide services to veterans, especially those who have served in combat. As previously discussed, the counseling profession has been strongly influenced by U.S. involvement in wars. Sadly, this continues today. Posttraumatic stress disorder (PTSD) and other mental health effects of combat can be seen in veterans years after they return home. Clawson (2007), testifying before the President’s Commission on the Care of Wounded Warriors, noted that approximately one in eight soldiers who fought in Iraq reported symptoms of PTSD and that more than one in three soldiers who served in combat in Iraq, Afghanistan, and other locations later sought help for mental health problems. These numbers may increase as military personnel have been required to serve for longer periods than ever before without significant breaks. Of course, this also has implications for their families and loved ones. In turn, this has implications for counselor education programs.

There also has been a marked increase in counseling services targeted to older individuals. This makes sense, given the “graying of America” shown by the steadily increasing average age of the population. One facet of the aging of baby boomers is the increasingly large numbers of individuals who are ready to retire or have done so already. These individuals may not fall under the purview of gerontological counseling and appear to be an underserved population (Gladding & Ryan, 2001). Given our strong roots in the career development area, this seems to be an excellent market for professional counselors. In addition, a report by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that the need for mental health care for older adults with substance abuse or psychiatric disorders is anticipated to increase by 13 to 50% (Bartels, Blow, Borckmann, & Van Citters, 2005). Vacc and Loesch (1994) predicted that in response to the needs of older people, gerontological counseling would continue to grow as an area of specialization for professional counselors. Although this may be true, as I previously noted, professional counselors did not seek certification as gerontological counselors in high enough numbers to warrant NBCC maintaining it as an area of certification. This still seems to be an important marketplace issue for counselors to consider.

I have seen estimates that 4 to 18% of the U.S. population are bisexual, gay, lesbian, or transgendered. This variance indicates the difficulty in obtaining accurate demographic information on sexual orientation. Sexual orientation and gender identification are not easily measured constructs, and individuals who are gay, lesbian, bisexual, or transgendered (GLBT) may be reluctant to identify themselves as such in surveys. Regardless, the results of several studies have strongly indicated that many individuals who are GLBT experience bullying and discrimination in their schools while growing up and in their workplaces as adults. For example, according to the Williams Institute (2007), since the mid-1990s, there have been 15 studies in which 15% to 43% of GLBT respondents experienced discrimination in the workplace (e.g., being fired or denied employment based on their sexual orientation, being verbally or physically abused). In addition, 15% to 57% of people who identified as transgendered reported experiencing employment discrimination. The 2005 National School
Climate Survey conducted by the Gay, Lesbian, and Straight Education Network (GLSEN, 2006) indicated that more than 75% of student participants have heard derogatory remarks and name-calling such as “faggot” or “dyke” frequently in their schools and 37.8% of students experienced physical harassment at school on the basis of sexual orientation. The results of the 2005 study further indicate that having supportive staff makes a difference to students and is correlated with positive indicators such as a greater sense of safety, reports of missing fewer days of school, and a higher incidence of planning to attend college. To assist counselors, ALGBTIC developed “Competencies for Counseling Gay, Lesbian, Bisexual, and Transgendered (GLBT) Clients” (http://www.aglbic.org/resources/competencies.html).

Counselors are likely to work with a client (child, adolescent, or adult) who is gay, lesbian, bisexual, or transgendered. Although clients may or may not be open about their sexual orientation, and their sexual orientation may or may not be a primary counseling issue, counselors must be prepared to work effectively with individual clients who are GLBT and to advocate for affirmation, respect, and equal opportunity for all individuals, regardless of sexual orientation or gender identity.

People with addictions (such as substance abuse problems, gambling, and sexual addictions) are yet another group being served by increased numbers of professional counselors. These services focus on delivering prevention and remediation of addictive behaviors in community mental health agencies, residential treatment programs, schools, and employee assistance programs (Gladding & Ryan, 2001). The expansion of services in this area can be seen in the numbers of professional organizations offering certification to people who specialize in the delivery of addictions counseling.

Although counselors traditionally have worked with well-functioning individuals, they increasingly have been serving people with severe and chronic mental illness in hospital and community settings. Counselors with both master’s and doctoral degrees are expected to provide a variety of assessment and diagnostic services with clients who exhibit a wide range of clinical disorders (Hosie, West, & Mackey, 1993).

Regardless of the functioning level of clients, a “wellness” orientation remains the basis for many counselors’ work. Counselors are working with clients who seek to achieve greater physical and mental health by making positive lifestyle choices and are doing so in a variety of settings, such as behavioral medicine clinics, HMOs, community centers, and employee assistance programs (EAPs). In 2000, there were approximately 14,000 EAPs in the United States (Gladding & Ryan, 2001). EAPs emphasize very short-term treatment and referral of employees to help them address problems that may influence their job performance. Counselors working in EAPs typically work on issues such as substance abuse, family concerns, financial problems, stress, and interpersonal difficulties that affect them in their work setting (Hosie & Glosoff, 2001). Counselors may be EAP program administrators or be employed as counselors directly by a corporation and have an office within a company. It is also not unusual for counselors to work on a contractual basis to provide counseling services to workers at a particular business (Hosie & Glosoff).

In addition to EAPs, counselors are being hired in business and industry to assist employees who have been laid off or reassigned as a result of new technology,
economic fluctuations, or shifts in services and products. Many counselors also have been hired to provide career counseling with an emphasis on training and retraining, outplacement, and relocation services to those employees (Hosie & Glosoff, 2001).

Many businesses also have focused on the effective use of their employees. Counselors have been hired or contracted to serve as consultants on organizational development and training issues, both of which typically require strong assessment and group process skills. Team building, stress management, preretirement planning, conflict management, and supervision are just a few examples of the types of training counselors provided in business and industry.

Unfortunately, many preventive and wellness-oriented programs have focused more on physical than on mental well-being. As professional counselors continue to make strides in being recognized as qualified providers of services to individuals with diagnosable disorders, it seems that the profession's roots in wellness may be forgotten. There are, however, wellness-based programs in business and health organizations that may be ripe for counselors who choose to market their services to expand wellness programs to include a stronger mental health component.

Multicultural Counseling and Social Justice Issues

One of the most significant trends in relation to professional counselors' clients is that they reflect the diversity of today's society in terms of age, race, ethnicity, gender, and sexual orientation. Sue (1991) wrote, “We are fast becoming a multicultural, multiracial, and multilingual society” (p. 99). He reported that 75% of people entering the labor market at that time were minorities or women. According to D’Andrea and Daniels (2001), the U.S. Bureau of the Census in 1998 indicated that 71% of the total U.S. population are from non-Hispanic, White European backgrounds. They further noted that by 2020, only 64% of the U.S. population is predicted to come from non-Hispanic, White European backgrounds.

These demographic changes have had a notable impact on society in general as well as on the counseling profession. Many leaders in the field consider multiculturalism to be the fourth force in the profession (Pedersen, 1991b). This force calls for reexamining assumptions that are inherent in the delivery of traditional counseling services. The leaders of ACA also realized the importance of addressing the assumptions inherent in the ACA Code of Ethics and have regularly reviewed and revised it. In 2002, ACA leaders appointed an ethics revisions task force to review the 1995 code. A key charge assigned to the task force members was to specifically review the 1995 revision of the Code of Ethics and Standards of Practice through a culturally sensitive lens. The revised Code of Ethics was approved by the ACA Governing Council in the summer of 2005, and one can see that issues related to cultural sensitivity have been infused in the document.

It is more likely than not that counselors will work with clients who have different cultural backgrounds than their own. Although people from all cultures may encounter problems that counselors are trained to address, these problems are experienced within a cultural context that counselors may not understand. The profession must determine the applicability of traditionally taught theories to diverse clientele, as well as explore
the effectiveness of how services are delivered (for example, 50-minute sessions, in counselors’ offices, that focus on intrapsychic phenomena).

Counselors need to develop an increased awareness and understanding of cultural factors if they are to effectively provide services to a pluralistic clientele. In addition, counselor educators must help prepare the next generation of counselors to work from multicultural perspectives. Further, counseling-related research will need to include recognition of cultural differences and ensure that findings adequately reflect the cultural influences of research participants. Pedersen (1991a) asserted that counselors need to “translate the skills, strategies, and techniques of counseling appropriately to many culturally different populations so that the counselor is prepared to match the right approach to each culturally different population” (p. 250). Although Pedersen presented no small challenge, it is clearly one that counselors and counselor educators must accept.

The ACA Code of Ethics (2005) requires counselors to develop and maintain cross-cultural effectiveness. Standards related to diversity and cross-cultural counseling are apparent throughout the code. For example, the preamble states that we “recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.” In addition, the majority of introductory statements speak specifically to ethical obligations of counselors to consider cultural contexts related to the standards in the related sections. Many sections of the ACA code speak specifically to diversity, multiculturalism, and advocacy. This is beyond the scope of this chapter, however, and is covered in Chapter 4.

Both CACREP and CORE standards mandate that accredited programs address social and cultural foundations. Kiselica and Ramsey (2001) anticipated that multicultural training will become more infused throughout counselor education curricula and offer some suggestions for ways to do this. One major development was the publication by AMCD of specific competencies associated with counseling clients from diverse populations. The multicultural competencies were adopted by ACA in 2003 and then by several ACA divisions. In addition, several theories of multicultural counseling have been presented in professional literature (Fuertes & Gretchen, 2001). More recently, the concept of the “fourth force” has been expanded by some from multicultural counseling to include diversity, advocacy, and social justice. As discussions about multicultural counseling have moved forward, there has been an increased emphasis on the interrelatedness of cultural competency, advocacy, and social justice. Although it is important to examine social and cultural foundations from a theoretical base, some say that this is not enough. Sue, Bingham, Porché-Burke, and Vasquez (1999), writing about the symbiotic relationship between multiculturalism and social justice, stated,

Our own stand on this matter, however, is quite clear. Multiculturalism is not only about understanding different perspectives and worldviews but also about social justice. As such it is not value neutral: Multiculturalism stands against beliefs and behaviors that oppress other groups and deny them equal access and opportunity." (p. 1064)

Conversely, others claim that the multicultural competencies and the advocacy competencies (also adopted by ACA in 2003) impose a political agenda of social activism on the counseling profession that extends beyond professional issues and into imposing mandates on the personal lives of counselors (Weinrach & Thomas, 2002).
Although debate about “mandating” advocacy and social justice continues, both have long been emphases in the counseling profession (Kiselica & Robinson, 2001), from the work of Frank Parsons and Clifford Beers to the establishment of AMCD, ALGBTIC, and CSJ as ACA divisions and the adoption by ACA of the Multicultural and Advocacy Competencies. This long-standing tradition, however, has not yet yielded clarity in the profession about how to most effectively have the concepts and practice of multiculturalism, advocacy, and social justice come together to affect the types of changes needed in our organizations and service systems to best serve individuals and groups who have been marginalized (Constantine, Hage, Kindaichi, & Bryant, 2007). In addition to conducting research and including issues of multiculturalism across counselor education curricula, there has been a call for faculty to go further by addressing sociopolitical development and dynamics across courses and incorporate lessons on how counselors can advocate for change in systems as well as for individual clients and the counseling profession.

Licensure

In the 32 years since the passage of the Virginia certification law, 49 states and the District of Columbia have enacted some form of counselor credentialing legislation, leaving only California without licensure for professional counselors (California does license marriage, family, and child counselors). It appears that counseling has made great progress in gaining recognition as a profession. For example, in 1996, 23 (53.5%) of the then 43 counselor credentialing laws regulated both the practice of counseling and the use of related titles (“practice acts”), and 46.5% of the credentialing laws provided protection only in reference to the use of counseling-related titles (Espina, 1999). In June 2007, 45 of the 50 jurisdictions (90%) with counselor credentialing laws were practice acts (ACA, 2007a). The model legislation endorsed by ACA’s governing body in 1994 is clearly a practice act and establishes a comprehensive scope of practice for licensed professional counselors (LPCs). This scope of practice represents the broad continuum of services provided by professional counselors in the general practice of professional counseling and across specialty areas (Glosoff et al., 1995). The broadness of the scope is not meant to imply that all LPCs are experts in providing all services. Including a comprehensive scope of practice does, however, legally protect LPCs who are practicing within their scope of expertise. Without this protection, LPCs practicing within their scope of training (for example, career counseling, crisis intervention, or assessment) may find themselves, like John Weldon, legally prevented from rendering the very services for which they have been trained (Glosoff et al., 1995).

The 1994 ACA model legislation for LPCs includes the following requirements for licensure:

1. Completion of a minimum of 60 graduate semester hours in counseling from a regionally accredited institution of higher education, including an earned master’s degree in counseling or an earned doctoral degree in counseling. The master’s degree must have a minimum of 48 semester hours. Applicants graduating
from programs offering at least 48 graduate semester hours but less than 60 can become licensed upon completing postmaster’s course work to meet the 60-hour requirement.

2. Applicants must document that their 60 semester hours consisted of study in each of the following areas: (a) helping relationships, including counseling theory and practice; (b) human growth and development; (c) lifestyle and career development; (d) group dynamics, processes, counseling, and consultation; (e) assessment, appraisal, and testing of individuals; (f) social and cultural foundations, including multicultural issues; (g) principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior; (h) marriage and/or family counseling therapy; (i) research and evaluation; and (j) professional orientation and ethics.

3. A minimum of 3000 hours of supervised experience in professional counseling performed over a period of not less than 2 years under the supervision of an approved supervisor.

4. Documentation that the 3000 supervised hours included at least 1200 hours of direct counseling with individuals, couples, families, or groups and a minimum of 100 hours spent in direct (face-to-face) supervision with an approved supervisor.

5. Successful completion of a written examination as determined by the counseling regulatory board.

Although a great deal has been achieved in the licensing arena and ACA’s model legislation has provided counselors with much guidance in the development of counselor-credentialing laws, the statutes are far from uniform in their scope and requirements. This may be due, in part, to the revisions of ACA’s model legislation for licensed professional counselors over the years. Licensure laws passed in the 1980s mirror the education, training, and supervision standards that were endorsed by the profession at that time, whereas those passed recently tend to be more comprehensive in the scope of practice and to impose more stringent requirements than earlier licensure laws.

The state of licensure, however, is confusing to many because the requirements vary from state to state. For example, 19 states and the District of Columbia have one tier of licensure. Other states have tiered licensing, with different scopes of practice and different criteria for eligibility. Twenty-two states have two tiers of licensure (e.g., licensed professional counselor as a “basic license” and licensed clinical counselor as a more “advanced” license), seven states have three tiers, and one state has four tiers of licensure (ACA, 2007a). As of June 2007, education requirements range from a master’s degree with no specified number of hours to 60 semester hours including a master’s degree, with 44 states and the District of Columbia requiring between 48 and 60 graduate semester hours. Wisconsin requires a minimum of 42, Iowa a minimum of 45, and Georgia, Washington, and West Virginia do not specify the number of credit hours required in their laws but may in their regulations. Some argue that most master’s-level professional counselors do not have 60 semester hours, yet 46% of the 1604 ACA members who participated in a 1993 study reported having earned a minimum of 60 graduate semester hours in counseling (Glossoff, 1993). In addition, Hollis (2000) predicted a
trend in counselor education programs of increasing the required credit hours for graduation to ensure that their graduates will meet state licensure requirements.

According to ACA (2007a), the majority of states require 3,000 hours or more of postmaster’s supervised counseling experience, to be completed in no less than 2 years. For example, 25 states and the District of Columbia require 3000 to 3600 hours of postmaster’s supervised counseling experience, 3 states require 4000 to 4500 hours, and 7 states require between 3000 and 4000 hours for the highest level of licensure. Even the titles granted to professional counselors by the regulatory boards vary. “Professional counselor” is the most frequently used title, followed by “mental health counselor,” “clinical professional counselor,” and “clinical counselor.” I believe this lack of uniformity in titles used by state-credentialed counselors has proven to be detrimental to credentialed counselors in their ongoing efforts to gain the same recognition afforded to psychologists and clinical social workers.

Requirements for counselors to continue their education once they are licensed also vary from state to state. According to ACA (2007a), the majority of jurisdictions (45 or 90%) specifically include continuing education credits as a requirement for licensure renewal (not including Nevada, which had not yet written regulations addressing this). The number of continuing education hours required ranged from 10 to 55 every 2 years.

I believe that continuing education requirements for counselors to renew their licenses increased, and will continue to increase, for three reasons. First, most professions require members to stay abreast of current information in their fields after graduation from training programs. Requiring continuing education is one way to inspire confidence in professional counselors, and this will be important in the profession’s continuing efforts to gain recognition from legislators, other policy makers, and the public. Next, NBCC and CRCC both require a minimum of 100 clock hours of approved continuing education during each 5-year period. Finally, requiring continuing education to renew licensure supports the professional standards set forth in the 2005 ACA Code of Ethics, which specifically directs counselors to maintain their level of competence in the skills they use and to stay reasonably aware of new scientific and professional information.

In addition to lack of uniformity, or maybe because of it, there have been legal challenges regarding what professional counselors can and cannot do as part of their scope of practice. For example, licensed counselors in several states have found themselves embroiled in legal battles over their ability to use standardized assessment instruments. This is ironic, given the strong roots that the counseling profession has in testing and assessment. The challenges are driven by efforts on the part of state psychological associations to proclaim that the use of most tests comes under the sole purview of doctoral-level psychologists. The tests noted by psychologists as requiring a doctorate in psychology to administer and interpret run the gamut from personality tests to psychoeducational and career-related measures.

Counselors will continue to fight for their right to administer and interpret those tests based on their education and training rather than on the name of the degree they earned. Legislation proposed by several state psychological associations may serve to bring together master’s- and doctoral-level counselors, social workers, marriage and family therapists, and speech therapists, who may all find themselves unable to legally provide testing services for which they are trained. In response to proposed legislation
that seeks to limit the use of tests based solely on degrees or licenses held, the national Fair Access Coalition on Testing (FACT) was created in 1996. FACT represents more than 500,000 counseling and mental health professionals. The organization has taken an active role in challenging proposed and enacted legislation and in defending mental health professionals who are charged with practicing psychology without a license based on their use of standardized instruments for which they have been adequately trained.

This same type of challenge has been put forth as to counselors’ abilities to diagnose and treat clients, especially those with mental disorders. These efforts to restrain trade require that counselor licensure laws include language similar to the 1994 ACA model legislation that specifically states that counselors “(c) conduct assessments and diagnoses for the purposes of establishing treatment goals and objectives. . . . Assessment means selecting, administering, scoring and interpreting psychological and educational instruments designed to assess achievements, interests, personal characteristics, disabilities, and mental, emotional and behavioral disorders” (Glosoff et al., 1995, p. 211). According to ACA (2007a), only 34 of 48 states and the District of Columbia (Nevada had not yet passed its licensure law) specifically include both the diagnosis of emotional disorders and the treatment of persons with emotional or mental disorders in the scope of practice of credentialed counselors. This does, however, represent gains made by the counseling profession in this area. In 1999, although the majority of jurisdictions (82.6%) specifically allowed credentialed counselors to treat people with emotional or mental disorders, only 40% specifically included diagnosis in the scope of practice of credentialed counselors (Espina, 1999). As presented earlier, laws passed in the 1980s tend to be less comprehensive in the scope of practice afforded to counselors. Rather than try to enact new laws, some states have attempted to broaden their requirements and scope of practice through changes in regulations.

There is clearly a great deal of variance in licensure laws, often making it difficult for counselors licensed in one state to easily move to another state and become licensed. Many states that have practice licensure laws in place include a provision to obtain licensure through a review of credentials or endorsement. This, however, is often cumbersome and time-consuming and still does not allow counselors to simply take their license with them from state to state. To assist with the portability of credentials, the American Association of State Counseling Boards (AASCB) established the National Credentials Registry (AASCB, 2004). This registry allows licensed counselors, for a fee, to deposit or store information relevant to licensure (e.g., their education, work history, and supervised experience). Once this information is “banked,” counselors who want to apply for licensure in another state can ask that AASCB send all information to that licensing board.

Another effort underway that may yield positive results in the long run for licensure portability is the 20/20 Future of Counseling Oversight Committee established by ACA and AASCB. This committee is comprised of representatives from all ACA divisions, and its charge included creating licensure portability by the year 2020. The committee’s charge, however, went far beyond this and addressed other issues that have been discussed in this chapter, such as to clearly define the profession of counseling, to examine how to present counseling as one profession rather than as a group of groups, to improve recognition and public perception of counseling, and to expand and promote the research base of the counseling profession.
Recognition and Reimbursement of Professional Counselors

Credentialing has far-reaching ramifications for hiring and reimbursing professional counselors. Contrary to popular belief, credentialing affects the reimbursement of those professionals in settings other than private practice. Administrative rules used by several federal, state, and local agencies specify that only state-licensed practitioners can be employed by these agencies. These same rules often stipulate that only licensed workers can supervise mental health services, and they call specifically for licensed psychologists. In the late 1970s, Alabama eliminated all counselor position titles because of this type of thinking. Many university counseling centers hire only licensed psychologists. These are just a few examples of how credentialing has become strongly related to employment opportunities for counselors, and there is an increasing trend in this direction (Glosoff, 1993).

Reimbursement for services rendered has played a strong part in the licensure movement for all mental health practitioners. A motivating force in the psychological licensing in the late 1960s and early 1970s was to secure third-party reimbursement and to be included in national health insurance (Hosie, 1991). To facilitate these two goals, in 1975 APA established the National Register for Health Service Providers in Psychology as a means of identifying qualified practitioners of psychological services. Since January 1, 1978, to be listed in the National Register, one was required to have obtained a doctoral degree in psychology from a regionally accredited educational institution. Even though it has been argued that proficiency can be developed just as well in a counselor education department as in a psychology department, criteria for inclusion in the National Register clearly does not allow anyone who was trained elsewhere than a psychology department to take the examinations for licensure or certification as psychologists in most states (Rudolph, 1986). This had direct economic consequences for many doctoral-level professional counselors who were previously eligible to be licensed as psychologists.

Legislation

As I previously discussed, legislation has greatly influenced the development of the counseling profession. Counselors have made strides in being recognized as providers of mental health services in many pieces of legislation enacted over the past 10 years. At the same time, the struggle and the need for ongoing advocacy in this area continue. Following are examples of current issues related to some key laws.

Health Professions Education Partnerships Act

Professional counselors are included in some federal legislation and federally funded programs. For example, counselors were successful in their efforts to be recognized as qualified providers under the Health Professions Education Partnerships Act (HPEPA). According to the American Counseling Association Office of Public Policy and Information (1998b), HPEPA revised the Public Health Services Act (PHSA) by
including counselors under the definition of mental health professionals. In addition, the HPEPA provisions directly affect counselor education programs in competing for clinical training grants by having graduate programs in counseling included in the HPEPA term “graduate program in behavioral and mental health practice.” The act did not include a specific authorization level for any programs. Therefore, the passage of HPEPA does not, in itself, guarantee that counselors will be eligible for any specific program. For example, although HPEPA added “counseling” to the current list of mental health professionals who are eligible for the Center for Mental Health Services (CMHS) clinical traineeship program, at the time HPEPA was enacted, the staff of the CMHS indicated that they did not expect any new clinical traineeships to be granted.

The passage of HPEPA resulted in counselors being included in the National Health Service Corps loan repayment program (ACA Office of Public Policy and Information, 1998b). This program provides financial assistance in repaying student loans in exchange for working in health professions in underserved areas for 2 to 4 years following graduation (e.g., serving in public inpatient mental institutions or federal or state correctional facilities or as members of the faculties of eligible health professions). Other programs authorized by HPEPA provide grants to schools to identify, recruit, select, and financially support people from disadvantaged backgrounds for education and training in health and behavioral and mental health fields, as well as grants to aid in the establishment of centers of excellence in health professions education for underrepresented minority individuals.

**Medicare and the Federal Employees Health Benefits Program**

As of 2007, counselors were not yet included as recognized providers under Medicare, except when providing services “incident to” the services of a physician or psychologist. This means that professional counselors are not recognized to practice independently, which has indirectly had a negative impact on counselors being included as reimbursable providers of service under other public and private insurance programs. This may change in the near future. During 2004–2007, the Senate twice approved legislation that would establish LPCs as recognized mental health providers who could practice independently. At the time I wrote this chapter, bills were pending in both the House and the Senate that would establish Medicare coverage for licensed professional counselors, as well as make other improvements in Medicare’s mental health benefits. Increased support for counselor reimbursement under Medicare in the House of Representatives should increase the chances for enactment of such a provision. Counselor recognition under Medicare, when achieved, should go a long way toward evening the playing field for counselors in the health care provider marketplace.

In addition to advocating for recognition of professional counselors in federal laws, ACA, AMHCA, and members of ACA’s state branches also have attempted to change the laws and regulations that have excluded professional counselors as eligible providers of services paid for through Medicare and federal employee health benefit plans (FEHBP). Although FEHBP is regulated by a federal law, group policies are written across the country by various insurers—most often Blue Cross/Blue Shield. At present, these policies are required by law to cover mental health services provided by psychologists and clinical
social workers. Although policy makers may cover services provided by professional counselors and marriage and family therapists, this coverage is optional rather than mandated.

Because professional counselors are not included as independent Medicare providers in the federal statute, they have been unable to “sign off” on the delivery of mental health services through Medicare. This, in turn, may deter administrators from hiring professional counselors. Many people are not aware that the Medicare policy on the coverage of partial hospitalization services furnished in community mental health centers (CMHCs) allows services to be provided by professionals other than physicians and psychologists. This has been used to have CMHCs and other state agencies write regulations and policies to include LPCs as employees. Even so, the law itself needs to be amended to specifically include LPCs or do away with the list of providers and include a statement that covered services include “individual and group therapy provided by any licensed mental health professional.”

Tricare
Another area for continued advocacy is the current Office of the Civilian Health and Medical Program of the Uniformed Services (known as Tricare) regulations that recognize licensed counselors and Certified Clinical Mental Health Counselors but only if clients are referred by a physician and if the physician provides ongoing supervision of the counseling. These limitations are not placed on services provided by clinical psychologists, clinical social workers, psychiatric nurses, and marriage and family therapists. ACA and AMHCA have been working for several years to enlist congressional support for parity between counselors and other Tricare mental health service providers. The Department of Defense (DoD) Authorization Act (P.L. 106-398), enacted in fiscal year 2001, included language requiring the Tricare Management Authority to conduct a demonstration project allowing mental health counselors to practice independently, without physician referral and supervision. The demonstration project concluded with a report to Congress by the Rand Corporation in May 2005. Physician referral and supervision requirements for both marriage and family therapists and clinical social workers were removed by Congress following similar demonstration projects (Scott Barstow, personal communication, August 25, 2003). Bills in Congress in 2005 and 2006 included LPCs in the DoD authorization law. Although the Rand report was essentially neutral with regard to the inclusion of professional counselors as independent mental health service providers, the Senate viewed the report as an indication that there were more reasons than not to disallow independent practice by counselors, and the bills, unfortunately, were rejected in both years. Receiving recognition by the Tricare Management Authority for professional counselors remains a strong priority.

Veterans Affairs
Public Law 109-461, the Veterans Benefits, Healthcare, and Information Technology Act of 2006, includes language that clearly recognizes LPCs and licensed marriage and family therapists as mental health specialists within all health care programs operated by the Department of Veterans Affairs (VA) (ACA, 2007b). Although it will take time to write regulations to fully implement this law, it will greatly expand the job
opportunities for counselors in the VA system. Rehabilitation counselors had long been employed by the VA, but the VA had not, until the enactment of this law, recognized counselors as mental health specialists (ACA). Because of that, counselors have not been paid at the same rate as clinical social workers and were not eligible to be considered for supervisory positions that have been open to social workers and others in the VA. The enactment of P.L. 109-461 should greatly affect counselors not only within the VA but also in all federal programs because the Office of Personnel Management (OPM) will need to create a new occupational classification for mental health counselors, which will be applied to other federally operated programs.

**Medicaid**

Medicaid, a federal program, is implemented through state regulations. The enactment of the 1997 Balanced Budget Act included provisions that prohibit Medicaid managed care plans from discriminating against providers on the basis of the type of license they hold. The act, however, did not extend to fee-for-service plans regulated through Medicaid, and most states have traditionally used fee-for-service programs. This is changing, however, and many states have moved to managed Medicaid care plans. The battle to include professional counselors as recognized Medicaid providers continues to be fought at the state level.

Most third-party reimbursers have major criteria for acceptance as reimbursable practitioners that include educational degrees and a license that allows the mental health provider to practice independently (Bistline, 1991; E. Bongiovanni, personal communication, April 27, 1993; Throckmorton, 1992). State licensure is also a prerequisite to becoming eligible for third-party reimbursement by insurance companies via any state mandates regulating insurance codes. Research indicates that LPCs do receive reimbursement from some insurance companies in states that do not legally mandate this (Throckmorton, 1992; Zimpfer, 1992). However, without a state mandate, there are no guarantees that LPCs or their clients will be reimbursed for services rendered.

A number of states have legislated mandates, often called “freedom of choice” (FOC) laws, that require reimbursement for services provided by specific professionals, such as LPCs, if these services are covered by a health plan. FOC laws increase consumers’ choice of providers, thereby expanding the markets for mental health providers. These laws, however, do not regulate managed care companies, employers that set aside money to pay for the medical claims of their employees, or publicly funded (state or federal) insurance programs. Licensed counselors are included as clinicians and as administrative staff in managed mental health systems (Throckmorton, 1992).

**Summary**

The roots of counseling are deeply embedded in a variety of disciplines that have come together and created different emphases at various points in time. These emphases have led to the development of counseling specialties, counselors working in a wide variety of settings and offering a broad range of services, and the profession struggling with the formation of an identity.
Counselors in the United States, regardless of work setting or theoretical orientation, are linked by the common belief that a person has the capacity and right to choose directions and activities that are most personally satisfying. Choices must be made within the bounds of social and moral value systems that will not bring harm to self or to others. The counselors who were pioneers and the counselors who work now are dedicated to helping individuals find their way in an increasingly complex society.

Counselors are active in dealing with a great number of social problems that affect the populations with which they work. Society is in turmoil, trying to deal with the use of illegal drugs; changing family structures; the effect of technology on education, occupations, and employment; immigration issues; and complex pluralism, leading to the development of special populations at risk of being inundated by the majority. There is not space here to discuss each issue and the role of counselors in addressing these. Counselors must work to ensure that through their systematic, scientific, and professional efforts, individuals and groups will be served well. The following Web sites provide additional information on chapter topics.

**USEFUL WEB SITES**

American Counseling Association:
http://www.counseling.org

American Counseling Association Public Policy Information:
http://www.Counseling.org/publicpolicy/

Chi Sigma Iota:
http://www.csi-net.org

National Board for Certified Counselors:
http://www.NBCC.org

Commission on Rehabilitation Counselor Certification:
http://www.crccecertification.com

**REFERENCES**


City of Cleveland, Ohio v. Cook, Municipal Court, Criminal Division, No. 75-CRB 11478, August 12, 1975. (Transcript dated August 19, 1975).


CHAPTER ONE / The Counseling Profession


CHAPTER 2

The Helping Relationship

ROCHELLE MOSS, PhD
University of Arkansas, Little Rock

Introduction

Imagine that you are the client, and you are about to walk through the door of the counselor’s office for your very first visit. For the past year, you have contemplated going to talk to someone, but fear and anxiety have kept you from seeking help. You have worried that the counselor might judge you or that the counselor might tell people in the community about your problems. You have questioned whether the counselor will truly be able to help you. But finally you have made the decision to obtain help, and with all the courage you can muster, you walk through the door.

What do you hope to find on the other side of the door? What will you need from this trained professional? And how will this person go about helping you get what you need from this experience?

When you place yourself in the position of the client, you can understand the importance most clients place on their decision to seek counseling and the apprehension they often feel about the counseling process. This chapter focuses on the characteristics, knowledge, and skills the counselor needs to build effective counselor–client helping relationships. The first section describes the helping relationship and its importance. The following sections review what research has shown to be the characteristics of effective counselors and the skills needed to help clients move toward positive change. Also, a case study provides examples taken from conversations between the counselor and client; these examples demonstrate specific techniques you might use when working with clients.

What Is the Helping Relationship?

There are many informal helping relationships in our lives in which we seek assistance from friends, family members, or coworkers. These relationships meet the mutual
needs of those involved. Unlike these relationships, the counselor–client helping relationship is unique in that it is established as a one-way relationship with the purpose of resolving a concern and/or fostering the personal growth of one person—the client. The counselor is designated as the helper and is assumed to have the knowledge and training to assist the client in an intentional and systematic way. Rogers (1961) defined a helping relationship as one “in which at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning and improved coping with life of the other” (p. 39).

The goals of any counselor–client relationship, whether in educational, career, or personal counseling, can be placed into four basic goal areas: changes in behavior and lifestyle, increased awareness or insight and understanding, relief from suffering, or changes in thoughts and self-perceptions (Brammer & MacDonald, 1996). An important aspect of the helping relationship is that it is a process that enables a person to grow in directions that person chooses. It is the counselor’s job to make the client aware of possible alternatives and encourage the client to accept responsibility for taking action on one or more of these alternatives.

The helping relationship minimally can be broken down into three phases: relationship building, challenging the client to find ways to change, and facilitating positive client action (Egan, 2007). In the first phase, the goal is to build a foundation of mutual trust that promotes the client’s exploration of the presenting issues. In the second phase, the client has a deeper level of awareness and understanding regarding the issues, and the helper then challenges the client to “try on” new ways of thinking, feeling, and behaving. In the final phase, the counselor facilitates client actions that lead toward change and growth in the client’s life outside the counseling relationship.

Seligman (2004) suggests that a positive helping relationship has the following characteristics:

- It provides a safe and protective environment for clients.
- It encourages collaboration, with both clients and counselors playing an active role in the counseling process.
- It has mutuality or a feeling of shared warmth, caring, affirmation, and respect.
- Clients can identify with their counselors and perhaps use them as role models.
- Client and counselor have an agreement on goals and procedures; sessions are structured in such a way as to clearly move toward accomplishment of these goals.
- Client and counselor view themselves as engaged in a shared endeavor that seems likely to succeed. (p. 212)

Studies repeatedly show that the quality of the helping relationship is the most important predictor of positive counseling outcomes (Horvarth & Symonds, 1991; Orlinksy, Grawe, & Parks, 1994; Sexton & Whiston, 1994). The contributions of the helping relationship are independent of the theoretical orientation or type of treatment (Norcross, 2001). Specific procedures and techniques have been proven to be much less important than the alliance between counselor and client (Assay & Lambert, 1999).

It is the counselor’s responsibility to begin establishing this vital relationship as quickly as possible. Researchers have found several essential elements that make the relationship more favorable for client growth.
Essential Components of a Helping Relationship

Several decades ago, Carl Rogers was instrumental in determining the core conditions necessary for a beneficial relationship in counseling. Rogers (1957) believed that congruence, unconditional positive regard for the individual, and empathic understanding needed to be present for the relationship to be therapeutic. When describing congruence, Rogers (1961) emphasized the importance of being genuine and real in the relationship. He explained that counselors should strive to have congruence between what they are feeling on the inside and what they are outwardly communicating. When a counselor is congruent, interactions with the client are characterized by honesty, transparency, and openness. Rogers believed that “it is only by providing the genuine reality which is in me, that the other person can successfully seek for the reality in him” (p. 33).

When Rogers (1961) explained the condition of having warm, unconditional positive regard for the clients, he stressed the importance of accepting the client without evaluation or judgment. He stated that this acceptance “makes for him [the client] a relationship of warmth and safety, and the safety of being liked and prized as a person seems a highly important element in a helping relationship” (p. 33). This attitude of valuing the client and showing positive regard is referred to as nonpossessive warmth by more recent writers (Cormier & Hackney, 2008).

Rogers (1961) described the condition of empathy as being necessary for the client to feel the counselor’s acceptance. Empathy is often defined as the understanding of the client’s experiences and feelings as if they were your own but without losing the “as if” quality (Rogers, 1957; Bozarth, 1997). When a counselor effectively communicates empathy, it assures clients that they are understood; it also can provide a sense of safety and encourage client exploration (Bohart, Elliott, Greenberg, & Watson, 2002). Rogers (1961) described this process:

- It is only as I understand the feelings and thoughts which seem so horrible to you . . . it is only as I see them as you see them, and accept them and you, that you feel free to explore all the hidden nooks and frightening crannies of your inner and often buried experiences. (p. 34)

Rogers’s core conditions have proven to be essential in establishing and maintaining effective helping relationships and are now considered to be basic helping skills used in the majority of counseling approaches. Additional elements necessary for a therapeutic relationship include commitment, respect, trust, confidentiality, and benevolent power (Kottler & Shepherd, 2008).

- Respect describes the helping attitude that communicates acceptance of the client as a person of worth and dignity (Rogers, 1957). In utilizing this skill, the counselor demonstrates a belief in the client’s ability to deal with his or her problems in the presence of a facilitative person. Respectful counselors use communication skills to actualize the power, ability, and skills the client already possesses. In other words, the counselor believes in the client’s problem-solving ability. These
skills and attitudes are very important in facilitating an effective helping relationship. They communicate a willingness to work with the client and an interest and belief in the client as a person of worth (Cormier, Cormier, & Cormier, 1997).

- **Trust** is essential in a healthy, productive counseling relationship. Trust can be established by being genuine and by expressing respect and positive regard for the client's individual worth. Trust can be maintained by consistently following ethical standards and always remembering to put the needs of the client first and foremost.

- **Confidentiality** assures clients that whatever they tell will remain private (within certain limits; see Chapter 4). This promise allows the client to feel safe and promotes telling information that would otherwise remain hidden.

- The **use of benevolent power** refers to using the interpersonal influence one has as a counselor in a careful manner. According to Strong and Claiborn (1982), counselors are influential because of their perceived levels of expertness, attractiveness, and trustworthiness and must use this power responsibly in facilitating change for the client.

- **Commitment** to carry out respective responsibilities in the helping relationship is important for both counselors and clients. Counselor responsibilities include delivering specified services and following ethical guidelines; client responsibilities include a commitment toward working on his or her problems and investing energy in the counseling process.

We have examined components of an effective helping relationship; next, we will outline specific counselor characteristics and attitudes that are linked with being an effective and competent helper.

### Personal Characteristics of Counselors

Effective counselors have specific personal qualities and are able to convey those qualities to the people they help. Increasing evidence supports the concept that helpers are only as effective as they are self-aware and able to use themselves as vehicles of change (Okun, 2008).

Combs (1986) summarized 3 studies that looked at helpers in a variety of settings. These studies supported the view that there are differences in the beliefs of effective and ineffective person-centered helpers. Effective counselors are interested in and committed to understanding the specialized knowledge of the field and find it personally meaningful. As such, they are challenged to remain current in their knowledge and skills. They like people and have a feeling of oneness with others. Effective counselors use interventions that focus on the individual's perception of self and expand the individual's view of life rather than narrowing it. They are committed to freeing rather than controlling the client and are able to be objectively involved with, rather than alienated from, their clients.

In other studies, effective counselors have been shown to be compassionate and believing of the client's world. In their own lives, they are open to a full range of experiences and feelings, are spontaneous, and have a sense of humor. When interacting
with others, they are able to be involved yet remain somewhat detached (Cormier et al., 1997). In the process of dealing with problems and issues, they help clients clearly see their own worlds while adding a fresh perspective to the issues.

Because counseling is demanding work, effective counselors often display high energy levels (Carkhuff, 1986). Intense focusing with another individual, trying to hear clearly, often needing to tolerate ambiguity (Pietrofesa, Hoffman, Splete, & Pinto, 1978), and taking appropriate risks can put heavy demands on the counselor’s physical and emotional energy. Therefore, a challenge to individuals pursuing the counseling profession is to have good self-care strategies (see Brems, 2000).

Examine the checklist of desirable counselor characteristics in Table 2.1. The items have been compiled from numerous resources (Combs, 1986; Gladding, 2007; Rogers, 1957, 1961; Seligman, 2004; Sexton & Whiston, 1994) and are listed in no particular order of importance. Check those you believe you possess, and make note of those you have not yet developed.

In the next section, the fundamental helping skills of counseling are explained, beginning, with microskills and attending skills.

### Basic Skills and Concepts

According to Ivey and Ivey (2007), the aim of counseling is personal and social development. They have described a hierarchy of microcounseling skills that define what the counselor does in an interview to achieve specific results. The hierarchy rests on a foundation of attending behaviors and basic listening skills. The list of skills presented here is based on Ivey and Ivey’s model, with additional information taken from Cormier and colleagues (1997) and Egan (2007).
Attending Skills

Attending behavior, including eye contact, body language, vocal quality, and verbal tracking, is one of the most powerful communication skills (Ivey & Ivey, 2007). In the counseling relationship, counselors communicate through body language and words that their full attention is on the client’s nonverbal and verbal behaviors. Eye contact, facial expressions, and body posture are the physical fundamentals that indicate to others that you are either carefully attending or not attending to them.

Eye Contact. Good eye contact is not an unwavering stare but an intermittent yet frequent looking into the eyes of the client. It tells others that you are interested in them and what they have to say. It also can signal understanding and provide feedback (Evans, Hearn, Uhlemann, & Ivey, 2008). Effective eye contact occurs more frequently when there is a comfortable distance between counselor and client and when topics being discussed are not too threatening. Cultural differences abound in what is considered appropriate eye contact (Ivey & Ivey, 2007). For example, Anglo-Americans usually have more eye contact when listening and less when talking; the opposite is true of many African Americans. In some cultures, eye contact is avoided when discussing serious topics (Evans et al., 2008). The counselor should first consider cultural differences if eye contact seems strained or awkward in the relationship.

Attentive Body Language. Body orientation can encourage or discourage interpersonal interactions. In Anglo-American culture, a slight forward body lean and a relaxed, comfortable posture are usually received favorably and indicate interest in the client. Egan (2007) uses the acronym SOLER to describe this attentive body posture: Squarely face the client, Open body posture, Lean forward slightly, Eye contact, and Relaxed manner. Facial expressions should fit the material being discussed.

Distance. The distance between counselor and client also affects communication. There is an optimal “comfort zone” for conversing that is largely controlled by cultural influences. It is about an arm’s length in American culture. The counselor must be aware of the level of comfort or discomfort that the client is experiencing with the distance and adjust it if necessary.

Although there are many things counselors can do to convey an interest in their clients, certain mannerisms are distracting. Behaviors such as gum chewing, cigarette smoking, or continual change of body position may seriously affect any interpersonal interaction and convey a lack of counselor interest.

Vocal Tone. Another aspect of attending behavior is voice tone. A warm, pleasant, caring voice strongly indicates an interest and willingness to listen. The pitch, volume, and rate of speech can convey much of one’s feeling toward another person or situation. Scherer (1986) has shown that the use of specific paralinguistic cues can convey either high or low levels of self-confidence. High levels of confidence are conveyed when you speak in a caring voice that is neither hesitant nor rapid and projects inner qualities of warmth, respect, and compassion for the client. These cues of self-confidence can
affect client perceptions of counselor expertness, attractiveness, and trustworthiness, as well as associated satisfaction with the counseling relationship (Barak, Shapira, & Fisher, 1988).

**Verbal Tracking.** Even when the client engages in long, irrelevant discourses, the counselor often needs to remain relaxed and follow the client’s topic and logic. The counselor can choose to either attend or ignore certain portions of the client’s statements, which is termed *selective attention*. The portions of the client’s statements to which a counselor attends depend upon the counselor’s theoretical orientation and professional beliefs. Counselors have to be aware of their own patterns of selective attention, for the topics their clients focus on will tend to be partially determined by those topics to which the counselor unconsciously attends.

*Silence* is another important part of verbal attending behavior. The counselor’s ability to remain silent while clients are silent facilitates clients listening to their inner voice (and also may give the counselor time to think of the most effective way to respond). Silence may give the client time to further contemplate or process the issues at hand, and a deeper level of understanding may be the result. Remaining silent is often an excellent tactic to start a reluctant client talking because silence is often perceived as a demanding condition that must be filled with a response. However, the

**TABLE 2.2 Helping Skills**

<table>
<thead>
<tr>
<th>Attending Skills</th>
<th>Description</th>
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<tbody>
<tr>
<td>Eye contact</td>
<td>Intermittent yet frequent looking into the eyes of the client</td>
</tr>
<tr>
<td>Attentive body language</td>
<td>Having a comfortable, relaxed, open posture</td>
</tr>
<tr>
<td>Distance</td>
<td>Awareness of personal space; distance appropriate from client</td>
</tr>
<tr>
<td>Verbal tracking</td>
<td>Attending to client’s story; may involve selective attention</td>
</tr>
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**Active Listening Skills**

| Observing nonverbals     | Noting physiological changes, facial expressions, body language             |
| Verbal behavior          | Noticing key words, topic changes, topic exclusions, incongruities          |
| Minimal encouragers      | Head nodding, “um-hmm,” interested facial expressions                      |
| Paraphrase               | Rephrasing the content of the client’s message                            |
| Summarization            | Restating overall meaning from a long period of conversation               |
| Reflection of feelings   | Accurately recognizing and communicating the client’s emotions             |
| Questions                | Using open-ended questions beginning with *what* and *how*                 |
| Concreteness             | Helping to make feelings, experiences, and behaviors more specific         |

**Advanced Skills**

| Advanced Empathy         | Communicating a deeper underlying meaning of client’s experiences          |
| Self-disclosure          | Sharing personal information for specific reasons, such as modeling        |
| Confrontation            | Communicating to the client his or her discrepancies or mixed messages    |
| Inmediacy                | Discussing what is happening in the moment or the “here and now”           |
meaning of silence is culturally based (Murphy & Dillon, 2008). The challenge for beginning counselors is learning to be comfortable enough with silence to use it effectively.

The following section begins with a case study that gives specific examples of basic helping skills and advanced skills.

Case Study

Melissa is a 16-year-old female who was brought in to counseling after swallowing a bottle of Tylenol. She told her mother what she had done, and her mother rushed her to the hospital, where the emergency staff pumped her stomach. She recovered and was referred for individual counseling.

During the first few sessions, the client explored several significant issues with the counselor. First of all, she emphasized the main issue behind the overdose was that her boyfriend broke up with her. She also said that she was very upset over the fact that a 19-year-old male friend was being deployed to the Middle East in a couple of months. She felt guilty and worried because she had not been on good terms with him and “had been mean to him.” Melissa stated that these two stressors were behind her taking the overdose.

In addition, Melissa explained that she has few, if any, true friends. She believes that she does not belong in any group. She is not a “goody-two-shoes,” nor is she a “nerd.” She also has decided that her old group may have some behaviors that she does not want to get mixed up with, such as drug use. However, she later reveals that she does smoke a little marijuana from time to time.

Melissa’s parents are divorced, and she lives with her mother. She is an only child. Melissa said that she wants to have a good relationship with her father and that they try to see each other about once a month. However, she added that if she has anything else to do, she will make an excuse and not see him. Her mother has a very busy work schedule with lots of job responsibilities but seems to pay attention to Melissa when there is a crisis situation.

The Basic Listening Skills

Active listening is an extremely important dimension of counselors’ work (Egan, 2007). Counselors need to be sure that they are hearing the client accurately, and clients must know that the counselor has fully heard them, seen their point of view, and felt the world as they experience it. The basic listening skills that facilitate active listening include client observation; noticing client nonverbal behavior; the use of encouraging, paraphrasing, and summarization statements; the reflection of client feelings; and the use of open and closed questions. The outcome of using these basic listening skills in combination is the establishment of an empathic relationship with the client (Carkhuff, 1969). The overall purpose of empathy is to “understand the situation of another person from that person’s perspective” (Berger, McBreen, & Rifkin, 1996, p. 210).
Client Observation

Simply observing the client provides the counselor with a rich source of “silent information.” Noticing and paying attention to the physiological cues expressed in another person’s appearance and physique provide a way to identify the internal emotional responses of the other person. These physiological cues may include changes in skin color, pupil dilation, muscle tone, and/or breathing, which can reflect the internal emotional processes and the physiologic changes occurring within the client. These physiologic messages are difficult to hide because they are generally involuntary reactions of the autonomic nervous system. Observing subtle changes in these areas can silently reveal the moments of emotional change for a client.

The points during the interview at which eye contact is broken, the voice changes, skin color changes, shifts in body posture occur, or muscle tension or facial expression changes may indicate moments when important information is being revealed.

Case Example

The counselor observes Melissa as she describes the breakup with her boyfriend. The client’s voice tone drops, and she speaks more slowly. Eye contact is broken as she looks down, and her skin becomes pale. From these observations, the counselor is aware of the strong emotions connected with the breakup.

Verbal Behavior

In addition to nonverbal behavior, the client’s verbal behavior can also reveal a great deal. At the most basic level, the counselor should note topic changes or topic exclusions and any key words that appear again and again. For example, the client’s frequent use of “should” or “ought” statements may indicate a lack of control in those areas and should be explored further. Noticing topics the client avoids may also give the counselor valuable information that can be explored later with the client.

Case Example

The counselor notes that Melissa often changes the topic when the relationship with her father is mentioned. Words that continue to resurface include alone, hurt, and guilty, which may point toward themes in this client’s current situation.

Sentence structure is an important clue to how the client views the world. Is the client the subject or the object of the sentence? Specifically, does the client feel he or she does the acting or is acted on? Are concerns portrayed as being in the past, the present, or the future? Are there key words and descriptions that give a clue to the client’s worldview? Certain patterns of words and ideas are clues to a client’s typical thought processes and self-perceptions.

Incongruities, discrepancies, and double messages are nearly universal in counseling interviews. They are often at the root of a client’s immobility and inability to respond creatively to difficult life situations (Egan, 2007). When counselors notice such incongruities, they may choose to either hold back and say nothing or try to bring the discrepancy into the client’s awareness. The emotional state of the client and the
impact upon the relationship should be the main considerations in making this decision. In time-limited counseling, or within certain theoretical frameworks such as Gestalt, immediate confrontation may be the preferred intervention. Confrontation skills are discussed later in this chapter.

**Case Example**

The counselor notices a couple of incongruities in Melissa’s communication. First, she said that she does not want to associate with her old friends because of the drug use but later revealed that she smokes marijuana from time to time. She also stated that she wishes to have a strong relationship with her father but makes excuses to avoid seeing him when possible.

**Encouraging, Paraphrasing, and Summarizing**

The skill of **encouraging** includes the use of both “encouragers” and “restatements,” both of which punctuate the interview and provide a smooth flow. Using encouragers such as head nods, an interested facial expression, or verbal utterances such as “ummm” or “uh-huh” is an active way to let clients know that they have been heard and understood. Encouragers can be used to influence the direction taken by the client and are part of selective attention as described previously.

One powerful type of encourager is the counselor’s restatement of a key word or a short phrase from the client’s statement, often in a questioning tone of voice.

**Case Example**

**MELISSA:** I felt alone and afraid when my boyfriend broke up with me.

**COUNSELOR:** Afraid?

The **paraphrase** is used to reflect the content of what the client has just said. It is not parroting the client (repeating back exactly what was said) but feeding back to the client the essence of what was said (Evans et al., 2008). It is an encapsulated rephrase of the content of the client’s message in the counselor’s words, sometimes containing the client’s key words and constructs. The strength of the paraphrase is that the counselor is giving of self yet is paying primary attention to the client’s frame of reference. The purpose of this skill is to let clients know that they have been heard accurately and to encourage them to continue discussing the issue in more detail.

**Case Example**

Consider the following example of a paraphrase.

**MELISSA:** I wish I could take back some of the mean, hurtful things I said to my friend, but now he’s being deployed, and I don’t have the chance. And who knows what will happen?

**COUNSELOR:** You wish you could talk to your friend and apologize for what you said in the past, but now you don’t have that opportunity, and you think of the uncertainty of the situation with him going to fight in the war.
Summarizations are similar to paraphrasing, except that they “paraphrase” a longer period of conversation. These responses gather together a client’s verbalizations—facts, feelings, meanings, and patterns—and restate them for the client as accurately as possible. Summarizations frequently give the client a feeling of movement as ideas and feelings are explored (Brammer & MacDonald, 1996).

Summarizations may be useful in the beginning of a session to warm up a client or at other times to bring closure to discussion on a theme. They can be used to add direction and coherence to a session that seems to be going nowhere (Egan, 2007). Also, summarizations are valuable to counselors as a check on the accuracy of their understanding of the information that has just been gathered.

Case Example

Here is an example of a summarization in an interview with Melissa.

COUNSELOR: You’re feeling uncertain about lots of things in your life right now—your relationships with friends, relationships with parents, and trying to figure out who you are and where you fit.

Reflection of Feelings

Besides hearing the words of the client accurately, the counselor must uncover and recognize the emotions underlying those words. The counselor listens and watches for both nonverbal messages and direct verbal communication to accurately determine the feeling(s) being expressed by the client. Reflection of feeling can help clients to feel understood, to sort out complex feelings, and to continue exploring their feelings at a deeper level (Egan, 2007; Evans et al., 2008). Seligman (2004) stated that a counselor’s use of this tool is the most powerful way to communicate empathy.

The counselor also has to know how to communicate the feeling accurately by recognizing and labeling the category of emotion (i.e., anger, gladness, sadness, fear, or uncertainty), as well as the correct intensity of the emotion (Carkhuff & Anthony, 1979).

Case Example

MELISSA: I know that Dad had an affair while he and Mom were married, and I’ll never get over that. And now he wants to just trade us in for his new family!

COUNSELOR: You’re really angry with your dad and resent the fact that he’s starting over with someone else.

When using reflection of feeling with clients of differing cultures, the counselor must be able to express culturally sensitive empathy by having knowledge of the client’s culture and communicating respect and understanding of the culture while understanding the client’s circumstances (Evans et al., 2008). Also, the counselor needs to be aware of how that specific culture views the open discussion of emotions.

Questions

The use of questions can open communication. In the helping relationship, the counselor’s effective, open communication is especially necessary. It facilitates moving the
client from self-exploration through increased understanding and finally to commitment to appropriate action. By using specific verbal leads, the counselor is able to bring out the major facts, feelings, and self-perceptions that a client brings to the session. Effective use of open and closed questions can encourage the client to talk more freely and openly.

Asking open-ended questions is considered to be the most beneficial type of questioning because the client is encouraged to talk more freely and openly. Open questions usually begin with what, how, could, or would and require the client to provide a longer, more expansive response than simply yes or no. Open questions are used to begin interviews; to encourage clients to express more information; to elicit examples of particular behaviors, thoughts, or feelings; and to increase the client’s commitment to communicate. Some examples might be:

**COUNSELOR:** What would you like to discuss today?

**COUNSELOR:** How do you plan to reestablish that friendship?

Sometimes a client is very talkative and rambles or jumps from topic to topic. In such a case, closed questions can be used to gather information, give clarity, gain focus, and narrow the area of discussion. These closed questions usually begin with is, are, do, or did. Counselors must use caution, though, because extensive use of closed questions can hinder conversation (Egan, 2007). A questioning counselor can appear to have all the power in the relationship, and this inequality can destroy the counselor–client alliance, especially during initial encounters. With too many closed questions, clients may feel as though they are being interrogated.

Clients from some cultures are rapidly turned off by counselor questions, as are clients who have not developed trust in their counselors. The same information can frequently be obtained by asking the client what goals they have, how they feel about those goals, and how they plan to attain them. (Note that asking too many questions at once can confuse clients.) “Why” questions are especially troublesome because they may put clients on the defensive or leave them feeling they must provide a logical explanation for their behavior.

Because questions may cause resistance with some clients, the skills of encouraging, paraphrasing, summarization, and reflection of feeling may be used to obtain similar information yet seem less intrusive to the client.

Counselors must be flexible and adapt their skills to accommodate the client’s culture. (See Chapter 3 for information on culture-specific issues.) To prevent counselors from making generalizations that lead to stereotyping, Hays (1996) developed a model for considering the multifaceted cultural influences that affect the helping relationship. These influences include gender, race and ethnicity, age and generation, social status, sexual orientation, religion, indigenous heritage, and national origin. Counselors must remember that the client’s issues are developed in a cultural context and listen for family and cultural issues that affect the client in order to resolve the issues within that context.

**Concreteness**

In the process of exploring problems or issues, a client often presents an incomplete representation of what has happened. The goal of concreteness is to make the
information and awareness gained through self-exploration more specific and concrete (Meier & Davis, 1993). It is the task of the counselor to help the client clarify the pieces of the puzzle and fit them together so that the whole makes sense to the client. This clarification increases the likelihood that an organized, specific, workable action plan will be accepted by the client and implemented. When encouraging concreteness, counselors attempt to focus very specifically on the situation at hand and try to make clear all facets of the issue, including the accompanying behaviors and feelings.

There are several ways to help clients become more concrete and focused. When a client makes a vague statement, the counselor can reflect in a more concrete way. At times, a rambling client may need to be focused. The effective use of concreteness in such situations may feel like interrupting but should lead to increased counselor–client interaction. When clients need to be more definite and clear, leads such as “what” and “how” rather than “why” will usually produce more relevant and specific information (Egan, 2007).

Case Example

MELISSA: I just want to feel like I belong somewhere.

COUNSELOR: Describe for me a specific time or situation in your life when you remember feeling that way.

Effective use of concreteness keeps the counseling session productively focused and aims at making vague experiences, behaviors, and feelings more specific. The more specific the information, the better the understanding and the more effective future choices and actions will be.

Self-Attending Skills

Counselors who are aware of their own values, beliefs, and assets find it easier to “be with” clients, help clients explore personal issues, and facilitate client action. Therefore, the self-attending skills are extremely important for each person who wishes to be an effective counselor. There are several components to the self-attending process. Shulman (1979) referred to these counselor components as “tuning-in.” The first component in the tuning-in process is self-awareness.

Self-Awareness

The personal knowledge and understanding that the counselor has of self and the counseling setting are essential to the self-attending process. Practically speaking, the counselor should not consciously rehearse how counselors are “supposed” to be. The effective counselor acts professionally but does not put on a professional front or play-act being some imaginary expert counselor. Effective counselors know their strengths as well as their weaknesses, and by understanding themselves they are able to overcome self-consciousness and devote fuller attention to what the client is trying to disclose.
In the process of learning counseling skills, there may be times when using the skills seems awkward and uncomfortable. The learning cycle for trainees can sometimes be an unsettling process. Unlearning competing behaviors and relearning new ones in their place take time, a great deal of concentration, and practice. Counselor self-awareness is crucial throughout this process.

**Centering and Relaxing**
Centering, or getting in touch and then in tune with oneself (Brammer & MacDonald, 1996), is an important skill for the counselor to develop. By becoming centered, the counselor is able to show more social-emotional presence (Egan, 2007) in the counseling relationship and give the client his or her undivided attention. With a keener focus than is common in most human interaction, the counselor is better able to empathically understand the client's problems and concerns. Similarly, the counselor's relaxation (both physical and psychological) helps clients relax as they face the stress and challenges of the counseling process.

**Nonjudgmental Attitude Toward Self**
Counselors need a broad awareness of their own value positions. They must be able to answer very clearly the questions “Who am I?” “What is important to me?” and “Am I nonjudgmental?” (Brammer & MacDonald, 1996).

This awareness aids counselors in being honest with themselves and their clients and in being free from judgments about themselves. In addition, it helps the counselor avoid unwarranted or unethical use of clients to satisfy personal needs. Although counselors may have opinions about the traits of people they like and want to associate with, one characteristic of effective counselors is that they try to suspend personal judgments about their clients' lives.

**Nonjudgmental Attitude Toward Others**
This attitude is respect for a client's individuality and worth as a person and very similar to Rogers's (1961) concept of “unconditional positive regard.” It allows clients to be open and be themselves, because they know that the counselor will not be judging them or what they say. The counselor conveys this nonjudgmental attitude by being warm, accepting, and respectful toward the client; this is especially important in the early phases of the relationship.

**Case Example**

**MELISSA:** I feel really awful. I had sex with my boyfriend, and then he broke up with me. I know my parents wouldn’t approve, but I thought he really loved me. But I don’t think they would understand.

**COUNSELOR:** You thought at the time it was the right decision because there were strong feelings involved. But you don’t think that your parents could ever understand.
Respect is rarely found alone in communication. It usually occurs in combination with empathy and genuineness.

Communicating Genuineness

When counselors relate to clients naturally and openly, they are being genuine. Being a counselor is not just a role played by the individual. Instead, it is the appropriate revelation of one’s own feelings, thoughts, and being in the counseling relationship. Egan (1975) cautions that “being role free is not license; freedom from role means that the counselor should not use the role or facade of counselor to protect himself, to substitute for effectiveness, or to fool the client” (p. 92).

The effective use of genuineness reduces the emotional distance between counselor and client (Cormier et al., 1997). It breaks down the role distance, links the counselor and client together, and allows the client to see the counselor as human, and a person similar to him or her. The genuine counselor is spontaneous, nondefensive, and consistent in relationships.

Case Example

MELISSA: Do you think I’m as crazy and weird as I feel?

COUNSELOR: You have been going through some difficult situations, and you’re feeling confused about what to do. I don’t experience you as being crazy and weird at all.

### TABLE 2.3 Multicultural Considerations in Establishing a Helping Relationship

<table>
<thead>
<tr>
<th>Beliefs</th>
<th>What are my beliefs about the client’s culture, and what impact has my culture had on my beliefs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td>Do I value cultural diversity presented by my client?</td>
</tr>
<tr>
<td>Skills</td>
<td>What skills and strategies do I need to work effectively with this culturally diverse client?</td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
</tr>
<tr>
<td>Acculturation</td>
<td>What is the client’s level of acculturation or assimilation into the majority culture?</td>
</tr>
<tr>
<td>Perceptions</td>
<td>How does my client view seeking help from a counselor?</td>
</tr>
<tr>
<td>Social philosophy</td>
<td>Is this client from an individualistic or collectivist society?</td>
</tr>
<tr>
<td>Approach</td>
<td>Will a direct or subtle approach be more effective? Will the client respond better to an equal relationship or to an expert stance?</td>
</tr>
<tr>
<td>Distance</td>
<td>At what physical distance is this client most comfortable?</td>
</tr>
<tr>
<td>Communication</td>
<td>What are the cultural norms for eye contact, vocal tone, speech rate?</td>
</tr>
<tr>
<td>Respect</td>
<td>How does this client view silence, questioning, confrontation?</td>
</tr>
<tr>
<td>How do I express politeness and respect to this client?</td>
<td></td>
</tr>
</tbody>
</table>
Cultural Competence

It is the counselor’s responsibility to learn about cultural diversity and become culturally competent. This process increases the counselor’s awareness and sensitivity for clients of different ethnicities. Daw (1997) emphasized several recommendations. First of all, become aware of your own cultural heritage and how it affects you as a counselor; also, become aware of your own biases and prejudices, including racism. Next, seek opportunities to interact with people of different cultures and learn from these experiences. Finally, examine your understanding of poverty and how it affects those of different cultures, plus take an honest look at your own positions of power and privilege. (See Chapter 3 for a more thorough discussion.)

Humor

The counselor who can enjoy and use humor effectively has an invaluable asset. The healing power of humor has long been valued and can be used in counseling as an emotional release. Although counseling is serious business, there are many truly humorous dimensions to the human condition, and when humor appears as a natural outgrowth of the counselor–client relationship, it should be attended to (Prochaska & Norcross, 2003). Humor can provide a means of connecting with clients, and counselors need to affirm any humor clients present. Laughter and joking can release built-up tensions, and laughing at oneself can be extremely therapeutic because it requires seeing one’s problems in a whole new perspective.

When using humor with clients of a different ethnic background, the counselor needs to exercise particular caution (Maples et al., 2001). Humor can be defined, interpreted, and valued differently by individuals from different cultures. For that reason, consider both the individual and cultural values of the client, and tailor or customize the use of humor to make it appropriate for the particular client.

Touch

Counselors should always be sensitive to the therapeutic value of touch. Using touch requires consideration of the client issues and sensitivity to the role that touch has played in creating the issue, as well as what professionals who are considered experts recommend as best practice. For example, counselors must use extreme caution when using touch with individuals traumatized by physical or sexual abuse.

Humanistic models suggest that touch that is genuinely felt may help create within the client a willingness to be open and share. Driscoll, Newman, and Seals (1988) found that college students observing videotapes felt that counselors who touched their college-age clients were more caring than counselors who did not. It must be emphasized, though, that touch without genuine feeling behind it may be more harmful than helpful.

The type of touch that is generally considered acceptable is one that is long enough (1–3 seconds) to make contact yet does not create uncomfortable feelings. Most professionals who do touch believe that appropriate touching is contact of the
counselor's hand or forearm with the client's hand, arm, shoulder, or upper back, and recognize that gender differences may influence how such contact is interpreted. Alyn (1988) suggested that touch can reinforce the culturally prescribed unequal power relationship between genders and perpetuate the routine infringement upon women's boundaries.

There are no specific ethical standards concerning nonsexual touching; however, there are strict ethical guidelines regarding sexual contact with clients. Some counselors who oppose touch believe that nonsexual touching may lead to crossing boundaries and the gratification of the counselor's needs. The decision to touch must be based on ethical, clinical, and theoretical principles and must always be based on the client's needs (Durana, 1998).

Touch may be perceived differently from culture to culture. For example, in Hispanic and other Latin cultures, most individuals report being comfortable with touch during casual conversation. In other cultures, people are more restrained. For instance, in Asian cultures, individuals are more comfortable standing far apart and do not engage in casual touching. Cultural views of appropriate touching may transfer to the counseling relationship. However, individual personalities and levels of acculturation and assimilation always need to be taken into account and will take precedence over general norms.

Advanced Skills and Concepts

The first goal of helping is to help clients tell their story in an understandable way (Egan, 2007). This requires facilitating clients' self-understanding. Such exploration helps both counselor and client understand the client's problems and concerns. Clients begin to focus and see more clearly the puzzles of their life and are skillfully led to identify the missing pieces and blocks. This exploration involves a look at the real self and related issues. The process leads to insightful self-understanding that invites the client to change or take action.

Once the beginning counselor is adept at using the basic counseling skills, advanced skills and concepts can be added to the repertoire. These skills and concepts are more action oriented and allow the counselor to facilitate deeper client self-understanding, change, and eventual termination of the helping relationship. The advanced understanding and challenging skills include advanced empathy, self-disclosure, confrontation, and immediacy (Egan, 2007).

Advanced Understanding and Challenging Skills

Advanced Empathy. Primary empathy forms the foundation and atmospheric core of the helping relationship (Gladding, 2007). It involves listening for basic or surface messages with frequent, brief responses to those messages. The skills of paraphrasing and reflection of feeling serve counselors well when they establish an empathic base of understanding (Carkhuff, 1969). The counselor sees the world from the client's frame of reference and communicates that it has been understood. The goal is to move the
client toward identifying and exploring crucial topics and feelings. During this early self-exploration phase, the counselor must be sensitive to signs of client stress or resistance and try to judge whether these arise from lack of accurate response or from being too accurate too quickly. As the counselor moves the client beyond exploration to self-understanding and action, advanced skills become more necessary.

Primary empathy gets at relevant feelings and meanings that are actually stated; the skill of advanced empathy gets at feelings and meanings that are hidden or beyond the immediate reach of the client (Egan, 2007). The most basic form of advanced empathy is to give expression and understanding to what the client has only implied. It challenges the client to take a deeper look at self.

Advanced empathy includes the identification of themes presented by the client. Feeling, behavioral, experiential, or combined themes may occur. Once the counselor recognizes the themes, the task is to communicate the relevant ones to the client in a way that will be heard and understood. The themes must be based solidly on an accurate understanding of the client's feelings, experiences, and behaviors and communicated as concretely as possible by using the client's experiences and communication style.

The act of bringing together and communicating relevant core material that the client has presented in only a fragmented way is part of advanced empathy. The counselor helps the client fill in the missing links in the information. When it becomes apparent that two aspects of client information are closely linked, this information should be shared, but the counselor must guard against premature speculation or unfounded linkages.

As the counselor explores the deeper, underlying meaning of an experience of the client, the skill of reflection of meaning can be used. It provides a way for the client to develop a new worldview and interpret old situations or information in new ways. Because information is always subject to individual interpretation (Gelatt, 1989), the counselor needs to reframe the situation, belief, or experience to help the client view it from a different perspective and also check that the interpretation is correct.

Advanced empathy gets at more critical, deeper, and delicate issues and, therefore, puts the client under additional stress. To avoid overwhelming the client and evoking resistance, the counselor's empathetic responses should be tentative and cautious. Leads such as “From what you have said,” “Could it be that” or “It seems like” may be most helpful.

Counselors may find it helpful to reflect back to clients what they see as the meaning of an experience.

**Case Example**

**MELISSA:** I believed everything my boyfriend told me and then he dumped me. It seems as though every time I trust someone, I get hurt.

**COUNSELOR:** You’ve had several situations in your life where people that you trust have disappointed you. I’m wondering if that may be part of the reason that you’re avoiding close relationships now? Maybe you’ve becoming more guarded because you don’t want to get hurt?
Self-Disclosure. Hendrick (1988) and Peca-Baker and Friedlander (1987) have found that clients want to have information about their counselors. Sharing oneself can be a powerful intervention for making contact with clients, but it should not be an indiscriminate sharing of personal problems with clients (Egan, 2007; Sexton, Whiston, Bleuer, & Walz, 1997).

Self-disclosure is defined as any information counselors convey about themselves to clients (Cormier et al., 1997; Cozby, 1973). It can generate a more open, facilitative counseling atmosphere, encourage client talk and additional trust, and create a more equal relationship. In some instances, a self-disclosing counselor may be perceived as more caring than one who does not disclose. At times, counselor self-disclosure can present a model for clients to increase their own levels of disclosure about events and feelings (McCarthy, 1982).

The use of self-disclosure as a skill involves consideration of timing, goals, genuineness, and appropriateness. Effective self-disclosure does not add another burden to an already burdened client (Egan, 2007), and it should not distract the client from his or her own problems (Sexton et al., 1997). The counselor must consider how the client will benefit from the information shared.

Perhaps the most important type of self-disclosure focuses on the counselor–client relationship. If you are having a difficult time listening to a client, for example, it could be useful to let them know that it is difficult. However, it helps to only describe your own feelings and reactions and not judge the client. It may be fairly easy for the counselor to self-disclose, but making the disclosure relevant to the client is the important and more complex task (Ivey & Ivey, 2007). The counselor's self-disclosure should be genuine and fairly close in mood and content to the client's experience. As a counselor, you must remember that self-disclosure is appropriate only when it is genuine, benefits the client, and adds to client movement or understanding and when it does not interfere with the counseling process or contribute to raised levels of client anxiety (Cormier et al., 1997).

Case Example

MELISSA: I can't believe I was so dumb and gullible.

COUNSELOR: It seems like you're being really hard on yourself. I've found when I get in these situations that it is easy to beat myself up. I've learned instead to think of ways to be gentle on myself.

How willing are you to engage in appropriate and relevant self-disclosure? You become vulnerable when you share your own experiences, feelings, and reactions, yet can you expect your clients to become vulnerable in front of you if you rarely show them anything of yourself? Good self-disclosure is a kind of sharing that clients can use to grow, and it lets them know how you're perceiving and experiencing them (Sexton et al., 1997).

Most evidence indicates that a moderate amount of self-disclosure has more impact than too little or too much. Counselors who disclose very little risk being seen as aloof, weak, and role-conscious (Egan, 2007), whereas the counselor who discloses
too much may be seen as indiscreet, untrustworthy (Levin & Gergen, 1969), preoccupied (Cozby, 1973), or needing assistance.

Concerning self-disclosure with clients of a different culture, be aware that disclosing personal information may be valued in some cultures and considered in appropriate in others. Become knowledgeable about the meaning and use of self-disclosure in that culture, and use this information to decide about the benefit of using the skill (Evans et al., 2008).

**Confrontation.** Confrontation is a skill that is used when there are discrepancies, conflicts, or mixed messages being sent by the client. The mixed messages may show up in conflicts between the verbal and nonverbal messages the client sends or between two contradictory verbal messages. Egan (1975) describes confrontation as “the responsible unmasking of the discrepancies, distortions, games and smoke screens the client uses to hide both from self-understanding and from constructive behavioral change” (p. 158).

When confronting a client, the counselor must always exercise concern for the client's understanding of the challenge so that there will be client progress, not denial and flight. To do this effectively, the counselor must accurately reflect the situation. Using a tentative reflection is important, especially if it is early in the relationship. Also consider the state of the client; an already distressed, confused, or disorganized client will not benefit from a confrontation. In fact, confrontation with such clients may add to their distress or confusion.

**MELISSA:** I want to have a close relationship with my dad. We have specific dates when we’re supposed to meet for dinner and that’s okay. But if I have anything else to do, I’ll usually just make an excuse and not go.

**COUNSELOR:** On one hand, I hear you saying that you want a close relationship with your dad, but on the other hand, you often make excuses so you don't have to meet him for dinner. Can you help me understand this?

Confrontation should be done with care and may be more effective if done gradually, which gives the client time to assimilate information. Good counselor practice demands a careful balance between confrontation and support in the form of primary empathy, positive regard, and respect (Ivey, Ivey, & Simek-Downing, 1987).

When considering cultural implications, the counselor needs to be aware that some cultures may consider confrontation to be insensitive and disrespectful. These cultures include Native North Americans, Canadian Inuit, and traditional Latino/Latina people. The counselor may need to choose alternate methods that are more culturally appropriate (Evans et al., 2008).

**Immediacy.** The phenomenon of immediacy involves the counselor’s sensitivity to the immediate situation and an understanding of what is occurring at the moment with clients (Pietrofesa, Hoffman, & Splete, 1984). It involves the ability to discuss directly and openly with another person what is happening in the “here and now” of an interpersonal relationship (Egan, 2007). This is sometimes referred to as “you–me” talk.
The use of immediacy combines the skills of confrontation and self-disclosure and requires the counselor to reveal feelings and/or challenge the client to deal more openly with his or her feelings. The purpose of immediacy responses is to help clients understand themselves more clearly, especially what is happening at that moment and how they are relating to the counselor in the session. The focus can be on the client, the relationship, or the counselor's own feelings and reactions (Murphy & Dillon, 2008). As interviews move more to the present tense, the counselor's presence in the interview becomes more powerful and important (Ivey & Ivey, 2007), and the counselor is modeling a kind of behavior that clients can use to become more effective in all their relationships.

Counselors usually know what is happening in a session but do not always act on it. Acting on what is happening at the moment is part of the phenomenon of immediacy. When either counselor or client has unverbalized thoughts or feelings that seem to be getting in the way of progress, the counselor should bring it up for discussion.

Case Example

MELISSA: I'm not sure I should tell you about all the other stupid things I've done.

COUNSELOR: It sounds like something is getting in the way of your trusting me to understand everything that's happened in your life.

There are many areas or issues in which the skill of immediacy might be used: trust, differences in style, directionless sessions, dependency, counterdependency, and attraction are areas where “you–me” talk might pay off (Egan, 2007). Other areas might include concern for the client's welfare, lack of follow-through on homework, and client doubts about the value of counseling.

Carkhuff (1969) suggests that the counselor ask, during the course of the interview, “What is the client trying to tell me that he or she can't tell me directly?” The answer lies embedded in the verbal and nonverbal behavior of the client. The skilled helper can uncover it and make it an “immediacy” topic.

In considering whether to use immediacy, the counselor should decide whether it is appropriate to focus the relationship on here-and-now concerns at this specific time. If so, then counselor-initiated leads will focus on the identification and communication of feelings. The counselor must seriously consider word choice; as in many other cases, a tentative statement may be more inviting.

When considering multicultural implications in the use of immediacy, several points need to be considered (Evans et al., 2008). First of all, individuals from some cultures may need present concerns communicated in a way that permits the client to save face. Another issue of immediacy may come up if the client feels the counselor is culturally biased. The counselor should use immediacy to resolve these issues before continuing the session (Chapter 3).

Action Skills

The goal of counseling is to have a client come away from the process changed. This growth or change often entails the counselor and client working together on an action
plan appropriate to the client’s stated goals. These action plans should grow out of the
counseling work itself and be based in part on the theoretical orientation of the coun-
selor and what is considered the standards for practice in the profession. For instance,
a behaviorally oriented counselor will be more inclined to use behavioral contracts; a
cognitive therapist may emphasize thought-stopping and thought-disputing exercises.

Nevertheless, the theoretical orientation is secondary to the development of
effective core helping skills. These skills seem to be shared by all effective helpers and
really address the quality of the interaction between the counselor and the client. With
respect to the action phase, for example, Egan (2007) has suggested that the counselor
must have skills to help clients choose effective strategies for change and maintain
action-based change programs.

Case Example

COUNSELOR: One of your main goals is to establish new friendships. I’m won-
dering how you might begin. What are some ways you’ve made new friends in
the past?

MELISSA: I think I’ll begin by accepting the invitation to go out Friday evening
with the group from my journalism club. They seem pretty cool.

COUNSELOR: It sounds like you’ve thought this over, and you have a good idea
about where to begin. I’ll be interested in hearing about how the plan worked.

Termination Skills. The ending of a helping relationship can be either gratifying or
difficult and frustrating. Termination may occur either by mutual agreement or prema-
turely (that is, before all goals of counseling are met). When counselor and client agree
that the goals of counseling have been accomplished, they may mutually agree that it is
time to terminate. Sadness about parting and some client anxiety may be expected, but
by exploring and sharing such feelings, each client is more likely to leave with a sense of
growth and accomplishment because goals have been achieved. This process also gives
clients time to prepare for the future (Murphy & Dillon, 2008). It is important to leave
time to discuss feelings about ending, and for a smooth termination, both individuals
must know when the last session will occur (Meier & Davis, 1993).

Either the counselor or the client may initiate premature termination. When
counselor-initiated termination occurs, the client needs to be informed as early as pos-
sible or reminded that only a limited number of sessions are available. Frequently,
counselors may be in the position of terminating counseling prematurely in schools
and agencies with session limits. On rare occasions, it may occur because of irreconcil-
able differences or a perceived lack of commitment by the client. When the counselor
does terminate the sessions, the reasons must be specified to the client. Most coun-
selors agree that early termination by the counselor violates the premise that clients
are in charge of solving their own problems, and early termination may make clients
feel personally rejected. These feelings should be dealt with before termination is
complete. Referring the individual to another agency and/or keeping the door open
for future sessions is sometimes helpful.

When the client prematurely terminates the sessions, the counselor should try to
explore with the client the reasons for termination. Letting clients know that they are
in charge of the decision to return in the future can be beneficial, as is exploring possible referral resources.

When termination is mutual or initiated by the counselor, several steps can benefit the outcome of the relationship (Ward, 1984). There should be discussion and evaluation of the goals that have already been reached. Closure issues and feelings need to be discussed, and clients must prepared for similar happenings in the future. Clients should be prepared for self-reliance and continued self-help. Finally, in the last session, discussion is likely to be lighter and more social. Okun (2008), for example, often shares a poster with the client that symbolizes the significance of the client’s journey. The termination process should not focus on the generation of new problems or issues but rather on an appreciation of the growth that has already occurred.

Summary

You began this chapter as a nervous client, apprehensive about your first visit to the counselor’s office. Now imagine you have switched roles. You are the counselor and waiting on the other side of the door to greet that client. You have learned the importance of establishing the counselor–client relationship and the conditions essential to a therapeutic relationship, including genuineness, empathy, and nonpossessive warmth.

You know that the helping relationship has three relatively distinct phases: building the relationship, challenging the client to find ways to change, and facilitating positive action. Also important are the characteristics most effective counselors possess, including high levels of self-awareness, empathy, genuineness, and respect for others, and an ability to use themselves as vehicles of change.

You have learned that effective counselors use attending skills (eye contact, body language, and vocal tone) and basic listening skills (client observation, encouraging, paraphrasing, summarizing, reflection of feeling, and open and closed questions) throughout the helping relationship. Also vital is the use of self-attending skills, which emphasize the importance of the person of the counselor in mediating the communications skills necessary in the helping relationship.

You have been introduced to primary and advanced empathy skills, as well as the challenging skills of confrontation, self-disclosure, and immediacy. These skills deepen the helping relationship and move the client toward therapeutic change. Counselor action skills facilitate behavior change around the client’s stated goals for counseling. Finally, termination skills are needed to bring closure to, and end, the helping relationship.

The following Web sites provide additional information relating to the chapter topics.

USEFUL WEB SITES

http://www.carlrogers.info/aboutCarl-Farson.html
REFERENCES


