CHAPTER 17
Clinical Mental Health Counseling

I'm working at a crisis center, and a client tells me he's being followed by the Mob. They want to kill him, he states. He asks me what he should do, and I say, "Why don't you call the FBI, or the State Police?" He calls the State Police, and they want to see him. I drive him out to the State Police barracks, thinking along the way, "This guy is paranoid." We get there. The cops talk with him for half an hour. They come out and tell him to lie down in the back of my car so no one will see him. My heart drops. "He's not paranoid?" I think, "Oh my God!" They tell me to take the back roads back to the crisis center!

I'm working at a mental health center with a client who had been hospitalized for depression a few years back. I've been seeing her for a few months and have built a fairly solid relationship with her. At the end of the session she tells me, "You know, when I was hospitalized, one of the staff molested me."

I'm at the same mental health center. I've been seeing a client for about a year. She's been psychotic, on and off, for a number of years and is pretty stiff in the way she interacts with people. She's on some heavy-duty antipsychotic medication. She sees me once every three weeks for a check-in. Suddenly, at the end of a session, she looks at me and tells me she had an abortion ten years ago. Her psychotic episodes started about ten years back. This certainly seems to be an interesting coincidence. I decide to see her weekly. She begins to share her guilt about the abortion, and within a couple of months, she's practically off her medication. Now, I wouldn't have said she was back to normal, but she certainly was doing better! What a success! A month later, she dies in the middle of the night!

I'm in private practice, and it's a Friday afternoon. I'm seeing one of my last clients of the day, looking forward to going away on a weekend trip to the country. He's a 15-year-old I've been seeing for a while. At the end of the session, he blurts out that he was molested when on a recent vacation. There goes my weekend trip, as I have to deal with his parents, the law, and him.

My girlfriend and I have just broken up. It's my birthday. I'm very depressed. I go to my part-time job at a small counseling center. A new client walks in. She immediately tells me it's her birthday and that she and her husband have just split up. Is this a coincidence, or what? I wonder if I can get through the session. Ed Neukrug

1 This chapter was co-written by Ed Neukrug and Kathleen Levingston.
So, you want to work as a mental health counselor? It can be fun. It can be boring. It can be scary. It can be sad, and it can be exhilarating. It's the best of jobs and the worst of jobs. Let's see what it's all about.

This chapter is about working in clinical mental health counseling. We'll start by defining this counseling arena. Then we'll offer a brief overview of the history of this specialty area. This will be followed by an overview of some of the places you can find clinical mental health counselors. We will examine some of the theories used by counselors in these settings and some typical roles and functions of the clinical mental health counselor. We'll present some special issues currently impinging on the clinical mental health counselor and offer information on current salary ranges. As we near the end of the chapter we will examine some multicultural and social justice issues, as well as some ethical, professional, and legal issues in the area of mental health counseling. We'll conclude the chapter with some thoughts about the changing nature of mental health counseling.

What Is Clinical Mental Health Counseling?

Probably, the best place to start in describing clinical mental health counseling is to examine the course content and field placements needed in such programs. Today, all counseling programs accredited by the Commission for the Accreditation of Counseling and Related Programs (CACREP) must provide content knowledge in eight areas: professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation. In addition, clinical mental health counseling programs must also offer course content in psychopathology, diagnosis, assessment psychopharmacology, treatment planning, crisis counseling and trauma, psychosocial history, report writing, marriage and family, program development, addictions, case conceptualization, evidence-based treatment, and more! In addition, a 100-hour practicum and 600-hour internship are also required.

Until recently, community counseling (aka agency counseling) and clinical mental health counseling were seen as similar programs that had different accreditation processes by CACREP, with community counseling programs requiring a minimum of 48 credit hours and clinical mental health counseling programs requiring 60 credit hours. However, with most states requiring 60 credits for licensure, and with differences between the two degrees seeming relatively minor, the 2009 CACREP standards have done away with the community counseling degree. To help programs adjust to these changes, the 2009 CACREP standards currently require any new programs in clinical mental health counseling to have a minimum of 54 credits, and after July 1, 2013, all new programs in this specialty area will be required to have 60 credit hours (CACREP, 2010).

Over the years, changes such as those just noted have been many in the field of counseling and may even be described as a bit of a roller coaster ride. Despite the fact that the clinical mental health counseling degree is generally viewed as the specialty area most appropriate for becoming a Licensed Professional Counselor (LPC), in most states today one can become a Licensed Professional Counselor regardless of specialty area (see Box 17.1). Although it hasn't been a straight path to get where we are today, the field of counseling is stronger than ever. It will be interesting to see where we are in 2025.
A History of Clinical Mental Health Counseling

The Beginning of the Mental Health Movement

As noted in Chapter 2, the fields of psychiatry and clinical psychology arose around the turn of the twentieth century. It was at that time that one's emotional state was seen as having "psychological origins" in contrast to physical or demonic ones. Freud's psychoanalytic approach was one major impetus for this new way of viewing emotional problems that drastically changed the manner in which mental disorders were conceptualized and treated. It was also during this period that sanitariums began to experiment with more humane methods of hospitalization (Smith & Robinson, 1995).

The early 1900s saw the beginning of vocational guidance. This movement, along with the development of the first assessment instruments, was to have an impact on the eventual role of counseling in the mental health field. Besides being a natural fit, vocational guidance and testing shared something else in common: they both were concerned about differences in people, and highlighting differences (uniqueness!) was soon to become the hallmark of counseling and psychotherapy in general.

During the 1930s, the federal government began to earmark small amounts of money for mental health treatment, especially for research in mental health. As the decade continued, one could see a new mindset sprouting in America. Influenced by psychoanalysis, vocational guidance, an increasingly humane attitude toward mental illness, and existential philosophers and psychologists (some of whom emigrated from Europe), America was now beginning to accept the concept that mental health services were a necessary and important aspect of living in a civilized world. However, traditional psychoanalysis was seen as too long-term and mostly used by the rich; vocational guidance was too limited, too short-term, and too directive in its approach; and existential philosophy was viewed as too ethereal. However, a merging of these three approaches seemed just right.
As the 1940s neared, a new approach to counseling and psychotherapy evolved, one that encapsulated many of the precepts of psychoanalysis, counseling, existentialism, and American take-charge philosophy. This approach was optimistic and relatively short-term as compared to psychoanalysis and was founded on the belief that if people worked hard enough, they could change. Not surprisingly, it was during this time that we saw the beginnings of self-help groups like Alcoholics Anonymous and groups to assist new immigrants adjusting to American life, groups that affirmed the idea that individuals can change.

As a byproduct of the Second World War, evaluation techniques to determine who was emotionally fit to enter the military became much more sophisticated. In addition, the recovery rates of individuals who had emotional problems that resulted from the war were very high. Mental health providers were suddenly becoming more assured about their ability to treat individuals (Hershenson, Power, & Waldo, 2003). It was on the heels of these successes that the National Mental Health Act was passed in 1946, which gave states funds for research, training, prevention, diagnosis, and treatment of mental health disorders.

During the late 1940s, the National Institute of Mental Health (NIMH) was created by Congress. NIMH supported increased research and training in the mental health field and was the impetus for the 1955 Mental Health Study Act. This act established the Joint Commission on Mental Illness and Health, which made a number of far-reaching recommendations around increased funding and services for mental health and mental illness. Partly as a result of this act, the 1950s saw the expansion and acceptance of mental health services around the country. It was also at this time that we began to see the widespread use of psychotropic medication. During the late 1950s and continuing into the 1960s a number of new, and at the time revolutionary, approaches to counseling began to take shape.

Expansion of Mental Health Services

The 1960s saw great upheaval in American society. There was unrest in the ghettos and a country in bitter turmoil over the Vietnam War. The civil rights movement was growing in momentum. Out of this turmoil came landmark civil rights, economic, and social legislation (Kaplan & Cuciti, 1986). One such legislative initiative was the 1963 Community Mental Health Centers Act, which funded the establishment of mental health centers in communities throughout the nation. These centers would provide short-term inpatient care, outpatient care, partial hospitalization, emergency services, and consultation and education services. This made it possible for individuals with a wide range of mental health concerns to obtain free or low-cost mental health services. In fact, approximately 600 community-based mental health centers could trace their origins to this act (Burger, 2010).

The late 1960s and early 1970s saw a number of federal laws passed that expanded the scope of community mental health centers and funded substance abuse treatment. In 1975, the Supreme Court decision in Donaldson v. O'Connor led to the deinstitutionalization of tens of thousands of state mental hospital patients who had been hospitalized against their will and who were not in danger of harming themselves or others (see Chapter 2, Box 2.3). Many of these former patients would receive services at the newly established local community mental health centers. The 1970s also saw the passage of a
number of important legislative acts that would have a direct impact on individuals with disabilities. One major legislative initiative was the Rehabilitation Act of 1973, which ensured access to vocational rehabilitation services for adults if they met three conditions: having a severe physical or mental disability, having a disability that interfered with their ability to obtain or maintain a job, and having feasibility of employment with their disability. This act increased the need for highly trained rehabilitation counselors.

With the election of President Carter in 1976, there was an increased focus on the importance of mental health treatment. In the late 1970s, President Carter authorized the expansion of mental health services. Near the end of this decade, we saw the establishment of the American Mental Health Counseling Association (AMHCA), the first division of the American Counseling Association (ACA) to be focused solely on mental health counseling and mental health concerns. Although legislative actions of the 1970s brought with them increased diversification of the counseling field and resulted in large numbers of counselors settling into a variety of community counseling agencies, the boom period of the 1970s was soon to end with the election of Ronald Reagan.

Carter's defeat by Reagan in 1980 led to the elimination and reduction of some mental health programs and a move toward federal block grants. Block grants had the effect of allowing the states to decide which programs to fund and resulted in less money for some programs, particularly mental health centers (Hershenson et al., 2003). Despite this temporary setback, the 1980s and 1990s saw a slow but steady expansion and diversification in the field of counseling and a settling-in phase in our profession. Counselors during these decades could be found in almost any mental health setting. In addition, it was during these decades that we began to see counselors working in settings where they had not been found before, such as family service agencies, prisons, gerontological settings, hospitals, business, and industry.

Beginning in the 1990s and into the twenty-first century we have seen dramatic changes in the delivery of mental health services as health maintenance organizations (HMOs) increasingly became the primary health insurance providers (Danziger & Welfel, 2001; Grey House Staff, 2010; Kongstvedt, 2007). Previously, clients who had medical insurance generally had choice as to the type of counseling services they desired as well as to which licensed professional they could see. However, in an effort to save money, HMOs carefully monitored which services would be allowable and oversaw which providers a client could see (Huber, 1997; Walsh & Dasenbrook, 2005).

Recent Events

In 2009, every state in the country had finally passed a counselor licensure law (Shallcross, 2009). With licensure being the first important step toward counselors becoming independent providers and obtaining third-party reimbursement, this was no small step. Today, most mental health counselors can complete separate applications to become providers for the vast array of managed care and health insurance companies (Walsh & Dasenbrook, 2010). With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, mental health benefits have become a part of the packages offered by state insurance exchanges, which will hopefully continue to broaden the eligible services mental health counselors may provide such as being included as Medicare providers (AMHCA, 2010a). Along these lines, ACA, AMHCA, and the National Board for Certified Counselors (NBCC) are often seen successfully advocating for the inclusion of clinical mental health
counselors in a wide variety of insurance plans, such as TRICARE, the large health care organization for our military families (Institute of Medicine, 2010; NBCC, 2010a). Although mental health services fulfill an important need in American society, it has become clear that where, when, and from whom one seeks specific counseling-related services is often not under the control of the consumer.

Somewhat related to the increased oversight of mental health services by HMOs and other insurance providers has been the gradual acceptance of the importance of diagnosis and the use of psychotropic drugs. With HMOs and other insurance providers insisting on a DSM-IV-TR (soon to be DSM-5) diagnosis if a client is to obtain services, clinical mental health counselors must know how to diagnose. Although there are benefits and drawbacks to the diagnostic and statistical manual (see Table 17.1; also see Table 10.2), it is clear that mental health counselors need a working knowledge of this classification system if they are to work side-by-side with other professionals. Whereas counseling programs had traditionally played down the importance of diagnosis (Patureau-Hatchett, 2009), this attitude is changing as counselors have become providers for most insurance companies and HMOs.

Closely related to the use of DSM is an increased willingness on the part of counselors to refer clients for psychotropic medication. With persuasive evidence that some emotional disorders are genetically linked (Douthit, 2006; Holloway, 2004; Neukrug, 2001), and with research now showing that the treatment of some problems, such as depression, is best facilitated through a combination of therapy and psychotropic medication, it is becoming evident that counselors will need to learn how to use such medications (Kalat, 2008; Kuat & Dickinson, 2007; Lewis, 2006; Manber et al., 2008; Paradise & Kirby, 2005; Schatzberg & Nemeroff, 2009). To not do so will undoubtedly find the counselor out of sync with the rest of the mental health field. In addition, it may leave the counselor open to ethical misconduct charges and possible malpractice suits, as in some cases not to use medication may be viewed as practicing incompetent therapy.

As community counseling agencies have become more prevalent and as licensure has taken hold in every state, the number of counseling programs that offer degrees in

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<td><strong>Drawbacks and Benefits of a Diagnostic and Statistical Manual Diagnosis</strong></td>
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<th><strong>DRAWBACKS</strong></th>
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<td>Objectifies and depersonalizes the person, as we view him or her in a dispassionate manner, much like watching a rat in a maze.</td>
<td>Offers us a way of understanding the person more deeply, as we are challenged to make a thorough assessment of the client.</td>
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<td>Labeling can lead to a self-fulfilling prophecy whereby the individual is seen as the diagnosis, is treated in a manner consistent with that diagnosis, and therefore is reinforced for that diagnostic label.</td>
<td>By understanding the diagnostic label and by knowing the research in the field, we can better match treatment plans and use of medication with the diagnosis, thus leading to better therapeutic outcomes.</td>
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<td>Provides clinicians with a common language that enables them to discuss clients as if they were not real people with real concerns.</td>
<td>Offers clinicians a common language by which they can consult with one another and jointly come up with more effective treatment decisions.</td>
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<td>Creates artificial categories that we &quot;buy into,&quot; and thus we believe such diagnoses exist. In fact, such diagnoses are a social construction and are thus a function of the values of society.</td>
<td>Provides clear-cut diagnostic categories from which research designs can be generated and new treatments found.</td>
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clinical mental health counseling has increased. Whereas most students in counseling programs used to specialize in school counseling, students are now evenly split between school counseling and clinical mental health counseling (about 36% in each) (Clawson et al., 2008). Today, students who specialize in community agency counseling and clinical mental health counseling, respectively, find jobs in one or more of the following settings: agencies, 67% and 65%; managed care, 14% and 19%; private practice, 11% and 12%; elementary schools, 11% and 10%; middle schools, 7% and 19%; secondary schools, 9% and 15%; and higher education, 6% and 19%. Approximately 12% and 11%, respectively, go on to pursue an advanced degree. It is clear that clinical mental health counseling has become one of the major specializations in the counseling profession.

Roles and Functions of the Clinical Mental Health Counselor

In view of the diversity of agencies in which clinical mental health counselors are found, it is clear that they can play roles that vary dramatically. Let's attempt, however, to generate a list of roles common to most mental health counselors.

Case Manager

All clinical mental health counselors are involved in some kind of case management. Whether working in a mental health center, residential treatment center, or religiously-affiliated counseling setting, the counselor has the responsibility to understand client needs, create treatment plans, and follow through on treatment goals. And, along with these tasks comes a wide range of mundane activities related to case management, including paperwork, evaluation, follow-up, billing, time management, and so forth.

Appraiser of Client Needs

Whether it is through a formal clinical interview, the use of the DSM, the use of tests, or an informal session with a new client, the clinical mental health counselor is assessing client needs and making some kind of determination about the disposition of the case.

Counselor

All clinical mental health counselors, of course, do counseling. Although some counselors may use brief-treatment approaches while others are doing long-term therapy, and some conduct individual or group counseling while others practice family counseling, there is little question that the major role of the mental health counselor is to assist the client through the counseling process.

Consultant

One of the most important roles of the clinical mental health counselor is that of consultant. As discussed in Chapter 8, consultation for the mental health counselor can be consulting outward or inward. The focus of outward consultation is on assisting individuals
who have some mental health concerns but are not clients directly involved with the agency, such as the parents and teachers of a client. Inward consultation happens when the counselor works to assist the agency in the successful functioning of that agency and ultimately the effective treatment of its clients. Consulting with other clinicians about a client would be an example of inward consultation.

Crisis Responder

With terrorist acts such as 9/11, natural disasters such as Hurricane Katrina, and school shootings such as those at Columbine and Virginia Tech, mental health counselors have increasingly become the first line of defense to assist in crisis management. Counselors assess the situation, provide information, offer support, and assist clients in developing coping skills. In addition, counselors serve as critical incident stress debriefers to address reactions of the other helpers (medical personnel, police officers, firefighters) who may be adversely affected while helping those in crisis.

Supervisor and Supervisee

You might remember from Chapter 8 that supervision is crucial to a client’s growth, as it is designed to optimize the therapeutic competence of the counselor (Bernard & Goodyear, 2008; Campbell & Herlihy, 2006). From a practical standpoint, supervision is also important because most states require a minimum of two years of clinical supervision as one aspect of obtaining licensure as a professional counselor.

A Professional Who Is Accountable

These days, accountability is a major requirement for all counselors. One way of showing accountability is through good record keeping. For instance, all counselors should be taking case notes, almost all counselors will be writing intake interviews and/or intermittent summary reports, and most counselors will be filling out paperwork for insurance companies or funding sources. Counselors are also accountable in other ways, such as when they complete needs assessments of their client population and when they evaluate the success of the counseling they do and the programs they run.

Other Roles

Some other roles you sometimes find mental health counselors taking on include (Neukrug, 2007; Southern Regional Educational Board, 1969; Taylor, Bradley, & Warren, 1996):

- **Outreach worker**, such as the counselor who goes on home visits to ensure the well-being of his or her clients
- **Broker/Networker**, such as the counselor who assists his or her clients in using other social service resources
- **Advocate**, such as the counselor who champions and defends clients’ causes and clients’ rights and who organizes client and community support in order to provide needed services
- **Teacher/educator**, such as the counselor who tutors, mentors, and models new behaviors for clients
- Community planner, such as the counselor who works with community members in designing, implementing, and organizing new programs
- Administrator, such as the counselor who runs, manages, and supervises community service programs
- Clinical assistant, such as the counselor who works closely with and may be supervised by more highly trained professionals in an effort to assist in client growth (Neukrug, 2007; SREB, 1969)

Finally, Gladding and Newsome (2009) offer another method of categorizing the work of mental health counselors. They suggest that the counselor distinguish whether his or her role is one of primary prevention, secondary prevention, or tertiary prevention. Those who focus on primary prevention concentrate on prevention of emotional problems and the promotion of wellness. Secondary prevention focuses on the control of non-severe mental health problems, while tertiary prevention concentrates on the control of serious mental health problems. A continuum exists whereby those who practice primary prevention focus less on assessment and intervention and more on presenting educationally oriented materials to ward off potential problems. Those involved with secondary and tertiary prevention respectively become increasingly involved in diagnosis, long-term treatment, and working with psychopathology (see Figure 17.1). Gladding and Newsome (2009) suggest that it is important for all counselors to spend some time focusing on primary prevention in order to ward off potential client problems.

Theory and Process of Clinical Mental Health Counseling

Because there are so many different settings, roles, and functions of mental health counselors, it is not a simple process to talk about a theoretical orientation for this kind of counselor. In fact, sometimes a counselor's theoretical approach is driven by the type of agency in which he or she works. For instance, if a counselor works in an agency that mandates a maximum of 10 sessions per client, he or she must resort to brief-treatment modalities. This leaves the counselor with a handful of theoretical approaches from which to choose. The counselor who works mostly with families must obviously have training in couples...
and family work; and, again, this counselor must choose from the existing family therapy approaches. Similarly, the rehabilitation counselor who mostly conducts career counseling must choose from the career development approaches. Therefore, to define a general theoretical approach taken by most mental health counselors would be impossible.

Although we might not be able to identify a general theoretical approach, there are some broad principles that are common to many counselors who work in these settings. For instance, Hershenson and colleagues (2003) suggest that the following seven principles govern the ways in which counselors deliver services at all agencies:

1. Respecting the client
2. Providing a facilitative environment that fosters client progress
3. Helping clients actively define goals in order to promote growth and development
4. Empowering clients and helping them understand that counseling is an educational process that involves client learning
5. Focusing on client strengths, not weaknesses
6. Focusing on both the person and the context (environment)
7. Using techniques that have been shown to be valid through prior research

Settings Where You Find Mental Health Counselors

With the spread of the community mental health movement, many agencies and settings have arisen that offer mental health services and provide employment for clinical mental health counselors (Burger & Youkeles, 2010; Gladding & Newsome, 2009). Although some counselors obtain related degrees (e.g., rehabilitation counseling, career counseling, gerontological counseling) the following settings represent the places where you are most likely to find the clinical mental health counselor.

Career and Employment Agencies

Counselors today can be found at college counseling or college career management centers, state employment offices, vocational-rehabilitation offices, and private agencies that offer career and employment counseling (Ferguson’s Careers in Focus, 2008). Such counselors typically will assist individuals in “choosing an occupation, changing a career, or adjusting to a work environment” (Helwig, 1996, p. 75). Usually, such work involves assessing clients’ interests and aptitudes and helping to bring self-knowledge to clients concerning their career development process. In addition to AMHCA (see www.amhca.org), one of the largest divisions of ACA, individuals who work in these settings often join one or both of the following ACA divisions: the National Career Development Association (NCDA, see www.ncda.org) and the National Employment Counseling Association (NECA, see www.employmentcounseling.org).

Community Mental Health Centers

Counselors have been working in mental health centers since they were first established more than 40 years ago (Ganzer, 2008; West, Hosie, & Mackey, 1987). Although a major function of the mental health center is to assist individuals with severe emotional
problems, the kinds of services they offer vary greatly. Today, many community mental health centers provide twelve types of services, and counselors can be found working in any of these service areas. They include:

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

Because community mental health centers offer such a wide range of services, they often employ hundreds of clinicians, including psychiatrists, psychologists, counselors, social workers, psychiatric nurses, and human service professionals (Garner, 2008). The responsibilities of clinicians at mental health centers vary and include such activities as clinical assessment; consultation; education; prevention; referral; retention and education, individual, group, couples, and family counseling; and much more. Because there are a variety of different kinds of clinicians at mental health centers, it is not unusual for clinicians to work as a team (Ferguson’s Careers in Focus, 2008; Gladding & Newsome, 2009). For instance, for a new client who enters the system, one clinician might conduct the intake interview, the psychiatrist might meet with the client for a medication assessment, and the case might be presented at a team meeting in order to determine which clinician might work best with this particular client.

As federal money for mental health centers has dried up, mental health centers have had to go elsewhere to secure funding. Thus, we see mental health centers obtaining grants from organizations like the United Way, and we have seen them increasingly rely on third-party billing for reimbursement of services. Because licensing is generally needed for insurance reimbursement, mental health centers have increasingly hired individuals who are licensed and who are eligible to receive third-party reimbursements.

Although clinical mental health counselors may be members of a variety of professional associations, many counselors who are employed at mental health centers belong to AMHCA, which is one of the largest divisions of ACA. AMHCA has a long history of advocacy for mental health issues and legislation (see www.amhca.org).

**Correctional Facilities**

In 2008, approximately 7.3 million Americans were in jail, on probation, or on parole—about 1 in every 198 United States adult residents—and of these, an extremely large number were minority males (Bureau of Justice Statistics, 2008a, 2008b). With most prisoners being undereducated, abused as children, abusers of drugs and alcohol, and coming from dysfunctional families, the need for counseling is paramount. It is not surprising that counselors today find themselves performing multiple functions when working with those who are incarcerated. Some of these functions include counseling, assessment,
crisis intervention, consultation, vocational training, assisting with day-to-day adjustment problems, and making referrals to outside agencies when the incarcerated individual is released from prison (Crichton & Towl, 2008; Helwig, 1996; Hershenson et al., 2003).

With so many incarcerated individuals having been found to be addicted to drugs and alcohol, it is no wonder that in addition to AMHCA, many correctional counselors join the International Association of Addictions and Offender Counselors (IAAOC), a division of ACA (see www.iaaoc.org).

**Family Service Agencies**

Because of a historically strong emphasis on family issues and community advocacy in the social work profession, many family service agencies were originally established by social workers. This resulted in social workers being the clinicians of choice for many family service agencies, and these agencies continue to be one of the largest employers of social workers (Ritter, Vakalali, & Kiernan-Stern, 2009). However, as counselors began to include couples and family counseling in their repertoire of skills, they have increasingly been hired by such agencies. These agencies often receive partial funding through such organizations as United Way and through government grants. In addition, these agencies also receive payments via clients' insurance companies or directly from clients on a fee-for-service basis. Although many of these agencies have a religious affiliation (e.g., Catholic or Jewish Family Services), religion usually does not play a major role in acceptance of clients for counseling (Male, 1996). Counselors who work in such agencies have a full range of responsibilities, including conducting intake interviews, providing case management, offering consultation and education, and providing individual, group, and family counseling. In addition to AMHCA, individuals who work for family service agencies are often members of the International Association of Marriage and Family Counselors (IAMFC, see www.iamfconline.org), a division of ACA, and/or the American Association of Marriage and Family Therapy (AAMFT; see www.aamft.org).

**Gerontological Settings**

As the population of individuals over 60 years old continues to rise (United States Census Bureau, 2010), so does their need for mental health services (Gibson & Mitchell, 2007; Goodman, Schlossberg, & Anderson, 2006; Schwiebert, Myers, & Dice, 2000; Walsh, Carrier, Shah, Lyness, & Friedman, 2008). Whereas older persons have traditionally been less amenable to counseling than younger people, as the baby boomers age, this trend is likely to end (Maples & Abney, 2006). It is, therefore, not surprising that across the country we have seen an increase in day-treatment programs for older persons at community mental health centers, long-term care facilities such as nursing homes, housing settings that are specifically geared toward older persons, senior centers, and programs for older persons offered through religious organizations and social services agencies (Ritter, Vakalali, & Kiernan-Stern, 2009).

When working with older persons, both prevention and treatment become important, and counselors will often be found assisting older persons with developmental challenges and with situational crises such as loss of a spouse (Ferguson's Careers in Focus, 2008; Gladding & Newsome, 2009; Walsh et al., 2008). Counselors often have to assist older persons in dealing with the negative stereotypes placed on them by society as well as the psychological and physiological changes they face as a result of aging. Issues of loneliness, physical illnesses, loss and bereavement, and expected developmental changes of growing older are some of the things that counselors will face when working with older
In an effort to understand some of the needs of older Americans, I visited a local community center that had organized senior services. This included meals at reduced prices; educational activities, such as guest speakers on a variety of topics; and social activities, such as movies, travel to local theater productions, and so forth. At the Center, I had lunch with Irving, Lasard, Izzi, Jeanette, Max, Joe, and some other senior citizens, with their average age being about 80 years old. We had an informal discussion about a number of issues facing older Americans. Although there was some debate concerning the amount of federal subsidies that should be given to seniors, some of their major issues seemed clear. For instance, all felt that seniors were entitled to safe and secure housing, access to good medical care, having their transportation needs met, having access to healthy meals, and having federal assistance in the delivery and implementation of these programs. Most of this group felt that they had spent a lifetime of hard work and now deserved something back in return.

Finally, it was clear that many of these seniors were dealing with losses in their lives—losses of spouses, of friends, and relatives. This psychological component, clearly, was not being attended to by any of the existing available services. Ed Neukrug

clients (see Box 17.2). Although both individual and family counseling can be means of treatment, some suggest that group counseling may be particularly effective when working with older persons (Gladding & Newsome, 2009; Thomas & Martin, 2006).

With some graduate programs offering emphasis areas in the counseling of older persons (Clawson et al., 2008), it is clear that this area of counseling has gained quite a bit of importance. In addition to AMHCA, individuals who have an interest in gerontological settings often join the division of ACA known as the Association for Adult Development and Aging (AADA, see www.aadaweb.org).

HMOs, PPOs, and EAPs

Ironically, although Health Maintenance Organizations (HMOs) and Employee Assistance Programs (EAPs) have cut into the ability of private practitioners to make a living (see discussion in “Private Practice” section), they have provided another possible place of employment for clinical mental health counselors (Clawson et al., 2008; Hayes & Paisley, 1996; Ritter, Vakalahl, & Kieman-Stern, 2009). For instance, some HMOs have designated clinicians for whom they provide office space, and subscribers must see one of these clinicians unless they receive special authorization to see someone else. HMOs such as these will often hire master’s-level counselors. Other HMOs will select specific private practices to which they will refer, and counselors are often one of the many kinds of clinicians that may be found in these practices. Finally, due to the overseeing of clinicians’ work that generally is handled by HMOs, some will hire counselors to review the casework of other clinicians.

Preferred Provider Organizations (PPOs), which are a type of HMO, are another source of employment for counselors. PPOs are organized to provide discounted rates to members. With PPOs there are gatekeepers who will refer clients to designated providers, although a client can go outside the PPO with the PPO paying for a portion of the services.

Some businesses now hire counselors as part of their employee assistance programs (EAPs). EAP counselors provide education and prevention on such topics as substance abuse and stress reduction, do assessment of employee problems, and sometimes provide short-term counseling. EAP counselors will often provide referrals to a wide range of
community services such as mental health centers, substance abuse agencies, lawyers, and private practice clinicians (Hayes & Paisley, 1996; Gladding & Newsome, 2009). Counselors who work for HMOs, PPOs, and EAPs will often join AMHCA (see www.amhca.org).

The Military and Government

The military and government are unique work settings that offer a wide range of counseling opportunities. One primary role of this counselor is to assist military or government personnel with the identification of educational or training programs that will offer opportunities for advancement within the military or government or help people transition to a new career (Helwig, 1996). In addition, military and government counselors are often found providing primary prevention and psychoeducational programs. Some military and government counselors conduct individual, group, and family counseling for military or government employees or their dependents. Such counselors sometimes work for a military family service center or an outpatient department of a military hospital or clinic, or serve as an in-house government employee, somewhat similar to an EAP counselor (see Box 17.3). With an increased awareness and focus on mental health

BOX 17.3

Meichell: A Military Counselor

I was raised in what some might call a typical military family. We moved every couple of years, changing schools 13 times in a 12-year period. I always loved school and am fond of the adventure of moving to different places and experiencing different cultures. However, for every place that I was able to thrive in military life, my two brothers suffered educationally and emotionally, both dropping out in early high school. Both received special education services, but something was missing. No one was dealing with what it meant for them to be military kids. Many marriages also succumb to the pressures and end in divorce, which was the case with my parent's marriage.

There is a special shell type of emotional exterior that military families create around themselves in order to withstand the many losses they endure. Every deployment is a loss of time, memories, shared joys, and pains, between husband and wife, parent and child, and general family wholeness. This often makes it hard to understand what is happening in the inner lives of these families. It takes special care and understanding of this organism that is its own culture.

I started out as a special education major in undergrad hoping to help children like my brothers. However, something was missing for me, and I made a drastic change to psychology my senior year. While exploring graduate studies, I met my husband, a Navy Sailor, and found myself marrying into the Navy (ironically, something I said I would not do). I began work on a graduate degree in counseling while my husband left for his first 1-year tour in the Middle East. After receiving my license, I opened my private practice. It was around this time that I was introduced to a consultant program sponsored by the Department of Defense. I serve as a contracted counselor to provide extra support on various military installations to both military personnel and their families. I also see military families in my private practice. It is rewarding to serve in this capacity having been raised in the military lifestyle/culture and continuing in this culture as the wife of a serviceman.

Why do I counsel military families? It is essential that these families have people in their communities that care about their struggles, are clinically trained, easily accessible, and willing to help them maintain strong families in the midst of constant change. Service men and woman deserve the best care and the secure knowledge that their families are emotionally cared for while they risk everything for the greater good of their country.
Pastoral, Religious, and Spiritual Counseling Agencies

Some counselors who obtain a degree in mental health counseling are interested in working in settings that have a religious and/or a spiritual orientation. In fact, spirituality seems to be an increasingly important aspect of counseling for many counselors (Morrison, Clutter, Pritchett, & Demmit, 2009; Stanard, Sandhu, & Painter, 2000; Young, Wiggins-Frame, & Cashwell, 2007).

Some who do pastoral counseling are ministers who may have had some coursework in counseling and sometimes pursue a master's degree in counseling. Others who have a strong religious orientation will obtain a degree in counseling and then seek out employment in a setting that fosters their particular point of view (e.g., Christian counseling agencies). These individuals tend to integrate the basic precepts of their religious viewpoints with what they've learned in graduate school (see Box 17.4). Obviously, at times, this makes for some interesting ethical dilemmas, such as the pro-life Christian counselor whose counselor education training has taught him or her to respect the client's right to make decisions for him- or herself, including those clients who might want to have an abortion. Besides pastoral and religious counselors, an increasing number of counselors have integrated a spiritual viewpoint into their counseling orientation. These counselors tend not to be driven by religious convictions but believe that spiritual issues are primary to understanding one's search for meaning in life.

Pastoral counselors who are affiliated with a church, synagogue, temple, or mosque can often be found ministering at these settings. Religious counselors are often found in private practice groups that offer their particular religious bent, while counselors with a spiritual orientation can be found in all kinds of agency/mental health settings. In addition to AMHCA, pastoral counselors or counselors with a spiritual orientation might join the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC; see www.aservic.org) and/or the American Association of Pastoral Counselors (AAPC; see www.aapc.org).

Private Practice Settings

Now that every state has a licensing law, there has been and will continue to be a rise in the number of counselors who are in private practice. Today, many private practice counselors can be found conducting individual, group, couples, and family counseling for individuals with developmental concerns and "normal" life problems (primary and secondary prevention). However, private practice counselors can also be found working with those who are seriously impaired (tertiary prevention), although additional training in
Let me start by saying that what I am doing as a vocation now was never considered in my earlier years. After a stint in the Navy in the late 70’s, I went into the ship repair industry and worked successfully in the field of electrical engineering for over 14 years. Subsequently, in the early 90’s, I went through a bitter divorce. Broken at a soul level, very alone and in deep despair, I sought out counsel with the minister at my church. Disappointed in his response, I went to a “Christian Counselor.” Even though I brought up my spirituality, I was dealt with very clinically—no prayer, no reference to Biblical context, and no mention of Jesus as Healer, which are part of my core Christian beliefs. At that moment, a seed was planted to do something about this for others who might face a similar situation. I prayed long and hard and found what I consider to be my calling by God: I wanted to help broken and shattered people by becoming a Christian counselor. I walked away from my prestigious career and simply followed this path. My quest led me to receive my master’s degree in counseling, become an ordained minister, and obtain my license as a professional counselor, which allowed me to be employed as a Pastoral Counselor with a local church.

For the past 5 years I was on staff with a large private Christian agency providing clinical counseling, within a Christian framework, to individuals, couples, and families who desire this perspective. Currently, I have opened a private practice of my own. By “Christian-based,” I mean that I operate from a Christian worldview and recognize that the broken and shattered are all spiritual beings created to be in a relationship with God and with each other. By “clinically sound,” I mean that I strive to constantly learn more in our field of expertise, counseling. This is partly why I am a member of the American Association of Christian Counselors and the International Society for the Study of Trauma and Dissociation. I diligently pursue knowledge on an ongoing basis to advance my deeper understanding of others so that I can provide effective interventions filtered through the Spirit of God.

psychopathology, psychopharmacology, and assessment is sometimes needed to work with this population.

With the cost of mental health services skyrocketing, insurance companies have increasingly cut back on the mental health services they provide (Allen, 2000; Fraser & Solovey, 2007; Huber, 1997). Also, many employers now provide medical coverage through the use of managed health programs such as HMOs and EAPs (Grey House Staff, 2009; Walsh & Dasesbrook, 2009). Such managed programs maintain low costs by referring only to providers who agree to the terms of the program, by providing peer review of proposed treatment plans, through early detection and treatment, by preauthorizing for admissions to hospitals, and by overseeing case management of clinicians (Gladding & Newsome, 2009). This kind of oversight of practice, as well as the increased amount of resulting paperwork, has added additional work and stress to the private practitioner and has cut into his or her ability to make a living (Daniels, 2001; Hunt, 2005; Janesick & Goldsmith, 2000). As a result, many private practice clinicians may also be found doing such things as marital and divorce mediation, parent education, consultation to business and industry, stress management and biofeedback, educationally oriented workshops, supervision, evaluations for adoption and custody, and professional
Chevette: A Nationally Certified and Licensed Professional Counselor

There is no magical story as to how I became a counselor; I am one of those rare people who knew from an early age that the mental health field was my area of interest. And perhaps like many in our profession, my path has taken some twists and turns.

I first worked with minority clients as a university counselor. I quickly realized that the word minority was inclusive of a number of areas, including ethnicity, culture, gender, socioeconomic status, and more. As a relatively young counselor, I tended to use one theoretical approach with all my clients. It didn’t yet occur to me to vary my approach based on the unique needs of the individuals with whom I was working.

My next job was at a local community college where I worked for a federally funded student support program called the Open Door Project whose purpose was to provide academic and counseling services to help students stay in college. Here I saw a variety of clients, some struggling with financial issues, which at times took priority over the desire to stay in college. Others were first generation college students who struggled partly because there was no “culture of college” in their family of origins, and they did not have the advantage of family members who understood their experience or could give them helpful advice on how to study, testing skills, or other tips that would lend to successful college completion. It was here that I began to change my “generic” approach to counseling and learned to meet the client “where he or she was.”

Today, I am in private practice. As I’ve grown as a counselor and professional, I’ve moved toward the idea that it is critical to have a broad base of knowledge and apply theories and techniques based on client needs and available resources. For example, clearly a middle class minority has different needs and resources from a minority who lives in subsidized housing. Although on the surface they may come from the same minority group, their backgrounds and available resources are dramatically different. To treat them the same would make little sense. And of course, all persons, regardless of where they come from, have their own unique concerns that are important to them and that are critical for me to understand.

As I look over my life as a counselor I can see how my approach to counseling has changed as I have held various jobs and as I have matured as a professional. I am excited to see where I will be in the next ten years.

writing (Bertram, 1996; Walsh & Dansenbrook, 2007). Private practice counselors often join AMHCA (www.amhca.org) (see Box 17.5).

Rehabilitation Agencies

In the United States today, close to 41.3 million (15%) Americans five years of age and older have a disability such as mental retardation, learning disabilities, emotional problems, speech impairment, hearing impairment, visual impairment, orthopedic impairment, multiple disabilities, or other health impairments (United States Census Bureau, 2006). These individuals are often counseled by rehabilitation counselors at one of three rehabilitation agencies: state departments of vocational rehabilitation, Veterans Administration (VA) hospitals, and private rehabilitation agencies (Fabian & MacDonald-Wilson, 2005; Ferguson's Careers in Focus, 2008; Matkin, 1997). Whereas state vocational rehabilitation agencies and VA hospitals obtain federal and/or state funding, private agencies mostly rely on insurance reimbursement, worker's compensation, and other client-related
methods of payment. At these settings, rehabilitation counselors often provide a wide range of services for their clients. For instance, they may

- help people deal with the personal, social, and vocational effects of disabilities;
- counsel people with disabilities resulting from birth defects, illness or disease, accidents, or the stress of daily life;
- evaluate the strengths and limitations of individuals, provide personal and vocational counseling, and arrange for medical care, vocational training, and job placement;
- interview both individuals with disabilities and their families, evaluate school and medical reports, and confer and plan with physicians, psychologists, occupational therapists, and employers to determine the capabilities and skills of the individual;
- develop a rehabilitation program that often includes training to help the person develop job skills;
- recognize and help remove environmental and attitudinal barriers;
- work toward increasing the client’s capacity to live independently. (United States Department of Labor, 2010–2011a, “nature of work,” para. 8)

In providing these services, the rehabilitation counselor often employs individual and group counseling techniques, and coordinates community services for clients (Ferguson’s Careers in Focus, 2008; Garfield & Beaman, 1996; Garner, 2008; Leahy, Muenzen, Saunders, & Strauser, 2009). Because of the wide range of disabilities with which the rehabilitation counselor works, it is often important that a team approach be taken when working with clients.

As new medical procedures make it possible for individuals to live longer with disabling and chronic health conditions, it is likely that we will see an increase in the number of individuals with disabilities. This will result in the need for additional services in which we will likely find the rehabilitation counselor taking an active role (Garner, 2008).

The rehabilitation counselor straddles two professional associations: the American Rehabilitation Counseling Association (ARCA, see www.arca-web.org), which is a division of ACA, and the National Rehabilitation Counseling Association (NRCA; see http://nrca-net.org). Like many of ACA’s divisions, ARCA has moved to a semi-independent state from its parent association, and one can now either join ARCA on its own or in conjunction with joining ACA.

Residential Treatment Centers

Increasingly, we are finding counselors working in residential treatment centers. Such centers tend to have a rehabilitative focus, provide a live-in setting for the duration of treatment, and provide counseling services. Today, residential treatment centers service many different people, including those who are incarcerated, individuals with physical disabilities, individuals with mental illness, the developmentally delayed, substance abusers, delinquent youths, and individuals with eating disorders, to name just a few (Lynch & Lynch, 1996).

Services provided in such settings vary but often include individual and group counseling, vocational counseling, assistance with reentry into the community, and consultation and referral to other professionals when the individual is ready to reenter
Don—A Counselor At a Residential Treatment Center

I have always been interested in what makes people tick, which made a career in counseling a natural fit for me. Fresh out of getting my undergraduate degree in sociology, I volunteered as a co-facilitator of poly-substance abuse groups. Running these groups allowed me to develop basic group facilitation skills in an often challenging and intimidating environment. Empowered by my developing skills, I packed my bags and headed into the woods as a group leader in a youth wilderness program. I lived alongside troubled adolescents in the sweltering heat of summer and bitter cold of winter. This allowed me to not only appreciate but also experience many of the struggles the residents were facing being away from home, battling the elements, and processing difficult emotions.

After leaving the wilderness program, I worked as a unit staff member in a residential treatment facility while returning to school to earn my master’s degree in community agency counseling. I completed my internship in the university’s counseling center, where I was exposed to a diverse student population presenting a wide variety of issues that required me to be aware of my own cultural beliefs, attitudes, and perspectives. Upon graduation, I became a case manager for a local youth shelter where I learned about family struggles and how different household roles influence family dynamics. I became increasingly interested in understanding the intricacies of youth and family issues. After becoming a Licensed Professional Counselor (LPC), I became an in-home clinician and had the unique opportunity of viewing families from within their own surroundings. Seeing some of the decrepit environmental conditions was an integral piece in identifying and understanding the stressors leading to family dysfunction.

In my current position at a residential treatment center for at-risk youth, I have been able to draw on my previous counseling experiences and thoroughly develop my counseling skills. This experience continues to teach me the value of empathy and unconditional positive regard as well as the importance of maintaining a family systems perspective when working with at-risk youth.

Substance Abuse Settings

The substance abuse statistics in the United States are staggering (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). For instance, for individuals aged 12 and older, in 2008 it was found that:

- 22.2 million (8.9%) were abusing or dependent on alcohol or drugs
- 15.2 million (6.5%) were dependent on or abused alcohol
- 20.1 million (8%) were actively using illicit drugs
- 129 million (51.6%) drank alcohol
- 17.3 million Americans (6.9%) were heavy drinkers
• 58.1 million (23.3%) had participated in binge drinking once or more in the past 30 days
• 23.1 million (9.2%) received treatment for a substance abuse problem

Drug and alcohol abuse today can be found in the inner cities and in middle-class America. It not only affects the users but also has a great impact on family members and on society (Fisher & Harrison, 2009; Woititz, 2002). There is little question that substance abuse is related to many of the problems facing our nation, including violent crime, problems on the job, and changing morals. Thus, the widespread abuse of substances, unfortunately, provides an array of places for counselors including hospital detoxification (detox) units, halfway houses, and drug and alcohol treatment centers (Gladding & Newsome, 2009; SAMSHA, 2008; Wischnitzer & Wischnitzer, 2005).

Counselors who work in substance abuse treatment centers provide individual counseling, group counseling, and periodic couples and family counseling (Ferguson's Careers in Focus, 2008). In addition, educational programs may be a part of this counselor's role as he or she attempts to bring increased awareness to the client and his or her family concerning the role that drugs and alcohol may play in their lives. In addition to joining AMHCA, many individuals with a focus on substance abuse will join the International Association of Addictions and Offender Counselors (IAAOC; see www.iaaoc.org), a division of ACA.

Youth Services Agencies

Today many state-assisted youth services programs employ master's-level counselors. Employment opportunities in such programs range from counselors who work with foster children, to counselors who work in residential treatment centers for delinquent youth, to those who are employed in state correctional systems with juvenile offenders. Youth counselors provide a full range of services, including intake interviewing, assessment, guidance activities, consultation and referral with other mental health professionals, and individual, group, couples, and family counseling (Helwig, 1996; Thompson & Henderson, 2010). With the tragic recent rash of youth violence in the schools and the increased recognition of youth mental health needs, the importance of providing counseling services to youth has become clear (McAuliffe, 2001; McGowan, 2004; McWhirter et al., 2007; Mellin, 2009). Because of its focus on children, some counselors who work with youth are members of the American School Counselors Association (ASCA; see www.schoolcounselor.org), while many simply decide to join AMHCA (www.amhca.org).

Counselors in Other Settings

In addition to the settings listed above, counselors can be found at many other community agencies, including crisis centers, psychiatric hospitals, hospices, group homes, women’s shelters, and departments of social services, to name just a few (see Baxter, Toch, & Perry, 1997; Collison & Garfield, 1996; Ferguson’s Careers in Focus, 2008; Garner, 2008). A degree in counseling is versatile and provides the counselor with a wide range of opportunities for employment. In fact, one might find the counselor in any setting where helping others is crucial. If you are considering a job in counseling, review the agencies listed above, but keep your options open.
Multicultural/Social Justice Focus

Broad Issues Hindering Multicultural Mental Health Counseling

Relative to multicultural counseling, clinical mental health counselors face a number of primary issues, including the following (Atkinson, 2004; D'Andrea & Heckman, 2008; Gladding & Newsome, 2009; Phelps, Taylor, & Gerard, 2001; Sue & Sue, 2008):

1. Clients from nondominant groups are underrepresented at mental health centers.
2. Clients from nondominant groups are frequently misunderstood, misdiagnosed, find therapy not helpful, attend therapy at lower rates, and are more likely to terminate therapy.
3. Clients from cultural backgrounds different from that of their counselor may experience the helping relationship more negatively than if the helper is of the same culture.
4. Most counseling theories are Western-based and might be dissonant with some minority cultures' values and attitudes.
5. Some community agency and mental health counselors may not have the sensitivity or the training necessary to work with diverse clients.
6. Some community agency and mental health counselors have an ethnocentric worldview.

Clinical mental health counselors must take heed of these concerns if they are to work effectively with the increasingly large numbers of clients from nondominant groups who will require services in the decades to come.

Assessment of Clients at Mental Health Agencies

When assessing clients through testing, it is of particular importance to understand the nature of bias in tests and to remember that a counselor's bias can lead to misinterpretation of tests, even when they are designed to be cross-culturally fair (Neukrug & Fawcett, 2010). Similarly, when assessing a client for a clinical diagnosis, counselors should consider the possibility that a diagnosis may be culturally predisposed, thus leading to the likelihood that individuals from some cultures will be misdiagnosed (Eriksen & Kress, 2005; 2006; 2008; Halstead, 2007; Kress, Eriksen, Rayle, & Ford, 2005; Horwitz, 2002). To a limited degree, DSM-IV-TR attempts to control for this by noting when cross-cultural issues may impact a diagnosis and by listing approximately 25 "culture-bound syndromes." These syndromes may represent normal behavior within the culture or abnormal behavior that is specific to the culture and for which there is no corresponding DSM classification. For instance, some African Americans and European Americans from the South may undergo what is called a "spell," in which they communicate with deceased loved ones or spirits while undergoing dramatic personality shifts, which may be misconstrued as a psychotic episode (American Psychiatric Association [APA], 2000). Clearly, when conducting a clinical assessment counselors must be extra careful to eliminate cultural bias.
Limited Numbers of Counselors from Diverse Cultures

One problem that has an impact on all of us is the limited number of individuals from diverse backgrounds who become counselors (see ACA, 2009). If agencies are to offer services to clients from nondominant groups, it is clear that more counselors from diverse cultures are needed, for research shows that minority clients sometimes work best with minority counselors (D’Andrea & Heckman, 2008; McKenzie, 1999; Phelps et al., 2001). It is all of our responsibility to encourage agency administrators to hire counselors from diverse cultures and to ensure that clients from nondominant groups are treated with respect and in culturally sensitive ways. Of course, counselor education programs need to take strong steps to increase the numbers of graduate students from culturally diverse groups who enter their programs.

Ethical, Professional, and Legal Issues

Ethical Issue: Ethical Complaints and Ethical Concerns

One manner in which we can assess the kinds of ethical difficulties mental health counselors may be facing is by examining the kinds of ethical complaints made against Licensed Professional Counselors. Although many mental health counselors are not LPCs, it is likely that most face similar ethical dilemmas to LPCs. In surveying 45 licensing boards Neukrug, Milliken, and Walden (2001) found that 24% of complaints were made for inappropriate dual relationship; 17% for incompetence in the facilitation of a counseling relationship; 8% for practicing without a license or other misrepresentation of qualifications; 7% for having a sexual relationship with a client; 5% for breach of confidentiality; 4% for inappropriate fee assessment; 1% for failure to inform clients about goals, techniques, rules, and limitations of the counseling relationship; and 1% for failure to report abuse. Another 33% of the ethical complaints were listed in an “other” category, with many boards indicating that drug abuse and felony or misdemeanor conviction was the cause. Although ethical complaints do not necessarily translate into ethical violations, it is likely that trends in ethical violations can be deduced from these data.

Table 3.2 in Chapter 3 (page 73) examines further research by Neukrug and Milliken (2011) which identifies behaviors about which counselors have little agreement regarding whether or not they are ethical (see further discussion in Chapter 3). To assess counselor responses, a random sample of ACA members, most of whom were mental health counselors, were pooled. The items in this table are grouped by logical categories. You may want to discuss these behaviors in class.

Professional Issues

AMHCA: The American Mental Health Counselors Association

Because mental health counseling covers a wide spectrum of counselors who work in many different types of settings, there is no one “perfect” professional association to meet the needs of its entire constituency (Hershenson & Berger, 2001). However, probably the association that comes closest is the American Mental Health Counselors Association (AMHCA).
The mission of AMHCA is “To enhance the profession of mental health counseling through licensing, advocacy, education and professional development” (AMHCA, 2010c, para. 2), and its vision is “To be the national organization representing licensed mental health counselors and state chapters, with consistent standards of education, training, licensing, practice, advocacy and ethics” (AMHCA, 2010c, para. 3). A few of the many activities that AMHCA conducts include advocating for licensed counselors, providing workshops and conferences, offering malpractice insurance, providing a code of ethics, providing job links, helping consumers find counselors, and publishing a journal.

As with ASCA, AMHCA felt that they could better address some of the unique needs of mental health counselors with their own separate association and has also moved to a semi-independent division status with ACA. Today, one can join AMHCA separately from ACA. If you want to join AMHCA, membership is rather inexpensive, especially considering the benefits. As you continue on your journey in the counseling profession, consider which organizations work best for you.

**Credentialing**

Many clinical mental health counselors are interested in becoming a National Certified Counselor (NCC) through the National Board of Certified Counselors (NBCC). In addition, many obtain additional certifications through NBCC as Certified Clinical Mental Health Counselors (CCMHC) or Master Addiction Counselors (MAC) (NBCC, 2010b, 2010c). Of course, many community agency and mental health counselors also want to become Licensed Professional Counselors (LPCs), as this will allow them to obtain third-party reimbursement. Most states require a master’s degree and 60 credits in designated curriculum areas to become licensed—but check your state to know the exact requirements. Usually, if your master’s degree is less than 60 credits, you will need to pick up the additional credits. In addition, a minimum of two years of post-master’s supervision and the passing of a licensing exam are generally required. While some states use the NCC or CCMHC for their licensure exam, other states have devised a separate licensing exam.

Of course, one can obtain other credentials depending on your area of specialization. For instance, on the national level, one can become a certified rehabilitation counselor, addiction counselor, art therapist, play therapist, or pastoral clinical supervisor. Increasingly, as other specialty areas become more popular, we will see additional certifications arise. Finally, you may want to find out if any specialty certifications exist in your state.

**Salaries of Mental Health Counselors**

As you can see, the settings in which you find the clinical mental health counselor vary dramatically. Generally, employment prospects for counselors are expected to be strong, as reported by the *Occupational Outlook Handbook* (United States Department of Labor, 2010–2011b). Although salaries might vary as a function of the setting or the region in which you live, generally, entry-level salaries for mental health counselors are between $25,000 and $40,000, with most counselors starting in upper 20s or low 30s. Because advancement in many of these agencies is possible, counselors can often earn up to $50,000 or $60,000. Counselors in private practice who are well networked and established can earn up to $100,000 or more (Baxter et al., 1997; Collison & Garfield, 1996; Ferguson's Careers in Focus, 2008).
Select Legal Issues

A number of legal issues that have a direct impact on clinical mental health counseling have been discussed throughout this text. Although we cannot highlight all of them, the following discussion identifies a few that seem to have been particularly important in recent years.

HIPAA

The passage of the Health Insurance Portability and Accountability Act (HIPAA) ensures the privacy of client records and adherence to rules concerning the sharing of such information (Zuckerman, 2008). In general, HIPAA restricts the amount of information that can be shared without client consent and allows for clients to have access to their records, except for process notes used in counseling (United States Department of Health and Human Services, 2010). In fact, HIPAA requires agencies to show how they have complied with this act. As a result of HIPAA, mental health professionals will generally have to do the following:

- Provide information to patients about their privacy rights and how that information can be used.
- Adopt clear privacy procedures for their practices.
- Train employees so that they understand the privacy procedures.
- Designate an individual to be responsible for seeing that privacy procedures are adopted and followed.
- Secure patient records. (APA Practice Organization, 2009, p. 3)

Confidentiality of Records

In addition to HIPAA, confidentiality of records continues to be a critical issue for clinical mental health counselors. As discussed throughout this text, a number of laws protect patients' rights to confidentiality. In terms of federal law, the Freedom of Information Act of 1974 allows individuals access to any records maintained by a federal agency that contain personal information about the individual, and every state has followed along with similar laws governing state agencies (National Security Archive, 2009). Similarly, the Family Education Rights and Privacy Act (FERPA), ensures parents the right to access their minor children's educational records, although this does not apply to case notes (United States Department of Education, 2010). Also, clients probably have a legal right to view their counseling records, and increasingly they have been exercising these rights (Swenson, 1997). Relative to children, although ethical guidelines usually support a child's right to confidential counseling, it has generally been assumed that parents have the right to view records of their children (Attorney C. Borstein, personal communication, May 24, 2010; Remley & Herlihy, 2009). Of course, specific local and state laws may vary, and each counselor should become aware of how local laws apply.

Confidentiality and Privileged Communication

In Chapters 4 and 5, we distinguished between the ethical obligation one holds toward confidentiality and the legal right clients hold toward privileged communication (Glosoff, Herlihy, & Spence, 2000). As a reminder, privileged communication is a conversation
conducted with someone that the law (state or federal statute) delineates as a person with whom conversations may be privileged (i.e., attorney–client, doctor–patient, therapist–patient, clergy–penitent, husband–wife, and the like). Because privileged communication is generally only given to clients of licensed practitioners, this raises issues for mental health counselors who are not licensed as they cannot guarantee confidentiality to their clients should a court decide to subpoena the counselor.

**Confinement Against One’s Will**

Earlier in this chapter and in Chapter 2, we discussed the case of Kenneth Donaldson, who had sued the state mental hospital in Florida for confining him against his will (see *Donaldson v. O’Connor*, 1975) (see Box 2.3). The Supreme Court unanimously upheld lower court decisions stating that the hospital could not hold him against his will if he was not in danger of harming himself or others (Swenson, 1997). As a result of this decision, every state in the country now prohibits long-term confinement of clients against their will unless there is a clear indication that they are a danger to self or others. And, even in these cases, a court hearing to show cause is generally necessary. This law has had a dramatic affect on how clinical mental health counselors work with clients and the kinds of decisions they make concerning those clients who may not be quite ill enough to be committed, but are also not well enough to adequately care for themselves. At times, clients such as these are cause for great concern among mental health counselors.

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**The Clinical Mental Health Counselor in Process:**

**Growing, Changing, Accepting**

The field of mental health counseling has undergone dramatic changes in recent years, and it is likely to continue do so in the foreseeable future (Cannon & Cooper, 2010). The ever-increasing acceptance of diagnostic tools such as DSM, the dramatic shifts in the health care delivery system, the increase in the kinds of counseling services offered, the ever-expanding knowledge of multicultural issues and their effects on client treatment, and the development of new ways of treating individuals with various emotional problems are just a few of the many issues that currently face the clinical mental health counselor. Thus, the clinical mental health counselor must not hide his or her head in the sand and continue to operate as usual. He or she must change with the times, attend conferences and participate in continuing education opportunities, and be flexible enough to adapt to new ways of working with clients from all backgrounds.

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**Summary**

In this chapter, we examined the unique characteristics of the clinical mental health counselor. We discussed the transition of merging community counseling into the clinical mental health counseling degree program. Then while exploring the history of mental
health counseling, we noted that this counseling specialty area had its origins with the development of psychoanalysis, the testing movement, and vocational guidance at the turn of the century. Over the years, the field was greatly influenced by existentialists from Europe and the Western philosophy of taking charge of one's life. The profession was launched into modern-day America through a series of legislative acts in the 1940s, 1950s, and 1960s. As a result of this legislation, research uncovered innovative therapeutic treatment modalities and new psychotropic medications that were to vastly change the way counseling was delivered. In addition, this legislation funded mental health centers and other counseling-related services, and soon counseling became more acceptable in America.

The growth of different types of agencies that offered various counseling services was rapid during the 1960s and 1970s. Very quickly we began to see mental health centers emerge in almost every community in America. In addition, other agencies, such as substance abuse centers, family service agencies, and vocational rehabilitation agencies, became part of the American landscape. Today, we see counselors working in just about every agency where counseling services are offered. We highlighted how all 50 states have passed a counselor licensure law and how our professional organizations continue to advocate for mental health counselors to be providers for a range of insurance companies (e.g., Medicare, TRICARE, etc.). We particularly noted how managed care, diagnosis, and the use of medications have recently affected the role of the clinical mental health counselor.

Although we noted that the roles and functions of clinical mental health counselors vary dramatically based on the setting, we did highlight some of the more common ones. These include the roles of case manager, appraiser of client needs, counselor, consultant, crisis debriefer, supervisee and supervisor, and a professional who is accountable. In addition, we highlighted other roles taken on by many clinical mental health counselors. These included the roles of outreach worker, broker/networker, advocate, teacher/educator, community planner, administrator, and clinical assistant. We also noted that roles may vary based on whether the clinical mental health counselor practices primary, secondary, or tertiary prevention.

Because there are so many different settings, roles, and functions of a clinical mental health counselor, the theories used by such counselors vary dramatically. However, we were able to identify some broad principles that underlie the counseling process of mental health counselors. These included respect for the client, creating a facilitative environment for client growth, helping clients define goals, empowering clients and helping them view counseling as a process that involves client learning, focusing on the strengths of the client, understanding the client within his or her environment or context, and using up-to-date techniques.

Because counselors can be found in just about every setting where counseling takes place, it would be impossible to list every agency where we might find clinical mental health counselors today. However, some of the more common settings we highlighted included career and employment agencies; community mental health centers; correctional facilities; family service agencies; gerontological settings; HMOs, PPOs, EAPs; the military and government; pastoral, spiritual, and religious counseling agencies; private practice settings; rehabilitation agencies; residential treatment centers; substance abuse settings; and youth service programs.

Within this chapter, we examined some primary issues related to multicultural counseling and the clinical mental health counselor. We noted that most counseling
theories are Western-based and may not be effective with some clients, that some clinical mental health counselors may have little sensitivity or training in working with diverse clients and may have an ethnocentric world view. We also stressed that the clinical mental health counselor needs to be aware of bias in testing and problems with diagnosing clients from diverse cultures. Finally, we stated the importance of having more counselors of color in mental health settings.

Examining some of the more prevalent ethical, professional, and legal issues, we noted some ethical concerns that are likely to be impinging on clinical mental health counselors. Specifically, we reported that ethical complaints were more likely to be made for inappropriate dual relationship, incompetence in the facilitation of a counseling relationship, practicing without a license or other misrepresentation of qualifications, or having a sexual relationship with a client. Other complaints were made for breach of confidentiality; inappropriate fee assessment; failure to inform clients about goals, techniques, rules, and limitations of the counseling relationship; failure to report abuse; drug abuse; or having a misdemeanor or felony charge. We also highlighted a recent study that explored a number of behaviors that mental health counselors tend to struggle with in the ethical decision-making process.

We stated that many clinical mental health counselors belong to AMHCA, and those who are rehabilitation counselors usually join ARCA or NRCA. However, we also noted that because of the varied types of clinical mental health counselors, there are many professional association which they can join. We stated that many clinical mental health counselors obtain an NCC, with some subsequently acquiring the CCMHC and/or licensure as professional counselors. We also noted that there are other certifications for clinical mental health counselors, with two of the more popular ones being Certified Rehabilitation Counselor (CRC) and Master Addiction Counselor (MAC). Next, we highlighted some of the salaries one might expect from employment in this specialty area.

Some select legal issues we discussed included the passage of the Health Insurance Portability and Accountability Act (HIPAA), which addresses the privacy of clients; the Freedom of Information Act and FERPA, which asserts the right of individuals to obtain their confidential records; the difference between confidentiality and privileged communication; and how “Donaldson v. O’Connor” asserted the rights of individuals to not be confined against their will unless they are in danger of harming themselves or others.

The chapter concluded by noting that clinical mental health counseling has undergone dramatic changes in recent years and that the astute counselor must keep up with these changes if he or she is to work effectively with all clients.

References