CHAPTER 1

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

... counseling has proven to be a difficult concept to explain. The public’s lack of clarity is due, in part, to the proliferation of modern-day services that have adopted the label counselor. They range from credit counselors to investment counselors, and from camp counselors to retirement counselors. Although their services share the common ingredient of verbal communication, those services have little in common with ... [psychological counseling]. (Hackney & Cormier, 2009, p. 2)

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

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

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

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

As we near the end of the chapter, I will provide an overview of the various professional associations in the counseling field, with particular emphasis on the American Counseling Association (ACA). I will conclude the chapter by highlighting
the importance of multicultural issues in the field of counseling and by focusing on ethical, professional, and legal issues that apply to counselors.

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

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

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

Over the years there have been a plethora of definitions of counseling that suggest it could be anything from a problem-solving, directive, and rational approach to helping normal people—an approach that is distinguishable from psychotherapy (Williamson, 1950, 1958); to a process that is similar to but less intensive than psychotherapy (Nugent & Jones, 2005); to an approach that suggests that there is no essential difference between the two (Neukrug, 2011; Patterson, 1986).

Some of the confusion among these words rests in their historical roots. The word guidance first appeared around the 1600s and was defined as "the process of guiding an individual." Early guidance work involved individuals giving moralistic and direct advice. This definition continued into the twentieth century, when vocational guidance counselors used the word to describe the act of "guiding" an individual into a profession and offering suggestions for life skills. Meanwhile, with the development of psychoanalysis near the end of the nineteenth century came the word psychotherapy. Meaning "caring for the soul," the word was derived from the Greek words psyche, meaning spirit or soul, and therapeutikos, meaning caring for another (Kleinke, 1994).

During the early part of the twentieth century, vocational guidance counselors became increasingly dissatisfied with the word guidance and its heavy emphasis on advice giving and morality. Consequently, the word counseling was adopted to indicate that vocational counselors, like the psychoanalysts who practiced psychotherapy, dealt with social and emotional issues. As mental health workers became more prevalent during the mid-1900s, they too adopted the word counseling, rather than use the word guidance with its moralistic implications, or psychotherapy, which was increasingly associated with psychoanalysis. Tyler (1969) stated that "those who participated in the mental health movement and had no connection with vocational guidance used the word counseling to refer to what others were calling [psychotherap[y] . . ."] (p. 12).

In the training of counselors today, the word guidance has tended to take a back seat to the word counseling, while the words counseling and psychotherapy are generally
used interchangeably in textbooks. Examine most texts that describe theories of counseling and compare them to a text that describes theories of psychotherapy, and you will find them to be nearly identical. In other words, theories of counseling and psychotherapy are indistinguishable. In fact, often both words are in the title. For example, C. H. Patterson noted in his very popular text, *Theories of Counseling and Psychotherapy*, that "...counseling and psychotherapy are both used in the title of this book because it appears to be impossible to make any clear distinction between them" (Patterson, 1986, p. xvii). In a similar vein, Corey (2009), the author of the best-known text on theories of counseling and psychotherapy, simply does not address the issue, choosing to use the words interchangeably.

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

### Comparison of Mental Health Professionals

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

For many years, the word counselor simply referred to any “professional who practices counseling” (Chaplin, 1975, p. 5). However, today, most individuals who call themselves counselors will have a master's degree in counseling. These days, counselors are found in many settings and perform a variety of roles. For instance, they may serve as school counselors, college counselors, mental health counselors, private practitioners, rehabilitation counselors, and counselors in business and industry. The counselor's training is broad, and we find counselors doing individual, group, and family counseling; administering and interpreting educational and psychological assessments; offering career counseling; administering grants and conducting research; consulting on a broad range of educational and psychological matters; supervising others; and presenting developmentally appropriate guidance activities for individuals of all ages. Even though counselors do not tend to be experts in psychopathology, they do have knowledge of mental disorders and know when to refer individuals who need more in-depth treatment.

Although there are many different kinds of counselors, all tend to have had common coursework in professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, the helping relationship, group work, assessment, and research and program evaluation. In addition to these common core areas, counselors generally have had coursework in a counseling specialty area, which might include classes in the history, roles and functions, and knowledge and skills of that specialty area. Finally, all counselors have had the opportunity to practice their acquired skills and knowledge at field placements, such as a practicum or internship.

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

All counselors can take an exam to become a National Certified Counselor (NCC) that is offered by the National Board for Certified Counselors (NBCC, 2009a). NBCC also offers subspecialty certifications in clinical mental health counseling, school counseling, and addiction counseling. In addition, today, all 50 states, Puerto Rico, and the District of Columbia have established licensing laws that allow a counselor who has a master's degree in counseling, additional training, and supervision to practice as a Licensed Professional Counselor (LPC) (some states use a related term) (ACA, 2010c). Whereas certification is generally seen as mastery of a content area, licensure allows counselors to practice independently and obtain third-party reimbursement for their practice (an in-depth discussion of credentialing can be found in Chapter 3). The professional association for counselors, which is called the American Counseling Association (ACA), currently has 19 divisions that focus on a variety of counseling concerns (a further discussion of ACA and its divisions is provided later in this chapter).
While keeping in mind that a person with a master's degree in counseling is primarily a counselor and secondarily a school counselor, mental health counselor, or a counselor in some other specialty area, the following are brief descriptions of some of the more prevalent counseling specialty areas.

**School Counselors**

A *school counselor* has a master's degree in counseling and a specialty in school counseling. Some states credential school counselors on the elementary, middle, and secondary levels, while other states offer credentialing that covers kindergarten through twelfth grade (K–12). Today, the majority of school counseling programs are CACREP accredited, which requires a minimum of 48-credit hours for the degree. The professional association for school counselors is the American School Counselor Association (ASCA), which is a division of ACA, although one can become a member of ASCA without joining ACA. In recent years, the ASCA National Model has been used as a model for the training of school counselors (see Chapter 16). In addition, over the past few decades, there has been a push by professional training programs, professional associations, and many in the field to replace the term *guidance counselor* with *school counselor*, as the latter term is seen as de-emphasizing the guidance activities of the school counselor (Baker & Gerler, 2008). If they so choose, school counselors can become NCCs, and, in most states, LPCs.

**Clinical Mental Health Counselors (Agency Counselors)**

A *clinical mental health counselor* is an individual who has obtained his or her degree in clinical mental health counseling or a closely related degree in counseling (e.g., agency counseling). Although in the past CACREP had included standards for 48-credit agency (or community counseling) programs, CACREP's 2009 standards have done away with those specialty areas and now support a 54-credit clinical mental health counseling degree, which, in 2013, will be increased to 60 credits. However, some master's programs may still be operating, and accredited, under the older 48-credit standards. As these programs' accreditation periods expire, they will have to either expand their master's degrees to the new 54 or 60-credit requirement, or disband their programs. Although not all programs are CACREP accredited, individuals who obtain a degree in clinical mental health counseling, or related degrees, are generally trained to conduct counseling or psychotherapy for those who are struggling with life problems, emotional issues, or mental health disorders. They are usually found working in a wide variety of agencies or in private practice conducting counseling and psychotherapy. The clinical mental health counselors' professional association is the American Mental Health Counselors Association (AMHCA), which is a division of ACA, although one can now be a member of AMHCA without joining ACA.

**Marriage, Couple, and Family Counselors**

Marriage, couple, and family counselors are specifically trained to work with couples and family systems and can be found in a vast array of agency settings and in private practice. These counselors tend to have specialty coursework in systems dynamics, couples counseling, family therapy, family life stages, and human sexuality, along with the more traditional coursework in the helping professions. The American Association of Marriage and Family Therapists (AAMFT) is one professional association for marriage...
and family counselors; another is the International Association of Marriage and Family Counselors (IAMFC, n.d.). IAMFC is a division of ACA, although one can join IAMFC without joining ACA.

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

**Student Affairs and College Counselors**

Student affairs and college counselors work in a variety of settings in higher education, including college counseling centers, career centers, residence life, advising, multicultural student services, and other campus settings where counseling-related activities occur. Usually, these counselors will have taken specialty coursework in college student development and student affairs practices and may have attended a 48-credit CACREP-accredited program. If they so choose, counselors who work in college settings can become NCCs, and, in most states, LPCs. There are two main professional associations of counselors in higher education settings: College Student Educators International (this organization was formerly the American College Personnel Association and has kept the acronym ACPA), which tends to focus on administration of student services; and the American College Counseling Association (ACCA), which is a division of ACA and tends to focus on counseling issues in college settings. Today, one can join ACCA without joining ACA.

**Addiction Counselors**

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

**Rehabilitation Counselors**

Rehabilitation counselors offer a wide range of services to people with physical, emotional, and/or developmental disabilities. “Rehab” counselors work in state vocational rehabilitation agencies, unemployment offices, or private rehabilitation agencies. The Council on
Rehabilitation Education (CORE) is the accrediting body for rehabilitation counseling programs. Although the curricula in rehabilitation counseling programs largely parallel those in CACREP-approved programs, rehab programs include coursework on vocational evaluation, occupational analysis, medical and psychosocial aspects of disability, legal and ethical issues in rehabilitation, and the history of rehabilitation counseling. Although CORE and CACREP attempted to merge, these efforts have failed and merger talks, for now, been been placed on hold (The CACREP Connection, 2007). Although rehabilitation counselors can become NCCs or LPCs, many choose to become Certified Rehabilitation Counselors (CRCs) through a separate certification process offered by the Commission on Rehabilitation Counselor Certification (CRCC). Many rehabilitation counselors join the National Rehabilitation Counseling Association (NRCA) and/or the American Rehabilitation Counseling Association (ARCA), a division of ACA. Today, one can join ARCA without joining ACA.

**Pastoral Counselors**

Pastoral counselors sometimes have a degree in counseling but can also have a degree in a related social service or even just a master's degree in religion or divinity. Pastoral counselors sometimes work in private practice or within a religious association. Pastoral counselors, religious counselors, or counselors with a spiritual orientation might join the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), a division of ACA and/or the American Association of Pastoral Counselors (AAPC). AAPC offers a certification process for those who are interested in becoming Certified Pastoral Counselors (CPC).

**Social Workers**

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

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

**Psychologists**

Many different types of psychologists practice in a wide range of settings, including agencies, private practice, health maintenance organizations, universities, business and industry, prisons, and schools. Psychologists are often found running agencies, consulting with...
business and industry, or serving in supervisory roles for all types of mental health professionals. Some of the many different kinds of psychologists include clinical, cognitive, counseling, developmental, educational, engineering, evolutionary, experimental, forensic, health, industrial/organizational, neuro, quantitative, rehabilitation, school, social, and sports. Today, each state determines the types of psychology licenses it authorizes as well as the requirements for obtaining those licenses (American Psychological Association, APA, 2003).

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

Clinical Psychologists

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

Counseling Psychologists

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

School Psychologists

School psychologists have a master’s or doctoral degree in school psychology and are licensed by state boards of education. Their work involves children, families, and the schooling process and their training tends to focus on consultation, evaluation and assessment, intervention, prevention, and research and planning (National Association of School Psychologists, n.d.). Many school psychologists today are found working closely with students with learning programs, their parents, and their teachers. Although most school psychologists work in schools, you can sometimes find them in private practice, in agencies, and in hospital settings. The professional associations for school psychologists are the National Association of School Psychologists (NASP) and Division 16 of the APA.
Psychiatrists

A psychiatrist is a licensed physician who generally has completed a residency in psychiatry, meaning that in addition to medical school, he or she has completed extensive field placement training in a mental health setting. In addition, most psychiatrists have passed an exam to become board certified in psychiatry. Being a physician, the psychiatrist has expertise in diagnosing organic disorders, identifying and treating psychopathology, and prescribing medication for psychiatric conditions. Although some states have granted psychologists prescription privileges for psychotropic medication (Johnson, 2009), currently it is psychiatrists, and in some cases psychiatric nurses, who take the lead in this important treatment approach.

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

Psychoanalysts

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

Psychiatric-Mental Health Nurses

Primarily trained as medical professionals, psychiatric-mental health nurses are also skilled in the delivery of mental health services (American Psychiatric Nurses Association, n.d.). Most psychiatric-mental health nurses work in hospital settings, with lesser numbers working in community agencies, private practice, or educational settings. Psychiatric-mental health nursing is practiced at two levels. The RN psychiatric-mental health nurse does basic mental health work related to nursing diagnosis and nursing care. The Advanced Practiced Registered Nurse (APRN) has a master's degree in psychiatric-mental health nursing and assesses, diagnoses, and treats individuals with mental health problems. Currently holding prescriptive privileges in all 50 states (Phillips, 2007), APRNs provide an important service in many mental health settings. Because of their training in both medicine and basic counseling skills, they hold a unique position in the mental health profession. Psychiatric-mental health nurses can acquire certification in a number of mental health areas based on their education and experience (see American Nurses Credentialing Center, 2010). The professional
association of psychiatric-mental health nurses is the American Psychiatric Nurses Association (APNA).

**Expressive Therapists**

Expressive therapists include art therapists, play therapists, dance/movement therapists, poetry therapists, music therapists, and others who use creative tools to work with individuals who are experiencing significant trauma or emotional problems in their lives (Malchiodi, 2006). Through the use of expressive therapies, it is hoped that individuals can gain a deeper understanding of themselves and work through some of their symptoms. Expressive therapists work with individuals of all ages and do individual, group, and family counseling. They work in many settings and are often hired specifically for their ability to reach individuals through a medium other than language. Many expressive therapists obtain degrees in counseling or social work and later pick up additional coursework in expressive therapy. However, there are programs that offer a curriculum in the expressive therapies, such as those approved by the American Art Therapy Association (AATA). Other expressive therapy associations include the Association for Creativity in Counseling (ACC), a division of ACA; the American Dance Therapy Association (ADTA); the American Music Therapy Association (AMTA); and the Association for Play Therapy (APT). Although certification exists for some kinds of expressive therapies (e.g., see Art Therapy Credentials Board, 2007), states generally do not license expressive therapists, although they can become licensed if their degree was in a field credentialed by the state (e.g., counseling or social work) and sometimes can become licensed if they take additional courses so their course work matches the curriculum requirements of the existing state licenses (Wadeson, 2004).

**Human Service Practitioners**

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

**Psychotherapists**

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

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

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

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

The American Counseling Association

The beginnings of the American Counseling Association (ACA) can be traced back to the 1913 founding of the National Vocational Guidance Association (NVGA). After undergoing many changes of name and structure over the years, today's ACA is the world's largest counseling association. This 45,000-member not-for-profit association serves the needs of all types of counselors in an effort to "enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity" (ACA, 2010c, para 4).

Divisions of ACA

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

- AACE: Association for Assessment in Counseling and Education (1965)
  Journal: Measurement and Evaluation in Counseling and Development
- AADA: Association for Adult Development and Aging (1986)
  Journal: Adultspan
• ACC: Association for Creativity in Counseling (2004)  
  Journal: *Journal of Creativity Mental Health*  
• ACCA: American College Counseling Association (1991)  
  Journal: *Journal of College Counseling*  
• ACEG: Association for Counselors and Educators in Government (1984)  
  Journal: None published  
• ACES: Association for Counselor Education and Supervision (1952)  
  Journal: *Counselor Education and Supervision*  
• AGLBIC: Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (1997)  
  Journal: *Journal of LGBT Issues in Counseling*  
• AMCD: Association for Multicultural Counseling and Development (1972)  
  Journal: *Journal of Multicultural Counseling and Development*  
• AMHCA: American Mental Health Counselors Association (1978)  
  Journal: *Journal of Mental Health Counseling*  
• ARCA: American Rehabilitation Counseling Association (1958)  
  Journal: *Rehabilitation Counseling Bulletin*  
• ASCA: American School Counselor Association (1953)  
  Journal: *Professional School Counseling*  
• ASERVIC: Association for Spiritual, Ethical & Religious Values in Counseling (1974)  
  Journal: *Counseling and Values*  
• ASGW: Association for Specialists in Group Work (1973)  
  Journal: *Journal for Specialists in Group Work*  
• C-AHEAD: Counseling Association for Humanistic Education and Development (1952)  
  Journal: *Journal of Humanistic Counseling, Education, and Development*  
  Journal: *Journal for Social Action in Counseling and Psychology*  
• IAAOC: International Association of Addictions and Offender Counselors (1974)  
  Journal: *The Journal of Addictions and Offender Counseling*  
• IAMFC: International Association of Marriage and Family Counselors (1989)  
  Journal: *The Family Journal: Counseling & Therapy for Couples & Families*  
• NCDA: National Career Development Association (1952 as NVGA, 1985 as NCDA)  
  Journal: *The Career Development Quarterly*  
• NECA: National Employment Counseling Association (1964)  
  Journal: *The Journal of Employment Counseling*  

**Associations Related to ACA**

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

• **The ACA Insurance Trust (ACAIT).** This organization provides liability insurance as well as a wide range of other kinds of insurance for its members (see [http://www.acait.com/](http://www.acait.com/)).
• The American Counseling Association Foundation (ACAF). ACAF offers support and recognition for a wide range of projects, including scholarships for graduate students, recognition of outstanding professionals, enhancement of the counseling profession, and support for those in need (see http://www.acafoundation.org/).

• The Council for Accreditation of Counseling and Related Educational Programs (CACREP). CACREP is an independent organization that develops standards and provides accreditation processes for counseling programs (see http://www.cacrep.org/).

• The Council on Rehabilitation Education (CORE). CORE develops standards and provides accreditation processes for rehabilitation counseling programs (see http://www.core-rehab.org/).

• The National Board for Certified Counselors (NBCC). NBCC provides national certification for counselors (National Certified Counselor; NCC); mental health counselors (Certified Clinical Mental Health Counselor; CCMHC), school counselors (National Certified School Counselor; NCSC), and substance abuse counselors (Master Addiction Counselor; MAC) (see http://www.nbcc.org/certifications/).

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

Branches and Regions of ACA

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

Membership Benefits of ACA

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

• Professional development programs, such as conferences and continuing education workshops
• Counseling resources, including books, ethical codes, video and audiotapes, electronic news, and journals
• Computer-assisted job search services
• Professional liability insurance
• Consultation on ethical issues and ethical dilemmas
• Assistance in lobbying efforts at the local, state, and national levels
• A counselor directory
• Networking and mentoring opportunities
• Graduate student scholarships
• Subscriptions to the Journal of Counseling and Development and other professional journals, based on division membership
• A variety of discount and specialty programs (e.g., rental cars, auto insurance, hotels, discounts on books, etc.)
• Links to ACA listservs for graduate students, international counseling issues, public policy issues, and counselor educators
• Links to ACA divisions and other relevant professional associations
• Legislative updates and policy setting for counselors

The American Art Therapy Association (AATA)

The American Art Therapy Association (AATA) was founded in 1969 and is open to any individual interested in art therapy. AATA is “dedicated to the belief that the creative process involved in art making is healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy” (AATA, 2010, Mission section). The association establishes criteria for the training of art therapists, supports licensing for art therapists, maintains job banks, sponsors conferences, and publishes a newsletter and the journal Art Therapy.

The American Association for Marriage and Family Therapy (AAMFT)

If you have a counseling degree, you may be interested in joining the International Association of Marriage and Family Counselors (IAMFC), which is a division of ACA. However, in recent years, the American Association for Marriage and Family Therapy (AAMFT), with its 24,000 members, has become another important association in the field of marriage and family counseling. Founded in 1942 as the American Association of Marriage and Family Counselors, AAMFT was established by family therapy and communication theorists. Today, AAMFT “facilitates research, theory development and education . . . [and develops] standards for graduate education and training, clinical supervision, professional ethics and the clinical practice of marriage and family therapy” (AAMFT, 2002, What We Do section, para 1). AAMFT publishes the Journal of Marital and Family Therapy, sponsors a yearly conference, and offers professional activities related to family counseling and family development.

The American Psychiatric Association (APA)

Founded in 1844 as the Association of Medical Superintendents of American Institutions for the Insane, today the American Psychiatric Association (which has the same acronym as the American Psychological Association, APA) has over 38,000 members. The association's main purpose is to “ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders” (American Psychiatric Association, 2010, para 1). The association offers workshops on psychiatric disorders, evaluates and publishes statistical data related to psychiatric disorders, supports educational and research activities in the field of psychiatry, and advocates for mental health issues. The APA publishes journals in the field
of psychiatry and is responsible for the development and publication of the Diagnostic and Statistical Manual.

The American Psychiatric Nurses Association (APNA)

Founded in 1986 with 600 members, today the American Psychiatric Nurses Association (APNA) has over 7,000 members. APNA today is “committed to the specialty practice of psychiatric mental health nursing, health and wellness promotion through identification of mental health issues, prevention of mental health problems and the care and treatment of persons with psychiatric disorders” (APNA, n.d., Welcome to APNA section). APNA offers a number of continuing education and professional development activities and publishes the Journal of the American Psychiatric Nurses Association. The association provides advocacy for psychiatric nurses to improve the quality of mental health care delivery.

The American Psychological Association (APA)

Founded in 1892 by G. Stanley Hall, the American Psychological Association (APA) started with 31 members and now maintains a membership of 150,000. The main purpose of this association is to “advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives” (APA, 2010, Mission statement section). The association has 56 divisions in various specialty areas and publishes numerous psychological journals. The Counseling Psychology Division (Division 17) of the APA shares many of the same goals and purposes of some divisions of the American Counseling Association.

The National Association of Social Workers (NASW)

The National Association of Social Workers (NASW) was founded in 1955 as a merger of seven membership associations in the field of social work. Servicing both undergraduate- and graduate-level social workers, NASW has nearly 150,000 members. NASW seeks “to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies” (NASW, 2010, About NASW section). The association publishes five journals and other professional publications. It has 56 chapters that include every state as well as additional chapters in New York City, District of Columbia, Puerto Rico, Virgin Islands, Guam, and an International chapter.

The National Organization for Human Services (NOHS)

Founded in 1975, the mission of the National Organization for Human Services (NOHS) is to “strengthen the community of human services by: expanding professional development opportunities, promoting professional and organizational identity through certification, enhancing internal and external communications, advocating and implementing a social policy and agenda, and nurturing the financial sustainability and growth of the organization” (NOHS, 2009, Our Mission section). NOHS is mostly geared toward
undergraduate students in human services or related fields, faculty in human services or related programs, and human service practitioners. NOHS publishes one journal, the *Journal of Human Services* (formerly, *Human Service Education*).

**Characteristics of the Effective Helper**

In 1952, Eysenck examined 24 uncontrolled studies that looked at the effectiveness of counseling and psychotherapy and found that "roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not" (italics added) (p. 322). Although found to have serious methodological flaws, Eysenck's research did lead to debate concerning the effectiveness of counseling and resulted in hundreds of studies that came to some very different conclusions:

*It is a safe conclusion that as a general class of healing practices, psychotherapy is remarkably effective. In clinical trials, psychotherapy results in benefits for patients that far exceed those for patients who do not get psychotherapy. Indeed, psychotherapy is more effective than many commonly used evidence-based medical practices. . . .* (Wampold, 2010a, pp. 65-66)

But what is it that makes counseling effective? First and foremost, some client factors such as readiness for change, psychological resources, and social supports may affect how well a client does in counseling (Asay & Lambert, 1999; Clarkin & Levy, 2004; Wampold, 2010a). However, these factors are intimately related to the counselor's ability to work with the client. When looking specifically at the counselor, there has been some emphasis in recent years on the importance of matching treatment methodologies to presenting problems. Called *evidence-based practice* (Norcross, Beutler, & Levant, 2006; Hayes, 2005; Stout & Hayes, 2005), this approach has become commonplace in training clinics. However, it has also become clear that specific counselor qualities, sometimes called *common factors*, seem to be even more important to positive counseling outcomes than matching a treatment approach to a presenting problem (Wampold, 2010a, 2010b, 2010c). For instance, the counselor's ability at developing a strong *working alliance* with the client may be the most significant factor in creating client change (Baldwin et al., 2007; Beutler et al., 2004; Marmarosh et al., 2009; Orlinsky, Ronnestad, & Willutzki, 2004). This alliance has been alluded to by almost every counselor and therapist from Freud to the modern day new age counselor. Based on the research, and perhaps some of my own biases, I would contend that this working alliance is composed of the following six components: empathy, acceptance, genuineness, embracing a wellness perspective, cultural competence, and something that I call the "it" factor.

In addition to the working alliance, additional common factors seem to be related to the counselor's ability to deliver his or her theoretical approach (Wampold, 2010a), which I view as containing three components: compatibility with and belief in your theory, competence, and cognitive complexity. Let's take a look at all nine essential characteristics for effective counseling (see Figure 1.2).
Empathy

More than any component, empathy has been empirically shown to be related to positive client outcomes and is probably the most important ingredient to building a successful working alliance (Bohart, Elliot, Greenberg, & Watson, 2002; Norcross, 2010). Understanding our clients, or being empathic,

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

Whether or not one could truly understand the inner world of another has been discussed for centuries and was spoken of by such philosophers as Plato and Aristotle (Gompertz, 1960). However, Carl Rogers (1957) is given credit for bringing this concept

to life in the twentieth century. With respect to the counseling relationship, understanding through empathy is seen as a skill that can build rapport, elicit information, and help the client feel accepted (Egan, 2010; Neukrug & Schwitzer, 2006). Because empathy is seen as an important personal attribute as well as a critical counseling skill to learn, it will be discussed in more detail in Chapter 5.

Acceptance

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

Genuineness

Genuineness refers to the counselor's ability to be authentic, open, and in touch with his or her feelings and thoughts within the context and parameters of the helping relationship. Thus, one may not have all aspects of his or her life “together,” but within the counseling relationship, the counselor is real and seen by the client as being in a state of congruence (feelings, thoughts, and behaviors are in sync). Genuineness may also be related to emotional intelligence, which is the ability to monitor one's emotions, a quality that counselors and counseling students seem to have more than others (Martin, Easton, Wilson, Takemoto, & Sullivan, 2004). Rogers (1957) popularized the term genuineness (or congruence) and noted that it was a core condition in the counseling relationship, along with empathy and unconditional positive regard.

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

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

Counseling students and counselors in general all need to attend to their own wellness by embracing a wellness perspective if they are to be effective counselors. One method of assessing your level of wellness is by examining what Myers and Sweeney (2008) identify as the Indivisible Self. This model views wellness as a primary factor composed of five subfactors and also takes into account an individual's context. The factors (creative self, coping self, social self, essential self, and physical self) and contexts are described in Table 1.1.

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

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

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

It appears that counselors and other mental health professionals understand the importance of being in counseling, as 85% of helpers have attended counseling (Bike, Norcross, Schatz, 2009).

However, some counselors resist, perhaps for good reasons (e.g., concerns about confidentiality, feeling as if family and friends offer enough support, or believing they have effective coping strategies) (Norcross, Bike, Evans, & Schatz, 2008). So, have you attended counseling? If not, have you found other ways to work on being healthy and well?

Cultural Competence

If you were distrustful of counselors, confused about the counseling process, or felt worlds apart from your helper, would you want to go to or continue in counseling? Assuredly not. Unfortunately, this is the state of affairs for many diverse clients. In fact, it is now assumed that when clients from nondominant groups work with majority helpers, there is a possibility that the client will frequently be misunderstood, often misdiagnosed, find counseling and therapy less helpful than their majority counterparts, attend counseling and therapy at lower rates than majority clients, and terminate
### Abbreviated Definitions of Components of the Indivisible Self Model

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

**Note:** 5F-Wel = Five Factor Wellness Inventory

counseling more quickly than majority clients (Evans, Delphin, Simmons, Omar, & Tebes, 2005; Sewell, 2009; United States Department of Health and Human Services, 2001). Unfortunately, it has become abundantly clear that many counselors have not learned how to effectively build a bridge—form a working alliance with clients who are different from them.

Clearly, the effective counselor needs to be culturally competent if he or she is going to connect with his or her client (Anderson, Lunn, & Ogles, 2010). Although some rightfully argue that all counseling is cross-cultural, when working with clients who are from a different culture than one’s own, the schism is often great. Therefore, cross-cultural competence is a theme we will visit and revisit throughout this text, and I will offer a number of ways for you to lessen the gap between you and your client. One model that can help bridge that gap is D’Andrea and Daniels’s (2005) RESPECTFUL Counseling Model, which highlights ten factors that counselors should consider addressing with clients:

- R – Religious/spiritual identity
- E – Economic class background
- S – Sexual identity
- P – Psychological development
- E – Ethnic/racial identity
- C – Chronological disposition
- T – Trauma and other threats to their personal well-being
- F – Family history
- U – Unique physical characteristics
- L – Language and location of residence, which may affect the helping process. (p. 37)

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

**The “It” Factor**

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

I believe all great counselors have their own it factor, although more often than not these great theorists want us to use their it factor. So, Carl Rogers, who was great at showing empathy, unconditional positive regard, and genuineness, suggested we all use these core conditions; and Albert Ellis, who was a master at showing how irrational one can be, suggested we all show our clients their irrational thinking; and
Michael White, who believed that social injustices fueled mental illness, wanted all
counselors to look at how individuals are oppressed by language; and of course Freud,
who believed in the unconscious, told us to show analytic neutrality to allow the un-
conscious to be projected onto the therapist. I believe Salvadore Minuchin’s (1974)
described this it factor best. A family counselor, Minuchin used the word “joining” in
highlighting the importance of each counselor finding his or her unique way of work-
ing with clients:

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

So, what is your it factor? What do you have that’s special and will enable you to
bond? Is it the way you show empathy, the way you make people laugh, a tone, a look, or
a way of being? Do you have it? (see Box 1.1)

Compatibility with and Belief in a Theory

There are many theories to choose from when I do counseling, but most don’t fit me. For
one reason or another, I am simply not compatible with them. Maybe it’s because they
place too much emphasis on genetics, or spirituality, or early child rearing, or maybe
they’re just a little too directive, or too nondirective—for whatever reason, they just
don’t sit well with me. I am not compatible with them, and I choose not to use them.
But, thankfully, there are enough theories out there with which I am compatible. I drift
toward them and those are the ones I use. Wampold (2010a) says that helpers “are at-
tracted to therapies that they find comfortable, interesting, and, attractive. Comfort
most likely derives from the similarity between the worldview of the theory and the at-
titudes and values of the therapist” (p. 48). Wampold (2010a, 2010b) goes on to say that
if you are drawn to a theory, and if you believe that the theory you are drawn to works,
then, and only then, will you likely see positive counseling outcomes. So, what theories
are you drawn to? And, if you aren’t sure yet, you’ll have an opportunity to explore this
more in Chapter 4 and in other courses where you will examine your own theoretical
orientation to counseling. Hopefully, over, time, you will feel an increased sense of com-
patibility with and belief in a theory.

**BOX 1.1**

<table>
<thead>
<tr>
<th>What Is Your “It”?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write down your unique personality characteristics that allow you to build a bond with others. Then the instructor can make a master list on the board. After reviewing the list, discuss whether the characteristics are inherent and which may be learned. Is it possible for a counselor to acquire new ways of bonding with clients as he or she develops?</td>
</tr>
</tbody>
</table>
Competence

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

Counselors have both an ethical and legal responsibility to be competent (Corey, Corey, & Callanan, 2011). For instance, the ACA (2005) ethical guidelines elaborate on eight areas of competence, including (1) practicing within one’s boundary of competence, (2) practicing only in one’s specialty areas, (3) accepting employment only for positions for which one is qualified, (4) monitoring one’s effectiveness, (5) knowing when to consult with others, (6) keeping current by attending continuing education activities, (7) refraining from offering services when physically or emotionally impaired, and (8) assuring proper transfer of cases when one is incapacitated or leaves a practice (ACA, 2005, Standard C.2). The legal system reinforces these ethical guidelines because “one function of lawsuits is to encourage competent therapy” (Swenson, 1997, p. 166).

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

Cognitive Complexity

The best helpers believe in their theory, but are willing to question it. This apparent contradiction makes sense. You have a way of working, but are also willing to constantly examine if your way is working. Deal (2003) describes such a counselor as a person who is as a critical thinker who is good at examining problems from multiple perspectives and good at analyzing and evaluating situations. Counselors who view the world with a fair amount of cognitive complexity are likely to be more empathic, more open-minded, more self-aware, more effective with individuals from diverse cultures, able to examine a client’s predicament from multiple perspectives, and better able to resolve “ruptures” in the counseling relationship (Deal, 2003; Eriksen & McAuliffe, 2006; Granello, 2002; Milliken, 2004; McAuliffe & Eriksen, 2010; Norcross, 2010). Such a counselor is willing to integrate new approaches into his or her usual way of practicing counseling, and is a helper who doesn’t believe his or her theory holds the “truth” (Wampold, 2010a). So, ask yourself, do you have this quality? Are you able to self-reflect, question truth, take on multiple perspectives, and evaluate situations in complex ways? Counselor training programs are environments that seek to expand this type of thinking ( McAuliffe & Eriksen, 2010). Hopefully, in your program, you’ll be exposed to such opportunities.

Now that we’ve looked at all nine characteristics, ask yourself, are you empathic, accepting, genuine, wellness oriented, and culturally competent? Do you have the “it”
factor? Are you compatible with and do you believe in your theory? Are you competent and cognitively complex? As we start on our journey to help others, let’s not forget to help ourselves, because clearly, helping ourselves will significantly improve the manner in which we help others.

---

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

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

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

---

**Ethical, Professional, and Legal Issues**

**Knowing Who We Are and Our Relationship to Other Professional Groups**

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

*Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.* . . . (Standard C.2.a.)
Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice. (Standard C.2.e.)

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

Impaired Mental Health Professionals

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

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

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work . . . . (Standard C.2.G)

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

The Counselor in Process: Personal Therapy and Related Growth Experiences

As you begin your journey in the counseling profession, I hope you have the opportunity to engage in growth experiences that will help you embody the counselor characteristics highlighted in this chapter. What kind of experiences should you seek out? First, I hope that you strongly consider undergoing your own personal counseling, for the many reasons noted earlier. In addition to counseling, you might want to consider other related growth
experiences, such as prayer and/or meditation, relaxation exercises and stress reduction, discussion and support groups, exercise, journaling, and readings.

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

Summary

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

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

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

As the chapter neared its conclusion, we discussed the importance of a number of ethical issues, including understanding our professional identity and knowing our professional limits, practicing within one’s area of competence, consulting with other
professionals, and terminating or referring clients when one is unable to work effectively with them. We then discussed the importance of assuring that we are not working while impaired. Related to this topic, we ended the chapter discussing the importance of being in our own personal counseling and/or finding other related personal growth experiences. We also expressed the hope that readers of this text were in an educational program that affords personal and intellectual growth experiences in a nurturing yet challenging environment.

**References**


