2

EVOLUTION OF CLINICAL MENTAL HEALTH COUNSELING

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Imagine the latter years of your professional career as you begin contemplating retirement. For some of you that could be a few years away. For others, retirement could be a distant goal 20, 30, or even 40-plus years in the future. Regardless of how far off this point in your career might be, envision what you think the profession will look like. What types of issues are you likely to be addressing with clients? What kind of services will you be offering, and how will they be offered? Will there even be professional counselors in the future? Only time will tell what the profession looks like in the future. What is for sure is the fact that counseling as a profession will look markedly different than it does today. This has always been the case for our profession and will continue to be so into the future.

Your ability to practice today and look toward the future was made possible by several pioneering individuals whose vision for a better society helped form the foundation of the mental health counseling profession. Through an exploration of the historical roots of the profession, today's practicing counselors are more knowledgeable and better equipped to face the evolving challenges facing the counseling profession as it continues to grow and mature.

LEARNING OBJECTIVES

After reading this chapter, you will be able to do the following:

- Articulate the history and development of clinical mental health counseling (CACREP 5C-1-a)
- Describe the origins of current theories and models related to clinical mental health counseling (CACREP 5C-1-b)

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- Name the important contributors, organizations, and legislation that have shaped the field through the years
- Understand the current state of the profession and the scope of mental health counseling practice across various settings
- Identify trends shaping the future of clinical mental health counseling practice

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MENTAL HEALTH COUNSELING: PAST, PRESENT, AND FUTURE

In Chapter 1 we introduced you to the specialized practice of clinical mental health counseling. Although community-based mental health services are relatively new, the practice of counseling extends well over 120 years. In those early times, several individuals, decisions, and events helped pave the way for the profession of today to emerge. Awareness of our past helps us understand where our profession is at and where it can go from here. In this chapter, we delve a bit deeper into the clinical mental health counseling profession by reviewing the past, examining the present, and looking toward the future.

In the 19th century, counseling was practiced very differently than it is today. Early counselors were seen more as teachers or social advocates who gave advice and educated their clients on the resources available to them for help. As such, in the first half of the 1900s the focus for and growth of the emerging counseling profession were educational institutions (Sangganjanavanich & Reynolds, 2015). However, evolving societal demands brought about the need for more structured services. At the turn of the century, a period commonly referred to as the Progressive Era, changes across three professional movements—guidance counseling and educational reform, mental health reform, and the emergence of psychometrics as a scientific discipline—helped form the foundation of counseling practice as we know it today. Without the vision of early pioneers dedicated to improving the lives of others and helping create a better society, these social reform movements likely would not have occurred.

PIONEERS IN THE PROFESSION

During the Progressive Era (1900–1920), the United States experienced a tremendous amount of growing pains associated with the rise of industrialization and immigration. Local governments struggled to keep pace with the large numbers of people moving to America's cities in search of better lives for themselves and their families. Lacking the proper infrastructure to support their growth, many cities became rife with political corruption, disease, and debilitating social inequities. Social reformers sought to combat the negative consequences of urbanization and create a better environment in which people could prosper and thrive. These community activists focused on humanitarian

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concerns, child and adult welfare, public education and guidance, legal reform, and immigration management (Smith, 2012). It is within this social reform movement that the counseling profession was born. In this section, we introduce you to a sample of progressive reformers whose efforts in the first half of the 20th century were instrumental in establishing the foundation from which the counseling profession would emerge. Collectively, they made it possible for individuals like you to train for a career as a mental health counselor.

Frank Parsons

Frank Parsons (1854–1908) was a bit of a renaissance man whose work made an indelible mark on the counseling profession. Born in Mount Holly, New Jersey, on November 14, 1854, Parsons was an inquisitive child whose quest for knowledge allowed him to excel academically. At the age of 15 he was admitted to Cornell University where he earned a degree in civil engineering in only 3 years. Upon graduating, Parsons became a railroad engineer in western Massachusetts. This position would prove to be short-lived, for the depression of 1873 bankrupted the railroad company and sent Parsons into unemployment. After initially finding work as a day laborer, he eventually accepted a position with the Southbridge public school system teaching courses in history, mathematics, and French. While teaching, he was encouraged by his friends and colleagues to pursue a career in law. Studying independently, Parsons passed the Massachusetts bar examination in 1881 and opened a small private practice in Boston. However, practicing law did not appeal to Parsons so he began writing legal textbooks for a local publishing house. Ultimately, he became a lecturer at the Boston University school of law, a position he held from 1892 to 1905 at which time his varied research and civic interests forced him to resign.

While in Boston, Parsons experienced firsthand the exponential population growth caused by the continued industrialization of America. An avid social reformer who was active in populist and progressive causes, Parsons noted the struggles newcomers experienced and tirelessly advocated for the improved living conditions of those adversely affected by the Industrial Revolution (Aubrey, 1983). In addition, he spoke out on the need for more systematic vocational guidance programs designed to help Boston's new citizens identify careers for which they were best suited. Consequently, with an initial staff of three and an advisory board comprised of local civic leaders, Parsons opened the Vocation Bureau in Boston in 1908. There Parsons and associates provided vocational assessment interviews, counseling, and information to aspiring young workers (Protivnak, 2009). Specifically, they worked with individuals to find careers in which they would excel using the following three principles of career choice that would become the basic tenets of the trait and factor approach to vocational counseling:

1) Developing a clear understanding of the individual including that person's aptitudes, interests, values, ambitions, resources, strengths, and weaknesses
2) Developing a knowledge of the world of work including an understanding of the requirements and conditions of success, advantages and disadvantages of various jobs, training needs, compensation, current opportunities, and prospects in that specific field of work

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3) Successfully merging the two previous characteristics, matching talent to job requirements, to facilitate satisfaction and success

Using these principles, the Vocation Bureau staff served 80 men and women in its first 4 months of existence. And, as Parsons (1909) noted, "according to their own spontaneous statements, all but two . . . received much light and help. Some even declaring that the interview with the Counsellor was the most important hour of their lives" (p. 30).

Though Parsons would pass away before the end of the bureau's first year, his work provided the foundation on which modern career counseling practices are based (Savickas, 2011), securing his legacy as father of the vocational guidance movement. As Brewer (1942) noted, in a brief period of approximately 2 years, Frank Parsons had accomplished the following:

1) Furnished the idea for the Vocation Bureau and began its execution
2) Paved the way for vocational guidance in schools and colleges by advocating their role in it and offering methods they could use (35 cities had adopted the Boston vocational guidance model by 1910)
3) Began the training of counselors
4) Used all the scientific tools available to him at the time
5) Developed "steps" to be followed in the vocational progress of the individual
6) Organized the work of the Vocation Bureau in a way that laid the groundwork for groups to model in schools, colleges, and other agencies
7) Recognized the importance of his work and secured for it the appropriate publicity, financial support, and endorsements from influential educators, employers, and other public figures
8) Laid the groundwork leading to the continuance and expansion of the vocational guidance movement by involving friends and associates and preparing the manuscript for *Choosing a Vocation*.

GUIDED PRACTICE EXERCISE 2.1

To gain a better understanding of Parsons's trait and factor approach, explore your own career choice and how it relates to you as an individual. Using the RIASEC Markers Scales (https://openpsychometrics.org/tests/RIASEC/) you can see how your individual constellation of personality traits match up with your chosen profession. What do your results suggest? Are you in the right field? Does your personality lend itself to the types of skills needed to be an effective mental health counselor? Should the results of this screening be taken as a valid and reliable indicator of whether counseling is a suitable profession for you? Share your results with a peer in class.

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Clifford W. Beers

Clifford W. Beers (1876–1943) was another influential early-20th-century social reformer whose work proved pivotal to the development of modern-day clinical mental health counseling practice. Recognized as the founder of the mental hygiene movement, Beers's personal experiences with mental illness led to him becoming a staunch advocate for the improved treatment of the mentally ill. Born in New Haven, Connecticut, Beers was the second youngest of five children. As a child, he experienced significant familial losses, including an older sibling who died during infancy and an older brother who was diagnosed with epilepsy as a teenager and ultimately died at a young age as well. These losses had a profound effect on Beers, who himself would go on to suffer from multiple bouts of depression as both a child and young adult. Despite his struggles with mental illness, he excelled academically. After graduating from Yale University in 1897, Beers began working as a financier in New York City. During this time, he became increasingly more anxious and depressed and feared he too would one day suffer the same fate as his brother. In 1900, during a bout of depression, Beers attempted suicide. At his family's Connecticut home, he let himself fall from a top-floor window to the ground below. Amazingly, he survived by narrowly missing the concrete alley and fencing behind the home and landing on a small patch of grass, shattering every bone in both legs. He subsequently would spend the next 3 years in various mental health institutions.

Although some staff members treated Beers well, the majority physically abused and subjected him to various forms of degrading treatment while institutionalized. This mistreatment troubled Beers and spurred his interest in championing reform. Following his release from treatment in 1903, Beers began writing about his experiences. His writings would ultimately be published in 1908 as book titled *A Mind That Found Itself*. The book brought newfound attention to the way patients were treated in mental health institutions, leading to public outcry for change. Though he voluntarily would be institutionalized again in 1904, Beers continued leading efforts to improve the quality of institutional care, challenge the stigma of mental illness, and promote mental health (Parry, 2010). In 1909, he founded the National Committee for Mental Hygiene (renamed the National Mental Health Association [NMHA] in 1950 and Mental Health America [MHA] in 2006). According to MHA's (n.d.) website, the organization "is the nation's leading community non-profit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all Americans." Today, MHA staff and volunteers from over 200 affiliates across 41 states are leading grassroots advocacy efforts to help Americans live mentally healthier lives by educating the public on mental illness and reducing barriers to treatment and services. Mental Health America would not be possible were it not for Beers sharing his personal struggles and promoting improved treatment conditions for others with similar afflictions.

Jesse B. Davis

Jesse B. Davis (1871–1955) is another early counseling pioneer whose efforts helped shape modern-day clinical mental health practice. Davis was working as a high school counselor in Detroit, Michigan, when he was appointed principal of Central High School on the west side of the state in Grand Rapids. Influenced by such progressive American

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educators as Horace Mann and John Dewey, Davis was a huge proponent of vocational guidance being an integral part of a child's education. As principal, he sought to increase the amount of didactic guidance students received and implemented what would become the first school-based systematic guidance program. In his program, all English teachers in Grades 7 through 12 required students to write weekly essays on topics related to vocational choice, career plans, and the type of person they hoped to become. Davis believed prompting students to think about their future and vocational choices would help address current challenges in American society, build moral character, and prevent problems. His pioneering work in establishing school-based vocational guidance programs in Michigan provided the foundation for the modern-day career counseling specialization (Pope, 2009).

In addition to his local work, Davis made an impact nationally. In 1912, at the second National Guidance Conference held in New York, Davis was appointed to an organizing committee tasked with exploring the possibility of establishing a national association that would advance the vocational guidance movement in response to growing economic, educational, and social demands (U.S. Bureau of Education, 1914). Following a year of meetings, the committee presented their findings in October 1913 at the third National Guidance Conference held in Grand Rapids, primarily because of Davis's presence and work in that community. Their report was well-received, leading to the creation of the National Vocational Guidance Association (now known as the National Career Development Association [NCDA]). According to its founding constitution, the purpose of NVGA was to "promote intercourse between those who are interested in vocational guidance; to give stronger and more general impulse and more systematic direction to the study and practice of vocational guidance; to establish a center or centers for the distribution of information concerning the study and practice of vocational guidance; and to cooperate with the public school and other agencies in the furtherance of these objects" (Feller, 2014). Inaugural officers also were voted on at the conference, with Davis being selected to serve as the NVGA's first secretary.

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Abraham and Hannah Stone

The efforts of Abraham and Hannah Stone helped expand the scope of counseling services outside of school-based and institutional facilities. Abraham Stone (1890–1959) was a urologist whose research interests included reproductive health issues including family planning, birth control, sterility, fertility, sexual relations, and global overpopulation. Together with his wife Hannah (1894–1941), also a physician whose pioneering work as an advocate for the birth control movement led to her being named the founding director of the Margaret Sanger Research Bureau, they established the first family and marriage counseling center in New York City. There they counseled thousands of couples with relationship and sexual problems. The approach they used deviated from any used previously to address issues such as these. They would go on to publish their counseling techniques in a book titled *A Marriage Manual: A Practical Guide-book to Sex and Marriage* (1931). This was one of the first books of its kind exploring marital relations and communication skills among couples. The work of Abraham and Hannah Stone was significant in that it marked a shift in counseling practice where career and vocational issues were the only focus of discussion.

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Edmund Griffith ("E. G.") Williamson

Edmund Griffith ("E. G.") Williamson (1900–1979) was a lifelong academic. After completing his doctorate in psychology, he joined the faculty at the University of Minnesota at the age of 31. Between 1931 and his retirement in 1969, Williamson remained affiliated with the university in various capacities including professor, director of testing and counseling, coordinator of student services, and dean of students. It was here that Williamson made his mark on the counseling profession.

During the 1930s, the Minnesota Employment Stabilization Research Institute was established at the University of Minnesota to assist those whose careers had been lost due to the Great Depression (Chartrand, 1991). Working at the institute, Williamson began applying many of the same principles Parsons was using in Boston at the Vocation Bureau. His approach, trait and factor theory, or the Minnesota point of view as it was called, is widely regarded as the first true comprehensive counseling model. Trait and factor theory expands on the concept of vocational matching by integrating psychometric data gathered in addition to client interviews to match dimensions. In fact, one of the career assessment instruments that emerged out of this work was the *Strong Interest Inventory*. After collecting data, the counselor would then analyze it using statistical techniques to quantitatively evaluate individuals and their potential career fits. The entire counseling process consisted of six steps designed to systematically assist college students with their career development concerns. The six steps in this process were (1) analysis, (2) synthesis, (3) diagnosis, (4) prognosis, (5) counseling, and (6) follow-up (see Table 2.1).

Carl Rogers

Carl Rogers (1902–1987) was one of the most influential psychologists of the 20th century. However, psychology was not always his career goal. He initially attended the University of Wisconsin with the intention of majoring in agriculture. While enrolled, his interests changed and he switched majors often, first to history and then to religious

TABLE 2.1 ■ Six-Step Sequence of the Trait and Factor Theory

Step	Tasks Performed
Analysis	Examination of the presenting problem; gathering of existing records, available test scores/results, and additional background on the client
Synthesis	Collating available information to identify patterns and develop a working hypothesis of the client's presenting problem
Diagnosis	Interpretation of the problem based on all available information
Prognosis	Estimating the likelihood that the client would be better adjusted under different conditions or career options
Counseling	Working collaboratively with the client to establish potential solutions to the presenting problem
Follow-up	Ensuring the client is satisfied with the resolution obtained and establishing safeguards and support systems for the future should the presenting problem reemerge or new problems arise

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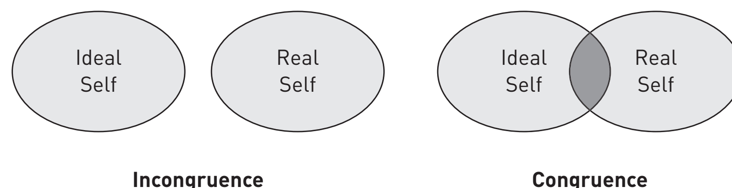
studies with an eye toward a career in ministry. While at the University of Wisconsin he participated in a study-abroad program and spent 6 months in Beijing, China, attending a World Student Christian Federation Conference along with nine other students. While in China, seeds of doubt were spread as Rogers began questioning his religious beliefs as he was exposed to new cultures and religious dogma. Upon his return to the United States, and subsequent graduation in 1924, Rogers moved to New York City and enrolled in Union Theological Seminary. In seminary he attended a student-led seminar titled "Why Am I Entering Ministry?" that led to his turning away from religion personally (he became an atheist) and professionally (he left the ministry). After 2 years in seminary he transferred to Columbia University Teachers College where he worked with John Dewey and earned his doctorate in clinical psychology in 1931.

After an initial clinical appointment, Rogers transitioned to a life in academe. He held faculty positions at the University of Rochester, Ohio State University, University of Chicago, and the University of Wisconsin. While at Ohio State University, Rogers began developing his theory of client-centered change. There he wrote *Counseling and Psychotherapy* (1942) in which he posited that clients who can build a strong working relationship with an accepting and empathic counselor would be able to resolve any problems they faced and gain the insight needed to live happier and healthier lives. His ideas represented a radical deviation from current therapeutic approaches that relied heavily on behavioral principles. For Rogers, behaviorism was too simplistic. He believed the approach had low ecological validity and completely neglected the fact that individuals could make their own decisions (free will). Initially, these ideas were not widely supported.

Undeterred, Rogers moved to Chicago in 1945 and continued refining his ideas regarding clinical work. There he founded a counseling center and wrote two of his more influential works, *Client-Centered Therapy* (1951) and *Psychotherapy and Personality Change* (1954). At his last academic appointment at the University of Wisconsin, Rogers wrote perhaps his most famous book, *On Becoming a Person: A Therapist's View of Psychotherapy* (1961). In it, he suggested that individuals have the innate ability to resolve their own conflicts and facilitate personal growth. Further, he outlined a process through which counselors could help their clients achieve self-actualization. According to Rogers (1959), we all have an actualizing tendency that is deeply rooted in our genetic makeup. This **actualizing tendency** is what guides us to grow and reach our full potential. True self-actualization occurs when a person's ideal self, who one would *like* to be, is congruent with one's real self, who one *actually* is (see Figure 2.1). In other words, we all can achieve our hopes, dreams, and aspirations in life. Our ability to do so depends on whether we are fully functioning persons (see Table 2.2).

FIGURE 2.1 ■ Carl Rogers's Conceptualization of Self-Actualization



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GUIDED PRACTICE EXERCISE 2.2

Consider your own ideal and real selves. Are you living in congruence? If not, what changes might you need to make to better align your ideal and real self? Additionally, consider what currently prevents you from doing so. How might these obstacles or barriers to self-actualization be like those experienced by your clients? Knowing yourself and your own challenges, how would you go about helping your clients overcome their barriers to self-actualization?

TABLE 2.2 ■ Characteristics of a Fully Functioning Person

Open to new experiences	Acceptance of both positive and negative emotions. The individual realizes that life has its ups and downs, and low points represent opportunities to be resilient and work through these negative issues.
Existential living	Being able to live in the here-and-now and appreciate the moment. The individual can experience life as it is without the filter of any preconceptions or prejudices.
Trust in feelings	Individuals should trust their basic instincts. Gut reactions should be acknowledged and trusted. Everyone is in the best position to make the right decision for himself or herself.
Creativity	A fully functioning individual is willing to take risks in life. Rather than playing it safe, these individuals seek adventure and positively adjust to changes in their world.
Fulfilled life	Individuals who are happy and satisfied with life. Individuals who are open to new challenges and experiencing all life has to offer.

Rogers's work was influential in that it ushered in a new school of thought known as humanism. Deviating from the dominant treatment approaches of the time, behaviorism and psychoanalysis, counselors began focusing less on symptom reduction and more on client empowerment. Clients became active participants in the counseling process and were viewed as experts in their own lives. Rather than providing solutions for client problems, Rogers believed counselors should instead work to create an environment conducive to growth for their clients. This environment included the need for what Rogers would call the core conditions of counseling: genuineness, acceptance, and empathy. Because of Rogers's efforts the humanistic approach flourished, with counselors referring to it as the "third force" in psychology (Maslow, 1968). This new perspective redefined the therapeutic relationship and how counselors interacted with their clients.

C. Gilbert Wrenn

Gilbert Wrenn (1902–2001) had a long and distinguished career that impacted the counseling profession in a profound way. A counseling psychologist by trade, Wrenn was one of the first presidents of the American Psychological Association's Division of Counseling and Guidance (now the Division of Counseling Psychology) and the founding editor of the *Journal of Counseling Psychology*. In 1962, his seminal work

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The Counselor in a Changing World introduced a shift in thinking for counselors in placing greater emphasis on developmental needs than career and vocational issues. Wrenn (1962) noted that individuals should not be viewed in isolation; rather, they needed to be seen as part of a larger system in which environmental and societal influences are considered. This perspective provided a foundation for which school counseling programs should be constructed in a society with changing views on human behavior and the role of school personnel (Gibson & Mitchell, 2011). Specifically, Wrenn (1962) thought school counselors should fill four primary functions: (a) counseling students; (b) consulting with parents, teachers, and administrators; (c) studying changing student demographics and interpreting this information for school administrators; and (d) coordinating school-based counseling services as well as school-community partnerships.

Wrenn's approach changed community-based mental health counseling services as well, for throughout the 1960s and beyond counselors began focusing more on the influence of cultural diversity and client background in the counseling process (Gladding & Newsome, 2018).

INFLUENTIAL PROFESSIONAL ORGANIZATIONS AND ASSOCIATIONS

As the mental health counseling profession began to grow and expand its scope, counselors nationwide began moving to establish professional organizations that would help promote the profession, provide networking opportunities for practitioners, and champion a new unified voice for the profession. Several organizations and associations emerged throughout the 20th century, but the following groups merit mentioning for the lasting impact they have had on the profession.

American Personnel and Guidance Association

The American Personnel and Guidance Association (APGA) was founded in 1952 to formally organize groups interested in guidance, counseling, and personnel matters (Gladding & Newsome, 2018). At a joint convention in Los Angeles, members of four professional organizations, the National Vocational Guidance Association (NVGA), the National Association of Guidance and Counselor Trainers (NAGCT), the Student Personnel Association for Teacher Education (SPATE), and the American College Personnel Association (ACPA), convened to find a way to collaborate on their shared interests and vision. These groups would become the first four divisions of the APGA. According to the new association's ethical standards, the APGA was established as an educational, scientific, and professional organization dedicated to service to society (APGA, 1961).

In 1983, the organization rebranded itself as the American Association of Counseling and Development (AACD). This name change was made to reflect changes and commitment to the counseling field and more accurately represent the evolving professional orientation of the organization's membership (Vacc & Loesch, 2000). Finally, in 1992 the organization adopted its current name, the American Counseling Association (ACA), to reflect the common bond among association members and to reinforce their unity of purpose (ACA, 2018). Today, the ACA functions as a not-for-profit organization comprised

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of 19 chartered divisions, four regions, and 56 branches across the United States, Europe, and Latin America that works to grow and enhance the counseling profession. Table 2.3 describes the ACA's core values.

American Mental Health Counseling Association

The American Mental Health Counseling Association (AMHCA), established in 1976, is the leading national organization for licensed clinical mental health counselors. In the 1970s, many counselors began to secure employment in nonschool settings. Community agencies, counseling centers, and private practice settings became popular sources of employment for mental health counselors. Despite this vocational shift, the primary professional organization at the time, the APGA, still focused primarily on counseling in school settings and had no distinct division for those counselors working out in the community. Seeking to rectify this situation and give a professional home to community and agency counselors, counselors in Florida and Wisconsin began lobbying efforts aimed at establishing a new APGA division that represented mental health counselors. At its July 1976 meeting, APGA leaders met to consider the proposal from AMHCA leadership to become a new divisional partner. Optimism was high, however, the APGA board instead passed a resolution placing a moratorium on any new divisions until further research could be conducted to gauge whether expansion would be beneficial. Undaunted, the leaders of the AMHCA incorporated the organization in Florida and began operating independent of the APGA. It would not be until the summer of 1978 that the AMHCA would officially become a division of the APGA.

Capitalizing on the uniqueness of mental health counseling and the counseling skills, developmental approach, and preventative strategies employed by its members, the AMHCA continues to use its influence to generate legislation more favorable to mental health counselors and to propose programs aimed at better health care (Weikel, 1985). Today, AMHCA leaders work to address such current professional issues as the role of mental health counselors

TABLE 2.3 ■ Core Values of the American Counseling Association

Diversity, equity, and inclusion	Values individuals for the diversity of identity, ideas, and interests they bring to the group and actively works to engage them in the association and profession
Integrity	Leadership and staff commit to being honest, transparent, and values-based in their communication, action, and advocacy efforts.
Proactive leadership	Serves as a leader in the counseling field, both creating a vision and taking action to advance the profession
Professional community and relationships	Creates opportunities for counselors to network, collaborate, and enhance their skills through lifelong learning
Scientific practice and knowledge	Espouses evidence-based methodologies and practices and supports their use in counseling research, practice, supervision, and teaching
Social justice and empowerment	Commits to being a champion for the provision of high-quality mental health care to all individuals

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in business and industry through employee assistance programs (EAPs), health maintenance organizations (HMOs), hospital privileges for counselors, counselors' roles and rights related to diagnosis, interprofessional liaisons, and full parity for mental health counselors in state and federal legislation as well as health care insurance plan coverage.

National Board for Certified Counselors

The National Board for Certified Counselors (NBCC) was established as a not-for-profit, independent certification organization in 1982 (NBCC, 2018). Today, the NBCC serves as the premier certification body of the profession and advances the counseling profession representing over 64,000 national certified counselors in 40 countries. In addition to offering the national certified counselor (NCE) credential, the NBCC also administers several specialty certifications including the certified clinical mental health counselor (CCMHC), master addictions counselor (MAC), and national certified school counselor (NCSC) credentials. The leadership at the NBCC is dedicated to advancing the counseling position. This dedication is evident in the role it plays in state and national advocacy and lobbying efforts.

CASE ILLUSTRATION 2.1

I have called the American Counseling Association my professional home since I began my career as a mental health counselor in 1998. Looking back at my time as a member, I would say it has been beneficial to my professional development and would encourage others to strongly consider joining. The association provides so much to its members, with many services available free of charge. In addition, participation in the ACA and attendance at conferences each year has helped me build a strong and supportive network of colleagues nationwide. These individuals are those I turn to for advice, counsel, and support. I also appreciate that the ACA advocates for me professionally. Their lobbying efforts on behalf of counselors and commitment to promoting counseling and counselor identity are important to me and represent a value for the membership dues I pay.

I also would recommend beginning counselors actively involve themselves in the ACA. Your membership is enhanced when you take an active role in helping the association grow and meet its goals and objectives. Throughout my career, I have had the opportunity to participate locally and nationally in a variety of roles and functions. I have served as a program proposal reviewer, committee member, state branch representative, division president, and member of the ACA's Governing Council and Executive Committee. Active participation lets me take ownership in helping build the profession. When students ask me whether they should get involved or what they should look to be doing I often respond that every little bit helps. Everyone can play a part in helping the organization be successful, and volunteers are always welcome.

—JCW

Chi Sigma Iota

Chi Sigma Iota (CSI) is the international honor society of professional counseling and for professional counselors. Established by Dr. Tom Sweeney in 1985 at Ohio University, CSI serves to provide recognition for outstanding achievement as well as outstanding

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service within the profession. CSI currently has over 120,000 initiated members, making it one of the largest single member organizations of professional counselors in the world (CSI, 2018). Members, who must meet stringent academic standards, have access to the CSI newsletter, *Journal of Counselor Leadership and Advocacy*, and are eligible for a series of awards, grants, scholarships, and fellowships. Many counselor training programs house local CSI chapters. Mental health counseling students often find CSI membership beneficial because it helps establish a professional identity and affords members opportunities to network with professionals nationwide through virtual and live meetings.

CASE ILLUSTRATION 2.2

Being a member of Chi Sigma Iota (CSI) is much more than a line on your curriculum vita. Rather, it means being a part of a counseling community whose focus is on excellence in counseling through leadership, service, advocacy, and scholarship. As counselors, service and advocacy do not stop when the last client leaves for the day. It is part of our professional identity and responsibility to be agents of change outside our offices. As a student, CSI provided me with opportunities to positively impact others within my own community and within the counseling field. With programs like the Leadership and Fellow Intern Program, it created an avenue for me to foster innate leadership qualities but also develop those I did not possess. Through opportunities like CSI Days at the American Counseling Association conferences, writing for publication in the Counselor's Bookshelf, participating in the free online webinars, and offering chapter and research grants, CSI was instrumental in establishing my burgeoning scholar identity. These programs and initiatives also gave me the chance to collaborate with colleagues and professors, to teach and be taught.

This guidance and encouragement has continued as I transitioned to a counselor educator and chapter faculty advisor. I can share that I have undeniably found a supportive home in Chi Sigma Iota. It is an affordable counseling organization that strives for excellence and caters to the needs of students, practitioners, and counselor educators. I encourage students, faculty, and alumni to stay active members of their local chapter. Being a member of CSI has most certainly been a worthwhile endeavor that has aided in my own personal and professional development as a counselor and counselor educator.

—J. Gerlach
Assistant Professor of Counselor Education

American Association of State Counseling Boards

The American Association of State Counseling Boards represents state boards regulating the practice of counseling. Created in 1986 by an AACD (now ACA) steering committee, the AASCB was established to encourage communication among individual state licensing boards. Specifically, the AASCB collects, interprets, and disseminates information on legal and regulatory matters directly and indirectly impacting the ability of licensed professional counselors to engage in independent practice. Today, the AASCB seeks to promote regulatory excellence and serve as the premier resource for information related to counselor licensing and regulation, test development, and standards for licensing. According to the AASCB (2018) website, the overarching goal of the group is to accept "competent counselors into the arena of professional practice rather than excluding individuals based on arbitrary or unreasonable criteria."

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Fair Access Coalition on Testing

Fair Access Coalition on Testing (FACT) is an independent group of professionals formed in 1996 dedicated to protecting and supporting public access to professionals and organizations demonstrating competence in the administration and interpretation of assessment instruments including psychological tests (FACT, 2018). Representatives from the following professional organizations, in addition to public members, sit on the FACT board of directors:

- American Association for Marriage and Family Therapy
- American Counseling Association
- American Mental Health Counselors Association
- American Speech-Language-Hearing Association
- Association for Assessment and Research in Counseling
- Association of Test Publishers
- National Association of School Psychologists
- National Board for Certified Counselors

The FACT coalition was established to protect the rights of counselors who use assessments and tests to develop treatment plans, provide appropriate referrals, and assess treatment progress of their clients. They also monitor state and national legislation and regulatory actions to assure that all qualified professionals are permitted to administer test instruments (FACT, 2018). Unfortunately, many counselors have been adversely affected by policies or legislation that includes unfair requirements or restrictive clauses that impede counselors' ability to provide quality care to their clients (Watson & Sheperis, 2010). In recent years, FACT has assisted counselors in defeating proposed legislation in Indiana, Kentucky, and Wisconsin that would have significantly limited, and in some cases prohibited, counselors' use of various tests and diagnostic assessments.

COUNSELING PROFESSION TODAY

The preceding sections were intended to provide you with foundational knowledge related to your profession's origins and development. The individuals and organizations included have made, and in some cases continue to make, invaluable contributions to the continued growth and maturation of mental health counseling. According to U.S. Bureau of Labor Statistics, mental health counseling is one of the few professions expected to grow at a rate almost 3 times the national average for all other forms of employment. In recent reports, the number of available mental health counseling positions was expected to grow 29% between 2012 and 2022. This growth represents the increasing demand for mental health services as well as the effect advocacy efforts of professional organizations like those previously mentioned have had to increase public recognition of professional counseling and the quality care its members provide. Subsequent chapters in this book

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address contemporary practice issues in mental health counseling we hope will allow you to become a more well-informed and competent practitioner.

EMERGING PROFESSIONAL TRENDS

Where the clinical mental health counseling profession goes in the future is anyone's guess. Although the destination may be unknown, we do know the profession will continue to evolve to meet the changing needs of persons across the globe as it has since the early parts of the 20th century. In addition to a growing need for mental health counselors, a changing professional landscape awaits those about to enter the profession. Shifting paradigms, evolving standards of care, and technological advances all are having a direct impact on the way mental health counselors practice, the services they deliver, and the clients with whom they will work. As a result, it is imperative for counselors to remain abreast of changes that may affect the work they do. In the remainder of this chapter, we attempt to forecast the future and identify some of the issues and potential challenges mental health counselors will face. We realize our list is by no means exhaustive and is likely to exclude issues and challenges that have not yet emerged.

Telehealth

The emergence of telehealth technologies is transforming the delivery of health care services for millions of persons (Dorsey & Topol, 2016) as providers, patients, and treatment funders all seek more effective and cost-efficient ways to deliver care. Although imperfect, telehealth services represent a promising treatment alternative for clients living in rural, remote, and underserved areas where sufficient health care options are lacking (Valentino, 2016). Several definitions of telehealth exist, with many states opting to create their own operating descriptions. At the federal level, the Health Resources and Services Administration (HRSA, 2018) defines **telehealth** as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. These technologies include several different service delivery strategies and employ multiple mediums such as terrestrial and wireless communications, the Internet, streaming media, and videoconferencing.

Although still in its infancy, telehealth has been shown to have a positive impact on individual health care. In a recent Altru Health System survey, an anticipated 7 million patients were expected to use telehealth services in 2018, up nearly 2000% from 2013. Further, an estimated 70% of employers had plans to begin offering telemedicine services as an employee benefit. These increases show individuals being receptive to this type of delivery method and providers adapting their practice to meet the needs of their patients. Among the benefits provided by telehealth services are these:

- Increased access to care
- Reduced travel time and costs
- Improved satisfaction with the health care system

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- Reduced delays in care
- Ability to ensure continuity of care
- Ability to consult with specialists in the field
- Reduced stigma associated with seeking mental health services

Mobile Health Apps

Smartphones have become ubiquitous fixtures in the lives of billions of users since their creation in the mid-2000s. In 2017, roughly three quarters of Americans (77%) owned a smartphone, a statistic more than double (35%) the amount reported in 2011 (Statista, 2018). Among millennials, smartphone ownership is even more pronounced; over 90% of Americans ages 18 to 29 reported owning a smartphone. As the number of smartphone users continues to grow, so too does the number of multimedia applications (apps) being developed. In 2016, there were over 6 million apps available for download with total time spent engaged in app usage topping 1.6 trillion hours globally (Hollander, 2017).

As app usage becomes a more ubiquitous part of everyday life, it only makes sense that mental health care providers explore ways to use this technology. Based on recent statistics, it appears this is the case. From 2009 to 2015, the National Institute of Mental Health awarded 404 grants totaling $445 million for technology-enhanced mental health intervention (NIMH, n.d.). Apps for self-management, mood tracking, passive symptom tracking, skills training, improved thinking skills, illness management and supported care, screening and assessment services, and mindfulness are all readily available. With the proliferation of apps being added to the marketplace daily, it can be difficult to distinguish quality tools from those that are not. To assist counselors in knowing which apps to use and recommend to their clients, the American Psychiatric Association has developed an online evaluation model to rate mental health apps (see Web Resources). The model includes five steps: (1) gather background information, (2) risk/privacy and security, (3) evidence, (4) ease of use, and (5) interoperability. Steps 2 through 5 are presented in sequence so that apps rating unsatisfactory at a lower level need not be evaluated at a higher level. In this model, it is important to note that there are no specified guidelines for how many criteria need to have been met for an app to be considered good or useful. Like all interventions and techniques, you the counselor must ultimately decide its utility for the clients you counsel. Table 2.4 highlights some of the advantages and disadvantages of mental health apps that counselors should consider.

CASE ILLUSTRATION 2.3

As part of their dissertation research, two former students in the doctoral program at the university I am affiliated with created a mobile mental health app to serve as a free psychoeducational tool to support pregnant women and new mothers who may be experiencing perinatal and/or postpartum depression. Their app, VeedaMom, is one of the first to use technology to detect depression during pregnancy. It is a multifunctional app a woman can use and share with her physician. The app allows women to complete self-screening assessments, manage symptoms of perinatal depression, and

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address personal wellness. As their two dissertations show, the initial research on the app and its efficacy looks promising. Qualitative data show that when women use the educational material in the app, they face their feelings and thoughts in positive ways, and our quantitative results have shown that using the app reduces depression by 15% in postpartum mothers compared with just information provided on paper. The students note that women who used the app have taken time for self-care, and this focused attention is reflected in their results. VeedaMom is a great resource for women who may be hesitant to seek counseling due to stigma, lack of resources, or accessibility issues. Like other mobile mental health apps, this technology helps to make mental health services more readily available and broadens our reach in local communities. Working with these two amazing students and seeing the impact their work is having has helped me gain a stronger appreciation for mobile app use in mental health counseling.

—JCW

TABLE 2.4 ■ Advantages and Disadvantages of Mental Health Apps

Advantages	Disadvantages
Convenience	Scant research evidencing their effectiveness
Anonymity	Challenging to address client individuality
Low-risk introduction to mental health care	No guidance for clients seeking services
Reduced cost	Privacy concerns
Access for those in remote areas	Limited regulation and practice guidelines
24-hour, around-the-clock service availability	Product overselling by developers
Consistent treatment experiences	
Added support for traditional counseling	

Neurocounseling

In recent years, mental health counselors have become increasingly interested in learning more about and applying principles of neuroscience in their counseling work with clients (Bray, 2018). The term **neurocounseling** has emerged to refer to the "integration of neuroscience into the practice of counseling, by teaching and illustrating the

GUIDED PRACTICE EXERCISE 2.3

Locate three to five mental health apps. There are several available for free download in both the App Store and Google Play. You also can search the Internet and find several websites with lists of current and popular mental health apps. After you have identified some apps you think might be helpful to you in your work as a mental health counselor, use the APA App Evaluation Model to rate each of them. Upon closer inspection, are these apps you still would feel comfortable using with clients? What would you need to see for you to introduce an app into the counseling relationship with your clients?

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GUIDED PRACTICE EXERCISE 2.4

In small groups, discuss the advantages and disadvantages of integrating neuroscience into counseling practice. Is this something you would use with all clients, or are there certain client groups for whom you believe this approach would not be appropriate? After discussing with your group, share with the rest of class. Did you notice differences among groups in terms of how and when neuroscience would be integrated?

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physiological underpinnings of many of our mental health concerns" (Russell-Chapin, 2016, p. 93). Attesting to the increased popularity of neurocounseling and its utility in counseling practice, the *Journal of Mental Health Counseling* introduced a new section titled "Neurocounseling" in its January 2017 issue with plans for it to be a regularly featured section. In addition to helping counselors teach their clients how their physiology and brain work to influence their behaviors and emotions (Russell-Chapin, 2016), principles of neurocounseling can help counselors better understand their clients' concerns, conceptualize cases, and plan treatment by using a brain-based perspective (Field, Jones, & Russell-Chapin, 2017). Further, researchers are now demonstrating that neurocounseling can be effectively used to establish more objective, measurable, and physiologically based therapeutic outcomes (Russell-Chapin, 2016). A more detailed introduction to and description of neurocounseling appears in Chapter 12.

Positive Psychology

One of the fastest growing areas of mental health, **positive psychology** refers to the scientific study of what makes life worth living (Peterson, Park, & Sweeney, 2008). What started as inquiry into happiness has evolved into an analysis of human flourishing (Seligman, 2012). Today, positive psychology has become an increasingly popular, evidence-based theory grounded in the foundational belief that personal happiness is derived from both emotional and mental factors. Its popularity among mental health counselors could be related to its close alignment with many of the fundamental principles of counseling that differentiate it from other helping professions. As Duckworth, Steen, and Seligman (2005) noted, positive psychology is a field concerned with well-being and optimal functioning that aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation.

Positive psychology as a therapeutic approach is applicable to the counseling field in many ways. As Kress and Paylo (2014) have noted, counselors are more frequently employing a strengths-based approach with their clients, and the core focus on positive events and influences in life including positive experiences, states and traits, and institutions found in positive psychology make for a natural fit. Within the positive psychology paradigm, positive psychology interventions readily can be applied. **Positive psychology interventions** (PPIs) are interventions within the positive psychology framework that aim to create positive outcomes for clients (Gander, Proyer, & Ruch, 2016). Seligman and Csikszentmihalyi (2000) identify the following as examples of positive outcomes clients may be able to realize:

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GUIDED PRACTICE EXERCISE 2.5

Identify two positive psychology–based interventions you could use with the client population(s) you intend to work with when you graduate. Practice implementing these interventions with your peers or in simulated counseling experiences you may have in your counseling training program. Become familiar with these interventions and how you will implement them now, so you can be more confident in your abilities when you are counseling in the future.

- Well-being, contentment, and satisfaction with the past
- Flow and happiness in the present
- Hope and optimism for the future

Since *positive psychology* was introduced into the professional lexicon by Martin Seligman in the 1990s, multiple theorists have posited various conceptualizations and actively are trying to shape the field. As these new conceptualizations emerge, mental health counselors should explore how this perspective might be useful in their work with clients presenting with a variety of concerns.

Holistic Wellness Counseling

According to researchers, concepts related to holistic wellness continue to inform best practices for counselors and other mental health professionals (Moe, Perera-Diltz, & Rodriguez, 2012). **Holistic wellness counseling** is a therapeutic approach in which counselors take the entire human experience into account when assessing and treatment planning. Various wellness models exist for counselors to follow. A thorough review of each is not possible here. However, we do want to introduce you to one model widely used and researched, the indivisible self model of wellness (IS-Wel; Hattie, Myers, & Sweeney, 2004).

Since its creation over 10 years ago, support for the IS-Wel model has grown exponentially. Developed through structural equation modeling of a large database, the IS-Wel model (see Figure 2.2) reflects a strength-based, choice-oriented, multidimensional approach emphasizing the interconnectedness of various dimensions of an individual's life. Conceptually, the factor structure of IS-Wel incorporates three levels of dimensions. At the center of the model is the higher-order factor labeled total wellness. According to Myers (1992), total wellness is best conceptualized as everyone's drive and ambition to achieve maximum functioning that encompasses the mind, body, and spirit. Comprising this higher-order total wellness factor are five second-order factors: creative self, coping self, essential self, social self, and physical self. Each of these second-order factors was conceptualized and labeled through a series or confirmatory and factor analyses performed on the 17 discrete wellness dimensions identified in previous wellness research (Hattie et al., 2004; Sweeney & Witmer, 1991). In addition to these dimensions, various local (basic safety), institutional (laws, policies, cultural views), global (current world events), and chronometrical (developmental lifespan) contextual variables also play an important role in the model.

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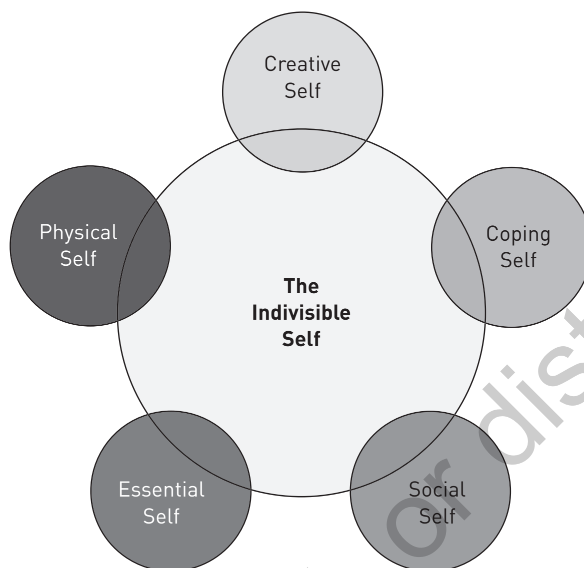
FIGURE 2.2 ■ Higher order total wellness factor labeled 'The Indivisible Self'.



Spirituality

Spirituality is a diverse concept that carries a unique meaning for everyone. Broadly speaking though, **spirituality** refers to an individualized practice extending beyond religious dogma and practice that serves to connect people to a power greater than themselves and bring them peace. Scholars have long advocated for the importance of discussing issues surrounding spirituality as a valuable part of the work we do with clients. As Corey (2006) noted over a decade ago, counseling is most effective when it addresses the body, mind, *and* spirit. Further, the counseling literature indicates that the recognition and validation of a client's spirituality in the counseling process has become increasingly important for mental health counselors (Matise, Ratcliff, & Mosci, 2018). As such, beginning mental health counselors should be cognizant of the role spirituality plays for their clients and how it influences psychosocial functioning.

When discussing spirituality, it is important to remember that it can either help or hinder the healing process (Plumb, 2011). Whereas spirituality can be a critical source of strength for some clients (Corey, 2006), others may view it as a salient part of their presenting problem. Resources are available to help counselors incorporate spiritual issues in counseling. The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) has developed a set of competencies for addressing spiritual and religious issues in counseling. The competencies address acknowledgement of both client and counselor worldview as well as application to various parts of the counseling process (e.g., assessment, diagnosis, treatment planning). A copy of the ASERVIC competencies can be found on the association's website (www.aservic.org). Adhering to these competencies will help counselors serve clients who espouse diverse religious and spiritual beliefs

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and contribute to the formulation of their culturally competent professional identity (Cashwell & Watts, 2010).

Social Justice

Social justice is a growing force within the counseling profession (Chang, Crethar, & Ratts, 2010). Like spirituality discussed earlier, the concept of social justice can be broadly interpreted. In general, the concept of **social justice** is often used to describe the promotion of equity and fairness in terms of the distribution of opportunities, resources, and privileges among all members of a society. Advocates for social justice seek to address examples of institutional oppression present in society and adversely affecting people's lives (Shin, 2008). They both acknowledge and understand how issues of unearned power, privilege, and oppression link with psychological stress and the potential manifestation of mental health disorders (Ratts, D'Andrea, & Arredondo, 2004).

In the counseling profession, social justice refers to a multifaceted approach in which counselors strive to simultaneously promote human development and the common good through addressing challenges related to both individual and distributive justice (Crethar & Ratts, 2008). More than an ethical or moral issue, social justice is a foundational belief for counselors and serves as one of the core values of the ACA. Because of the work you will do as a professional counselor, you will be uniquely positioned to be a strong social justice advocate. Through various outlets, you will have opportunities to advocate for social justice at the individual (micro), community (meso), and public policy (macro) levels (Decker, Manis, & Paylo, 2016). Resources such as the Multicultural and Social Justice Counseling Competencies (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) assist counselors by providing a framework from which they can implement multicultural and social justice competencies in theory, practice, research, and supervision. Further, organizations such as the ACA division Counselors for Social Justice (CSJ) provide a way for social justice advocates to collaborate and connect.

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CASE ILLUSTRATION 2.4

Historically marginalized populations face adversity at alarming rates throughout their life span. Adversities, to name a few, include experiencing childhood abuse and neglect, being low-income or economically disadvantaged, having a racial and ethnic minority status, facing oppression and discrimination, or being exposed to violence. Individuals who face these types of adversities are more at risk for suboptimal physical and emotional health outcomes and poor relationship quality. Considering these dire outcomes, social justice and advocacy are integral to my role as a counselor and counselor educator. I also firmly believe acting is critical to achieving the goal of equity for historically marginalized populations.

I promoted healthy relationships and family stability in my clinical work with low-income individuals and couples living 200% below the federal poverty threshold. I provided case management and brief counseling services and facilitated evidence-based relationship education interventions. These efforts provided access to community resources, improved relationship outcomes, and reduced the risk of family fragmentation.

(Continued)

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(Continued)

Next, in my role as an educator, I encourage counseling students to develop awareness of their sociocultural identities. I then prompt them to think about contextual and socioeconomic barriers, as well as adversities prevalent among historically marginalized populations. Finally, I challenge counseling trainees to consider these obstacles and disadvantageous experiences as they conceptualize their clients and create socioeconomically responsive treatment plans that support positive client outcomes.

—S. Griffith
Assistant Professor of Counselor Education

Mindfulness

According to Brown, Marquis, and Guiffrida (2013), mindfulness is a relatively new construct in counseling that is rapidly gaining interest as it is applied to people struggling with a myriad of problems. In general, **mindfulness** refers to a way of being in which individuals focus their attention on what is happening in the present and how they are experiencing the moment. It includes awareness of personal thoughts, feelings, and sensory experiences (Mayorga, De Vries, & Wardle, 2016). The origins of mindfulness practices can be traced to Eastern meditation practices and Buddhist teaching (Baer, 2003), but their integration into Western healing practices dates to the work of Jon Kabat-Zinn in the 1990s. These practices have been shown to yield positive client outcomes (Brown et al., 2013).

Counselors integrating mindfulness strategies into their work look to bring about cognitive and behavioral changes in their clients. Specifically, counselors work to help their clients (a) observe their thoughts, feelings, and sensations; (b) act with greater awareness; (c) describe their inner experiences; (d) remain nonjudgmental toward their inner experiences; and (e) maintain nonreactivity to their inner experiences (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Several mindfulness-based strategies are available for counselors to use. We recommend those of you interested in incorporating mindfulness in your counseling work explore the current literature because new approaches are consistently being developed and researched. Further, new approaches such as mindfulness-based cognitive therapy (MBCT), which combines traditional theoretical paradigms with elements of mindfulness, are emerging as compelling ways to approach counseling (Schwarze & Gerler, 2015).

Keystones

- The counseling profession was born out of the Progressive Era and is a by-product of the influential work of several social reformers invested in helping individuals displaced by the Industrial Revolution or unemployed due to the Great Depression.
- Early forms of counseling were vocational in nature and naturally fell under the purview of educators and college personnel.
- In response to growing demands for mental health services, federal legislation paved the

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way for increased access to mental health services. The Community Mental Health Act of 1963 authorized federal funding for the establishment of a nationwide network of public, nonprofit community mental health centers.

- The establishment of the American Mental Health Counselors Association along with other counseling organizations in the 1970s and 1980s provided a professional home for mental health counselors and a voice for a profession seeking recognition and parity with established health care specialties.
- Technology has helped counselors extend services to clients who previously were unable or unwilling to access treatment through traditional methods. When using technology as a counseling medium, it is important for counselors to be aware of the limitations and ethical ramifications of this approach.
- The counseling profession continues to redefine itself. The integration of neuroscience, positive psychology, and holistic wellness into service delivery models will continue to alter the way counseling services are provided.
- The continued expansion of integrated health care models is closing the loop on treatment services provided to clients. Being able to competently and effectively work as part of a multidisciplinary treatment team is becoming required knowledge for counselors working in clinical mental health settings.

Key Terms

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Web Resources

American Association of State Counseling Boards (www.aascb.org)

American Counseling Association (www.counseling.org)

American Mental Health Counselors Association (www.amhca.org)

American Psychiatric Association (APA) Mental Health APP Evaluation Model (www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model)

Association for Spiritual, Ethical, and Religious Values in Counseling (www.aservic.org)

Chi Sigma Iota International (http://csi-net.org)

Fair Access Coalition on Testing (www.fairaccess.org)

National Board for Certified Counselors (www.nbcc.org)

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