INTRODUCTION

ABOUT *MASTERING THE NATIONAL COUNSELOR EXAM AND COUNSELOR PREPARATION COMPREHENSIVE EXAM*

Mastering the National Counselor Exam and the Counselor Preparation Comprehensive Exam is a powerful resource and tool to help you prepare for two of the most important examinations in counselor preparation and credentialing: the National Counselor Examination for Licensure and Certification (NCE) and the Counselor Preparation Comprehensive Examination (CPCE). This study guide is organized into nine chapters, with the first eight chapters coinciding with the Council for Accreditation of Counseling and Related Educational Programs (CACREP) core content areas:

Chapter 1: Professional Orientation and Ethical Practice
Chapter 2: Social and Cultural Diversity
Chapter 3: Human Growth and Development
Chapter 4: Lifestyle and Career Development
Chapter 5: Helping Relationships
Chapter 6: Group Work
Chapter 7: Assessment
Chapter 8: Research and Program Evaluation

Each chapter is made up of sections addressing major topics within its CACREP core content area. Each section has five self-administered, multiple-choice questions to test your knowledge of the presented material and allow you to maximize your learning while making the reviewing of course material more manageable. This study guide also contains a glossary of key terms and several full-length practice tests to help you retain this information. Finally, the content of a new Chapter 9: *From Envisioning to Actualization: Marketing Yourself in the 21st Century*, is about you: what you need to know about getting a job and marketing yourself as a professional counselor as you make the transition from student to practitioner.

NEW TO THIS EDITION

This edition features several important additions and content revisions:

- A new chapter, *From Envisioning to Actualization: Marketing Yourself in the 21st Century*, addresses transitioning from student to professional counselor.
- Voices from the Field entries and self-assessment activities are provided in the final chapter to give on-the-ground perspectives from practicing counselors and counselors in training.
- Citations have been replaced and updated across all chapters to give the most recent scholarly information (28% of references from 2010 and beyond; 52% of references from 2000 and beyond), while maintaining the focus on classic citations underscoring the rich history of counseling theory and research.
- New test preparation items have been included comprising two full-length sample NCE administrations and two full-length CPCE administrations.
- The glossary of key terms has been updated to facilitate vocabulary review as an additional study aid.
- Revised and updated content has been provided to better align with the 2009 CACREP standards, current NCE/CPCE content, and expected changes in the 2016 CACREP content standards.

Before delving into each of the CACREP core content areas, it is important to present some introductory information about the NCE and CPCE and some test-preparation and test-taking strategies for mastering the NCE and CPCE.

ABOUT THE NATIONAL COUNSELOR EXAMINATION (NCE)

To obtain certification from the National Board for Certified Counselors (NBCC), professional counselors must first pass the National Counselor Examination for Licensure and Certification (NCE), which NBCC creates and administers. Counselors who pass the exam and meet NBCC's standards of education and training are entitled to receive NBCC's general practitioner credential, the National Certified Counselor (NCC) credential. Although taking and passing the NCE is voluntary, many states require the NCE for their own licensure and credentialing purposes. One of the primary benefits of taking the NCE and working toward the NCC is that the credential is nationally recognized and strengthens the credential holder's professional reputation (NBCC, 2014b).

The NCE is a paper-and-pencil multiple-choice test. It contains 200 multiple-choice questions, which test-takers are allowed up to 4 hours to complete. The NCE aims to assess test-takers' knowledge and understanding of areas thought to be essential for effective and successful counseling practice. The NCE's test questions stem from CACREP's (2009) eight core content areas and five work behaviors. The eight content areas and the topics they cover are

1. ***Professional Orientation and Ethical Practice.*** Professional counselors' roles and functions; history and philosophy of the counseling profession; professional credentialing; professional organizations; legal and ethical standards.
2. ***Social and Cultural Foundations.*** Multicultural and pluralistic trends; theories of multicultural counseling; identity development and social justice; strategies for working with and advocating for diverse populations; counselors' roles in developing cultural self-awareness.
3. ***Human Growth and Development.*** Theories of individual and family development across the lifespan; learning theories; personality, cognitive, and moral development; normal and abnormal behavior.

4. ***Career and Lifestyle Development.*** Career development theories and decision-making models; vocational assessment instruments and techniques relevant to career planning and decision making; the relationship between work, leisure, and family; career counseling for specific populations.
5. ***Helping Relationships.*** Wellness and prevention; essential interviewing and counseling skills; counseling theories; family theories and related interventions; counselor characteristics and behaviors that influence helping processes.
6. ***Group Work.*** Principles of group dynamics; theories of group counseling; group leadership styles; methods for evaluation of effectiveness.
7. ***Appraisal.*** Basic concepts of standardized and nonstandardized testing; statistical concepts associated with appraisal; principles of validity and reliability; interpretation of testing results; ethical and legal consideration in appraisal.
8. ***Research and Program Development.*** Qualitative and quantitative research designs; descriptive and inferential statistics; program evaluation and needs assessment; research's role in the use of evidence-based practices; ethical and cultural considerations in research.

The NBCC seeks to reflect the actual work that professional counselors do by incorporating work behavior categories into the NCE. The five work behaviors provide the context for the eight CACREP content areas. The following are the five categories:

1. *Fundamental Counseling Issues*
2. *Counseling Process*
3. *Diagnostic and Assessment Services*
4. *Professional Practice*
5. *Professional Development, Supervision, and Consultation*

The NCE is administered throughout the United States two times each year (April and October), and each administration of the NCE involves a varying set of questions from the NCE test item bank (NBCC, 2014a). Of the 200 multiple-choice questions administered, only 160 count toward the test-takers' final score. Thus, the highest score an examinee can receive on the NCE is 160. The NBCC includes the 40 remaining questions for field-testing purposes to determine whether these 40 questions may be suitable for inclusion in future examinations. Examinees are not informed of which questions are scored. Each multiple-choice question has four answer choices, with only one correct answer per question. Test-takers are not penalized for guessing, so examinees should be sure to select an answer for each question. According to the NBCC, the questions on the test do not equally represent the eight content areas. The NCE has 29 professional orientation and ethical practice items, 11 social and cultural diversity items, 12 human growth and development items, 20 career development items, 36 helping relationship items, 16 group work items, 20 assessment items, and 16 research and program evaluation items.

The minimum passing score for the NCE changes for each examination and is decided according to a modified Angoff procedure, which calculates the likelihood that a nominally skilled individual would answer each question correctly and then, on the basis of that information, determines a cutoff score for the entire set of items. Thus, the NCE is a criterion-referenced test, and the total score is interpreted as pass or fail based on a determined cutoff score. Usually within 8 weeks after taking the test, candidates receive their score report in the mail. The score report includes candidates' scores in each of the 13 domains (delineated above), their score for the entire test, and the minimum passing score for the version of the NCE the examinee completed.

ABOUT THE COUNSELOR PREPARATION COMPREHENSIVE EXAMINATION (CPCE)

The Counselor Preparation Comprehensive Examination (CPCE) was created by the Research and Assessment Corporation for Counseling (RACC) and the Center for Credentialing and Education (CCE), both affiliates of NBCC, for use in colleges and universities with master's programs in counseling. Over 330 colleges and universities use the CPCE for program evaluation and, frequently, as an exit exam (Center for Credentialing and Education, 2009). Results of the test give an educational institution a sense of their students' and their program's strengths and weaknesses in relation to national data. In addition, many colleges and universities use this examination to encourage their students to engage in frequent, cumulative studying and reviewing of the information learned in their courses and field experiences.

The format of the CPCE resembles the NCE. The CPCE comprises 160 questions, with 20 questions for each of the eight CACREP areas. Only 17 questions from each area count toward the test-takers' score, which means that the highest score a person can achieve on the examination is 136. Because the CPCE is based on the same eight CACREP areas as the NCE, students have the ability to simultaneously prepare for both examinations. However, the CPCE does not offer a cutoff score to indicate a passing or failing score; instead, university program faculty are left with that responsibility if they intend to use the CPCE scores for high-stakes evaluation decisions.

PREPARATION STRATEGIES FOR SUCCESS

Taking the NCE or CPCE is undoubtedly an important event in your counseling career. Although the breadth of knowledge that you are expected to learn can be overwhelming—even intimidating—mastering the domain of knowledge of essential counseling information is definitely possible. Remember, you have already learned a large portion of this information in your classes. So, to prepare for these tests, much of your time will be dedicated to reviewing previously mastered information and concepts and ensuring that you understand how to apply them. Before you start working through this study guide, consider the following strategies for success as you work toward your test date.

1. ***Manage your time and plan ahead.*** Neither the NCE nor the CPCE lends itself to cramming; therefore, it is much more advantageous to begin studying ahead of time. One of the easiest ways to make the tasks of learning and reviewing so much information easier is to break up the task into manageable sections. Write out a study schedule for yourself, and plan on reviewing only small segments of information at each study session so that you do not become overwhelmed or frustrated. It may be helpful for your schedule to include when you will study (e.g., the date and time), what you will study (e.g., the material and any pages numbers), and how you will study (e.g., read, highlight key terms, answer multiple-choice questions). It is also important to schedule time off from studying. Allowing yourself to mentally recharge will help you approach the material with greater clarity and focus. Do not put yourself at a disadvantage by procrastinating.
2. ***Practice.*** Practice is a key factor in preparing for both the NCE and CPCE. Specifically, it is important to be familiar with the test format and types of questions that will be asked on each exam. This study guide is packed with sample questions similar to those that you will encounter on the NCE and CPCE. The more familiar you are with applying this information to sample questions, the better prepared you will be for the actual tests.
3. ***Apply rather than memorize.*** Although you may feel pressure to memorize everything word for word, doing so is not an effective study strategy. Both the NCE and CPCE will require you to apply the knowledge you have gained. Nor is it useful to memorize the test questions you review during your preparation for the exams. Each administration of the NCE and CPCE includes new questions, so you will not find any questions in this study guide that will occur exactly as written on future NCEs or CPCEs. Of course, some of the questions in this guide will resemble some of the actual questions. After all, the questions all measure the same domain of knowledge. But it is a much better use of your time to master the domain of knowledge presented in this guide than to master an item set.
4. ***Employ a study strategy.*** The use of a study strategy can help you to both learn and apply the material you study. One of the most well-known strategies for retaining the material you read is Survey, Question, Read, Recite, and Review (SQ3R). Specifically, this strategy recommends first surveying the material's words in boldface type, tables, headings, and introductory sentences. Next, you are advised to turn headings and boldface words into questions, then to read the text to answer the previously developed questions. Finally, you should restate the material in your own words and engage in an ongoing process of review. Other study strategies that can be employed to assist you in reading and reviewing the test material include taking notes, highlighting key words and phrases, reviewing key words presented in the glossary, reviewing flash cards, and forming a peer study group. Given that there are numerous study strategies and that everyone learns differently, it is important for you to find and use the strategies that will work best for you.
5. ***Give yourself positive reinforcements.*** Studying for the NCE and CPCE is hard work. Be sure to reward yourself with enjoyable activities or treats as you work through the study material. Build in time between study sessions to relax, too.
6. ***Apply the Premack principle to your study schedule.*** The Premack principle demands that high-frequency behaviors (i.e., what people like to do) should follow low-frequency behaviors (i.e., what people don't like to do); thus, you should do what you don't want to do before you do what you do want to do! As pertains to studying for the NCE or CPCE, complete a period of study and follow it with an activity that you find more enjoyable and rewarding.
7. ***Seek accommodations.*** If you have a disability and will need accommodations while taking the NCE, it is your responsibility to contact the NBCC prior to your test date. E-mails can be sent to examinations@nbcc.com, or you can contact a representative at (336) 547-0607. If you decide to send an e-mail regarding accommodations, include your name, address, phone number, and state or residence, along with your question or request. When taking the CPCE, notify your program faculty ahead of time regarding your need for accommodations.
8. ***Take good care of yourself before the exam.*** Keep in mind that cramming the night before the exam will most likely make you more anxious, so try instead to engage in a relaxing activity that will calm your nerves and enable you to get a good night's sleep. So that you will be mentally alert and focused when you arrive at the test center, make sure that you are fully rested and have had a nutritious breakfast before taking the exam.
9. ***Arrive prepared for the examination.*** Remember to bring several sharp #2 pencils, your admission ticket, and two forms of identification (one with a photo). If you are not familiar with the area where you will take the test, print out directions beforehand. Finally, be sure to arrive at least 30 minutes early so that you are not rushing before the exam.

TEST-TAKING STRATEGIES

With successful preparation, counselors and counselor trainees will have the necessary competence *and* confidence when taking the NCE and CPCE. In addition, mastering these exams involves several strategies to use while taking the exam itself. During the exam, remember the following:

1. ***Answer all questions.*** As mentioned, you will not be penalized for guessing. If you do not know the correct answer to a question, it is better to use your common sense and guess than to leave the answer blank.
2. ***Make educated guesses.*** You are better off making an educated guess about a question than leaving it blank.

With no penalty for guessing, you have a 25% chance of guessing correctly, whereas if you leave the question blank you will automatically receive zero points for that question. When guessing, start by eliminating obviously incorrect answers and then use cues and common sense to infer which remaining answer makes the most sense.

3. ***Pace yourself.*** On the NCE, you will have 4 hours to answer 200 questions, which gives you 60 minutes for every 50 questions. Do not spend more than 1 minute on each question on your initial pass through the items. If you are unsure of the answer to a question, skip it and return to it later so that you give yourself adequate time to respond to the questions that you are sure about first.
4. ***Stay calm.*** No doubt you have learned some useful relaxation techniques over the years to help you through school. Likely, you have also learned counseling techniques to help your clients cope with stress. Use these skills to help you through your exam. For example, if you find yourself stressed during the test, try some deep breathing exercises, progressive muscle relaxation, positive self-talk, or visual imagery to help alleviate some of your anxiety.
5. ***Think and read carefully.*** Some questions on the NCE and CPCE will include qualifiers that ask you to choose the answer that is "not true" or the "best" choice. The former asks you to choose the answer that does not accurately answer the question. Regarding "best" choice questions, a question may have four answer options, several of which may seem right, and your task will be to select the choice that is *better* than all the others. Therefore, make sure you read each question and *all of the possible answer options* thoroughly before marking your response. For example, the first answer choice you read may seem correct, but perhaps the second, third, or fourth option is even better, so do not be tempted to rush through a question just because one of the first choices you read seems to fit.
6. ***Skip difficult or confusing questions.*** All questions are worth the same number of points, so if you are hung up on a question, skip it and come back to it later, or make a guess. Spending too much time on questions you are unsure about takes away precious time from questions to which you do know the answers.
7. ***Check your answer sheet frequently.*** Pay close attention to your answer sheet to be sure that you are marking answers to the correct questions, especially if you are temporarily skipping some questions. Place a question mark, hyphen, or some other symbol next to the questions you are skipping so that you do not accidentally mark that question with the answer to a different item.
8. ***Keep your answer sheet neat.*** If you need to write down anything to assist you in working through a question, use your response booklet. Your answer sheet will be optically scanned, so it is important that you completely color in all of your answer choices and avoid leaving stray marks on the answer sheet. If you put a question mark or hyphen next to an item you want to come back to, make sure you erase it after you have returned and filled in the answer.
9. ***Stay focused.*** Ignore any distractions that arise. Instead, keep your concentration centered on the test questions. Four hours is adequate time to complete the test if you maintain your focus.
10. ***Keep the test in perspective.*** You are not expected to receive a perfect score on these tests, and you can get many questions wrong and still pass, so do not stress out if you do not know the answer to every question. Study, practice, prepare, and try your best—that is all you can do!

CHAPTER 1

Professional Orientation and Ethical Practice

1.1 INTRODUCTION TO PROFESSIONAL ORIENTATION AND ETHICAL PRACTICE

Professional orientation and ethical practice encompass much of the counseling curriculum. Professional counselors must become very familiar with ethical and legal practice considerations and with historical perspectives and advocacy models. Counselors also must understand the roles of professional organizations and counseling specialties in counseling practice, as well as the diverse nature of credentialing.

Administrations of the NCE include (in addition to some trial items that do not count) 29 scored items (of the 160 total, or about 18%) designed to measure professional issues and ethical practice (rank = 2 of 8; the second most items of any of the eight domains). The average item difficulty index was .77 (rank = 2 of 8; second easiest domain of item content), meaning that the average item in this domain was correctly answered by 77% of test-takers.

Over the past several years, administrations of the CPCE have included 17 scored items designed to measure professional issues and ethical practice, plus several trial items that do not count in your score. The average item difficulty index was .72, meaning that the average item in this domain was correctly answered by 72% of test-takers, which made this set of items among the easiest on the examination.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) defined standards for Professional Orientation and Ethical Practice as follows:

> studies that provide an understanding of all of the following aspects of professional functioning:
>
> **a.** history and philosophy of the counseling profession;
> **b.** professional roles, functions, and relationships with other human service providers, including strategies for interagency/interorganization collaboration and communications;
> **c.** counselors' roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster, or other trauma-causing event;
> **d.** self-care strategies appropriate to the counselor role;
> **e.** counseling supervision models, practices, and processes;
> **f.** professional organizations, including membership benefits, activities, services to members, and current issues;
> **g.** professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;
> **h.** the role and process of the professional counselor advocating on behalf of the profession;
> **i.** advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and
> **j.** ethical standards of professional organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling. (p. 9)

Each of these standards is addressed throughout Chapter 1. In the remainder of this first section, we discuss key historical events in counseling; key legal issues, including important laws, abuse, and minor consent; accreditation and CACREP; advocacy counseling; health maintenance organizations (HMOs); liability insurance; licensure; and the National Board for Certified Counselors (NBCC).

1.1.1 Key Historical Events in Counseling

The counseling profession today comprises counselors who work in myriad settings, from educational institutions and hospitals to community health centers. As evidenced by the numerous counseling specializations and associations, counseling is an all-inclusive profession dedicated to meeting the needs of diverse individuals and families at every stage of the life cycle. However, the counseling profession had its genesis in the late 1800s with vocational guidance. During the following decades, individuals began introducing additional approaches to counseling and types of counseling services to the public to promote the wellness of clients and students in need, and the profession slowly expanded from its vocational guidance roots. The timeline in Table 1.1 highlights some of the key historical events that transformed the counseling profession into the diverse field that it is today.

1.1.2 Key Legal Issues in Counseling

It is the responsibility of professional counselors to abide by the American Counseling Association (ACA) *Code of Ethics* (2005), which provides counselors with mandatory ethics rules they *must* follow and aspirational ethics rules they *should* follow if they want to meet the highest standards of professional practice and conduct (Remley & Herlihy, 2010). Likewise, it is also the duty of professional counselors to be knowledgeable of and adhere to applicable laws. The principal difference between ethics and laws is that **ethics** are developed by associations to help members practice in a reputable manner, whereas **laws** are included in the penal code and often carry more serious consequences when individuals fail to comply with them. Violation of ethical standards may carry sanctions, but those penalties vary greatly and are determined by ethics committees rather than courts. Although the law trumps ethics in all circumstances, professional counselors rarely have to violate ethical standards to follow the law. When studying for the NCE or CPCE, counselors should become thoroughly familiar with the NBCC *Code of Ethics* (NBCC, 2012; see www.nbcc.org/ethics/) and the ACA *Code of Ethics* (ACA, 2005; see http://www.counseling.org/Resources/aca-code-of-ethics.pdf; and see Section 1.4) and be able to apply these ethical concepts to practice situations. This section presents an overview of some of the key legal issues that are crucial for you to be aware of, including the Family Educational Rights and Privacy Act (FERPA), Individuals with Disabilities Education Improvement Act (IDEA), U.S. Rehabilitation Act of 1973 (Section 504), Health Insurance Portability and Accountability Act (HIPAA), child abuse and neglect, counseling minors, and elder abuse.

1.1.2.1 FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) Enacted in 1974, the **Family Educational Rights and Privacy Act (FERPA)**, also known as the Buckley Amendment, is a federal law that affects any counselor who works in an educational setting that receives funding from the U.S. Department of Education (USDE, 2011). Private schools, colleges, or universities that do not receive *any* funds from the USDE for *any* of their programs do not have to follow this act, but those institutions represent the minority.

Key Points of FERPA

- FERPA was created to specify the rights of parents (if the child is a minor) and nonminor students to access and examine the educational record, petition to have incorrect information found in the record amended, and ensure that certain information is not released to outside agencies without permission.
- An **educational record** refers to any document or information kept by the school relating to a student, such as attendance, achievement, behavior, activities, and assessment.
- Parents have the right to access their children's educational information until the child is 18 years old or begins college, whichever comes first, at which point the rights shift to the student.
- Educational institutions are required to obtain written permission before releasing any information in a student's educational record.
- An exception to the preceding rule is that schools have the ability to give out **directory information** about students without consent. Directory information includes the student's name, address, telephone number, date of birth, place of birth, honors or awards, and dates of attendance at the school. However, schools must send an annual notice to students and/or parents informing them that they have the right to have their information, or their child's information, barred from release.
- Educational institutions that fail to comply with FERPA may face punitive action, such as loss of federal funding.
- Professional counselors' personal notes on students, considered an expansion of the counselor's memory that are kept separate from the educational record in a secure location, are considered confidential (Stone, 2009). Students and parents do not have the right to access counselors' personal notes. That being said, *general* counseling case notes may be considered part of a student's educational record, depending on the state.

1.1.2.2 INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT (IDEA) Also pertaining to counselors who work in educational settings, the Individuals with Disabilities Education Improvement Act (IDEA) is a civil rights law passed to guarantee that students with disabilities receive the services they need to gain the benefits of education. Like FERPA, this act applies to any school that receives federal funding and prohibits educational institutions from putting any student at a disadvantage based on a disability. It is important

TABLE 1.1 Timeline of Historical Events.

- **Late 1800s**—Vocational guidance counseling emerges as a result of the Industrial Revolution and social reform movements.
- **Early 1900s**—Frank Parsons, heralded as the father of vocational guidance, opens the Bureau of Vocational Guidance in Boston, which helps match individuals with suitable careers based on their skills and personal traits.
- **1908**—Frank Parsons dies, but his influential book *Choosing a Vocation* is published posthumously.
- **1913**—The National Vocational Guidance Association (NVGA) is founded.
- **1913**—Clifford Beers, the leader of the mental health movement, which advocated for the construction of mental health clinics and more humane treatment of institutionalized patients with psychological disorders, founds the Clifford Beers Clinic in New Haven, Connecticut, considered the first outpatient mental health clinic in America.
- **1930s**—E. G. Williamson creates the Minnesota Point of View, a trait and factor theory considered to be one of the first counseling theories.
- **1932**—The Wagner O'Day Act is passed, which creates U.S. Employment Services to aid the unemployed in finding work through vocational guidance.
- **1940s and 1950s**
  - Carl Rogers' humanistic approach to psychology gains widespread support in the counseling profession.
  - Soldiers return home after World War II and increase the need for counseling, readjustment, and rehabilitation services.
  - Increased numbers of counselors begin working full-time at postsecondary educational institutions, community agencies, and vocational rehabilitation centers.
  - More associations sprout up to help new counseling specializations form a unified and professional identity.
- **1952**—To gain a larger voice in the counseling field, the American Personnel and Guidance Association (APGA; since renamed the American Counseling Association [ACA]) is formed as a union among the National Vocational Guidance Association (NVGA; since renamed the National Career Development Association [NCDA]), the National Association of Guidance and Counselor Trainers (NAGCT; since renamed the Association for Counselor Education and Supervision [ACES]), the Student Personnel Association for Teacher Education (SPATE; since renamed the Counseling Association for Humanistic Education and Development [C-AHEAD]), and the American College Personnel Association (ACPA).
- **1952**—The American School Counselor Association (ASCA) is formed and becomes a division of APGA the next year.
- **1958**—Congress passes the National Defense Education Act (NDEA) in response to the launch of the *Sputnik* satellite in 1957, which signaled that the Russians were leading in the Space Race. The NDEA provides schools with increased funds to improve their curriculum and hire school counselors to pick out students showing promise in math and science.
- **1958**—The American Rehabilitation Counseling Association (ARCA), a division of APGA, is chartered.
- **1961**—APGA publishes its first code of ethics.
- **1963**—President Lyndon Johnson signs into law the Community Mental Health Act, which allots money for the creation of mental health centers.
- **1965**—The Association for Measurement and Evaluation in Guidance (AMEG), currently known as the Association for Assessment and Research in Counseling (AARC), is chartered as a division of APGA.
- **1966**—The National Employment Counseling Association (NECA), a division of APGA, is chartered.
- **1970s**
  - Legislation for individuals with disabilities emerges, leading to a heightened demand for rehabilitation counselors and school counselors.
  - Individuals in the counseling field publish books and articles that increase the counseling profession's interest in multicultural issues, such as cultural identity development, multicultural awareness, racism, and counseling minorities.
- **1972**—The Association for Multicultural Counseling and Development (AMCD), a division of APGA, is founded.
- **1973**—The Association for Specialists in Group Work (ASGW), a division of APGA, is created.
- **1974**—The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) and the International Association of Addictions and Offender Counselors (IAAOC), both divisions of APGA, are chartered.
- **1975**—The U.S. Supreme Court's decision in *Donaldson v. O'Connor* results in the deinstitutionalization of patients in state mental hospitals. This precedent-setting decision has been one of the most significant in mental health law. It barred mental institutions from committing individuals involuntarily if they were not an immediate threat to themselves or other people.
- **1976**—Virginia is the first state to offer counselors the option to seek licensure.
- **1978**—The American Mental Health Counselors Association (AMHCA), a division of APGA, is chartered.
- **1981**—The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is established to provide accreditation for master's and doctoral programs in counseling that adhere to its standards of preparation.
- **1982**—The National Board for Certified Counselors (NBCC), which develops and implements the first national examination to certify counselors, the National Counselor Exam (NCE), is formed by APGA.

(Continued)

TABLE 1.1 Timeline of Historical Events. *(Continued)*

- **1983**—APGA changes its name to the American Association of Counseling and Development (AACD).
- **1984**—The Association for Counselors and Educators in Government (ACEG), a division of AACD, is chartered.
- **1985**—Chi Sigma Iota, the international honor society for the counseling profession, is founded.
- **1986**—The Association for Adult Development and Aging (AADA), a division of AACD, is chartered.
- **1989**—The International Association of Marriage and Family Counselors (IAMFC), a division of AACD, is chartered.
- **1991**—The American College Counseling Association (ACCA), a division of AACD, is chartered.
- **1993**—AACD, formerly known as APGA, changes its name to the American Counseling Association (ACA).
- **1995**—ACA makes a major revision to its code of ethics, allowing members and divisions to submit suggestions and ideas and revising the format of the document to make it more cohesive and organized.
- **1997**—The Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC) is chartered by ACA.
- **2002**—Counselors for Social Justice (CSJ), a division of ACA, is chartered.
- **2004**—The Association for Creativity in Counseling (ACC), a division of ACA, is established.
- **2005**—The most recent revision of the ACA code of ethics includes new sections on technology, end-of-life care, making diagnoses, ending practice, and choosing therapeutic interventions.
- **2007**—The AGLBIC name is changed to the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC).
- **2009—**California becomes the final state to offer counselors the option to seek licensure. Also, CACREP publishes revisions to its accreditation standards.

for professional counselors to be knowledgeable of this act if they work in an educational institution because part of their role is to advocate for the academic needs of their clients.

Key Points of IDEA

- Children are eligible to receive services under IDEA from birth until the age of 21 years.
- Counselors and educators serve as advocates for children with special education needs. School counselors are frequently part of the child study team, which evaluates a child's educational, psychological, sociological, and medical needs to determine eligibility for services.
- To qualify for eligibility under IDEA, a student must have a documented disability in at least one of the following areas: mental retardation, hearing impairment (including deafness), speech or language impairment, visual impairment (including blindness), serious emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairment, or specific learning disability. In addition, the student must *need* special education services as a result of a disability.
- All students with disabilities must be given **free appropriate public education (FAPE)** that addresses their individual needs and helps ready them for higher levels of education or employment.
- Every student who is eligible to receive special education services under IDEA must have an **individualized education plan (IEP)** on file (USDE, 2007). School systems convene meetings of multidisciplinary teams to create the IEP. A student's IEP delineates what services the student will receive; when and how often; and goals for the student's learning, which are updated and reviewed yearly.
- It is required that each student's IEP ensure that the child receive the benefits of education in the **least restrictive environment (LRE)**, which was mandated to allow as many students as possible to remain in regular classrooms if their needs could be met there with only limited accommodation.
- Students covered under IDEA often are also covered under the more expansive Section 504 of the U.S. Rehabilitation Act of 1973.

1.1.2.3 U.S. REHABILITATION ACT OF 1973 (SECTION 504) The **U.S. Rehabilitation Act of 1973 (Section 504)**, a civil rights act, protects individuals with disabilities from being discriminated against or denied equal access to services and opportunities because of their disability, IDEA being one of those protections. Often, in a school setting, students who do not qualify for special education services under IDEA may be eligible for accommodations under Section 504, which has a more inclusive definition of *disability*. Unlike IDEA, Section 504 applies not only to educational institutions receiving federal funds but also to any organization or employer in the United States receiving federal funds.

Key Points of Section 504

- Eligible individuals must have a physical or psychological impairment that substantially limits at least one **major life activity**. These major life activities include walking, seeing, hearing, speaking, breathing, working, performing manual tasks, learning, and caring for oneself (U.S. Department of Health and Human Services [USDHHS], 2006a).
- To receive consideration, individuals must also be viewed as having the disability or have documentation of the disability, and it must interfere with their ability to meet their needs.
- In a school setting, when a student indicates a need, a multidisciplinary team meets to assess the student's eligibility

under Section 504. If the student is eligible, a **504 plan** is constructed, which dictates the accommodations or other special considerations the student is entitled to receive. The team looks at multiple sources of information when determining students' eligibility, including any test scores, grades, educational records, and medical documentation.
- Although there exists a whole host of possible accommodations a student may be given, a few examples of accommodations that school personnel make for eligible individuals include building ramps and installing elevators for students who are wheelchair-bound or injured, giving students more time to complete tests or other classroom tasks, and allowing students to use laptop computers to take notes.

1.1.2.4 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) HIPAA is a federal law, passed in 1996, to protect the privacy of individuals' medical and mental health records. Health organizations were to be compliant with this law by 2003. Under HIPAA, patients are given rights to control who can view their health records as well as the ability to inspect their own medical record and request that changes be incorporated (USDHHS, 2006a). In essence, patients have a right to control who sees their identifiable health record. HIPAA applies to doctors, nurses, hospitals, clinics, insurance companies, health maintenance organizations (HMOs), Medicare, Medicaid, mental health professionals, and a variety of other health care providers. In fact, it would be difficult to find a health care provider who is *not* subject to the stipulations outlined in HIPAA, so understanding this law is essential to avoid violating the confidentiality of private client information.

Key Points of HIPAA

- All patients must be given a copy of the HIPAA **privacy policy**, which outlines their rights; with whom their **protected health information (PHI)**—that is, individually identifiable health information—might be used or shared; and the procedures for requesting that their information not be released to certain parties.
- Patients, for their part, are required to sign a document affirming that they have received information on HIPAA.
- Health organizations must secure all PHI from unauthorized individuals and organizations.
- Patients have a right to obtain a copy of their medical record usually within 30 days.
- Patients have a right to request changes to adjust inaccurate health information in their record. Should there be a disagreement by the health organization about making such changes, the disagreement must be noted in the file.
- Health organizations are to honor reasonable requests to contact patients in different locations or by different methods.
- A counselor following HIPAA must allow clients to view their records and petition for changes to the counselor's notes if they believe any information is false or inaccurate (USDHHS, 2014).

1.1.2.5 CHILD ABUSE AND NEGLECT The federal **Child Abuse Prevention and Treatment Act (CAPTA)** defines child abuse and neglect as "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or, an act or failure to act which presents an imminent risk of serious harm" (Child Welfare Information Gateway, 2014).

Key Points of CAPTA

- Any counselor who suspects child abuse or neglect is required by law to report the suspicion to the local **child protective services (CPS)** agency within 72 hours from the time of first awareness of the potentially abusive or neglectful event (Stone, 2009). Counselors also must submit a written report to CPS after submitting the initial account.
- Anyone who reports suspected abuse or neglect will not be held liable, even if CPS fails to find any evidence supporting the claim during the investigation (Stone, 2009), unless a false report was filed with malicious intent.
- The ACA *Code of Ethics* (2005, B.2.a.) upholds this legal duty, allowing counselors to ethically break confidentiality to protect a client from a potentially dangerous situation.

1.1.2.6 COUNSELING MINORS When counseling minors, particularly in a nonschool setting, it is crucial for counselors to obtain **informed consent** from the parents or legal guardian and assent, or agreement, of minors before any counseling begins. The necessity of informed consent in school systems ordinarily is dictated by local school or state policies (Stone, 2009).

Key Points of Informed Consent

- During the informed consent and assent process, minors and their parents must receive details on what they can expect from counseling, limitations to confidentiality, and their right to withdraw from treatment at any time (ACA, 2005, A.2.a., A.2.b., & A.2.d.).
- Informed consent should be given in writing to parents and explained by the counselor to minors in age-appropriate language so that they are able make an educated decision about whether they want to enter into the counseling relationship. Some minor children, because of substantial disability (e.g., mental retardation) or age, are unable to give assent for counseling, thus requiring special precautions in care and parental consent.
- All counselors should note that although, ethically, the child (if under the age of 18 years) should be able to expect confidentiality, parents still retain the legal right to know what their child discusses in counseling sessions should they choose to exercise that right. Therefore, counselors must carefully balance the needs of both parties to most effectively implement services and must work diligently to uphold the minor's ethical rights whenever feasible.
- Some states allow minors of a certain age to consent to various community health services, including mental

health treatment, without parental consent. However, these **minor consent laws** vary among states, so it is essential to become very familiar with the laws governing the state where you are practicing or plan to practice.
- In a school setting, most professional school counselors are *not* required to obtain parental consent before delivering counseling services to students, although professional school counselors should familiarize themselves with the policies of their state and local school boards.

1.1.2.7 ELDER ABUSE Elder abuse typically involves three different forms of maltreatment toward a vulnerable or incapacitated older adult: physical, sexual, or verbal abuse; financial exploitation; and neglect of a caregiver to provide proper care. Estimates of elder abuse frequency typically range from 2% to 10% depending on type, definition, and degree of reporting. Perpetrators of elder abuse are generally male and can include family members, paid caregivers, or fellow residents in a care facility (Forman & McBride, 2010).

Key Points of Elder Abuse

- Elder abuse is a criminal offense in all 50 states, with a majority of states having mandatory reporting laws (Administration on Aging [AoA], 2010). In cases where an older adult is neglecting him- or herself in some manner, some states allow law enforcement to intervene when these individuals refuse services (Forman & McBride, 2010).
- The Older Americans Act was passed in 1965 by Congress to increase social and nutrition services for older persons and was reauthorized in 2006. Two specific pieces of this legislation, Title II—Elder Abuse Prevention and Services and Title VII—Vulnerable Elder Rights Protection, are particularly salient to the topic of elder abuse. Collectively, these chapters discuss inclusion of long-term care ombudsman programs, legal assistance, greater coordination with law enforcement and court systems, and greater allotment of funds for detection, assessment, and intervention of elder abuse (AoA, 2010).
- The AoA was developed as part of the Older Americans Act and oversees major grant programs and other initiatives related to this legislation. It is a useful resource for counselors to be familiar with, particularly for dealing with elder abuse.

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

Accreditation is a process that eligible educational institutions and organizations can elect to undergo (i.e., it is voluntary) to demonstrate that the institution meets set standards. Although accreditation applies to many careers and professions, for the purposes of this study guide, we are concerned with **educational accreditation**.

- An educational institution seeking accreditation must apply to the appropriate association. For example, for colleges and universities to have their counseling programs accredited, they apply to the **Council for Accreditation of Counseling and Related Educational Programs (CACREP)**, the association in charge of the accreditation for the majority of counseling and counseling-related programs, and undergo its accreditation process.
- The purpose of accreditation for educational institutions is to signify to the public that the accredited program's educators and curriculum adhere to specific standards of quality; only those institutions that meet the specified criteria become accredited (CACREP, 2009).
- Institutions may seek accreditation for a variety of reasons:
  - It increases the institution's status and prestige.
  - It requires institutions to hold themselves accountable for the quality of their program and educators.
  - It encourages colleges and universities to continually evaluate and assess the effectiveness of their programs and make changes and improvements as necessary to ensure adherence to the standards of accreditation. Educational institutions accredited by CACREP must undergo and pass the accreditation process every eight years to retain their certification, so the process of meeting CACREP's standards is ongoing (CACREP, 2009).
  - Students who graduate from an accredited institution may be more marketable than those students graduating from an unaccredited institution because they have succeeded in meeting specified programmatic standards. Part of this may result from similarities between CACREP requirements and state licensure requirements.

CACREP was established in 1981 to promote excellence in counseling and counseling-related educational programs. CACREP has developed and revised educational standards over the years that institutions must meet to gain the organization's accreditation approval. These standards were created to respond to society's comprehensive needs, ensuring that institutions seeking accreditation are providing students with the necessary tools to address those needs at graduation and on entrance into the counseling profession (CACREP, 2009). CACREP is currently revising its 2009 standards, to be implemented in 2016.

CACREP accredits master's-level programs in addiction counseling; clinical mental health counseling; marriage, couple, and family counseling; school counseling; student affairs and college counseling; and doctoral-level programs in counselor education and supervision (CACREP, 2009). Currently, more than 220 universities in the United States have received CACREP accreditation.

1.1.3.1 CACREP APPLICATION PROCESS The following are the components of the CACREP application process (CACREP, 2009):

1. The CACREP application process requires educational institutions with a counseling or counseling-related program seeking accreditation to complete the *application* and submit a *self-study report*, which outlines how the institution meets CACREP's standards.

2. Once the application and self-study report have been received, a CACREP review board convenes a team of trained counseling professionals and educators to conduct an *on-site visit* of the institution for several days to tour the facilities and conduct extensive interviews with students, faculty, administrators, and graduates to further determine if the program adequately meets CACREP standards.
3. At the completion of the visit, the team writes a *report* delineating whether the standards were met and areas of particular strength or weakness within the program. The educational institution receives a copy of this report and is given the opportunity to respond to any comments made by the site-visit team.
4. Accreditation decisions are made by the CACREP board after reviewing an institution's application, self-study report, and site-visit report. If the program meets all the necessary criteria, the board gives the program the status of being CACREP accredited for a duration of eight years. If the program meets most, but not all, of the standards, the board can grant accreditation for two years, giving the educational institution an opportunity to improve its program during the two-year probation period, after which it may or may not receive accreditation. Finally, if the board determines that a program does not sufficiently meet its requirements, it is denied CACREP accreditation.

1.1.4 Advocacy Counseling

Advocacy counseling is concerned with supporting and promoting the needs of clients (e.g., individuals, groups, communities) and the counseling profession at all levels (local, state, regional, national). Examples of advocacy counseling include teaching clients to self-advocate, being involved in changes in public policy, writing to or meeting with policymakers about bills that affect counselors and clients, or backing licensure laws. Advocacy counseling also can take many other forms, such as educating people about the counseling profession, providing leadership and advocacy training, networking with the media to have important issues covered, and working with community organizations to meet the needs of clients.

- Counselors are expected to be advocates not only for their profession but also for their clients, and to help clients overcome any barrier that is preventing them from making progress. The ACA *Code of Ethics* (2005, A.6.a.) demands that counselors empower clients to advocate for themselves when needed or that counselors advocate on their clients' behalf (with client consent) when clients are unable to do so for themselves. ACA has published "Advocacy Competencies" that counselors should be familiar with (see www.counseling.org/knowledge-center/competencies).

1.1.5 Health Maintenance Organizations (HMO)

A **health maintenance organization (HMO)**, also known as a managed care organization, is a health care organization that allows members to access health and mental health services at a lower cost than many standard health insurance plans. Although members often pay only a small fee per month, a frequent criticism is that they can visit only hospitals and providers that are part of their HMO's network, and often they must receive a referral from their primary-care physician before visiting any specialists, including counselors.

- A benefit for mental health providers who are part of an HMO is that they are given a stable influx of clients and are ensured payment if they follow the organization's regulations. However, a criticism of HMOs is that mental health providers must give the organization a diagnosis and detailed history of each client before the HMO will approve and pay for the treatment, perhaps infringing on the client's confidentiality (Mentor Research Institute, 2009). Mental health professionals also are often limited in how much time they have to treat clients, and they are usually required to follow specific guidelines or treatment modalities in working with their clients.

1.1.6 Liability Insurance

In the field of counseling, **liability insurance** has become something of a necessity for all counselors, counseling students, and counselor educators. In the event that professional counselors find themselves in a legal dispute or the subject of a complaint, having liability insurance can be instrumental in the protection of their assets and also greatly reduces the financial burden they may face if found guilty of **malpractice** or **negligence**. Many professional organizations, such as ACA and NBCC, offer reasonably priced liability insurance to members.

- Although counselors are urged to abide by applicable ethics codes, and doing so will help decrease the likelihood of negligence or malpractice, there is always inherent risk in treating clients, and even the best-intentioned professionals can make mistakes. Even counselors who are wrongly accused of negligence or unethical behavior will still have to respond to the claim, which is costly and can jeopardize their assets (Wheeler & Bertram, 2012).

1.1.7 Licensure

Licensure in the counseling field emerged in the 1970s in an effort to validate the counseling profession by passing state laws controlling who could legally practice counseling (Wheeler & Bertram, 2012). The underlying purpose of state licensure is to protect the public by ensuring that only qualified professionals, granted a license from the state, can legally render certain counseling services. Just as people must obtain a driver's license to legally operate a vehicle, so too must professional counselors procure a license to practice in most states. Once an individual has been licensed, he or she usually is granted the title of Licensed Professional Counselor (LPC), or a similar title as determined by a specific state's law; some examples include Licensed Clinical Professional Counselor (LCPC), Licensed Mental Health Counselor (LMHC), and Licensed Clinical Mental Health Counselor (LCMHC).

- Although the requirements for obtaining licensure vary from state to state, most states require individuals to achieve

at least a master's degree from an approved institution (thereby fulfilling specific coursework requirements), accrue a certain number of years or hours of supervised clinical experience, and pass an examination, such as the NCE.

- Virginia was the first state to license professional counselors (in 1976). All 50 states have licensure laws, as do the District of Columbia, Guam, and Puerto Rico (American Association of State Counseling Boards [AASCB], 2014a).
- Although professional counselors can secure national certification, to enhance their professional credibility, through the NBCC, currently there is no nationally recognized licensure. However, a push for licensure portability is beginning to take hold within the profession (Wheeler & Bertram, 2012). Portability would establish **reciprocity** for licensed counselors. This would allow a counselor who is licensed in one state to work in another state without having to reapply for licensure or fulfill additional requirements.

1.1.8 The National Board for Certified Counselors

The **National Board for Certified Counselors (NBCC)** is the chief credentialing organization in the United States for professional counselors seeking certification. Founded in 1982 as the result of an ACA committee recommendation, NBCC is a nonprofit organization that certifies counselors who have met its criteria for education and training and have passed the **National Counselor Examination (NCE)**, which it developed and administers. The mission of NBCC is to promote and recognize counselors who meet established standards of quality in delivering counseling services.

- Certification with NBCC is voluntary, but counselors who obtain certification strengthen their professional reputation. In some cases, the certification has made counselors eligible for salary increases.
- NBCC offers counselors general and specialty credentialing options (NBCC, 2014a). NBCC's premier credential is the **National Certified Counselor (NCC)**. Specialties within this credential are the National Certified School Counselor (NCSC), the Certified Clinical Mental Health Counselor (CCMHC), and the Master Addictions Counselor (MAC). Candidates must first attain the NCC before they can earn a specialty credential; in some cases, though, they may apply concurrently for both the general and a specialty credential. Acquiring a specialty credential provides counselors with greater notoriety within the counseling community and can increase financial remuneration or professional opportunities.
- The Center for Credentialing and Education (CCE), an affiliate of NBCC, offers the Approved Clinical Supervisor (ACS) credential to promote the professional identity and accountability of clinical supervisors (CCE, 2014).
- The NCC is NBCC's general-practice credential (NBCC, 2014a). Approximately 80,000 counselors have gained this national certification. To be eligible for the NCC, the candidate must meet one of the following educational requirements: (1) be a current student in a counseling program that participates in the Graduate Student Application process; (2) have earned at least a master's degree from a CACREP-accredited program; (3) have earned at least a master's degree in a counseling field and have taken courses in the following areas: human growth and development, social/cultural foundations, helping relationships, group work, career and lifestyle development, assessment, research and program evaluation, and professional orientation and ethical practice, and have been employed in the counseling profession under supervision for two or more years; or (4) hold a counseling license conferred by the candidate's state board and possess at least a master's degree in a mental health field.

1.1.9 Practice Multiple-Choice Items: Introduction to Professional Orientation and Ethical Practice

1. The American Counseling Association was originally named
a. American Association of Counseling and Development.
b. American Personnel and Guidance Association.
c. National Vocational Guidance Association.
d. American Counseling Association.

2. When working with an 8-year-old child in a nonschool setting, it is ethically necessary to obtain
a. assent from the child and informed consent from the parent.
b. informed consent from only the child.
c. informed consent from only the parent.
d. informed consent from both the child and the parent.

3. When counseling minors, the legal right to confidentiality belongs to
a. the child.
b. the counselor.
c. the parents or legal guardians.
d. both the child and the parents.

4. The Buckley Amendment is also known as the
a. Health Insurance Portability and Accountability Act.
b. Section 504 of the U.S. Rehabilitation Act.
c. Individuals with Disabilities Education Improvement Act.
d. Family Educational Rights and Privacy Act.

5. All of the following statements are correct EXCEPT
a. licensure was created to protect the public.
b. counselors who hold a license from one state have reciprocity in every other state.
c. Virginia was the first state to license counselors.
d. the requirements for acquiring licensure vary from state to state.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** a; **3.** c; **4.** d; **5.** b.

1.2 COUNSELING SPECIALIZATIONS

The counseling profession contains a number of specializations, each of which is dedicated to addressing the needs of a particular group of people. Each specialization requires counselors to meet its specific training requirements, and all are driven by the same overarching mission to promote the growth and potential of all individuals.

A **professional counselor** works in diverse settings with diverse clientele, including colleges, hospitals, clinics, private practices, and schools. Many of the counselors from special counseling disciplines are described in the sections that follow. Other types of professional counselors not described here include career and substance abuse counselors. These specialty areas are described in other chapters of this study guide within a more specific context. Regardless of the specialization within counseling, all professional counselors are concerned with working not only to treat but also to prevent psychological problems, and to promote healthy human development through all stages of life. Professional counselors often work with clients to overcome developmental and unexpected life changes, come to terms with their environment, adjust to foreign situations, and find ways to improve the quality of clients' lives.

If properly trained in administration of psychological tests, professional counselors are eligible in most states to administer such tests as part of their practice. As previously mentioned, to become a professional counselor individuals must earn at least a master's degree in the field of counseling. This second section of Chapter 1 outlines the predominant counseling and related specializations currently in existence, specifically clinical mental health counseling, college admissions counseling, college counseling, rehabilitation counseling, school counseling, and other types of mental health counseling.

1.2.1 Clinical Mental Health Counseling

Mental health counselors first surfaced in the 1940s and 1950s but did not benefit from formal training or employment in significant numbers until the passing of the Community Mental Health Act of 1963, which provided funding for the establishment of mental health centers across the United States to provide greater access to mental health care services.

- Clinical mental health counselors work with individuals, groups, and families in many different settings, including community organizations, hospitals, drug and alcohol treatment centers, and private practices.
- Mental health counselors are trained in assessment; diagnosis; treatment planning; psychotherapy; substance abuse treatment, prevention, and intervention; crisis counseling; and brief therapy (American Mental Health Counselors Association [AMHCA], 2014).
- To become licensed as a mental health counselor, individuals must earn a master's degree in a counseling field, pass their state's required examination, and have at least two years of work experience under supervision (AMHCA, 2014).
- Many mental health counselors work toward the NCC credential and the CCMHC specialty credential, both granted by NBCC, to forward their careers, become eligible providers for certain insurance companies, or strengthen their professional reputation.
- AMHCA is the division under ACA that serves as the professional association for mental health counselors.

1.2.2 College Admissions Counseling

College admissions counseling focuses on helping students maneuver through the college admissions process to select and, ideally, to secure entry into suitable postsecondary educational institutions.

- College admissions counselors work in a variety of settings, most commonly in colleges, universities, and high schools. Often, *professional school counselors* who work in high schools are highly involved in this process, although some high schools employ a separate counselor whose sole responsibility is to work with students interested in attending college; these individuals are usually called *college counselors*, but the role is relegated to college admissions counseling—not to the wellness and mental health roles of the college counselors discussed in the next section. *Educational consultants* are people who work outside the school district and provide college counseling services to students for a fee (National Association for College Admission Counseling, 2014). Finally, some areas have *commercial college counseling centers* that offer students a variety of services ranging from test preparation classes to assistance with college applications.
- The bulk of college admissions counseling occurs at the secondary level, particularly in students' junior and senior years, although some schools believe it is useful to integrate college counseling programs into the middle school curricula as well.
- Counselors at the high school and college levels assist students in the college admissions process through academic advising, during which they help students choose high school courses beneficial to their postsecondary aspirations and often administer **interest assessments**, which facilitate students' personal exploration of career options in concert with their interests. College admissions counselors also work with students individually to discuss specific college options, and they work with groups to guide students in preparing to complete college applications, take the Scholastic Achievement Test (SAT) or American College Testing (ACT) examinations, and obtain financial aid, if necessary.
- The **National Association for College Admission Counseling (NACAC)** is the professional association for individuals who work in this specialization. NACAC is not affiliated with ACA.

1.2.3 College Counseling

The previous section provided an overview of college admission counseling primarily at the secondary level. *College counseling*

at the postsecondary level has a much different charter, and counselors who work in this specialty have a distinct job description. Although college admissions counselors are concerned with helping students apply and gain admittance to postsecondary schools, college counselors in higher education work in *counseling centers* on college campuses to support students who have *mental health and educational concerns* that are negatively affecting their personal, social, and academic endeavors.

- Individuals working in college counseling centers are often professional counselors and psychologists who hold doctoral degrees; they may also be counseling interns. College counselors engage in individual and group counseling and serve as liaisons to community services and resources. Most college counseling services are free to students.
- College counselors help students deal with diverse issues, including homesickness, social problems, relationship issues, academic problems, stress, eating disorders, and mental illnesses. Because of the variety of issues presented to college counselors, most are trained in crisis counseling, diagnosis, and treatment planning.
- The American College Counseling Association, a division of ACA, is the professional association for counselors working in higher education.

1.2.4 Rehabilitation Counseling

A **certified rehabilitation counselor (CRC)** seeks to help individuals with disabilities work through personal and vocational issues they may encounter as a result of their impairment. A CRC's clients have wide-ranging disabilities. Some are a result of illness, although others are due to accidents, birth defects, or many other causes (U.S. Department of Labor, 2014).

- CRCs are employed in a wide range of settings, such as public vocational rehabilitation agencies, hospitals, community centers, schools, and employee assistance programs.
- After conducting a thorough assessment of the client and gathering information on the client's condition and job skills from a variety of sources, CRCs begin to work with the client to improve the quality of the client's life and help him or her cope with disabilities, find jobs that match skill levels and interests, and learn to live more independently (Commission on Rehabilitation Counselor Certification [CRCC], 2014a). Part of a CRC's work may also involve connecting clients with community resources, such as health care and occupational training. The ultimate goal of a CRC's work is to assist individuals with disabilities in either returning to their place of employment or finding a different vocation.
- To become a CRC, individuals must be granted certification from the CRCC (see CRCC, 2014a). Certification with CRCC is voluntary; however, some employers require rehabilitation counselors to become certified.

1.2.4.1 THE COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION The **Commission on Rehabilitation Counselor Certification (CRCC)** is a nonprofit organization that was formed in 1974 to certify rehabilitation counselors who meet particular professional standards and have achieved adequate education and work experience related to rehabilitation (CRCC, 2014b). CRCC is the equivalent of the National Board for Certified Counselors (NBCC) for rehabilitation counselors seeking certification.

- CRCC operates with the belief that effective rehabilitation counselors work in a holistic fashion, take into consideration each client's environment and background, believe in the innate dignity of all individuals, and commit to adhering to its code of professional ethics (CRCC, 2014b). Accordingly, requirements for certification are based around these principles.
- Eligible applicants must submit an application to CRCC and pass its examination to become certified by the organization. Once counselors have become certified, CRCC requires them to renew their certification every five years, which entails either retaking their exam or accumulating at least 100 hours of continuing education (CRCC, 2014b).

1.2.5 School Counseling

Professional school counselors work in elementary, middle, and high schools to serve the *personal–social*, *career*, and *academic* needs of the school's students. School counseling began as a profession dedicated primarily to vocational guidance, and then school counselors began also addressing the personal–social issues of students in need through individual counseling. Since then, the role of the school counselor has undergone a substantial transformation. Today, the role of the school counselor, as outlined by the American School Counselor Association (ASCA), the division of ACA that serves as the professional association for school counselors, is that of an educator with special training in counseling who is committed to increasing student achievement and success (ASCA, 2014).

- ASCA's main ideal is that school counselors should meet the needs of every student (ASCA, 2014), not just the ones who seek help or are referred to the counselor by teachers or parents. Implementation of a comprehensive, developmental school counseling program is accomplished through individual counseling, individual student planning, group counseling, delivery of classroom guidance lessons, and consultation. In addition, ASCA urges school counselors to infuse their work with accountability, collaboration, advocacy, and leadership to ensure that all students have equal access to a high-quality education.
- To help school counseling programs meet the needs of all students, ASCA (2012) published the *ASCA National Model: A Framework for School Counseling Programs*, which provides school counselors with guidelines on how to reshape their programs to fully meet ASCA's standards and ensure that they are comprehensive, accountable, and developmental.

1.2.6 Other Types of Mental Health Counseling

A **mental health practitioner** is a person trained to treat individuals with mental health issues and mental illnesses. Many types of the professional counselors reviewed in preceding subsections are mental health practitioners, but this extensive occupational category incorporates a wide range of professionals, a handful of whom are described in this section, including psychologists, psychiatrists, psychoanalysts, social workers, psychiatric nurses, and marriage and family therapists. All these professionals help individuals with similar concerns and problems, but they differ in the types of treatment that they have been educated and trained to administer in working with clients.

1.2.6.1 PSYCHOLOGISTS A **psychologist** diagnoses and treats psychological, learning, and behavioral disorders in a variety of settings, including clinics, schools, hospitals, counseling centers, and private and group practice. Psychologists use interviewing and psychological testing when assessing and diagnosing client issues. Specializations within the field include clinical, counseling, and school psychology. To obtain licensure in most states, individuals must earn a doctoral degree in psychology.

1.2.6.2 PSYCHIATRISTS A **psychiatrist** is a medical doctor who works with clients with severe psychological disorders. Psychiatrists provide psychotherapy, prescribe medications, perform physical examinations, and order laboratory testing for clients. To become a psychiatrist, individuals must earn a medical degree, participate in a residency program, and pass licensure examinations.

1.2.6.3 PSYCHOANALYSTS A **psychoanalyst** helps clients resolve psychological issues through psychoanalysis—an intervention developed by Sigmund Freud—a long-term process that attempts to help clients remedy and alleviate their symptoms through exploring their unconscious conflicts. To become a psychoanalyst, individuals are usually required to earn a terminal degree in the mental health field, train at a psychoanalysis institute, and engage in personal psychoanalysis by a trained psychoanalyst. Psychoanalysts generally work in private practice.

1.2.6.4 SOCIAL WORKERS A **social worker** is characterized by his or her commitment to pursuing social reform and social justice, and affecting public policy. The social worker's role is one of counselor, case manager, and change agent, which is accomplished through delivering therapeutic treatments to clients, connecting clients with valuable community resources, advocating to fix societal conflicts, working with communities to develop programs to meet the needs of citizens, conducting research, and teaching. Educational requirements for social workers include a minimum of a bachelor's degree in social work.

1.2.6.5 PSYCHIATRIC NURSES **Psychiatric nursing** is a specialization within the nursing profession. Psychiatric nurses are trained to deliver counseling services to patients with severe psychological disorders, develop nursing care programs, and, in many states, prescribe medication. Individuals can pursue psychiatric nursing at the bachelor's, master's, and doctoral levels.

1.2.6.6 MARRIAGE AND FAMILY THERAPISTS A **marriage and family therapist** approaches working with individuals, couples, and families from a systems theory perspective, helping clients to develop more effective patterns of interaction with significant others and family members. To become a marriage and family therapist, individuals must earn at least a master's degree in marriage and family therapy.

1.2.7 Responding to Crises

Professional counselors are integral to any crisis team. A **crisis** can be defined as any event that disrupts a person's previously effective coping mechanisms. **Individual trauma** refers to one person's ability to cope with a crisis, whereas **collective trauma** refers to an entire community's reaction to a crisis. A **crisis team** is a group of professionals from different backgrounds (e.g., mental health professionals, medical professionals) who have been trained to respond to those in crisis. Following a traumatic event, many people experience a decrease in their psychological functioning, so it is important that counselors be available during the aftermath of a crisis, whether it is local or widespread, to help those in need recover.

- One method of working with individuals during a crisis is called **psychological first aid (PFA**; Everly, Phillips, Kane, & Feldman, 2006). PFA requires the professional counselor to first meet clients' essential survival needs (i.e., food, water, shelter, safety), then their psychological needs by using the core counseling skills (e.g., active listening, reflecting, showing empathy). Finally, the counselor should work with clients to help them establish contact with friends and family to mitigate feelings of loneliness or isolation.
- After natural disasters, the **crisis counseling program (CCP**; Castellano & Plionis, 2006) can be used to help restore a sense of safety. Using this model, professional counselors should work with a team to identify the problem, inventory the available resources, help reduce the disorder and confusion, assist victims in adjusting to their new life situations, provide victims with support and empathy, and educate individuals about common and atypical reactions to crisis and what to do should they need extra help.
- Although two specific models have been discussed, there exist a variety of approaches that counselors can implement effectively with crisis victims, including client-centered counseling, existential counseling, cognitive-behavioral therapy, and play therapy for children. The most important aspect to keep in mind is that early intervention is the best intervention, regardless of the approach.

1.2.8 Self-Care Strategies

To function effectively with clients, it is vital that counselors take the appropriate steps to ensure that they are tending to

their own personal needs and well-being. Counselors who suffer from burnout lack the ability to sufficiently meet the needs of their clients, so self-care should be a top priority. Although burnout will vary from person to person, the following activities and skills are thought to help prevent or mitigate the effects of burnout:

- Learn and implement time management skills.
- Engage regularly in enjoyable activities and hobbies.
- Establish and maintain meaningful connections with others.
- Pursue professional development.
- Monitor physical and psychological health.
- Seek professional support when needed.

1.2.9 Counselor Supervision Models

Counselor supervisors are experienced professionals who train new counselors and help them in the development and improvement of their clinical skills. All counselor supervisors are responsible for their own clients, and for those of their supervisees. Before becoming a counselor supervisor, professional counselors should undergo training to learn the necessary skills to assist and guide their supervisees. In addition, counselors should use a specific supervision model to facilitate the supervision process. A few general types of such models are as follows:

- **Theory-based models of supervision** extend the basic counseling theories to the supervisory relationship. For example, a counselor who uses a cognitive-behavioral supervision approach would concentrate on teaching new skills to counselor-trainees, encouraging them to practice their skills and working with them to help improve particular areas of weakness. A counselor using a client-centered approach would establish a warm, trusting environment where counselor-trainees feel comfortable and confident enough to practice and refine their counseling skills.
- **Developmental supervision approaches** emphasize counselor-trainees' progress through a series of stages as they become more experienced, competent, and independent. To meet the needs of the trainee at each stage, supervisors must adjust and adapt their supervisory style.
- Beyond theory-based and developmental supervision approaches, some models have been developed *specifically* for supervision. For example, the **discrimination model** requires the supervisor to be aware of the supervisee's intervention, conceptualization, and personalization skills and address supervisee needs by adopting the role of either teacher, counselor, or consultant as needed.

Supervision can occur in a variety of formats. Supervisors might meet privately with supervisees to discuss particular cases, meet with supervisees in a group format, watch videotapes of supervisee counseling sessions, and/or actually sit in during a supervisee session with a client (called a **live observation**). It is of utmost importance for a counselor supervisor to establish positive, honest, and trusting working relationships with his or her supervisees to foster their professional growth and reduce their anxiety.

1.2.10 Practice Multiple-Choice Items: Counseling Specializations

1. CRCC certifies the following type of counselor:
   a. Clinical mental health counselors
   b. School counselors
   c. College counselors
   d. Rehabilitation counselors
2. The mental health practitioners who most commonly administer psychological testing are
   a. psychiatrists.
   b. psychologists.
   c. professional counselors.
   d. psychiatric nurses.
3. A ________ works in counseling centers at postsecondary institutions to meet the mental health and wellness needs of students.
   a. school counselor
   b. college admissions counselor
   c. college counselor
   d. clinical mental health counselor
4. By license, all __________ can prescribe medication to their clients.
   a. psychiatrists
   b. psychologists
   c. professional counselors
   d. All of the above
5. The professionals most involved in working to affect public policy are
   a. marriage and family therapists.
   b. social workers.
   c. rehabilitation counselors.
   d. school counselors.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** d; **2.** b; **3.** c; **4.** a; **5.** b.

1.3 PROFESSIONAL ORGANIZATIONS

In this third section of Chapter 1, you will find brief summaries in alphabetical order of over 20 **professional associations** and organizations important to the counseling profession, that demonstrate the scope and diversity of this profession, many of which are affiliated with ACA and represented in Figure 1.1. Professional associations serve a multitude of purposes within the counseling field. They unite members through a shared identity, advocate on behalf of the profession, provide members with professional development opportunities and access to valuable resources, and often publish journals containing current research and news about their counseling specializations.

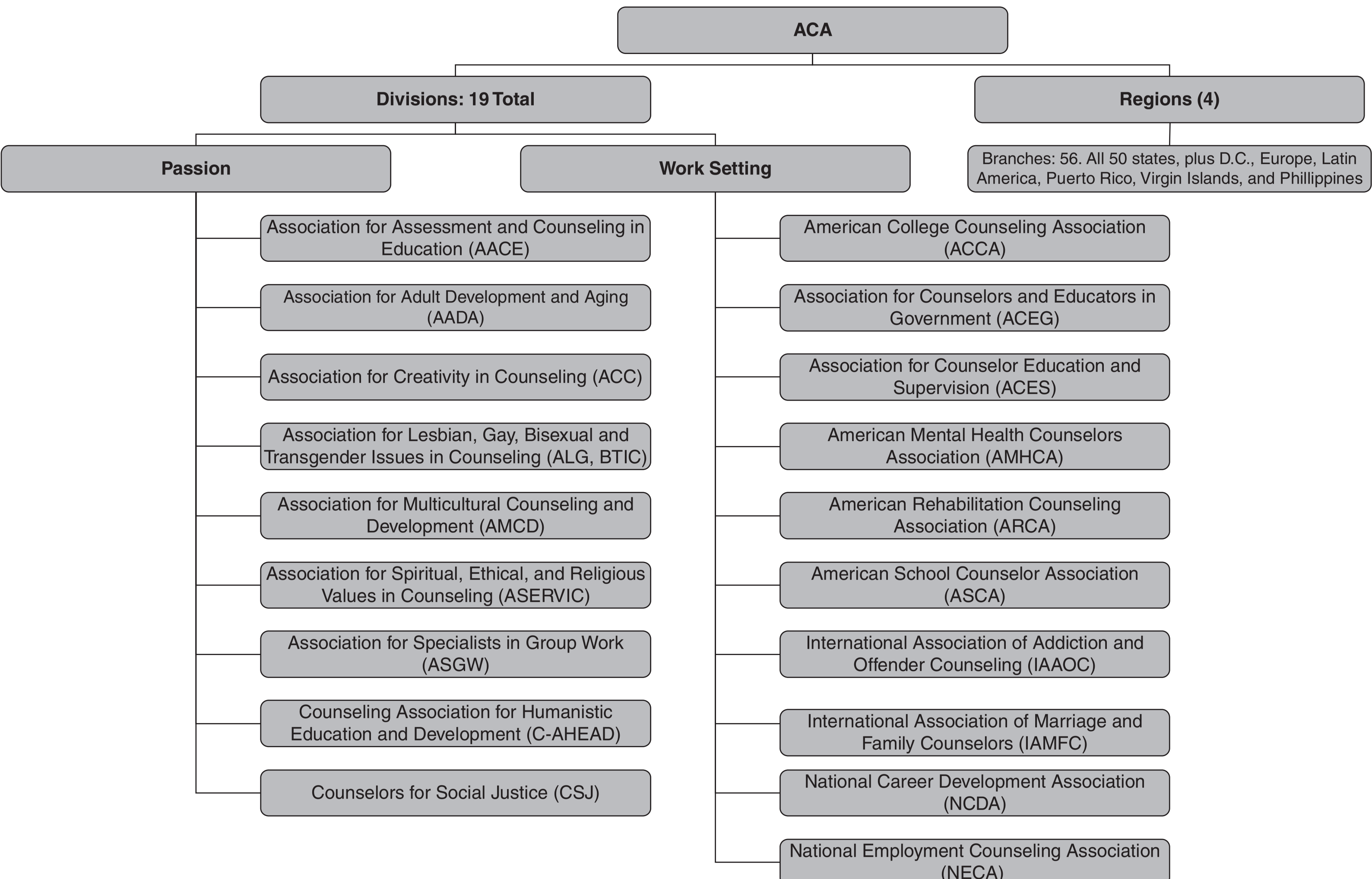

FIGURE 1.1 ACA divisions and branches.

Source: From B. T. Erford. (2010). *Orientation to the counseling profession*. Upper Saddle River, NJ: Pearson.

1.3.1 American Association of State Counseling Boards

Founded in 1986 through an ACA committee recommendation, the **American Association of State Counseling Boards (AASCB)** was created to connect states that have licensure boards in order to promote communication to the public and collaboration among states regarding licensure laws and legal matters (AASCB, 2014b). The mission of AASCB is to ensure that all proficient counselors have the ability to become licensed by their state boards as well as to spark discussion and cooperation among state boards with the purpose of making the licensure process simpler and more standardized across states.

1.3.2 American College Counseling Association

The **American College Counseling Association (ACCA)**, a division of ACA, was chartered in 1991 to unify counseling professionals working at postsecondary institutions in support of the mental health and growth of students (ACCA, 2014). ACCA's mission is to bring together college counselors from all professional backgrounds to improve the profession, share ideas, encourage ethical practice, and advocate for college counseling. ACCA publishes the *Journal of College Counseling*.

1.3.3 American Counseling Association (ACA)

The **American Counseling Association (ACA)**, headquartered in Alexandria, Virginia, was first established in 1952 as the American Personnel and Guidance Association (APGA) when four autonomous associations (National Vocational Guidance Association, National Association of Guidance and Counselor Trainers, Student Personnel Association for Teacher Education, and American College Personnel Association) united to gain more of a presence in the counseling field and in governmental and legislative initiatives at the federal level. The organization changed its name in 1983 to the American Association of Counseling and Development (AACD) and again in 1993 to ACA, the name it still uses today. The final name change was endorsed to demonstrate the shared affiliation of all members. Today, ACA has over 50,000 members and serves as a nationally recognized organization with 19 divisions, which represent nearly all the diverse disciplines within the counseling field. The 19 divisions are listed in Figure 1.1.

ACA's mission statement is "To enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession and practice of counseling to promote respect for human dignity and diversity" (ACA, 2014). Working under that charter, ACA is a nonprofit organization that advocates and provides services not only for professional counselors in the United States but also for counselors in 50 other countries. With the goal of helping professional counselors, and the profession itself, ACA offers benefits and support to those in need, has created a code of ethics to which members must adhere, offers continuing educational opportunities to help members stay current in their individual areas, publishes literature on topics of interest to counselors, and promotes the profession's mission in Congress and in the media. The flagship journal of the ACA is the *Journal of Counseling & Development*.

1.3.4 American Mental Health Counselors Association

The **American Mental Health Counselors Association (AMHCA)** was formed in 1976 and became a division of ACA in 1978 to help mental health counselors establish a clear and unified identity, separate from other counseling professionals. One of AMHCA's primary goals when it was formed was to begin the process of establishing licensure laws in states without licensure laws as well as to create accreditation standards for relevant counseling programs. The present vision of AMHCA is to advocate for the profession, provide members with professional development opportunities, and continue promoting licensure for mental health counselors (AMHCA, 2014). AMHCA publishes the *Journal of Mental Health Counseling*.

1.3.5 American Rehabilitation Counseling Association

Founded in 1958, the **American Rehabilitation Counseling Association (ARCA)**, a division of ACA, is the professional association for rehabilitation counselors, educators, and students. The missions of ARCA are to foster quality practice, education, and research within the profession; improve the lives of people who have disabilities; advocate the removal of barriers for people with disabilities; and raise public awareness regarding rehabilitation counseling (ARCA, 2014). ARCA is a separate association from the National Rehabilitation Counseling Association (NRCA), although efforts have been made in the past to merge the two associations. ARCA publishes the *Rehabilitation Counseling Bulletin*.

1.3.6 American School Counselor Association

Established in 1953, the **American School Counselor Association (ASCA)**, a division of ACA, was created to serve the needs of all professional school counselors by hosting professional development classes and seminars, publishing cutting-edge research on effective programs, providing helpful and practical resources to members, and promoting ethical behavior (ASCA, 2014). The vision of ASCA is to function as the voice for school counselors, advocating on their behalf, and to provide professional school counselors with the tools they need to successfully support students. ASCA publishes *Professional School Counseling*, which keeps readers informed about research and new ideas within the school counseling field.

1.3.7 Association for Adult Development and Aging

The **Association for Adult Development and Aging (AADA)**, chartered by ACA in 1986, was created to improve the counseling services available to adults at all stages of life through advancing counselor education and preparation related to human development and aging (AADA, 2014). AADA is also committed to campaigning for higher standards of care for

older adults and partners with organizations that share its mission. AADA publishes *Adultspan*, a journal that prints current research on aging and adult development.

1.3.8 Association for Assessment and Research in Counseling

The **Association for Assessment and Research in Counseling (AARC)**, a division of ACA since 1965, was founded to guide the proper development, training, and use of assessment, research, and evaluation in the realm of counseling and education (AARC, 2014). In addition, AARC backs legislation that is in alignment with its mission and encourages professional development for individuals who use diagnostic or assessment tools and conduct research and evaluation in their practice. AARC leaders and members have been involved in numerous committees formed to develop guidelines for the ethical use of tests and other evaluation tools, such as the "Responsibilities of Users of Standardized Tests" and ACA's "Position Statement on High Stakes Testing." AARC publishes two journals: *Measurement and Evaluation in Counseling and Development* (*MECD*) and *Counseling Outcome Research and Evaluation* (*CORE*).

1.3.9 Association for Counselor Education and Supervision

The primary goal of the **Association for Counselor Education and Supervision (ACES)** is to enhance counseling services in all specializations through the promotion of quality education, supervision, and credentialing of counselors (ACES, 2014). The vision of ACES is to support educational programs and supervisory practices that are culturally competent and shown both to be successful and to possess value to the community. ACES was one of the founding associations of ACA. ACES publishes the journal *Counselor Education and Supervision*.

1.3.10 Association for Counselors and Educators in Government

Founded in 1978, the **Association for Counselors and Educators in Government (ACEG)** became a division of ACA in 1984. Formed to connect counselors and educators working in government and military settings, ACEG's mission is to provide adequate support to its members so that counselors and educators in government can work effectively with their clients, and to create a network of professionals to share ideas and give assistance to other members (ACEG, 2014).

1.3.11 Association for Creativity in Counseling

The **Association for Creativity in Counseling (ACC)** was established in 2004 and has since become a division of ACA. ACC champions imaginative and creative approaches to counseling and comprises counseling professionals from diverse specializations, including dance, art, music, and play therapy (ACC, 2014). ACC's mission is to increase the recognition and appreciation of creative approaches to counseling within the profession, promote the use of such techniques, and determine which factors serve to increase creativity in counselors and in clients. ACC publishes the *Journal of Creativity in Mental Health*.

1.3.12 Association for Humanistic Counseling

The **Association for Humanistic Counseling (AHC)** was formed in 1931 and became one of the founding organizations of ACA in 1952. AHC has evolved over the years to become "the heart and conscience of the counseling profession" (AHC, 2014).

- According to AHC (2014), some of the core convictions of humanistic counselors include the belief in the worth and dignity of all human beings, self-determination, the capacity for clients to make progress and enhance their own lives, and the need for clients to help others and the community to grow and improve their mental health.
- AHC attempts to look after the mental health and wellness of clients and counselors. The association hosts a Wellness Center for counselors at each ACA convention. It also gathers donations from ACA members to support its Empty Plate Project, which gives money to a local food bank during each convention (AHC, 2014).
- AHC publishes the *Journal of Humanistic Counseling, Education, and Development*.

1.3.13 Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling

The **Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)** was established in 1975 (known then as the Caucus of Gay and Lesbian Counselors) in the midst of the gay activism of the 1970s to fight in the crusade for recognition of sexual minority issues within the counseling profession (ALGBTIC, 2014).

- The organization, originally called the Association for Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC), received in 1997 divisional status from ACA after more than 20 years of endeavoring to gain the association's official endorsement. The same year, ALGBTIC created *Competencies for Counseling LGBT Clients*, which provides counselors with an overview of the skills counselors should possess to work effectively with these clients.
- The overriding mission of ALGBTIC is to improve the delivery of counseling services to sexual minorities and to promote professional understanding of the effect of society on lesbian, gay, bisexual, and transgender (LGBT) issues and challenges (ALGBTIC, 2014). Also at the core of ALGBTIC's mission is the attempt to remove barriers that interfere with the development of LGBT clients and to ensure that LGBT counselors and counseling students have the same access to quality education and equal professional standing as other counselors and students.
- ALGBTIC publishes the *Journal of LGBT Issues in Counseling*.

1.3.14 Association for Multicultural Counseling and Development

Created in 1972 to raise awareness about multicultural issues in counseling, the **Association for Multicultural Counseling and Development (AMCD)**, like ALGBTIC, encountered difficulty in its attempts to become a division of ACA and receive the association's official recognition and support (AMCD, 2014). However, it eventually secured divisional status.

The mission of AMCD is to foster the growth and mental health of all individuals by working to identify and eliminate obstacles preventing the development of clients, appreciate human diversity and multiculturalism, and ensure that counselors and counseling students from all backgrounds receive equal status, treatment, and access to higher education (AMCD, 2014). The AMCD Multicultural Counseling Competencies were published in 1992 to guide counselors in delivering effective counseling services to clients from dissimilar backgrounds. AMCD produces the *Journal of Multicultural Counseling and Development*.

1.3.15 Association for Specialists in Group Work

The **Association for Specialists in Group Work (ASGW)**, a division of ACA since 1973, was founded to serve as the international association for group workers. ASGW's undertakings are to create standards of ethical group practice, promote group work, encourage research on counseling groups, and inspire members to become leaders in the field through modeling successful techniques in group practice (ASGW, 2014). ASGW publishes the *Journal for Specialists in Group Work* as well as best practice guidelines, training standards, and multicultural group work principles.

1.3.16 Association for Spiritual, Ethical, and Religious Values in Counseling

The **Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)** was originally developed as a joining together of the Catholic members of APGA and Catholic guidance councils across the United States, the first of which was formed in 1951 in the Archdiocese of New York to provide guidance for students at diocesan parochial schools (ASERVIC, 2014). These two groups joined forces in 1961 to create the National Catholic Guidance Conference (NCGC), and in 1974 the NCGC was granted divisional status in APGA. The name of the organization was changed in 1993 to the name it uses today. No particular religious group controls the association, so the name change was enacted to reflect the increased diversity of members and member faiths.

The mission of ASERVIC is to promote the incorporation of spiritual, religious, and ethical values into counselors' educational programs and professional practice (ASERVIC, 2014). To help achieve this goal, ASERVIC has generated Competencies for Integrating Spirituality into Counseling, which is aimed at helping counselors work with clients from various religious and spiritual backgrounds in an ethical and sensitive manner. ASERVIC publishes the journal *Counseling and Values*.

1.3.17 Chi Sigma Iota

Chi Sigma Iota (CSI) is the international honor society for professional counselors, counselor educators, and counseling students. CSI was created in 1985 to foster achievement and scholarship within the profession and to acknowledge exceptional leaders in the field (CSI, 2014).

- To become a member of CSI, professional counselors and counselor educators must have achieved a GPA of 3.5 or above, based on a 4.0 scale, in their counseling program and be endorsed by their chapter. In addition, they must be credentialed as counselors at either the state or national level.
- Counseling students who have completed at least one semester of full-time coursework at the graduate level in a counseling program, have attained a GPA of 3.5 or above, and have been recommended by their chapter are also eligible to join.
- Members are able to apply for CSI's award, research grant, fellowship, and internship programs.

1.3.18 Counselors for Social Justice

Counselors for Social Justice (CSJ), a division of ACA since 2002, was established with the mission of "confronting oppressive systems of power and privilege" relevant to counselors and their clients (CSJ, 2014). CSJ aspires not only to advocate on behalf of clients but also to empower clients to fight injustices affecting them. Counselors working with a social justice philosophy recognize the necessity of considering their clients' cultural backgrounds and the social contexts in which they live when developing treatment plans and counseling goals. CSJ, in conjunction with Psychologists for Social Responsibility, publishes the *Journal for Social Action in Counseling and Psychology*.

1.3.19 International Association of Addiction and Offender Counselors

The **International Association of Addiction and Offender Counselors (IAAOC)**, a division of ACA, was chartered in 1974. The association comprises substance abuse and corrections counselors, students, and counselor educators who are dedicated to helping individuals with addictions and those who have engaged in adult or juvenile criminal behaviors (IAAOC, 2014). The mission of IAAOC is to promote suitable services for and treatment of clients addressing these issues and also to forward this counseling specialization by endorsing ongoing research, training, advocacy, prevention, and intervention related to these groups.

IAAOC was a strong proponent of the development of the Master Addictions Counselor (MAC) credential, one of NBCC's specialty credentials, which is available to counselors who have achieved advanced training and experience in addictions counseling and who have also passed the Examination for Master Addictions Counselors. IAAOC publishes the *Journal of Addictions and Offender Counseling*.

1.3.20 International Association of Marriage and Family Counselors

The **International Association of Marriage and Family Counselors (IAMFC)** was founded in 1986 at Ohio University and chartered by ACA in 1989. IAMFC's mission is to encourage leadership and distinction in marriage and family counseling. Some of IAMFC's goals include advocating on behalf of clients and the profession; disseminating helpful information to the public about couples and family counseling, thereby increasing the public knowledge of IAMFC; promoting excellence in counselor preparation that includes training in systems theory; encouraging research related to marriage and family counseling; and offering professional development opportunities to counselors (IAMFC, 2014). IAMFC publishes *The Family Journal: Counseling and Therapy for Couples and Families*.

1.3.21 National Career Development Association

The **National Career Development Association (NCDA)**, one of the founding associations of ACA in 1952, was established in 1913 to champion the career development issues faced by people of all ages and to serve as the leading association for individuals who provide career services (NCDA, 2014). NCDA is involved in creating standards of practice for career counselors, establishing ethical guidelines for counselors working in career services settings, and appraising career materials and resources. The association also advocates on behalf of its members in Congress.

- In November of each year, NCDA sponsors National Career Development Month, which aims to inspire career development professionals to celebrate and host career-related activities. During this career development month, NCDA holds a poetry and poster contest centered around a career theme that is open to children and to adults (NCDA, 2014).
- NCDA publishes the journal *Career Development Quarterly*.

1.3.22 National Employment Counseling Association

The **National Employment Counseling Association (NECA)** was chartered by ACA in 1966. The mission of NECA is to make strides in the field of employment counseling by providing members with helpful resources, promoting research and knowledge related to effective career counseling techniques and tools to best serve job seekers and society, staying abreast of legislation affecting employment counselors, and creating a community in which professionals can network and share ideas (NECA, 2014). The *Journal of Employment Counseling* is the official journal of NECA.

1.3.23 National Rehabilitation Counseling Association

Founded in 1958, the **National Rehabilitation Counseling Association (NRCA)** was created to help individuals with disabilities become as independent and self-reliant as possible through counseling interventions and advocacy (NRCA, 2014). NRCA also works to uphold the professional standards of preparation for rehabilitation counselors set forth by CRCC and the Council of Rehabilitation Education, ensure that clients from all backgrounds receive equal services and treatment, encourage professional rehabilitation counselors to practice in an ethical manner, and advocate for licensure and certification for rehabilitation counselors. NRCA collaborated with CRCC and ARCA to develop the rehabilitation counseling *Code of Ethics* and the *Scope of Practice Statement*, which guide ethical practice for the profession. NRCA publishes the *Journal of Applied Rehabilitation Counseling*.

1.3.24 Practice Multiple-Choice Items: Professional Organizations

1. The ________ is *not* a founding member of ACA.
   a. Counseling Association for Humanistic Education and Development (C-AHEAD)
   b. American School Counselor Association (ASCA)
   c. National Career Development Association (NCDA)
   d. Association for Counselor Education and Supervision (ACES)
2. The most recently established division of ACA is
   a. Association for Creativity in Counseling (ACC).
   b. Counselors for Social Justice (CSJ).
   c. Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC).
   d. Association for Multicultural Counseling and Development (AMCD).
3. NECA and NCDA are both professional associations devoted to the specialization of
   a. career counseling.
   b. rehabilitation counseling.
   c. college counseling.
   d. marriage and family counseling.
4. The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) began as an association for counselors who were
   a. Jewish.
   b. Protestant.
   c. Catholic.
   d. Baptist.
5. Members of IAAOC are committed to helping clients who
   a. are dealing with addictions.
   b. have engaged in criminal acts as adults.
   c. are juvenile delinquents.
   d. are all of the above.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** a; **3.** a; **4.** c; **5.** d.

1.4 ETHICAL AND LEGAL ISSUES

1.4.1 Ethics

Ethics are moral principles that guide an individual's behavior. For professional counselors, ethics and, more specifically, codes of ethics are what guide professional practice to ensure that the welfare and safety of clients and counselors are secure. According to Remley and Herlihy (2010), codes of ethics serve a variety of purposes. The most fundamental objective of codes of ethics is to give information to professionals about how to practice in an ethical manner. To behave ethically, counselors are required to familiarize themselves deeply with applicable ethical codes. Although many ethical standards are straightforward, others are more complex and ambiguous, necessitating that counselors take adequate time to ensure they understand both the content of the code and how to resolve any ethical quandaries they may encounter.

Codes of ethics are also established as accountability measures and as means to enhance professional practice (Remley & Herlihy, 2010). For example, when professions have ethical codes, they are able to hold their members liable for any breaches of ethical conduct. Also, by including in their codes not only **mandatory ethics**, which are the lowest standards to which all members must comply to behave ethically, but also **aspirational ethics**, which describe best practices, professions can inspire members to work on continually improving their own knowledge base and skills to advance their practice and the reputation of the profession itself.

1.4.1.1 PRINCIPLES OF ETHICAL CODES Many codes of ethics embrace certain principles considered necessary for ethical conduct in that field. In the counseling profession, these principles are autonomy, nonmaleficence, beneficence, justice, and fidelity (Remley & Herlihy, 2010). When confronted with questions about ethics on the NCE or CPCE, it can be immensely helpful to think through these five principles; they will assist in determining whether an ethical violation is evident in a scenario and what a sound course of action might be in a given situation.

- **Autonomy** refers to the ability of clients to exercise free will and act independently. For counselors, this means respect for clients' rights to make their own decisions, even if the counselor does not agree with them or believe it is in their best interest.
- **Nonmaleficence** is the foundational principle on which counselors operate. It means to do no harm to clients. In any situation, counselors' first priority should be to ensure that the client is not injured—physically, mentally, or psychologically—or could potentially become injured as a result of the counselor's actions.
- **Beneficence**, in contrast to nonmaleficence, means doing only good. For counselors, this means being proactive in advancing the health and well-being of their clients.
- **Justice** is characterized by fairness. Counselors adhering to the principle of justice will not discriminate against clients and will ensure that all clients receive equal treatment.
- **Fidelity** means being faithful and loyal. For counselors, this means facilitating trust, keeping one's word, and fulfilling any obligations they make to clients.

In some situations, these principles will contend with each other (Remley & Herlihy, 2010). In these cases, the counselor must judge which principle takes precedence.

1.4.1.2 ETHICAL DECISION MAKING When faced with ethical dilemmas, it is also helpful to use some form of decision-making model. Herlihy and Corey (2006) describe one possible model in the *ACA Ethical Standards Casebook*, which serves as a helpful guide for counselors:

1. Identify the problem or concern.
2. Study pertinent codes of ethics and research.
3. Reflect on the principles of autonomy, nonmaleficence, beneficence, justice, and fidelity.
4. Consult with other professionals.
5. Maintain an awareness of your emotions to ensure that emotions do not cloud your judgment.
6. Include the client in the decision-making process whenever feasible.
7. Decide how you would like to see the situation resolved and brainstorm courses of action.
8. Examine the possible consequences for all courses of action and then select the one you would like to take.
9. Assess your chosen course of action.
10. Take action.

1.4.2 ACA *Code of Ethics*

As the professional association for all counselors, ACA publishes its *Code of Ethics* to serve as a basis for ethical behavior, providing counselors with a foundation and model for behavior, a useful resource when ethical questions arise, and a procedure for filing and responding to ethical complaints (ACA, 2005). Since 1961 when the first *Code of Ethics* was created, ACA's *Code of Ethics* has undergone five revisions to update both its content and format, aiming to ensure the code's continued relevance and comprehensiveness. As the profession evolves, so too does the ethical code, and it is the responsibility of professional counselors to stay abreast of any changes that are implemented. For example, in the most recent revision of the code in 2005, new sections were added on such topics as technology and end-of-life care. As important issues surface within the profession, ACA revises its code to ensure that professional counselors understand how best to respond.

Becoming intimately familiar with the content of the ACA and NBCC codes of ethics will prove invaluable when answering ethics questions on the NCE or CPCE. To help facilitate that process, this section summarizes the key points of the eight sections that constitute the ACA *Code of Ethics*:

A. The Counseling Relationship
B. Confidentiality, Privileged Communication, and Privacy
C. Professional Responsibility
D. Relationships with Other Professionals
E. Evaluation, Assessment, and Interpretation

F. Supervision, Training, and Teaching
G. Research and Publication
H. Resolving Ethical Issues

You should review the most current version of the ACA *Code of Ethics* prior to taking the NCE or CPCE. It can be downloaded in its entirety by visiting http://www.counseling.org/Resources/aca-code-of-ethics.pdf.

1.4.2.1 SECTION A: THE COUNSELING RELATIONSHIP

Section Highlights **Counselors must:**

- Keep accurate records and document their activities as required by their employer and by the law.
- Develop realistic counseling plans in conjunction with clients.
- Obtain informed consent (verbally and in writing) from clients.
- Obtain assent from those unable to give informed consent (e.g., minors).
- Seek permission to make contact and work collaboratively with any additional counselors or mental health professionals whom their client is seeing.
- Avoid any romantic or sexual relationships with clients, their significant others, or their family members. In addition, counselors must not engage in any romantic or sexual relationships with previous clients, their significant others, or their family members for five years after the date the client was last seen professionally.
- Avoid any interactions with clients outside of the professional context unless the interaction could be potentially beneficial (e.g., attending a wedding, graduation, or funeral). If counselors decide to engage in a potentially beneficial interaction, they must gain consent from the client and document their reasoning in writing.
- Gain consent from the client before changing roles in the counseling relationship (e.g., switching from acting as an individual counselor to a family counselor).
- Advocate on behalf of clients, with their consent, to help them overcome barriers to improvement, and encourage clients to advocate on their own behalf when possible.
- Screen potential group members prior to starting a group, and only select clients whose goals align with the group's purpose.
- Assist terminally ill clients in receiving excellent end-of-life care and being involved in educated decision making regarding their care.
- Establish appropriate fees.
- Refrain from engaging in bartering unless it is fair, suggested by the client, and an admissible convention in the community.
- Exercise prudence when offered a gift from a client. Consider the potential effect on the counseling relationship before deciding to accept or decline the gift.
- Make arrangements for clients to continue to receive care in the case of extended absence, illness, or death.
- Terminate the counseling relationship when it is evident that the client no longer needs or is benefiting from treatment.
- Abide by applicable laws when engaging in technology-assisted distance counseling.
- Ensure that clients are capable of using the appropriate technology before engaging in technology-assisted distance counseling.
- Include information about technology in the informed consent process, when applicable, such as limits to confidentiality.

1.4.2.2 SECTION B: CONFIDENTIALITY, PRIVILEGED COMMUNICATION, AND PRIVACY

Section Highlights **Counselors must:**

- Address the issue of confidentiality in a culturally sensitive manner, inform clients of the limits to confidentiality, and refrain from divulging confidential information about clients to outside parties without client consent or a legal or ethical rationale.
- Understand limits to confidentiality when
  - "disclosure is required to protect clients or identified others from serious and foreseeable harm" (ACA, 2005, B.2.a.). For example, if a client is threatening to hurt himself or herself or someone else, or if someone is threatening to hurt the client, counselors are ethically obligated to break confidentiality.
  - Clients disclose that they have a life-threatening and communicable disease that they may be infecting an identified other with and refuse to inform that person of their disease. However, counselors are only "justified" (ACA, 2005, B.2.b.) in breaking confidentiality under these circumstances, not required to do so.
  - Ordered by the court.
- Communicate their plans to break confidentiality to the client, if possible and appropriate.
- Only disclose the minimum amount of information required when breaking confidentiality is necessary.
- Obtain client consent before sharing confidential information with treatment teams or third-party payers.
- Ensure that any confidential discussions with clients occur in private settings.
- Discuss confidentiality and its limits when conducting group work, marriage counseling, or family counseling.
- Recognize the rights of parents/legal guardians to access confidential information of minor clients and work in concert with parents/legal guardians to meet the needs of the minor.
- Keep records in a safe location, protected from those who do not have the authority to access them.
- Allow clients to have "reasonable access" (ACA, 2005, B.6.d.) to their records and answer any questions clients have about the information found therein.
- Obtain consent before recording a session with a client, observing a session with a client, or showing a recorded session to an outside party.

- Discuss the limits of confidentiality with research participants, and refrain from publishing information about any participants that could reveal their identities, unless consent has been obtained.
- Protect the identity of clients when consulting with other professionals, unless the client has given his or her prior consent.

1.4.2.3 SECTION C: PROFESSIONAL RESPONSIBILITY

Section Highlights **Counselors must:**

- Practice within the parameters of their education, training, and experience.
- Only accept jobs that align with their qualifications; only hire employees who are capable and qualified.
- Evaluate the effectiveness of their skills and techniques and work to improve any weaknesses identified.
- Participate in continuing education and professional development to stay informed about current techniques and procedures and to improve their effectiveness.
- Remain cognizant of their own level of functioning and abstain from performing professional duties when they are experiencing an impairment (e.g., emotional, psychological, physical) that is likely to interfere with their ability to help their clients.
- Select a "records custodian" (ACA, 2005, C.2.h.), a colleague whom they will inform of their plan regarding what should happen to their records and clients in the event of their death, impairment, or discontinuation of practice.
- Truthfully represent their services in advertisements.
- Refrain from pressuring individuals with whom they are in a professional relationship to buy their products (e.g., books).
- Honestly represent their qualifications and credentials (e.g., counselors should not put the prefix "Dr." before their name if their doctoral degree is in a field unrelated to counseling).
- Denounce and avoid participation in any discriminatory behavior or sexual harassment, whether physical, verbal, or nonverbal.
- Use techniques that are "grounded in theory and/or have an empirical or scientific foundation" (ACA, 2005, C.6.e.) or else label their techniques as "developing"/"unproven" and make sure to discuss any possible risks with the client.

1.4.2.4 SECTION D: RELATIONSHIP WITH OTHER PROFESSIONALS

Section Highlights **Counselors must:**

- Show respect for professionals and organizations that use counseling procedures or techniques that are different from the ones they use.
- Strive to create positive relationships with other professionals (inside and outside of their field) to enrich their own practice and effectiveness with clients.
- Only give staff members job responsibilities for which they are trained and qualified to perform.
- Protect client confidentiality and promote the welfare of the client when working in interdisciplinary teams.
- Recognize that by accepting employment at an organization, they are indicating their accordance with that organization's practices and procedures.
- Notify their employer about any improper or unethical organizational practices that negatively affect clients, or counselors' ability to provide services, and work to change those policies.
- Refrain from firing or persecuting an employee who has revealed, in an ethical manner, improper or unethical practices within his or her organization.
- Only function in a consultative capacity in areas for which they are trained and qualified.
- Obtain informed consent before providing consultation.
- Ensure that the problem to be addressed and the goals to be worked toward during the consultation process are constructed in collaboration with the consultee.

1.4.2.5 SECTION E: EVALUATION, ASSESSMENT, AND INTERPRETATION

Section Highlights **Counselors must:**

- Safeguard client welfare by making accurate interpretations of assessment results, explaining to clients the results and their interpretations in terms they can understand, and working to ensure that other professionals do the same.
- Only use assessment tools that they are trained and qualified to use.
- Monitor the use of assessment techniques by any individuals under their supervision to ensure that they are being used appropriately.
- Obtain informed consent prior to engaging in an assessment of a client.
- Make culturally sensitive diagnoses of mental disorders.
- Consider abstaining from making a diagnosis if they think it would damage the client in any way.
- Only use assessment tools with sound psychometric properties.
- When choosing assessment tools for culturally diverse populations, exercise discretion to ensure their suitability. If counselors use assessments that were not normed on the client's population, they make sure to report the results in the appropriate context. For example, if a counselor uses an assessment for depression that was not normed on any Native American individuals, the counselor would take that into account when making an interpretation of a Native American client's results.
- Administer assessment tools "under the same conditions that were established in the standardization" (ACA, 2005, E.7.a.), document any "irregularities" or disruptions that occur during administration, and consider any irregularities or disruptions in the interpretation of results.
- Avoid making copies or replications of assessments without gaining permission from the publisher.

- Refrain from using any assessments or results from assessments that are dated or no longer used in the evaluation of a certain construct.
- Follow the appropriate, contemporary procedures when creating assessments.
- Refuse to perform forensic evaluations on current or former clients, as well as refuse to accept clients who are currently or have previously been evaluated for forensic purposes.

1.4.2.6 SECTION F: SUPERVISION, TRAINING, AND TEACHING

Section Highlights **Counselors must:**

- Observe the performance of counselors-in-training and ensure that clients' needs are being met. To that end, counseling supervisors discuss cases with supervisees, observe live counseling sessions, and watch recorded sessions.
- Ensure that supervisees discuss the limits of confidentiality with clients in regard to the supervisory relationship.
- Complete training in supervision before supervising counselors-in-training.
- Avoid romantic or sexual relationships with supervisees.
- Refrain from entering into a supervisory relationship with family members, friends, or significant others.
- Avoid any interactions with supervisees outside of the professional context unless the interaction could be potentially beneficial (e.g., attending a wedding, graduation, or funeral). If counseling supervisors decide to engage in a potentially beneficial interaction, they must gain consent from the supervisee and document their reasoning in writing.
- Recognize that they, along with their supervisees, may end the supervisory relationship at any time provided that sufficient notice and rationale are given.
- Provide supervisees with regular formal and informal evaluation and feedback. If counseling supervisors notice that a supervisee is struggling in a certain area, they help him or her in gaining assistance to improve his or her performance.
- Propose supervisee dismissal from his or her training program if the supervisee exhibits an unreasonable lack of skill in his or her performance.
- Endorse supervisees who they believe are competent and ready for employment or to move forward in their training program.

Counselor educators must:

- Integrate information about multiculturalism into all classes to foster counselors who are culturally competent.
- Teach students about the ethical issues related to the counseling profession and their ethical obligations as students.
- Involve students in both academic coursework and supervised practical training.
- Develop procedures for assigning students to field placements, ensuring that all site supervisors are qualified to carry out their duties. In addition, counselor educators must ensure that both students and supervisors understand their responsibilities and ethical obligations.
- Give prospective students sufficient information and orientation about the counseling program's goals, requirements, and expectations.
- Use discretion when integrating activities or assignments in class that involves self-disclosure, making it clear to students that their level of self-disclosure will not affect their grade in the class.
- Provide students with regular formal and informal evaluation and feedback. If counselor educators notice that students are struggling in a certain area, they help them in gaining assistance to improve their performance.
- Refrain from engaging in romantic or sexual relationships with current students.
- Avoid any interactions with students outside of the professional context unless the interaction could be potentially beneficial (e.g., attending a wedding, graduation, or funeral). If counselor educators decide to engage in a potentially beneficial interaction, they must gain consent from the student and document their reasoning in writing.
- Promote the recruitment of diverse faculty members and students.

Counseling students must:

- Abide by the ACA *Code of Ethics* and any applicable laws.
- Recognize that their obligations to clients are the same as those of professional counselors.
- Remain aware of their own well-being and abstain from performing professional duties when they are experiencing an impairment (e.g., emotional, psychological, physical) that is likely to interfere with their ability to help their clients.

1.4.2.7 SECTION G: RESEARCH AND PUBLICATION

Section Highlights **Counselors who conduct research must:**

- Abide by relevant ethics and laws pertaining to research practices, including approval of human subjects research through an institutional review board (IRB).
- Hold themselves accountable for the safety of research participants.
- Understand that the principal researcher holds the greatest responsibility for ensuring ethical conduct, although others involved in a research project are, of course, also obligated to adhere to ethical standards.
- Take appropriate preventative measures to avoid creating disturbances in the lives of research participants.
- Obtain informed consent from research participants, ensuring that participants know that they may choose to drop out of the study at any time.
- Avoid using deception as part of a research study unless it is necessary, is justifiable, and will not cause harm to

the participants. After the study is complete, researchers inform the participants about the deception and the rationale for using it.

- Keep confidential any information gleaned about research participants during the study.
- Explain the exact purpose of the study to research participants once it has been completed.
- Report the results of the study to pertinent organizations, sponsors, and publications.
- Dispose, in a timely manner, of any materials related to a completed study that contains confidential information about participants.
- Recognize that romantic or sexual relationships with research participants are not permitted.
- Avoid any interactions with participants outside of the professional context unless the interaction could be potentially beneficial. If researchers decide to engage in a potentially beneficial interaction, they must gain consent from the participant and document their reasoning in writing.
- Faithfully report the results of their studies, even if the results are negative or discouraging, and include an explanation about the limitations of the study.
- Disguise the identities of participants in any information disseminated about the study, unless participants have given their consent.
- Publish enough information and detail about their study so that interested researchers can replicate it.
- Give credit in publications through such means as "joint authorship, acknowledgement, footnote statements" (ACA, 2005, G.5.d.) to individuals who have made substantial contributions to the research.
- Refrain from submitting articles for consideration to more than one publication at a time.
- Maintain author confidentiality when serving as a professional reviewer for a publication. In addition, counselors should only evaluate submissions that they are qualified to review.

1.4.2.8 SECTION H: RESOLVING ETHICAL ISSUES

Section Highlights **Counselors must:**

- Familiarize themselves with the ACA *Code of Ethics*, along with any other relevant codes of ethics (i.e., codes of ethics from other professional associations).
- Realize that not understanding the *Code of Ethics* is not a valid excuse for acting in an unethical manner while carrying out their professional duties.
- Try to resolve any conflicts that arise between the code of ethics and the law. When unable to do so, counselors may follow the law.
- Confront counselors who they believe are violating, or may be violating, the ethical code, and try to resolve the issue informally.
- Report any ethical violations that cannot be resolved informally to ACA's Ethics Committee or other applicable committees.
- Consult with colleagues, supervisors, organizations, or other professionals when in doubt about the ethical, appropriate course of action to take in a situation.
- Only file ethical complaints when they have sufficient information to back up the claim.
- Refrain from discriminating against individuals based only on the knowledge that they have filed ethics complaints or have had ethics complaints filed against them.
- Cooperate with any investigations made by ethics committees.

1.4.3 National Board for Certified Counselors *Code of Ethics*

The NBCC *Code of Ethics* (2012) applies directly to professional counselors who have been certified by its board. Any counselors who pass the NCE and subsequently become certified must abide by NBCC's ethical code and so, too, must any counselors aiming to become certified by NBCC. Unlike ACA's code, which provides counselors with mandatory and aspirational ethics, the NBCC code consists solely of mandatory ethics. The most recent revision includes a preamble and the following directives:

1. ***NCCs take appropriate action to prevent harm.*** This directive references standards related to issues of confidentiality and client privacy, gifts and bartering, multiple relationships with current and past clients/supervisees, sexual harassment, sexual or intimate relationships with previous clients after two years but never with current clients or supervisees, availability of the counselor and protection of records, gatekeeping responsibilities of supervisors, handling of assessment and research data, and the use of social media.
2. ***NCCs provide only those services for which they have education and qualified experience.*** This directive alludes to the mandate for counselors to engage only in clinical, assessment, and other professional activities in which they are generally and multiculturally competent, and to seek supervision or consultation when necessary.
3. ***NCCs promote the welfare of clients, students, supervisees, or the recipients of professional services provided.*** Counselors and supervisors are to provide adequate information about their respective activities to individuals with whom they work. In addition, this directive highlights guidelines for with whom and how counselors consult and how assessments are to be administered and interpreted appropriately with clients.
4. ***NCCs communicate truthfully.*** This directive asserts that counselors accurately represent their credentials to others; provide accurate records for clients, supervisees, and other relevant parties; and integrate assessment and research information into their work honestly.
5. ***NCCs recognize that their behavior reflects on the integrity of the profession as a whole, and thus, they avoid actions which can reasonably be expected to damage trust.*** Counselors are to act responsibly with client records by retaining them for at least 5 years, releasing

client information appropriately; understand restrictions for which they may provide forensic evaluations; interact with clients professionally and avoid any conflicts of interest and situations with the potential for exploitation; and provide accurate information about clients when working with other professionals or integrating assessment data.

6. ***NCCs recognize the importance of and encourage active participation of clients, students, or supervisees.*** This directive requires counselors to work collaboratively with other professionals with whom clients are working, outline limits to confidentiality when working with multiple clients at a time, provide and obtain informed consent related to the counseling process, respond to client requests for records within a reasonable time frame, work collaboratively with clients and keep ongoing records, discuss termination or provide referrals as necessary, and provide clients with accurate information related to assessments and research.
7. ***NCCs are accountable in their actions and adhere to recognized professional standards and practices.*** This directive relates to counselors' responsibility to comply with procedures and policies of NBCC and university/work settings, as well as follow assessment and research guidelines.

1.4.4 Legal Issues in Counseling

Along with adhering to ethical codes, counselors must be knowledgeable of and follow relevant legal guidelines. Some of the most consequential laws related to counselors were highlighted in Section 1.1 of this chapter. In this section, legal concepts and definitions are discussed. Having a clear knowledge of this information will benefit you when taking the NCE or CPCE and in your professional counseling career.

- **Liability** is the legal responsibility of the counselor to act with due care in professional practice. Counselors who neglect to practice with due care become vulnerable to legal action being taken against them.
- If clients believe that they have been injured or wronged in some way by the behavior of a counselor and want legal retribution, the client can file a tort. According to Wheeler and Bertram (2012), a **tort** is a legal response to harm against an individual person or property. The two types of torts that are essential for counselors to be aware of are negligence and malpractice.
- Negligence and malpractice are both usually considered an **unintentional tort**, meaning that the counselor did not plan or aim to cause harm to the client (Wheeler & Bertram, 2012). However, either tort could be considered an **intentional tort** if it seems obvious that the counselor's action would result in harm to the client, even if the counselor did not intend to injure the client.
- **Negligence** occurs when counselors fail to use reasonable care in carrying out their professional duties, resulting in injury to the client. For the plaintiff to win in a negligence case, they must prove the following four components (Wheeler & Bertram, 2012):
    1. The defendant owed the plaintiff some kind of legal duty as stipulated by their counselor–client relationship.
    2. The defendant breached that legal duty.
    3. The plaintiff has an authentic injury (e.g., physical, financial, psychological).
    4. The defendant's breach of duty caused the plaintiff's injury.
- **Malpractice** occurs when professional counselors fail to provide the standard of care expected of them based on their credentials, skills, and experience (Wheeler & Bertram, 2012). Standard of care is often established by comparing the defendant's behavior to that expected of other professional counselors with comparable credentials in similar situations. Like in a negligence case, the plaintiff is required to prove the same four components outlined above for negligence: legal duty, breach of legal duty, real injury, and causal connection between duty and injury. Unlike a negligence case, however, for a malpractice lawsuit to be brought against a counselor, it is ordinarily necessary for the counselor to be licensed or certified by his or her state.
- Another type of tort is **defamation**, which occurs when a counselor mars someone's reputation through the intentional spreading of falsehoods. There are two types of defamation: libel and slander. **Libel** is defamation through writing, whereas **slander** is defamation through a spoken statement(s). It is possible for a counselor to be held liable for defamation if counseling notes, records, or communications with others about a client are erroneous, injurious to that person's reputation, and shared maliciously (Wheeler & Bertram, 2012).

1.4.5 Duty to Warn/Protect

There are limits to counselor–client confidentiality. Counselors are ethically and legally obligated to break client confidentiality under certain circumstances. Although counselors' obligations vary by state, counselors have a duty in general to protect clients from harming themselves or someone else and to protect clients from individuals who are threatening to harm them. This section provides a review of counselors' duty to warn, with specific attention given to cases of child abuse and neglect, elder abuse, domestic violence, suicide, and a discussion of the precedent-setting legal case *Tarasoff v. Regents of the University of California*, which addressed counselors' responsibilities when clients threaten to harm others.

- ***Child and elder abuse/neglect.*** The protocol for handling cases of potential child or elder abuse are fairly straightforward. According to Wheeler and Bertram (2012), all states legally require counselors to report any cases of suspected or known child abuse or neglect to the appropriate authorities. Likewise, almost all states also require counselors to report any suspicion of elder abuse as well as abuse of a person who is disabled or vulnerable

due to a severe mental illness. Essentially, it has been decided by the courts that protecting these vulnerable groups from possible harm overrides the need for confidentiality. Counselors who fail to report these cases are likely to lose if they find themselves in a legal battle.

- ***Domestic violence.*** The majority of states do not have a legal requirement mandating that counselors report suspected or known domestic violence to law enforcement agencies, although some states require physicians to report suspected cases or provide patients with helpful resources or referral information. Counselors should research the domestic violence laws in their state to address these cases.
- ***Suicide/self-harm.*** As outlined in the ACA *Code of Ethics*, counselors can ethically break confidentiality when clients make serious threats to harm themselves (ACA, 2005, B.2.a.). The two moral principles that conflict in these circumstances are autonomy and beneficence (Remley & Herlihy, 2010; Wheeler & Bertram, 2012). However, in certain cases, such as **suicide**—the taking, whether intentionally or unintentional, of one's own life—beneficence is more important than preserving client autonomy. This means that the counselor is ethically justified in breaching confidentiality, or violating autonomy, in order to promote the ultimate welfare of the client. For clients who make overtures that could lead to suicide, it is appropriate for the counselor to breach confidentiality to protect the client by contacting the family of the client, and possibly hospitalizing the client (if the risk appears imminent). In cases of client self-harm, such as cutting (self-mutilation), counselors walk a finer line, during which time autonomy may triumph (i.e., when the client's cutting is superficial and does not lead to infection).

  In both cases (suicide and self-harm), it is important for counselors to make a thorough assessment of the client's behavior, prior history, and future plans before making any decisions. As always, counselors should document any actions they take along with the rationale behind their decisions, and consult with others when unsure about how to proceed. In addition, counselors should be familiar with any specific laws related to suicide in their state, particularly in relation to minors.
- ***Clients who are a threat to others.*** In 1974, the Supreme Court of California ruled in *Tarasoff v. Regents of the University of California* that counselors could be held legally responsible for failing to take adequate steps to warn third parties about clients who present a serious threat to them (Wheeler & Bertram, 2012). In 1976, the law was extended to require counselors not only to warn but also to protect third parties from serious and foreseeable harm. That is, if a client makes a serious threat to harm someone the counselor can identify, the counselor must warn the third party about the threat that has been made and take steps to protect the identified individual, such as notifying the police. Although most states have now adopted this precedent, it is important for all counselors to determine to what extent it applies in their state. For example, although the majority of states fully follow the *Tarasoff* ruling, Texas is one state that does not.
  - ***Background.*** The *Tarasoff* case arose after a graduate student at the University of California, Prosenjit Poddar, disclosed to his psychologist (employed by the university) his plans to kill a woman, Tatiana Tarasoff, who would not enter into a romantic relationship with him (Wheeler & Bertram, 2012). The psychologist notified campus police; however, he did not warn Tatiana Tarasoff or city police, and Poddar was released after campus officials decided that he did not seem to pose a threat. On release, Poddar proceeded to kill Tarasoff, after which her family filed a case against the psychologist, the campus police, and others at the university.

When uncertain about what course of action to take in any of these circumstances, it can be helpful to:

- Familiarize oneself with applicable laws and related court decisions.
- Review codes of ethics.
- Consult with a lawyer, colleague, or supervisor.
- Document the decisions made in relation to these cases, including an explanation of why certain decisions were made.

1.4.6 Privileged Communication/ Confidentiality

Confidentiality refers primarily to counselors' ethical duty to keep client disclosures private, whereas, **privileged communication** is a legal term that protects certain counselor–client communication in the court systems (Wheeler & Bertram, 2012). For example, in most states counselors, like doctors, are protected under privileged communication from having to reveal information about a client in a legal proceeding, even if they receive a subpoena (see explanation below). Both confidentiality and privileged communication belong to the client, meaning that a client can choose to waive his or her right to either, allowing the counselor to ethically and legally disclose private information about the client.

- Privilege varies among states, so be sure to research the laws in your area. Some states have limitations to the privileged communication statute. For example, some states do not recognize privilege in criminal court cases and child custody cases, so it is essential that one be aware of how the law is applied in one's state.
- A **subpoena** is a legal document that orders a person to appear in court to serve as a witness or to provide the court with certain documents (Wheeler & Bertram, 2012). It is not uncommon for counselors to receive subpoenas, especially in child abuse and custody cases. The most important aspect for counselors to remember is to always consult with an attorney before providing any information to the court in order to best protect the client's confidentiality and determine if privileged communication applies.

- In addition to seeking legal advice, the counselor should contact the client or the client's attorney to ascertain how the client would like the counselor to proceed (Wheeler & Bertram, 2012). If the client is agreeable to the counselor providing the requested information, the counselor should ask the client to sign a written authorization. If the client does *not* want the counselor to divulge information, the counselor should ask the client's attorney to file a motion to quash the subpoena. At this point, the court will normally decide whether the counselor's information is necessary and, if so, will provide the counselor with a court order demanding the release of information. If a counselor receives both a subpoena and a court order, he or she *must* comply or be held in contempt of court. However, as outlined in the ACA *Code of Ethics*, if counselors have to share private information, they should only disclose information germane to the case and nothing more (ACA, 2005, B.2.d.).

1.4.7 Practice Multiple-Choice Items: Ethical and Legal Issues

1. A counselor who receives both a subpoena and a court order must
   a. assert privilege.
   b. request that the client's attorney immediately file a motion to quash.
   c. provide the court with the appropriate information or be held in contempt of court.
   d. only comply with the court order.
2. Libel is all of the following, EXCEPT
   a. the intentional spreading of falsehoods through spoken word.
   b. the intentional spreading of falsehood through writing.
   c. a type of defamation.
   d. addressed by tort law.
3. An ethical principle that encourages counselors to actively promote the welfare of their clients is known as
   a. justice.
   b. beneficence.
   c. autonomy.
   d. fidelity.
4. The ACA *Code of Ethics* prohibits sexual or romantic relationships between counselors and clients
   a. for 2 years after they last saw each other professionally.
   b. for 5 years after they last saw each other professionally.
   c. only until the counseling relationship has been terminated.
   d. None of the above.
5. When Internet counselors are unable to use encryption software, they are ethically required to
   a. refrain from providing their services over the Internet.
   b. be extra careful with any information they store on their computer.
   c. use code words to identify their clients.
   d. tell their clients about the potential risks involved in their online communications.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** c; **2.** a; **3.** b; **4.** b; **5.** d.

1.5 KEY POINTS FOR CHAPTER 1: PROFESSIONAL ORIENTATION AND ETHICAL PRACTICE

- The counseling profession emerged in the late 1800s in the form of vocational guidance.
- IDEA and FERPA prohibit discrimination against individuals with disabilities.
- Counselors who suspect child abuse are legally and ethically required to file a report with child protective services.
- CACREP is an accreditation body that approves educational institutions with counseling programs that meet predetermined standards of quality.
- Counselors obtain liability insurance to protect their assets in the event that a negligence or malpractice case is brought against them.
- Licensure laws regulate who is allowed to practice counseling.
- NBCC offers voluntary certification to counselors who meet its criteria for education, training, and experience, and who have passed the NCE.
- The counseling profession is composed of numerous specializations and associations.
- ACA serves as the professional voice for all counselors, regardless of specialization.
- Ethical codes provide counselors with a guide for professional behavior.
- When faced with an ethical dilemma, counselors should consult codes of ethics, other professionals, applicable laws, and ethics committees, as appropriate.
- Counselors are justified in breaching confidentiality if clients make a serious and impending threat to hurt themselves or an identified third party, or if someone makes a serious and impending threat to hurt the client.
- Laws always overrule ethics.
- In malpractice and negligence cases, these four aspects are examined to determine whether the defendant is liable: legal duty between plaintiff and defendant, breach of legal duty by the defendant, injury caused to the plaintiff, and causal connection between the defendant's breach of duty and the plaintiff's injury.
- Privileged communication is a legal term, whereas confidentiality is an ethical principle.
- Malpractice is considered professional negligence. Anyone can be sued for negligence; only certain professionals can be sued for malpractice.

CHAPTER 2

Social and Cultural Diversity

2.1 INTRODUCTION TO SOCIAL AND CULTURAL DIVERSITY

Social and cultural diversity is a core subject area that addresses how culture and social justice efforts affect the counseling relationship and the worlds of clients and counselors in general. Hays and McLeod (2014) stated,

> We as a profession are attending more to the complexities of both counselors and clients in their cultural makeup, the systems by which they are surrounded, and the impact these two components have on what earlier counselors and psychotherapists viewed as "universal" expressions of mental health. In addition, we are challenging each other to address biases and assumptions we have that prevent us from forming an affirming, therapeutic alliance with clients we counsel. (p. 3)

This CACREP core area is becoming increasingly important in counselor preparation, given that the U.S. population is steadily becoming more culturally diverse. Several racial and ethnic groups make up the population of the United States today. The predominant racial group in 2010 was White (72.4%; 63.7% non-Hispanic), followed by Black/African American (12.6%), Asian American (4.8%), and all other races (e.g., Native American, Alaska Native, Native Hawaiian making up 5.2% of the total U.S. population; U.S. Census Bureau, 2010a). However, the percentage of those identifying as White is projected to continue to decrease. The overall foreign-born population in 2009 made up approximately 11% of the U.S. population. Individuals from Latin America (e.g., the Caribbean, Central America, South America) represent the largest number (53.3%) of foreign-born individuals presently in the United States (U.S. Census Bureau, 2010b).

Over the past several years, administrations of the National Counselor Examination (NCE) have included only 11 (of the 160 total, or about 7%) of the scored items (plus some trial items that do not count) designed to measure social and cultural diversity (rank = 8 of 8, the fewest items of any of the eight domains). The average item difficulty index was .69 (rank = 6 of 8, the third most challenging domain of item content), meaning that the average item in this domain was correctly answered by 69% of test-takers.

Over the past several years, administrations of the Counselor Preparation Comprehensive Exam (CPCE) have included 17 scored items designed to measure social and cultural diversity, plus several trial items that do not count in one's score. The average item difficulty index was .61, meaning that the average item in this domain was correctly answered by 61% of test-takers, making this set of items among the most difficult on the examination.

The Council for Accreditation of Counseling and Related Programs (CACREP, 2009, pp. 9–10) defined standards for Social and Cultural Diversity as studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural society, including all of the following:

a. multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;
b. attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students' understanding of self and culturally diverse clients;
c. theories of multicultural counseling, identity development, and social justice;

d. individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;
e. counselors' roles in developing cultural self-awareness, promoting cultural social justice, advocacy and conflict resolution, and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind, or body; and
f. counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

Eight major sections make up Chapter 2, including: Introduction to Social and Cultural Diversity; Key Cultural Group Categories; Social Justice Concepts; Cultural Identity Development; Counseling Racial and Ethnic Groups; Counseling Other Cultural Groups; Crisis, Trauma, and Specialized Interventions; and Additional Considerations in Multicultural Counseling Practice. But first, let's review some key historical events and ethical issues in social and cultural diversity and foundational terms.

2.1.1 Culture and Multicultural Counseling

Before moving forward, it is important to define culture and multicultural counseling. **Culture** refers to the human experience mediated by biological, psychological, historical, and political events. It includes behaviors, attitudes, feelings, and cognitions related to our identities living within the world. Culture exists on three levels: universal, group, and individual—that is, culture organizes how groups as a whole, individuals within a particular group, and individuals as a human race behave, think, and feel. Because of this, we each have a unique cultural makeup that affects our experiences in counseling and in the world.

- The extent to which a group membership is labeled as "cultural" depends on how broadly individuals define culture. For example, a broad definition might include variables such as race, ethnicity, gender, sexual orientation, educational status, language, and geographical origin. A more narrow definition might label culture as race and gender only.
- Because we have varying ways of defining culture, we may consider certain cultural group memberships as more significant to ourselves and more valued when examining mental health issues. As professional counselors, we may use a biased lens (our own cultural values) to examine client issues. Oftentimes, the dominant cultural view is regarded in counseling as more important, leading the counselor to evaluate and treat clients from this perspective and disregard individual culture. Typically, the counselor does not understand the client's worldview or cultural identity and thus fails to integrate this information in practice. This is known as **cultural encapsulation**.
- **Multicultural counseling** may be defined as the integration of cultural identities within the counseling process. **Cultural identity** refers to the degree to which individuals identify belonging to subgroups of various cultural groups or categories—that is, how the combinations of the various cultural group memberships for the client and counselor interact to affect the counseling relationship and the process and outcome of counseling. Most counseling scholars note that all counseling is multicultural counseling in some manner.

2.1.2 Key Historical Events in Social and Cultural Diversity

Culture's role in mental health was first discussed in the 1960s and 1970s when scholars stated that the cultural identities of clients should be acknowledged because they affect clients' experiences in counseling. In addition, several wrote about the negative ways in which counselors inhibit clients' well-being when not addressing client cultural experiences in counseling sessions. Table 2.1 presents some key historical events in

TABLE 2.1 Key Historical Events in Social and Cultural Diversity.

- **1962**—C. Gilbert Wrenn authors *The Culturally Encapsulated Counselor*.
- **1970s**—William Cross, Jr., develops one of the first racial identity development models, the Cross Nigrescence Model.
- **1990s**—Janet Helms edits *Black and White Racial Identity: Theory, Research and Practice*. This book and subsequent research make significant strides in cultural identity development research.
- **1991**—The ACA (known then as the American Association of Counseling and Development) approves the multicultural counseling competency standards (see Section 2.1.3 for more information).
- **1991**—Paul Pedersen labels multiculturalism as the "fourth force" in counseling, moving to center stage the importance of culture in counseling. This force follows the three forces of psychodynamic, behaviorism, and humanism–existentialism.
- **1992**—The Multicultural Counseling Competency standards are published concurrently in the *Journal of Counseling and Development* and the *Journal of Multicultural Counseling and Development*.
- **1996**—Patricia Arredondo and colleagues operationalize the 31 multicultural counseling competency standards in a seminal article (see Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996).
- **2001**—The U.S. Department of Health and Human Services (USDHHS, 2001) publishes the Surgeon General's Report (*Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*) that highlights significant research related to how race and ethnicity (and associated oppression and resiliency experiences) influence mental health outcomes.
- **2003**—The Advocacy Competencies are approved by the American Counseling Association (Lewis, Arnold, House, & Toporek, 2003).
- **2004**—Manivong Ratts and colleagues (Ratts, D'Andrea, & Arredondo, 2004) label social advocacy as the "fifth force" of counseling.
- **2005**—The ACA *Code of Ethics* is revised to include a greater emphasis on culture.

social and cultural diversity. This list is not intended to be exhaustive.

2.1.3 Key Ethical Issues in Social and Cultural Diversity

Attending to social and cultural diversity (and avoiding cultural encapsulation) is an ethical imperative. Avoiding cultural bias is integral to all major counseling documents, including the ACA *Code of Ethics* (ACA, 2005), CACREP standards (CACREP, 2009), NBCC *Code of Ethics* (NBCC, 2012), and all ACA division guidelines, to name a few. Ramsey (2009) identified several pertinent ethical challenges:

- Counselors have an ethical obligation to build their knowledge, awareness, and skills to work with culturally diverse clientele—that is, multicultural counseling competence (described in more detail in the next subsection) is a continual developmental process.
- Counselors must be aware of both the strengths and challenges of traditional counseling theories and must familiarize themselves with indigenous healing practices.
- Although counselors are charged with practicing only within the bounds of their competence, it is unlikely that counselors will be knowledgeable about every culture. However, it is important for counselors to "stretch the boundaries" (Ramsey, 2009, p. 497) of their competence to increase their cultural awareness, knowledge, and skills.
- Counselors make client referrals when the setting in which they work fails to provide for the client, and that setting cannot or will not alter its policies and procedures to cater to that client.
- Counselor educators are to be properly trained in social and cultural diversity issues and are to implement a culturally sensitive and advocacy-based curriculum.
- Counselors must consider client cultural idioms of distress and cultural bias among practitioners when evaluating client symptomology and providing clinical diagnoses.
- Counseling researchers must consider culture throughout the research process, including involving a representative sample, avoiding harm in data collection, and interpreting data in a culturally sensitive manner.

2.1.4 Multicultural Counseling Competence

Sue and colleagues (Sue et al., 1982; Sue, Arredondo, & McDavis, 1992) constructed 31 multicultural counseling competencies (MCC) to introduce counselors to more effective ways to serve clients of color, given the increasing diversity and ethical challenges that counselors face. The standards have been increasingly applied to other cultural identities, including gender, spirituality, sexual orientation, and socioeconomic status, to name a few.

- The **tripartite model of multicultural counseling** (Ponterotto, 1997) involves three components: awareness (e.g., self-awareness of values and biases), knowledge (e.g., understanding of client's worldview), and skills (e.g., intervention in a culturally appropriate manner). Thus, these MCC standards guide counselors to be self-aware, examine their beliefs and attitudes regarding other cultures, understand how various forms of oppression influence counseling, appreciate other cultural norms and value systems, and skillfully employ culturally appropriate assessments and interventions (Arredondo, 1999; Sue, Arredondo, & McDavis, 1992). Table 2.2 provides more detail about the tripartite model.
- In developing MCC, counselors are to be familiar with two perspectives that can be considered a continuum: etic vs. emic perspectives. An **etic** perspective refers to viewing clients from a universal perspective. This likely means that an individual client's culture is minimized to focus more on basic counseling processes and strategies that apply across individuals. As there is more attention to social and cultural diversity, counselors are increasingly taking an emic perspective in their work with clients. An **emic** perspective refers to using counseling approaches that are specific to a client's culture. Thus, a counselor using an emic perspective would more likely use indigenous healing practices and look for alternative explanations of symptoms based on specific cultural expressions.

2.1.5 Communication Patterns

Communication between a counselor and client, an important aspect of multicultural counseling, affects the extent to which trust and empathy in the counseling relationship are established. Both verbal communication and nonverbal communication are important to attend to in counseling dyads.

- Most major counseling theories rely on spoken words as a primary tool for promoting growth and change. Individuals who are not fluent in the dominant language (i.e., English) may be marginalized and prevented from accessing resources and opportunities that are available to individuals who are fluent in standard English.
- Many clients who speak English as a second language may prefer to express themselves in their native language during the counseling process, and counselors should encourage clients to use the language with which they feel most comfortable expressing themselves. At minimum, counselors must be aware of community resources for clients who do not speak the dominant language.
- Approximately 85% of communication is nonverbal (Ivey, Ivey, & Zalaquett, 2010). Even though the notion of nonverbal communication is universal across cultures, the same nonverbal expressions can have drastically different meanings in different cultures. For example, acceptable interpersonal distance and eye contact vary from culture to culture.
- Nonverbal communication includes many types:
  - **High-context communication** involves individuals relaying messages by relying heavily on surroundings; it is assumed that "many things can be left unsaid," and

TABLE 2.2 Tripartite Model of Multicultural Counseling Competence.

I. Counselor awareness of own cultural values and biases

1. *Attitudes and Beliefs:* Counselors are aware of themselves and their clients as cultural beings and appreciate these cultural differences. They also understand how their cultural backgrounds affect the counseling process.
2. *Knowledge:* Culturally sensitive counselors understand how their cultural backgrounds and values impact their definitions of optimal mental health, understand how oppression affects them personally and professionally, and understand the impact these two knowledge competencies have on their clients.
3. *Skills:* Counselors recognize limitations to their MCC and seek out continuing education and personal growth experiences to increase their competencies, which include developing a nonoppressive identity.

II. Counselor awareness of client's worldview

1. *Attitudes and Beliefs:* Counselors are aware of how stereotypes and other negative reactions they hold about minority clients affect the counseling relationship, process, and outcome.
2. *Knowledge:* Counselors have knowledge of the cultural backgrounds, sociopolitical influences (e.g., acculturative stress, poverty, racism), help-seeking behaviors, within-group variation, identity development, and culturally relevant approaches specific to a particular cultural group with which they are working.
3. *Skills:* Counselors engage in personal and professional immersion experiences and research in which they can gain an understanding of unique mental health concerns and daily experiences for minority groups.

III. Culturally appropriate intervention strategies

1. *Attitudes and Beliefs:* Counselors identify and respect community-specific values (e.g., spiritual beliefs, indigenous healing practices, language preferences) and actively integrate them into counseling interventions.
2. *Knowledge:* Counselors have knowledge of the culture and current practice of counseling, its limitations for work with minorities (including existing bias in assessment and diagnostic procedures), limited accessibility for some communities, and restricted use of culturally specific and community resources.
3. *Skills:* Counselors engage in both verbal and nonverbal helping responses that are congruent with the helping style of their clients. During helping, counselors understand and articulate expectations and limitations of counseling assessments and interventions. In addition, counselors seek support and consultation from those in clients' communities in cases where healers and practitioners (e.g., language match, spiritual leadership) are appropriate and engage in social justice efforts to improve their clients' lives.

Source: From D. G. Hays & B. T. Erford (Eds.). (2014). *Developing multicultural counseling competence: A systems approach* (2nd ed., p. 22). Columbus, OH: Pearson.

thus nonverbal cues create social harmony. **Low-context communication** refers to individuals communicating primarily verbally to express thoughts and feelings.

- **Paralanguage** refers to verbal cues other than words. These may be volume, tempo, prolongation of sound, disfluencies (e.g., utterances such as *uh* and *um*), and pitch (highness or lowness of one's voice).
- **Kinesics** involve postures, body movements, and positions. These might include facial expressions, eye contact and gazes, and touch.
- **Chronemics** is how individuals conceptualize and act toward time. **Monochromic time** refers to an orientation toward time in a linear fashion (use of schedules, advanced planning of activities), and **polychromic time** refers to the value of time as secondary to relationships among people.
- **Proxemics** is the use of personal physical distance. The four interpersonal distance "zones" include intimate distance (0 to 18 inches), personal distance (18 inches to 4 feet), social distance (4 to 12 feet), and public distance (12 feet or more).

2.1.6 Acculturation

Acculturation is the process in which an individual (usually an immigrant) makes sense of a host culture's value system in relation to his or her own. An individual may completely embrace or reject a new culture, reject both cultures, or integrate the new culture to some degree into a current value system.

- Acculturation level is largely determined by the number of years a client has been involved in the acculturation process, the client's country of origin, and the age at which the client began the acculturation process.
- Paniagua (2005) identified four main models of acculturation with which counselors should be familiar. These include the (a) **assimilation model**, in which highly acculturated individuals identify solely with the new culture and adopt values and customs of the other, more dominant group; (b) **separation model**, in which individuals refuse to adapt to cultural values outside of their own cultural values; (c) **integration model**, or **biculturalism**, in which individuals identify with both their own culture and that of the host culture; and (d) **marginalization model**, in which individuals reject the cultural values and customs of both cultures.
- The more immigrants identify with and belong to a particular ethnic group, particularly if their ethnic values contrast with general U.S. cultural values, the more difficult the process of acculturation becomes.

2.1.7 Worldview

Worldview is defined as individuals' conceptualization of their relationship with the world. We will present two worldview models typically referenced in counseling programs.

- Sue (1978) described how individuals guide their behaviors on the basis of two intersecting dimensions: locus of responsibility and locus of control. **Locus of responsibility** refers to what system is accountable for things that happen to individuals. An internal locus of responsibility (IR) refers to the idea that success (or failure) is viewed as an individual's own doing and is thus the result of individual systems. An external locus of responsibility (ER) refers to the notion that the social environment or external system is responsible for what happens to individuals. The second dimension, **locus of control**, is the degree of control individuals perceive they have over their environment. An internal locus of control (IC) is the belief that consequences are dependent on an individual's actions. An external locus of control (EC) refers to the notion that consequences result by chance, outside of an individual's control. These dimensions result in four worldview combinations: IR-IC, IR-EC, ER-IC, and ER-EC.
- The second worldview model was developed by Kluckhohn and Strodtbeck (1961) and contains five components that integrate in various cultures to create unique cultural worldviews:
  - *Human nature* involves the continuum that humans are basically good, bad, or both good and bad.
  - *Relationship to nature* refers to how individuals view the power of nature: harmony with nature, power over nature, or power of nature.
  - *Sense of time* relates to what aspect of time individuals focus upon: past, present, or future.
  - *Activity* is how self-expression occurs for individuals. These may include *being* (i.e., present-oriented with an internal focus on self), *being-in-becoming* (i.e., present- and future-oriented goal development to create an integrated self), and *doing* (i.e., actively engaging in activities that are deemed important by external standards).
  - *Social relationships* involve three categories that relate to the degree of hierarchy and group focus within a culture: *lineal–hierarchal* (i.e., traditional cultures with hierarchal positions, typically patriarchal structures), *collateral–mutual* (i.e., collectivistic focus), and *individualistic* (i.e., the needs of groups are secondary to those of individuals).

2.1.8 Practice Multiple-Choice Items: Introduction to Social and Cultural Diversity

1. Labeling clients as resistant because they do not make eye contact during a counseling session might be an example of
a. cultural encapsulation.
b. an emic perspective.
c. chronemics.
d. integration.

2. __________ is NOT a component of the tripartite model of multicultural counseling competence.
a. Knowledge
b. Awareness
c. Skills
d. Relationship

3. An individual fidgeting during a counseling session is an example of what form of nonverbal communication?
a. Chronemics
b. Kinesics
c. Context communication
d. Proxemics

4. After spending 5 years in the United States, Maya believes she no longer belongs in her home culture and does not fit in the host culture. Which acculturation model best describes her acculturation level?
a. Assimilation
b. Biculturalism
c. Separation
d. Marginalization

5. The worldview that the environment accounts for actions that occur is best captured by which of Sue's (1978) dimensions?
a. Locus of responsibility
b. Locus of control
c. Activity
d. Relationship to nature

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** a; **2.** d; **3.** b; **4.** d; **5.** a.

2.2 KEY CULTURAL GROUP CATEGORIES

This section outlines several cultural group memberships. These include race, ethnicity, socioeconomic status, gender, sexual orientation, spirituality, and disability. Review Case 2.1. What cultural group categories do you notice? Circle them.

2.2.1 Race

Race describes how groups of people are thought to be identified by physical characteristics, such as a person's skin color, facial features, hair texture, or eye shape. The concept of race is a social and political classification system historically based on a genetic and biological background.

- Research, on the other hand, has shown that fewer biological differences exist between various groups and that racial categories are inappropriate and not scientifically based. Therefore, the classification of individuals on the basis of race is now seen as more of a vehicle to allow racial discrimination to occur in a variety of forms, such as exploitation, adverse treatment, and segregation.
- The U.S. Census Bureau (2012a) defines race as the group with which a person most closely self-identifies. Racial classifications include White, Black or African American, Asian, American Indian or Alaskan Native, and Native Hawaiian or Other Pacific Islander. The U.S.

CASE 2.1

The Case of Susan

Susan is a 77-year-old African American woman. She works two jobs most days of the week and is barely able to pay the bills. Susan wishes she could save money to move into a nicer house like the one her boss has.

She would like to have been an athlete of some sort or perhaps a coach for a female basketball team. However, she has never been allowed to play sports due to a heart condition.

She has a handicapped-parking pass that permits her to use the closer spots. But she sometimes finds people think she is not entitled to this privilege because she looks relatively young and healthy; in fact, sometimes they are quite rude.

Susan tries to keep active in her church, but things have been a bit tense lately since one of Susan's children disclosed he was gay.

Census also recognizes 165 racial combinations and has added a new designation entitled "Two or More Races Population." It is important to note that Hispanic/Latino is considered not a race but an ethnicity; thus, individuals of Latin descent may identify with any race or races.

- One way individuals consider someone's "race" in social interactions involves **color blindness**, or treating individuals equally by ignoring their racial group, or color of their skin, as a component of their identity. This concept was historically used in relation to the ill treatment that African Americans received and the intention that they not be judged by the tone of their skin. However, acting "color blind" presents challenges. A professional counselor who operates under this assumption is likely to perpetuate a continuing distrust of White counselors for clients of color, diminish the importance that the client's cultural background has on his or her worldview, and fail to create culturally appropriate counseling goals and interventions.
- Color consciousness and colorism are two other important terms to know regarding race. **Color consciousness** describes the process of how Whites, in response to guilt for their role in perpetuating racial discrimination for racial minorities, focus predominantly on racial (or perceived) differences. Color consciousness can be a form of unintentional racism due to the magnification of one's position as a minority instead of attention to a presenting concern that may not have much to do with race. A positive aspect of color consciousness, however, is that this new recognition of cultural differences offers the counselor a platform from which to address the topic in the counseling relationship and to be mindful of the individual.
- **Colorism** refers to the judgment of worth based on how closely an individual's skin color approximates that of Whites. The practice of valuing more highly one who has more European American features originates from a time when African American slavery was a prominent practice and the offspring of a slave and her owner were given treatment preferential to that of offspring who had no European features.
- **Biracial individuals** are those who are biological children of parents from two different racial backgrounds. For example, a **mulatto** is designated as one with both White and African lineage, and the term **mestizo** characterizes one born of Native American and Caucasian parents. Discrimination against biracial individuals occurred originally as a result of the **eugenics movement**, or a method to monitor a person's inborn characteristics and an attempt to keep the Caucasian race "pure" by directing who could marry and reproduce. As part of this movement, European Americans and African Americans—as well as the uneducated, those with mental illnesses, and those in poverty—could not intermarry.
- Unlike the term *biracial*, which connotes only two racial backgrounds, **multiracial** refers to one who is from multiple racial lineages. A multiracial family includes both those with birth parents of different racial backgrounds and those who were brought into a family by adoption.

2.2.2 Ethnicity

Although race refers to characteristics that are biological in origin, **ethnicity** refers to a person's identification with a group of people who have a similar social or cultural background. A person's ethnicity is rather flexible, depending on changes in his or her own **ethnic identity** and experiences. Individuals from the same ethnic group may have very different ties to that group, resulting in differences in ethnic identity.

- Ethnic groups often share patterns within their culture that may take the form of a shared language, religious preference, close proximity geographically, traditions, gender, or ancestry. Subsets of a cultural group are common as well.
- Examples of ethnic groups are Arab Americans, Hispanic/Latin(o/as), African Americans, Italian Americans, Jewish Americans, Japanese Americans, and Irish Americans.
- **Ethnocentrism** is a concept defining a cultural group's belief that it is superior in comparison to all other cultures. Although all ethnicities may use their own as a reference against which to measure other groups, ethnocentrism carries with it the notion that a group's ethnicity is the "gold standard" by which to judge others. In the counseling profession, ethnocentrism may appear in the form of the counselor not taking a client's ethnicity into consideration when planning treatment or being prejudicial toward the client.

2.2.3 Socioeconomic Status

Socioeconomic class or status (SES) is another cultural group categorization for a counselor to consider. Individuals in each SES can have a different worldview, conceptions of problems, perceptions of themselves, and needs to be met. In particular, working-class and underclass individuals may exhibit hopelessness or addiction, or may have difficulty reaching services to address their physical or mental health needs. SES includes factors such as income, financial status, educational background, resource availability (e.g., housing, clothing), and job held. SES traditionally is used to guide social roles among groups, and racial and ethnic minorities tend to be disproportionately represented in statuses with fewer resources. Even though the United States has no formal class system, as some other countries do, four classes can be identified in the United States, and each represents a distinct culture:

- ***Upper-class status.*** The wealthy, who have made or inherited large sums of money. **Wealth** refers to a surplus of social, educational, and/or economic resources.
- ***Middle-class status.*** Able to meet immediate needs plus those that arise in the future. Employed in technical or professional occupations.
- ***Working-class status.*** Live paycheck to paycheck, working to get immediate needs and bills met. Often work in service or labor industries and are put under extreme pressure to make ends meet.
- ***Underclass status.*** Generally have an underpaying job or are not employed. Struggle greatly to maintain basic needs, such as food, housing, health care, and even access to transportation. Can be considered to be at the **poverty** level and also to suffer from great anxiety over how to meet their needs.
- Poverty has two other delineations: **generational poverty**, occurs when poverty has been a factor in numerous generations, and **situational poverty** occurs when the lack of resources is due to an extenuating circumstance, such as a divorce, unexpected unemployment, or a death.
- A term related to SES is **classism**, which is a form of discrimination founded on a person's social status. Classism is generally thought to have its origins in the higher classes who would try to discriminate and oppress the lower classes, but **modern classism** proposes that those of lower statuses may exhibit classism as well (Liu, Soleck, Hopps, Dunston, & Pickett, 2004). **Structural classism** promotes a current status quo or arrangement of classes. For example, it can be said to be similar to being "grandfathered" into an organization, meaning that one who is the ancestor of a predecessor at a job or at a university is automatically accepted into the fold. **Internalized classism** is the result of a person feeling shame for the class to which they belong and their "place" in society due to SES.

2.2.4 Sex and Gender

The concepts of sex and gender, like race and ethnicity, are often incorrectly used interchangeably. **Sex** refers to whether a person is biologically a male or a female as determined by hormones, genetics, and physical makeup. **Gender** refers to the social categories of masculinity or femininity, with placement heavily guided by culture. Individuals often base how they behave socially, and how they justify their behaviors, on gender.

- **Sex roles**—similarly to the biological basis on which the definition of sex is derived—tend to focus on a person's physiological functioning. (For example, a woman's sex role would include her ability to conceive and birth a child.) **Gender roles**, on the other hand, take into account many factors, which include expectations put on a person by society about how someone should behave, think, and be treated and what beliefs he or she should hold. Gender role is a fluid concept that differs from culture to culture or from one time period to another. **Gender expression** refers to how individuals portray their gender, which may or may not be aligned with gender role expectations.
- The binary system of male and female has been challenged within the past few decades, with increased attention to transgender individuals. **Transgender** refers to identity and roles that, to varying degrees, do not conform to cultural norms and expectations associated with one's biological sex. (The concept is discussed in more detail in Section 2.6.2).
- Three terms that are important to know concerning gender are *femininity*, *masculinity*, *and androgyny*. These concepts represent how society would generally characterize someone as being stereotypically female or male. **Femininity** refers to attributions that are commonly associated with a woman, such as relational, nurturing, and emotional. **Masculinity** includes the features typically affiliated with a male, such as aggression, rationality, competitiveness, and independence. **Androgyny** alludes to the meshing of both masculine and feminine properties. Sandra Bem (1974) determined that androgyny was the most ideal psychologically, a finding disputed by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), who concluded that the masculine traits were more desirable and deemed healthier.
- Bem's **gender schema theory** interprets the "why" behind an individual's placement of genders into certain categories. Bem proposed that children learn gender roles and behaviors that conform to a society's standards and color their view on what proper gender behavior is expected to be. Those with a pre-existing view, or gender schema, will exhibit the stereotypical traits of the gender role in which they fall; this being so, society should remove these notions of a gender template to allow more personal freedom of choice and individuality.

2.2.5 Sexual Orientation

Sexual orientation is a multifaceted and complicated concept. Definitions of sexual orientation range from a person's biology, attitudes, and beliefs to the traditions of culture. On a more basic level, **sexual orientation** can be thought of as the way

people prefer to meet their sexual needs and the object of their sexual attraction.

- Chaney and Marszalek (2014) identified four components of **sexual identity**, a term they believe more comprehensively defines sexual orientation. These four components include physical identity (biological makeup of an individual), gender identity (belief about one's gender), social sex role identity (sex roles individuals adopt due to culture), and sexual orientation identity (sexual and emotional attraction to individuals of the same and/or opposite sex). Thus, sexual orientation involves gender, although it should also be considered independently.
- Sexual orientation is generally categorized as the following orientations:
  - **Homosexual***:* A person of the same sex is usually the object of sexual attraction and fantasizing. Persons with this orientation can be referred to as being "gay" or "lesbian," and they do not prefer to be called "homosexual."
  - **Heterosexual***:* A person of the opposite sex is usually the object of sexual attraction and fantasizing. This orientation, also known as being "straight," is the most socially accepted.
  - **Bisexual***:* A person is attracted to and fantasizes about both the opposite and the same sex. A bisexual may encounter discrimination similar to that experienced by the gay community but also may encounter resistance from the gay community.
  - **Questioning***:* This is a relatively new term that refers to an individual who is questioning his or her sexual orientation and/or gender identity. The letter *Q* is used to represent this concept, although for many young people *Q* represents queer (i.e., any gender and/or sexual orientation outside the mainstream).
- **Affectional orientation** is a recent term suggested by researchers to describe sexual minorities because it broadens discussion beyond simple sexual attraction. Relationships also involve attraction based on intelligence, emotional stability, communication style, and other interpersonal factors and feelings.
- A healthy sexual identity is possessed by those who are aware of their needs and desires, able to express themselves, and content with their sexual orientation.
- **Heteronormativity** refers to societal expectations that individuals, on the basis of their biological sex, adhere to gender roles that complement those of the opposite biological sex. It involves an assumption that there is a binary gender system and that heterosexuality is the normal orientation.
- **Heterosexism** is the discriminatory practice toward those who do not fall within the "mainstream" category of heterosexual. It involves imposing heterosexually based social norms and positively regarding those who abide by such norms. Some of those norms include recognizing marriage among heterosexuals, providing insurance coverage to heterosexual couples, allowing legal and financial rights to property, and valuing custody and adoption rights of heterosexuals.
- **Homophobia** refers to fear and hatred of sexual minorities, often resulting in hate crimes. **Internalized homophobia** is the process by which sexual minorities accept heterosexist messages; this can hinder their sexual identity development.
- **Homoprejudice** is a term that has recently emerged in research as scholars suggest that prejudice is more the cause of discrimination than an actual phobia per se.

2.2.6 Spirituality

Spirituality can best be understood as meaningful experiences that possibly include a relationship with a divine entity, the universe, or nature. Usually spirituality encompasses a sense of well-being and fulfillment, and it can also be said to be closely tied to a person's **soul**, or the quintessential nature of a person. Spirituality is not to be confused with **religion**. Religion involves the actual ritualized practices that may involve a church or other organization, authority figures, and religious mores.

- Spirituality may be polytheistic (believing in many gods), monotheistic (believing in one God), or nontheistic (nonbelief in God or gods).
- There are seven major types of religions (Cashwell & Giordano, 2014):
  - ***Buddhism.*** Goal is to increase awareness and understanding of life so as to reduce the anxieties of life. This final state is called *nirvana*, reached by means of meditation. Peacefulness, forbearance, and a belief in *karma* and reincarnation are further hallmarks of this faith.
  - ***Christianity.*** Belief in one God who sent his son Jesus Christ to die for the forgiveness of sins for all. Focuses on God's transformative love and the gift of grace to have a personal relationship with God. Forgiveness, mercy, and personal growth are further precepts of this faith.
  - ***Confucianism.*** Focuses on the completion of a person through lifelong educational growth concerning various aspects, including moral and cognitive. Persons are expected to conduct themselves harmoniously and humbly. Relationships, family, and tranquility in social transactions are key to Confucianism. The proper mannerisms, traditions, ethics, and regulations, called *li*, dictate these social interactions.
  - ***Hinduism.*** A "pantheistic" faith that believes in Brahman being the creator of Earth and that all things in nature are manifestations of Brahman. Meditation is a key element in this faith, as is *karma*, or the belief that a person's actions in this life determine his or her destiny in the next life. *Karma* is the core precept of Hinduism, rather than a core focus on Brahman. Hindus believe in reincarnation and the transcendence of the self.

  - ***Islam.*** A faith based on the belief in Allah, who is Islam's only god, and whose doctrine was proclaimed by the messenger Muhammed in the holy book of Islam, the Koran. Abraham and the first five books of the Old Testament are also incorporated into this faith. Focus is on prayer, sharing wealth, forgiveness, benevolence, religious fasting, and making a spiritual pilgrimage to the holy city of Mecca.
  - ***Judaism.*** With a focus on interacting with others humbly and performing good deeds, religious Jewish clients focus on the Torah, which comprises the first five books of the Bible. Some ascribe to the more mystical Kabbalah, or the "Force of the Creator," which allows that wisdom provides growth and an opportunity to focus on the life that follows this earthly one. The focus for most Jews is solidly on actions in this life.
  - ***Taoism.*** Concentrates on harmony with nature, a peaceful existence with the world, and power from Dao. Taoism has three foci that include the ways of ultimate reality, human life, and the universe. Intense study, it is believed, leads to enlightenment. Taoism also follows the precept that all humans have a moral center.
- **Agnosticism** is the belief that any ultimate being is unknown or unknowable.
- **Atheism** is the disbelief in the existence of God.
- Spirituality is an important and pervasive aspect of a person's life and has an impact on the counseling relationship. In fact, research has shown that spirituality is correlated with an increase in health, inner strength, mental well-being, and happiness. A critical aspect of many faiths is the existence of hope, which is a key element in counseling. Hope allows a client to move toward goals and believe that a positive change can be achieved.
- Complications can occur in many spheres of one's life, including the psychological, physical, emotional, cognitive, relational, or behavioral levels. **Spiritual bypass** refers to the avoidance of these problematic issues by a person "misusing their spiritual beliefs, practices, or experiences rather than address the struggle at the level at which it occurs" (Cashwell & Giardano, 2014, p. 470). Although this may seem helpful in avoiding the pain in the here and now, in the long run spiritual bypass is a maladaptive practice. An example of spiritual bypass is a person driven by an inner need to cover up deep insecurities becoming overly involved in services and outreach to others instead of striving for spiritual fulfillment.

2.2.7 Disability

A mental or physical challenge that greatly limits a person's ability to function in activities of daily living is a **disability**. Examples of these impairments include diminished ability to be independent, take care of oneself, move about freely, breathe, talk, see, hear, or be educated.

- **Ableism** is the form of discrimination afflicting this population by which people believe that one who is disabled is limited in the extent of what he or she can truly do and underevaluate his or her abilities. Although some disabilities may be readily apparent, others are not, and they make persons have to justify themselves and their status. The U.S. government has put in place three laws—the 1973 Rehabilitation Act, the 1990 Americans with Disabilities Act, and the 2004 Individuals with Disabilities Education Improvement Act—to protect citizens with disabilities.
  - **Rehabilitation Act of 1973 (PL 93-122)**. Prohibits discrimination against persons with disabilities in federally sponsored or federal programs.
  - **Americans with Disabilities Act (ADA) of 1990**. Prohibits discrimination of persons with disabilities in employment, public services, telecommunications, and accommodations.
  - **Individuals with Disabilities Education Improvement Act (IDEA) of 2004**. Provision of nondiscriminatory education process for children with disabilities in the least restrictive environment.
- *People-first language* is a recent move to undo the harm caused by labeling a person. For example, it's not "disabled person" but "person with a disability." It is important to note that the term *handicap* is no longer accepted.

2.2.8 Practice Multiple-Choice Items: Key Cultural Group Categories

1. The faith that focuses on *karma* and the deity Brahman is
a. Buddhism.
b. Taoism.
c. Islam.
d. Hinduism.

2. Situational poverty is due to
a. being poor for generations.
b. lacking resources due to an extenuating circumstance.
c. being poor due to geographic location.
d. lacking money because of poor investments.

3. What socioeconomic class recognized in the United States encompasses people who are able to meet current expenses, plus plan for the future, but are not necessarily wealthy?
a. Upper class
b. Middle class
c. Working class
d. Underclass

4. The view that one's own culture is superior to another culture is called
a. classism.
b. ethnocentrism.
c. racism.
d. colorism.

5. Which law most protects children with disabilities concerning public education?
a. ADA of 1990
b. IDEA of 2004
c. Rehabilitation Act of 1973
d. Buckley Amendment

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** d; **2.** b; **3.** b; **4.** b; **5.** b.

2.3 SOCIAL JUSTICE CONCEPTS

This third section discusses the premise behind social justice and related terms. **Social justice** is the belief in an equitable world for all individuals and the corresponding goal of promoting fairness by addressing privilege and oppression associated with various cultural identities.

2.3.1 Social Justice

Social justice promotes working with individual clients to empower them and engage in advocacy to promote equity in society and the client's systems. Crethar (2009) outlined four main foci of social justice:

- ***Equity.*** Balanced allocation of services, rights, and duties within a society. Counselors promote diminishing inequity while bringing awareness and empowerment to the client.
- ***Access.*** Fair access to services, resources, and education that allow the individual to reach a good quality of life with the ability to make one's own decisions. Access forms the main piece of the *Bill of Rights*, which calls for equality for all citizens. It is assumed marginalized individuals (e.g., within the minority, those not experiencing White privilege) will have less access to resources than those who are not pushed aside in society.
- ***Participation.*** It is the right of all individuals to have their opinion taken into consideration on decisions that will influence their lives. Participation increases hope, control, motivation, and community. Counselors work to empower individuals and find appropriate resource referrals.
- ***Harmony.*** Harmony, that is, working for the greater good of all of the community instead of being merely self-serving, means that every group's wants and needs are supplied fairly and evenly. Counselors should be able to work within various systems and understand the subtleties of a cultural group.
- The American Counseling Association (ACA) has created the Counselors for Social Justice Division and the ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2003), which give counselors knowledge about how to advocate against oppression.

2.3.2 Privilege and Oppression

Privilege and *oppression* refer to a bidirectional system in which individuals, depending largely on their cultural group combinations, experience differential levels of power, access, advantage, and social status (Hays, Chang, & Dean, 2004). Typically, cultural groups that experience oppression are various ethnic, religious, or sexual minorities; women; and those with disabilities. Those with privilege predominantly include Whites, males, able-bodied individuals, middle- to upper-class individuals, and heterosexuals.

- **Privilege** is the ability of a group to receive benefits and prestige that are not as readily available to other groups. McIntosh (1988), in a seminal article on White and male privilege, outlined everyday privileges individuals experience. These privileges tend to be unearned and involve creating oppression experiences (intentionally and unintentionally) for other cultural groups. A belief that one's group is superior is also part of privilege. Systems in which a group may experience privilege are in the workplace, judicial system, media, schools, and housing.

  White privilege is the most commonly discussed type of privilege. It involves the positive treatment and disproportionate access to resources due to being White, or the benefits received on the basis of skin color. Those individuals who do not identify as White but have lighter skin color that approximates being White may experience White privilege. It is closely linked to **White supremacy**, or the wrongful justification that Whites deserve certain advantages because they are the superior race. Examples of White privilege include favorable experiences in job interviews, positive portrayal in the media, and having access to adequate and safe housing.
- **Oppression** may occur by force or deprivation. *Oppression by force* refers to imposing a role, experience, or condition on someone, whereas *oppression by deprivation* refers to not providing someone with a necessary experience or resource (Hanna, Talley, & Guindon, 2000).
- The several types of oppression include racism, sexism, heterosexism, ableism, and classism. Every cultural group category has associated "-isms" whereby individuals with higher status within a particular group oppress those with lower status and power.
- Hanna, Talley, and Guindon (2000) described three different levels of oppression:
  - ***Primary oppression.*** Obvious acts by both force and deprivation.
  - ***Secondary oppression.*** Oppressive acts in which individuals do not get directly involved but from which they may benefit.
  - ***Tertiary oppression.*** When minority group members adopt the majority opinion so they fit in. This is also known as *internalized oppression*, which is prevalent in ethnic minority literature and basically means internalizing, or taking in, the dominant message about the minority's low self-worth and importance. Tertiary

oppression can lead to posttraumatic stress disorder (PTSD), mood disorders, eating disorders, drug and alcohol abuse, identity problems, and health issues.
- Double or triple jeopardy refers to discrimination faced by individuals because of their possession of multiple minority statuses, such as being a racial minority and a female (**double jeopardy**) or being a racial minority, female, and having a disability (**triple jeopardy**).
- **Structural violence** relates to the result of individuals being marginalized—intentionally or unintentionally—by political, economic, and social institutions. Results include inadequate school facilities in poorer neighborhoods, limited access to health care, and significant unemployment and underemployment.

2.3.3 Prejudice

Prejudice, closely related to oppression, involves making assumptions about an individual. It can have either positive or negative feelings attached to it, but negative prejudice is the most common type.

- Prejudice may affect individuals of various genders, races, financial situations, religions, and so forth. Often, the concept of phobias is intricately tied to prejudice, with fear causing prejudicial attitudes. For example, homophobia is the fear and hatred of same-sex couples that results in prejudice and oppression.
- The five stages of prejudice include different levels of severity (Allport, 1979):
  - ***Antilocution.*** The sharing of harmful views with those who have the same belief system, whether they are known to the person or not. Antilocution involves pure discussion, no actions.
  - ***Avoidance.*** Purposely trying to not be around disliked persons.
  - ***Discrimination.*** Purposely making sure individuals do not have access to resources for a better quality of life.
  - ***Physical attack.*** Acting either overtly violent or with violent undertones when in a high-pressure situation against a targeted group.
  - ***Extermination.*** A focused effort to demolish certain groups of people (e.g., genocide).
- Prejudice harms both the perpetrator (by anger and malice) and the victim (by shaming and creating feelings of isolation, suicidal or homicidal thoughts, and health problems). The creation, sustainment, and actualization of prejudice stem from three causes: individual personality, social traditions, and political system.

2.3.4 Racism

Racism is a predominant form of prejudice and oppression. **Racism** involves the belief that a group of people are inferior to one's own group due to recognized or perceived differences in physical characteristics. Racism also involves the ability to act on such beliefs overtly or covertly, intentionally or unintentionally (Hays & Grimmett, 2014). *Covert racism* is not directly obvious but is done insidiously, either through conscious or unconscious motivations. For example, diagnosing a client incorrectly due to not taking client behaviors in cultural context or repeatedly not seeing clients who are in a target population are examples of unintentional and intentional covert acts of racism, respectively. *Overt racism* is a more obvious and focused prejudice, and it is never unintentional or unconscious.

- Racism occurs at three levels: individual, institutional, and cultural. *Individual racism* is the individual perspective that another race is less intelligent, inferior, and so on. These beliefs maintain racial status quo and are both unconscious and conscious. *Institutional racism* is racism perpetrated by institutions such as businesses and government. Examples of this include racial profiling by law enforcement or loan officers, or difficulty obtaining employment due to race. In addition to oppressing minority races, institutional racism benefits Whites. *Cultural racism* refers to devaluing cultural artifacts (e.g., art, media, religion) that do not approximate White cultural values. *Structural racism*, closely related and often used interchangeably with institutional racism, emphasizes that the oppression of racial and ethnic groups, originating with the social construction of race and racial classification systems, is organized by institutional, cultural, and social structures (i.e., components of institutions) that create and maintain racial inequities.
- **Racial worldview** is a defining cultural characteristic in which individuals and groups perceive and understand each other; this understanding is transmitted to succeeding generations.
- Consequences of racism on the victim include the inability to access resources such as medical services resulting in poorer health, lower salary and education levels, stress, and lower quality of life due to living conditions. Anger, depression, and guilt may also be manifest. Victims may experience **internalized racism**, which is the taking in of majority beliefs about minority groups that will cause the minority group to believe stereotypes concerning itself, resulting in low self-esteem, feelings of worthlessness, and lowered motivation levels. Whites may experience shame, guilt, fear, and ignorance of other races and have incorrect notions about other groups.

2.3.5 Sexism

Sexism, defined as the oppression of individuals on the basis of gender, stems from the belief that males are the superior gender and thus are more competent and deserving of power. Examples of sexism are unfair pay, the glass ceiling effect or limited career opportunities, unequal distribution of labor within the family system, and exploitive portrayal in the media.

- **Male privilege** is closely related to sexism and involves the unearned societal benefits afforded to men based on being male.
- Consequences of sexism for women and others not identifying as male include depression, disordered eating,

increased physical risk for interpersonal violence and other forms of trauma, and unequal economic, occupational, and social opportunities (Cannon & Singh, 2014). **Internalized sexism**, or the belief that males deserve a privileged status and others do not, may occur.

2.3.6 Resilience

Resilience is an important social justice concept helpful for working with clients who experience oppression. **Resilience** is defined as "a person's ability to maintain equilibrium, adjust to distressful or disturbing circumstances, or to 'bounce back' toward a level of positive functioning in spite of (or often in response to) adverse situations" (Cheek, 2009, p. 458).

- Three characteristics are observed in persons with higher resilience: espousing hopeful attitudes and worldviews; having a supportive network of family, friends, and so forth; and having a connected and safe community with sufficient services available. It is important that professional counselors help clients build resilience within these characteristics.

2.3.7 Practice Multiple-Choice Items: Social Justice Concepts

1. Tertiary oppression is
a. internalized oppression.
b. not helping another who is being oppressed.
c. committing covert acts of oppression.
d. benefiting from oppression.

2. A resilience characteristic is
a. not espousing upbeat attitudes and worldviews.
b. having a supportive social network.
c. living in an unsafe community.
d. not being able to bounce back.

3. White privilege includes all of the following EXCEPT
a. seeing one's race represented often in the media.
b. being able to obtain work easily.
c. being free from much oppression based on race.
d. being discriminated against due to being in the majority.

4. __________ is NOT likely associated with privilege.
a. Power
b. Control
c. Advantage
d. Minority status

5. Working for the collective good of society refers to which tenet of social justice?
a. Equity
b. Harmony
c. Access
d. Participation

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** a; **2.** b; **3.** d; **4.** d; **5.** b.

2.4 CULTURAL IDENTITY DEVELOPMENT

This fourth section addresses the process by which individuals identify with various cultural groups, or cultural identity development. It addresses the identity development processes for the cultural group categories of race, gender, sexual orientation, and spirituality.

- Cultural identity development is contextual. How we identify ourselves and others culturally is based on social interactions with members of different cultural groups. These interactions are guided by privilege and oppression experiences (e.g., a White individual "advances" to higher status by addressing his or her privileged racial status).
- Cultural identity development is always changing. Typically, the more frequent and culturally diverse our social interactions, the more cognitively complex our identity. And individuals can cycle through statuses or possess characteristics of multiple statuses within a particular identity model.
- The purpose of cultural identity development models is to explain individuals' process of defining themselves and how this is associated with their relationships with other cultural groups.
- A positive cultural identity has been linked to greater mental health and more effective cross-cultural relationships (Poll & Smith, 2003).
- Hays and Gray (2014) identified some common themes of the cultural identity development process that can apply to many specific identity development processes, such as racial identity or sexual identity development. These themes are (a) unawareness or denial of cultural group membership; (b) conflict or anxiety when encountering those who differ in cultural identity; (c) retreat into one's own cultural group and then cautious interaction with others; (d) integration of one's own cultural identity with other self-identities and other factors; and (e) advocation for those who belong to cultural group memberships who may experience oppression. Table 2.3 provides a list of these themes and corresponding statuses of the cultural identity development models.
- We present the identity development models independently, although individuals go through several identity development processes at a time given their multiple cultural identities.

2.4.1 Racial Identity Development

Racial identity refers to an orientation to one or more racial groups. We present five racial identity models here: two people of color racial identity development models, two White racial identity development models, and a biracial identity development model. You will note that developing one's racial identity deals partly with addressing racism issues and partly with integrating racial identity with other identities (Hays & Gray, 2014).

2.4.1.1 PEOPLE OF COLOR RACIAL IDENTITY DEVELOPMENT The two models presented here are Cross's Nigrescence

TABLE 2.3 Themes of Cultural Identity Development Models.

Themes	Identity Stages/Statuses
Unawareness/denial	Naiveté, contact (WRID) Pre-encounter (POCRID) Personal identity (BID) Passive acceptance (FID) Pre-awareness, diffusion (SPID)
Conflict/anxiety	Resistance, disintegration, reintegration, pseudo-independence (WRID) Encounter (POCRID) Choice of group categorization, enmeshment/denial (BID) Revelation (FID) Identity confusion, identity tolerance, awareness, initial confusion (SID) Awakening, foreclosure (SPID)
Retreat into own group/interact cautiously	Redefinition, immersion/emersion (WRID) Immersion, emersion (POCRID) Embeddedness-emanation (FID) Identity acceptance, identity pride, exploration, deepening commitment, finding and applying the label of bisexuality (SID) Moratorium (SPID)
Integrate cultural identity with other identities and other factors	Internalization (WRID) Internalization (POCRID) Appreciation, integration (BID) Synthesis (FID) Identity synthesis, identity integration, settling into the identity (SID) Recognition, integration, achievement (SPID)
Advocacy	Autonomy (WRID) Integrative-awareness (POCRID) Active commitment (FID)

Note: WRID = White Racial Identity Development (Hardiman, 1994; Helms, 1995); POCRID = People of Color Racial Identity Development (Cross, 1971, 1995; Helms, 1995); BID = Biracial Identity Development (Poston, 1990); FID = Feminist Identity Development (Downing & Roush, 1985; Hoffman, 2006); SID = Sexual Identity Development (Cass, 1979; McCarn & Fassinger, 1996; Troiden, 1989; Weinberg, Williams, & Pryor, 1994; Worthington, Bielstein-Savoy, Dillion, & Vernaglia, 2002); SPID = Spiritual Identity Development (Griffith & Griggs, 2001; Poll & Smith, 2003).

Source: D. G. Hays & G. M. Gray. (2014). In B. T. Erford, *Orientation to the counseling profession: Advocacy, ethics, and essential professional foundations* (2nd ed., pp. 163–192). Boston, MA: Pearson. © 2014.

Model (Cross, 1971, 1995) and Helms's People of Color Racial Identity Model (Helms, 1995). Cross was interested in the process of Blacks "becoming Black," or **Nigrescence**, and developed a racial identity model in the 1970s. This model serves as a description of stages that Blacks experience as they come to understand and embrace their Black identity. Cross's Nigrescence model is considered a guide for other racial identity development models. The statuses are as follows:

- ***Preencounter.*** Pre-experiencing of a racial event; race or anti-Black attitudes are not viewed as important by the Black individual.
- ***Encounter.*** A specific experience, or encounter, that prompts the Black individual to begin to notice and question his or her racial identity.
- ***Immersion-Emersion.*** A response to conflict and anxiety from the Encounter status, which prompts the individual to retreat and embrace symbols and artifacts of Black identity and then develop a more sophisticated Black identity.
- ***Internalization.*** The Black individual is more accepting of his racial identity and integrates it with other cultural identities (e.g., gender, sexual orientation).
- ***Internalization-Commitment.*** Represented by the individual being an advocate for Black issues.

Helms's (1995) People of Color Racial Identity Development Model (POCRID) adopted Cross's principles and applied them to all people of color. The five statuses include the following:

- ***Conformity.*** Individuals of color may embrace racial stereotypes, blaming people of color for their problems. Individuals at this status may not socialize with other people of color. There is no awareness of racism.
- ***Dissonance.*** Individuals in this status experience a crisis that increases their awareness that racism exists. Conflict may lead individuals of color to appreciate aspects of their respective racial groups and distrust the dominant racial group (i.e., Whites).
- ***Immersion/Emersion.*** Similarly to Cross's model, individuals in this status actively reject White culture and have increased racial pride, retreating in their own racial group practices.
- ***Internalization.*** Individuals increasingly identify with individuals of other oppressed identities and develop an individualized racial self-concept. Individuals interact with Whites with more flexibility and objectivity.
- ***Integrative Awareness.*** Individuals develop a more complex view of all racial groups and work to eliminate all forms of oppression (e.g., racism, sexism, classism). This status differs from Cross's last status, which focuses on advocacy for Black issues only.

2.4.1.2 WHITE RACIAL IDENTITY DEVELOPMENT Helms's (1995) and Hardiman's (1994) White racial identity development models are presented in this section. Helms developed a White racial identity development (WRID) model to illustrate

that the general developmental issue for Whites is abandonment of entitlement—that is, Whites develop a more complex racial identity as they learn to relinquish some of the White privileges they receive. Helms's model is the best known and researched White racial identity development model. The statuses of the WRID model are as follows:

- ***Contact.*** Whites in this status are unaware that racism exists and deny race plays a role in their interactions with others.
- ***Disintegration.*** This status refers to when Whites become uncomfortable with the notion of racial superiority. Similarly to the second status of minority racial identity development models, there is a racialized event that increases Whites' awareness that racism exists, creating feelings of anxiety, guilt, and/or anger.
- ***Reintegration.*** Whites that experience this status typically try to lessen the anxiety experienced in the Disintegration status and demonstrate intolerance and anger toward those of different racial groups.
- ***Pseudo-Independence.*** Alternatively, Whites may move toward this status, whereas they address conflict by making a superficial commitment to racism issues. However, there are often discrepancies between attitudes and behaviors toward other racial groups: they do not "walk the walk."
- ***Immersion/Emersion.*** Whites in this status renew their efforts to address racism and redefine their "Whiteness." This status involves increased self-reflection and self-understanding of individuals' role in perpetuating racial privilege.
- ***Autonomy.*** This final status is one of advocacy for Whites: Whites strive to relinquish some of their White privilege and dismantle the racial status quo.

Helms (1995) also created the **racial interaction theory**, whereby she conceptualized how Whites and people of color, at various racial identity development statuses, might interact and whether those interactions would be adaptive or maladaptive. There are three types of racial interactions according to her theory:

- ***Parallel interactions.*** Both individuals are at similar racial identity statuses, resulting in more harmonious race-based communications. In counseling, the counselor and client will either address or avoid racial discussions.
- ***Regressive interactions.*** One individual (typically the one with more social power [e.g., White]) is at a lower racial identity status than the other individual. This creates frustration and leads to early termination in a counseling setting.
- ***Progressive interactions.*** One individual of a higher social power exhibiting a more advanced racial identity status than the other individual. This creates an interaction whereby race and culture may be addressed in counseling, facilitating the racial identity development process for both individuals.

Hardiman (1994) developed a model of White racial identity development that asserted that the general developmental issue for Whites is to integrate their "Whiteness" with other components of their cultural identities. The five-stage model is represented as follows:

- ***Naiveté.*** This initial stage is characterized by Whites categorizing others by racial groups and receiving and transmitting messages about power and privilege.
- ***Acceptance.*** Whites in this status believe that there is an equal opportunity for all racial groups, although they hold White values as the gold standard for others to follow.
- ***Resistance.*** Similarly to Helms's (1995) Disintegration status, Whites in this status experience conflict and anxiety about their beliefs of equal opportunity, as they engage in significant and meaningful cross-racial interactions.
- ***Redefinition.*** This status involves a self-reflection process about Whites' ethnic identity membership (unlike Helms's model, which involves redefining Whiteness). Whites in this status increase their understanding of their ethnic identities independent of their attitudes toward other racial/ethnic groups.
- ***Internalization.*** In this final status, Whites define themselves independently of the anxiety and resistance of earlier stages.

2.4.1.3 MULTIRACIAL IDENTITY DEVELOPMENT According to the U.S. Census Bureau (2012b), there has been a 32% increase in the number of individuals identifying as having two or more races (i.e., being **multiracial**). With the increasing number of multiracial individuals in the United States, counselors need to become familiar with available multiracial identity development models. Kenney and Kenney (2014) provide an overview of the major multiracial identity development models (see Table 2.4).

2.4.2 Gender Identity Development

Gender identity refers to the degree to which individuals endorse gender role expressions associated with their perceived gender. Gender identity most often (but not always) corresponds with biological sex. Thus, a biological female typically will identify as female and will endorse feminine characteristics. Gender identity development, then, is the process by which individuals come to terms with gender expression. A majority of the gender identity development research focuses on the identity process for females. Two gender identity development models are presented here: the Downing and Roush (1985) and the Hoffman (2006) feminist identity development models.

Downing and Roush (1985) developed a feminist identity development model to help explain how women come to know themselves in a sexist society. Gender identity, for women, involves addressing sexism according to this model. There are five stages:

- ***Passive Acceptance.*** This stage refers to women internalizing traditional gender roles and societal views of women. Women in this stage often do not interact with women who identify as feminist.

TABLE 2.4 Multiracial Identity Development Models.

Poston (1990) Preschool–Adult	Jacobs (1992) Preschool–Age 12	Kerwin and Ponterotto (1995) Preschool–Adult	Kich (1992) Preschool–Adult	Phinney (1993) Adolescence	Root (1990) Children–Adult
Stage 1 *Personal Identity* Sense of self with no racial/ethnic awareness	**Stage 1 (0–4½)** *Pre-Color Constancy* Play and experimentation with color	**Stage 1 (preschool–5)** Awareness of differences in physical appearances	**Stage 1 (3–10)** Awareness and dissonance	**Stage 1** Unexamined ethnic identity	Individual accepts identity assigned by society
Stage 2 *Choice of Group Categorization* Child is pressured to identify with one group	**Stage 2 (4 ½–8)** *Post-Color Constancy* Biracial label and racial awareness	**Stage 2 (entry into school)** Defines self on the basis of physical appearance	**Stage 2 (8–late adolescence)** Struggle for acceptance	**Stage 2** Ethnic identity search moratorium	Individual identifies with both racial groups
Stage 3 *Enmeshment/Denial* Individual is confused by single identity choice	**Stage 3 (8–12)** Biracial identity	**Stage 3 (pre-adolescence)** Awareness of biracial status	**Stage 3 (adulthood)** Self-acceptance and assertion of an interracial identity	**Stage 3** Achieved ethnic identity	Individual identifies with a single group
Stage 4 *Appreciation* Individual values multiple backgrounds, but identifies with single identity		**Stage 4 (adolescence)** Pressure to identify with one racial heritage			Individual identifies with multiracial group
Stage 5 *Integration* Individual identifies with and has integrated multiple backgrounds		**Stage 5 (college–emerging adult)** Affiliation with one racial heritage with movement toward biracial awareness			
		Stage 6 (adulthood) Biracial awareness and integration			

Source: Information summarized from K. R. Kenney & M. E. Kenney. (2014). Multiracial identity development models. In D. G. Hays & B. T. Erford (Eds.). *Developing multicultural counseling competence: A systems approach* (2nd ed., Chapter 15, p. 425). Columbus, OH: Pearson.

- ***Revelation.*** Women move into this stage if they experience an event of sexism so salient that it calls into their awareness that their development is hindered in some way. This event, or series of events, may lead to dualistic thinking (e.g., all women are good, all men are bad).
- ***Embeddedness-Emanation.*** This stage is best characterized by women developing a support network with other women to deal with negative feelings of the Revelation stage. Toward the end of the stage, women remain guarded in their interactions with men.
- ***Synthesis.*** Women in this stage integrate evolving feminist principles with other personal and cultural values. Events deemed previously as solely caused by sexism are re-examined to consider other causes as well.
- ***Active Commitment.*** This stage involves women advocating for other women and working to eradicate sexism.

Hoffman (2006) developed a feminist identity development model that gives special attention to the concept of gender self-confidence. **Gender self-confidence** involves the degree to which an individual defines himself or herself according to traditional views of masculinity and femininity *and* accepts those views. There are four statuses in Hoffman's model:

- ***Unexamined Female Identity.*** This status is similar to Downing and Roush's (1985) Passive Acceptance stage. It involves the acceptance of traditional gender roles for women.
- ***Crisis.*** This stage is similar to Downing and Roush's (1985) Revelation stage in that women become aware of societal discrimination in the form of sexism. This usually occurs because of one or more events.
- ***Moratorium/Equilibrium.*** Women in this stage are actively committed to a feminist identity search.

- ***Achieved Female Identity.*** The final stage involves the synthesis of new feminist identity with other aspects of identity. Gender self-confidence occurs.

2.4.3 Sexual Identity Development

As previously noted, sexual identity refers to the process by which individuals become oriented in terms of sexuality, whether this is heterosexual, bisexual, or homosexual. Sexual identity development is viewed as a continual, developmental journey, whereas sexual orientation is conceptualized as a continuum. Three gay identity development models (i.e., Cass, 1979; McCarn & Fassinger, 1996; and Troiden, 1989), one bisexual identity development model (Weinberg, Williams, & Pryor, 1994), and one heterosexual identity development model (Worthington, Bielstein-Savoy, Dillion, & Vernaglia, 2002) are presented.

2.4.3.1 GAY IDENTITY DEVELOPMENT Cass (1979) was the first to publish a gay identity development model, and this model has been widely cited in the counseling literature. There are six stages to Cass's model:

- ***Conscious Awareness.*** Individuals in this stage feel different and note that they may not be heterosexual.
- ***Identity Comparison.*** This stage represents the initial attempts individuals may make as they accept or reject various aspects of a gay identity. Three possible responses might be rejecting a gay identity and seeking to be heterosexual, passing as heterosexual while working toward accepting a gay identity, or rejecting traditional societal views of being gay while still accepting a gay identity.
- ***Identity Tolerance.*** In this stage, which is similar to the Immersion/Emersion statuses of racial identity development models and the Embeddedness/Emanation and Moratorium/Equilibrium stages of feminist identity development models, there is some movement to retreat into the culture. Specifically, individuals desire to connect with other sexual minorities and distance themselves from heterosexuals.
- ***Identity Acceptance.*** There is movement toward a more active commitment to the gay community, beyond simple tolerance of it.
- ***Identity Pride.*** There is stronger commitment to an active gay identity with some activism.
- ***Identity Synthesis.*** A gay identity is integrated with other cultural identities.

Troiden (1989) developed a model that is similar to Cass's (1979) model, yet focuses more on how the social context creates a nonlinear gay identity development process. The four statuses are these:

- ***Sensitization.*** There is an awareness of same-sex attraction; the individual sees self as different from peers.
- ***Identity Confusion.*** This status is characterized by uncertainty about sexual orientation by the individual; there is an awareness of an incongruence between societal assumptions of heterosexual and gay identities.
- ***Identity Assumption.*** There is exploration within the gay community, and individuals present as gay ("come out").
- ***Commitment.*** Individuals in this status are fully active in the gay community and have a positive gay identity.

McCarn and Fassinger (1996) developed a gay identity development model, partly in response to a traditional focus in the literature on the experiences of White men. Although this model was initially created to address lesbian identity development, it has increasingly been used to explain gay identity development more comprehensively. This model contains two discrete yet parallel individual and group developmental processes. The four statuses are these:

- ***Awareness.*** At an individual level, the individual feels different. There is also acknowledgment at a group level of sexual orientations other than heterosexual.
- ***Exploration.*** Individuals begin to have strong same-sex attractions and seek to belong, on a group level, by seeking information about others who identify as gay.
- ***Deepening Commitment.*** Individuals in this status confirm their gay identity at an individual level and actively commit to a gay identity at a group level.
- ***Identity Integration.*** Individuals at this status internalize their gay identity and integrate it with other aspects of their identity. At a group level, there is synthesis of the gay culture into self-identity.

2.4.3.2 BISEXUAL IDENTITY DEVELOPMENT Weinberg, Williams, and Pryor (1994) outlined four stages of bisexual identity development:

- ***Initial Confusion.*** Individuals in this status may experience anxiety about their sexual identity. They are attracted to both sexes and display discomfort about selecting a gay or heterosexual identity.
- ***Finding and Applying the Label of Bisexuality.*** Individuals become more comfortable with being attracted to both sexes and select the "bisexual" label.
- ***Settling into the Identity.*** This status is characterized by individuals' increased acceptance of a bisexual identity.
- ***Continued Uncertainty.*** This final status may occur for some individuals and is characterized by individuals feeling intermittent uncertainty about their bisexual identity.

2.4.3.3 HETEROSEXUAL IDENTITY DEVELOPMENT Worthington, Bielstein-Savoy, Dillion, and Vernaglia (2002) developed a five-status model that incorporates both individual and group identity development processes and is similar to McCarn and Fassinger's (1996) model. The heterosexual identity statuses are these:

- ***Unexplored Commitment.*** Individuals accept themselves as heterosexual without exploring this identity. They conform to heterosexual norms present in society.
- ***Active Exploration.*** This status involves a more active identification with heterosexuality and attention to heterosexual privilege (either positive or negative).

- ***Diffusion.*** This status represents a period of no commitment or exploration at the individual or group level.
- ***Deepening and Commitment.*** Individuals show a greater commitment to their heterosexuality and focus more attention on acknowledging heterosexual privilege and dismantling oppression.
- ***Synthesis.*** This final status involves the development of an overall sexual self-concept, which involves solidified attitudes toward self and others' sexual identities.

2.4.4 Spiritual Identity Development

Spiritual identity refers to the degree of connection individuals have with their spiritual force. Poll and Smith (2003) described a developmental process by which individuals become more personally connected with a higher power. Their model includes four stages:

- ***Pre-Awareness.*** Individuals in this status do not view spirituality as salient in their lives.
- ***Awakening.*** This status refers to the notion that individuals become aware of themselves as spiritual beings after a spiritual event or conflict.
- ***Recognition.*** Spirituality is integrated throughout life experiences. Individuals begin to develop spiritual practices.
- ***Integration.*** Spirituality is synthesized with the overall self-concept during this final status.

2.4.5 Practice Multiple-Choice Items: Cultural Identity Development

1. Which identity development model includes Encounter, Immersion-Emersion, and Internalization as some of its statuses?
a. McCarn and Fassinger's lesbian/gay identity development model
b. Cross's Nigrescence model
c. Hardiman's White racial identity development model
d. Helms's White racial identity development model

2. A racial interaction in which an individual of a lower racial identity status holds more social power over an individual would be considered a(n)
a. parallel interaction.
b. progressive interaction.
c. autonomous interaction.
d. regressive interaction.

3. Which of the following best describes the developmental issues of feminist identity development models?
a. Women must relinquish their gender privilege.
b. Men are to actively commit to support networks that include women.
c. Women are to accept traditional gender roles for men and women.
d. Women grow psychologically as they address sexism.

4. One of the most popular sexual identity development models that was often used in developing other identity development models was developed by
a. Troiden.
b. Coleman.
c. Cass.
d. Weinberg.

5. Mary becomes angry with God after the death of her close friend, and she questions herself as a spiritual person. What spiritual identity development status is Mary most likely in?
a. Recognition
b. Awakening
c. Pre-Awakening
d. Integration

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** d; **3.** d; **4.** c; **5.** b.

2.5 COUNSELING RACIAL AND ETHNIC GROUPS

In this fifth section, we cover six major racial and ethnic groups, including African Americans, Arab Americans, Asian Americans, European Americans, Latin Americans, and Native Americans.

2.5.1 African Americans

African Americans make up approximately 12.6% (38.9 million) of the U.S. population (U.S. Census Bureau, 2010a), primarily originating from areas including Africa, the Caribbean, the West Indies, Latin America, central Europe, and South America (Kent, 2007).

- African Americans have a unique "immigration" history in that beginning in the 1600s they have historically been enslaved and forced to migrate for indentured servitude. Colorism (see Section 2.2.1) has been around since slavery and still exists today. Further, laws against racial mixing and interracial marriage existed for over three centuries. These laws implied that being Black was unfortunate, and a **one drop rule** was put in place (i.e., a hierarchical social system that implied that possessing one drop of Black blood indicated you were Black and thus of a lower social status).
- After slavery ended in 1865, **Jim Crow laws** were enacted to maintain separate and unequal social and economic situations for Blacks.
- Depression, anxiety, posttraumatic stress, and schizophrenia are seen in the African American community at similar rates as in Whites. However, research has indicated that overdiagnosis may be prevalent. African Americans face environmental stressors that affect mental health, including poverty, higher unemployment rates, education and occupational barriers, higher rates of incarceration for Black men, higher rates of violence in urban communities, and often a single-parent family status and associated economic hardships.

- Common African American cultural values include the following, although these may be mediated by acculturation level and other individual experiences (Bounds, Washington, & Henfield, 2014):
    - Emphasis on a kinship network and extended relative and nonrelative family relationships, especially to care for children and the elderly
    - Respect for the family, particularly adult figures, by children
    - Collectivism and interdependence
    - Spiritual and/or religious orientation
    - Harmony with nature
    - Egalitarian gender roles within the family and other interpersonal relationships
    - Educational attainment
    - Flexible time orientation
    - Racial socialization of children
    - Assertiveness and expressiveness in communication style

2.5.2 Arab Americans

Arab Americans make up approximately 0.42% (1.2 million) of the U.S. population (U.S. Census Bureau, 2003) and originate from a 22-state League of Arab States that includes Gulf states, Greater Syria, and Northern Africa (Nassar-McMillan, Gonzales, & Mohamed, 2014).

- Geographically, Arabs are those with ties to the Saudi Arabian peninsula and historically have practiced Islam (Abudabbeh & Aseel, 1999). However, only about 80% of Arabs in the Middle East are Muslim, and the majority of the Muslims in the world reside outside of the Middle East. Thus, it is inaccurate to consider *Arab* and *Muslim* synonymous.
- Approximately 40% of Arab Americans identify as Lebanese, 20% as Arab, 12% as Egyptian, and 12% as Syrian (Nassar-McMillan, 2009).
- Nassar-McMillan, Gonzales, and Mohamed (2014) noted that Arab Americans migrated to the United States in four waves: (a) individuals from Lebanon, Syria, Palestine, and Jordan arrived at the end of the 19th century and beginning of the 20th century to escape religious persecution; (b) those from Egypt, Syria, Jordan, Iraq, Yemen, and Lebanon (mostly educated Muslims with the means to leave) arrived after World War II to escape political tension; (c) Muslims, mainly from Palestine, migrated in the 1960s for economic opportunity; and (d) Iraqi refugees fled to the United States after the Persian Gulf War in the 1990s.
- Since the terrorist attacks against the United States on September 11, 2001, discrimination in the form of ethnic profiling and hate crimes has dramatically increased for Arab Americans, even those who do not fit stereotypical "Middle Eastern" images (e.g., religious fanatics, dictators, desert nomads; Nassar-McMillan, Gonzales, & Mohamed, 2014).
- Common Arab American cultural values include the following:
    - Collectivism: extended family, community-oriented; decisions made by consulting others and considering what is best for family and community
    - Hierarchical family relationships
    - Duty and family honor
    - Religious diversity, including Catholic, Muslim, Orthodox, and Protestantism
    - Educational attainment
    - Use of nonverbal communication, comfort with touching, and use of high volume or repetition to elucidate main points

2.5.3 Asian Americans

Asian Americans make up approximately 4.8% of the U.S. population (14.7 million), and by 2050 Asian Americans will increase by 200% and constitute about 8% of the population (U.S. Census Bureau, 2010a).

- There are 43 distinct Asian groups from 24 countries of origin. These may be categorized into three primary groups: (a) East Asians (e.g., China, Taiwan, Philippines, Korea, and Japan); (b) South Asians (e.g., Pakistan, India, Nepal, Bhutan, Sri Lanka, and Bangladesh); and (c) Southeast Asians (e.g., Cambodia, Vietnam, Laos, and Hmong; Tewari, Inman, & Sandhu, 2003).
- The influx of Asian immigrants and refugees to the United States is a recent phenomenon. Inman and Alvarez (2014) note that the history of Asians immigrating to the United States began in the mid-1800s, when Chinese laborers arrived in California and Hawaii to work on sugar plantations and in the gold mines, respectively. Since then, Asian immigrants have been drawn to the United States for economic opportunities or in some cases to escape political or social persecution, famine, or war.
- An important concept specific to Asian Americans is the **model minority myth**, which states that Asian Americans have excelled in U.S. society without confronting Whites, despite past experiences of discrimination from them. It further states that Asian Americans should serve as a "model minority" for other racial/ethnic minority groups to follow to achieve the American Dream. Unfortunately, this myth insinuates that all Asian Americans no longer experience discrimination and thus no longer need social services.
- Although a heterogeneous group, Asian Americans possess some similar cultural values (see Table 2.5). Degree of acculturation will affect how salient each of the values are for individual Asian Americans.

2.5.4 European Americans

European Americans are those individuals originating from Europe, also labeled as Whites or Anglo-Americans. European Americans are the predominant racial/ethnic group in the

TABLE 2.5 Asian American Cultural Values.

Family	Primary socialization unit; kinship network, patriarchal with traditional gender roles, authoritarian and directive parenting styles, **filial piety** (needs of individual often are secondary to those of the family, especially to parents and elders), **saving face** (an individual's behaviors are reflective of family and thus should protect the honor of the family).
Gender and sexuality	Traditional gender roles, with males as the primary decision makers and women having main roles as spouses and mothers; traditional and nondemonstrative of sexuality, youth not encouraged to date, homosexuality discouraged.
Harmony	Harmony with nature, harmonious interpersonal relationships (i.e., nondirective, nonconfrontational, humility).
Emotional restraint	Self-restraint and self-control is viewed as a strength.
Education	Education is highly valued and indicative of a "good family."
Religion	Various religions followed depending on geography, belief in fatalism and rebirth, mind-body-spirit connection.
Help-seeking	Mental health issues cited in research include racism, depression, PTSD, domestic violence, anxiety, and schizophrenia. Three times less likely than Whites to use mental health services, although college students are open to counseling for career-related concerns.

Source: Information summarized from A. G. Inman & A. N. Alvarez. (2014). Individuals and families of Asian descent. In D. G. Hays & B. T. Erford (Eds.). *Developing multicultural counseling competence: A systems approach* (2nd ed., pp. 278–312). Columbus, OH: Pearson.

United States and constitute approximately 72.4% of the U.S. population, with 63.7% of the U.S. population identifying as White, non-Hispanic (U.S. Census Bureau, 2010a).

- Individuals identifying as White are from families that immigrated to the United States at some point (unlike Native Americans; see Section 2.5.6). Immigration began in the late 15th century and included individuals primarily from Germany, France, Scotland, and England. These immigrants came to the United States for economic security and political freedom. The English had the most influence in the Americas in shaping European American (White) cultural values, as evidenced by the use of English as the primary language.
- European Americans have continued to immigrate to the United States over the past five centuries for economic, religious, and political reasons. Between 1820 and 1998, approximately 60% of documented immigrants were from Europe; this number has decreased to about 30% since 1998 (McMahon, Paisley, & Molina, 2014).
- European Americans throughout history have oppressed other racial and ethnic groups mentioned throughout this section. Having the most power and influence, they have been able to establish the dominant U.S. cultural values (see Table 2.6).

2.5.5 Latin Americans

Latin Americans make up over 16.3% (50.5 million) of the U.S. population (U.S. Census Bureau, 2010a) and originate from approximately 20 countries. Latin Americans have also been labeled as "Hispanic" by the U.S. Census Bureau, a term originating from the Spanish word *Hispano*, indicating one of Spanish heritage. It is important to note that not all Latin Americans have a Spanish heritage. There are four major groups of Latin Americans (Latinos):

TABLE 2.6 European American Cultural Values.

Individualism	Individual needs are most valued; independence, competitiveness, live the "American Dream," overcome obstacles.
Religion	Judeo-Christian most prevalent, dedication to God and moral living.
Time orientation	Future time orientation, everything is planned and scheduled.
Family	Patriarchal family system, extended family not as valued as nuclear family.
Relationship with nature	Mastery over nature, individuals have a right to exploit the environment.
Scientific method	Values insight and reason, rationality.
Status	Status and power necessary for survival.
History	U.S. history constructed as European American history.
Communication	Verbal communication.

- *Mexicans* make up approximately 65.5% of Latinos (Pew Hispanic Center, 2011). A treaty signed at the end of the Mexican-American War in 1848 ceded Mexican territory to the United States, and most Mexican Americans can trace their roots to ancestors who were living in U.S. territory before then. Since the 1970s, there has been an increase in Mexican immigration for economic reasons.
- *Puerto Ricans* constitute 9.1% of all Latinos (Pew Hispanic Center, 2011). Because Puerto Rico is a U.S. territory, all are considered U.S. citizens.
- *Cubans* make up about 3.5% of Latin Americans (Pew Hispanic Center, 2011). Cubans have immigrated more recently (past 50 years), seeking economic security and political freedom from Communism.
- *Central Americans, South Americans, and Caribbeans* make up a group including at least 500,000 from each country in these regions (Pew Hispanic Center, 2011). This final group immigrated to the United States for economic and political reasons.

For Latin Americans as a whole, there seem to be fewer educational and economic opportunities as compared to Whites. Another barrier or stressor involves the immigration process. Latin Americans often experience **acculturative stress**, or cognitive and affective consequences associated with leaving one's own country and entering a host country (in this case, the United States). Individuals with acculturative stress have to adapt to a new culture and lose some of their cultural identity in the process. In fact, research shows an increase in mental health issues for those immigrants residing longer in the United States and, presumably, having higher acculturation levels. Some common Latin American cultural values include

- ***Language.*** Because about 72% are born outside the United States, many Latin Americans hold Spanish as their dominant language.
- ***Family.*** This value, often termed **familismo**, refers to the strong connection Latinos have to their extended families. Latin Americans comprise a collectivist culture that considers the needs of the family primary.
- ***Interpersonal relationships.*** **Personalismo** refers to having compassion and caring for those in their communities and families. This often coincides with **confianza**, or possessing trust and confidence in those with whom one is in a relationship.
- ***Catholicism.*** Roman Catholicism is the predominant religion of Latin Americans. The Virgin Mary is revered, and women who emulate her characteristics are more valued.
- ***Gender.*** There are traditional gender roles, in which masculinity is termed **machismo** (traditional male traits such as competitive, powerful, decision maker and breadwinner for the family) and femininity is termed **marianismo** (traditional female traits such as nurturing, emotional, and sexually pure).

2.5.6 Native Americans

Native Americans constitute about 2.9 million (1%) of the U.S. population (U.S. Census Bureau, 2010a). Of this number 1.7 million are enrolled tribal members of 563 federally recognized tribes and nations. More than 200 tribes or nations are currently petitioning for federal status.

- Although not considered U.S. citizens until 1924, Native Americans were the first inhabitants of North America. Unfortunately, genocide and disease decimated this population, beginning in the late 1400s.
- Approximately 78% of Native Americans live in urban areas, with the remaining living in suburban or rural areas, or on one of 314 federally recognized or 46 state-recognized reservations (U.S. Census Bureau, 2013).
- The U.S. Bureau of Indian Affairs (1988) declared that a Native American is an individual enrolled in a tribe or nation with at least one-fourth blood quantum. The U.S. Census Bureau relies on individuals self-identifying as Native American as "evidence" of their race/ethnicity.
- Garrett et al. (2014) cited mental health and public health issues with which Native Americans struggle, include tuberculosis, alcoholism, diabetes, pneumonia, homicide, and suicide (U.S. Library of Medicine, 2012). In addition, only 52% of Native Americans finish high school, 75% earn less than $7,000 per year, 45% live below the poverty line, and the majority who live on reservations (and in other areas) reside in substandard housing (U.S. Census Bureau, 2013).
- Table 2.7 notes some common Native American cultural values.

TABLE 2.7 Native American Cultural Values.

Sharing	Group needs significant, emotional relationships valued, patience encouraged, sharing freely and keeping only needed materials important.
Cooperation	Avoidance of competition, participation after observation, speaking softly and at a slower rate.
Noninterference	Try to control self and not others, self-discipline, humility.
Time orientation	Present-time focus; "Time is always with us."
Extended family orientation	Reliance on extended family.
Harmony with nature	Explanation according to nature.

Source: Information summarized from M. T. Garrett, J. T. Garrett, T. A. A. Portman, L. Grayshield, E. T. Rivera, C. Williams, M. Parrish, T. Ogletree, & B. Kawulich. (2014). Counseling Native Americans. In D. G. Hays & B. T. Erford (Eds.). *Developing multicultural counseling competence: A systems approach* (2nd ed.; pp. 341–381). Columbus, OH: Pearson Merrill.

2.5.7 Multiracial Individuals

Multiracial individuals are those with lineage from two or more racial backgrounds. Other terms that have been used to describe this population include biracial, interracial, mixed race, and multiple heritage (Kenney & Kenney, 2014). Approximately 2.9% (9.1 million) of the U.S. population identifies as having two or more races (U.S. Census Bureau, 2010a).

- The 1967 case *Loving v. Virginia* was a salient historical marker related to abolishing U.S. laws outlawing interracial marriage (i.e., anti-miscegenation laws).
- In 2000 the U.S. Census Bureau allowed individuals to check more than one box to identify their race, increasing the ability to accurately measure the number of multiracial individuals in the United States.
- Root (1990) identified six interrelated themes of identity issues and concerns that multiracial individuals may experience: (1) uniqueness, whereby they are treated as different or unique from their peers; (2) acceptance and belonging, or the struggle of deciding to which racial groups to align; (3) physical appearance, in that they are perceived in various ways depending on which race may be more prominent; (4) sexuality, or sexual stereotypes experienced particularly by multiracial women; (5) self-esteem; and (6) identity, or affirmation of a positive multiracial identity development.

2.5.8 Practice Multiple-Choice Items: Counseling Racial and Ethnic Groups

1. __________ comprise the smallest percentage of the U.S. population.
a. Native Americans
b. Arab Americans
c. Asian Americans
d. European Americans

2. Filial piety regarding family applies most closely to which cultural group?
a. Latin Americans
b. African Americans
c. Native Americans
d. Asian Americans

3. ______________ are considered the fastest-growing racial and ethnic group.
a. African Americans
b. Arab Americans
c. Native Americans
d. Asian Americans

4. The largest group making up what constitutes Latin Americans is
a. Puerto Ricans.
b. Muslims.
c. Mexicans.
d. Cubans.

5. _____________ are mistakenly considered to be the model minority.
a. African Americans
b. Arab Americans
c. Latin Americans
d. Asian Americans

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** d; **3.** d; **4.** c; **5.** d.

2.6 COUNSELING OTHER CULTURAL GROUPS

In addition to racial and ethnic groups, other cultural classifications are reflected in NCE and CPCE items. These include sexual minority clients, transgender individuals, the elderly, adolescents, and international students.

2.6.1 Sexual Minority Clients

Sexual minority individuals include lesbian, gay, bisexual, queer, and those questioning their sexual orientation. This group also often includes transgender individuals (see Section 2.6.2). These clients may experience the same issues that arise when counseling any other client. However, these clients may need additional services related to coming out and other identity development concerns, and help coping with individual and institutional discrimination and violence that hinders physical and mental well-being.

- The sexual identity development process may be an important counseling consideration when working with this population. The **coming out process** involves recognizing oneself as a sexual minority and disclosing one's sexual identity to others. This process mostly occurs in the teenage years; however, some individuals hide their identity for years and even have opposite-sex relationships. Aspects of the coming out process indicated in sexual identity development models (see Section 2.4.3) include becoming aware of attraction to same sex; being sexually involved; becoming familiar with the sexual minority community; self-identifying as gay, lesbian, bisexual, or transgender; and coming out to others. Although this process seems linear, individuals can cycle through components of it and opt to come out to various individuals at different times.
- Counselor competency in counseling sexual minority clients includes dedication to the ideas set forth by the Multicultural Counseling Competencies by Sue, Arredondo, and McDavis (1992) and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling's (ALGBTIC's) Competencies for Counseling Gay, Lesbian, Bisexual, and Transgendered Clients (Terndrup, Ritter, Barrett, Logan, & Mate, 1997).
- Counselor competency also includes knowing one's own ideas and biases about this population. In addition, counselors have a responsibility to understand current events that involve this group, the group's culture and community, and oppression against sexual minorities. Practitioners must also be aware of how their own spiritual and

religious background may affect the client, while keeping in mind that some clients may have been ostracized by the religious community. Counselors should never impose their own values about sexual orientation and the intersection of gender onto a client (ACA, 2005). If a counselor deems that he or she cannot work with a client, it is an ethical requirement for him or her to refer the client. Counselors must seek out educational opportunities, such as seminars and current literature, to maintain quality services for these clients.

- Mental health professional organizations reinforce the idea of acceptance of sexual minority clients, as opposed to working to change them. **Reparative therapy** or **conversion therapy**, or attempting to change one's sexual orientation, has not been supported by research or any professional organization, although many attempts have been made using shock therapy, pain therapy, hypnosis, medications, and religious counseling. The American Psychiatric Association not only announced the inefficacy of reparative therapy but also discussed how this form of treatment could further complicate the client's identity and reinforce negative feelings.

2.6.2 Transgender Individuals

Virginia Prince coined the term *transgender* to identify men who lived as women but did not have a sex change operation. Now, the term is used more broadly to describe persons who do have the biology or appearance of someone that is in line with traditional gender roles. Transgender is not sexual orientation but rather gender identification, a fact that is often confused. Transgender also includes the following categories:

- ***Transsexuals.*** Persons who choose to alter their biology to be more in line with their identified gender.
- ***Cross-Dressers.*** Persons who dress in clothing traditionally worn by the opposite sex. Most commonly seen as men in women's clothes, and may provide sexual pleasure. *Drag kings* (females dressing as males) and *drag queens* (males in female attire) are terms also used to describe individuals who cross-dress to entertain. About 1 person in every 50 is estimated to be a cross-dresser.
- ***Transgenderist.*** Persons who live the life of the opposite sex without biological intervention.
- ***Intersexed.*** Formerly known as hermaphrodites, these individuals possess both male and female genitalia and hormones.
- ***Genderqueer.*** Persons who do not conform to traditional ideas of gender roles and sexual orientation.
- ***Two-spirited.*** A Native American term that identifies a person with the spirit of both a male and a female. It is important to note, however, that individuals from the dominant culture would be disrespectful if they used this term to describe a Native American.
- ***Gender dysphoria.*** Experienced by persons who were born one gender, identify with another, and feel conflicted about it. This occurs in an estimated 3% to 10% of the population.
- Accurate counts of transgendered persons are difficult to obtain.
- Much like sexual minority clients, transgender individuals will present with issues similar to those of other clients. However, they may also present with issues such as substance abuse, low self-worth, and an HIV/AIDS diagnosis. Counselors should discuss **transphobia**, or discrimination against this community due to their nonalignment with cultural expectations, and also take a **trans-affirmative approach**, which involves the counselor adopting the role of an advocate by being involved politically, teaching the client how to advocate, and rallying for equal community resources.

2.6.3 Gerontological Clients

Gerontological counseling is an area of counseling tailored for individuals 65 years of age and older, an age group that continues to increase as a percentage of the U.S. population. In the year 2010, there were 36.2 million individuals 55 to 64 years, 21.4 million 65 to 74, and 13 million over 75 years old (U.S. Census Bureau, 2010c). Gerontological counselors must have the special skill set put forth by the Association for Adult Development and Aging (AADA) in the Gerontological Competencies.

- There are unique counseling considerations for those over the age of 65 years. Clients may present with terminal illness, grief and loss issues, physical challenges, and caregiver issues. Clients may be living alone, having an identity crisis, or experiencing **ageism**, which is discrimination based on one's age. In particular, this population may also have changes in memory and decreases in speed, attention span, and vision/hearing.
- Counselors must be able to distinguish between depression symptoms and aging issues to make the proper diagnosis and also must assess this high-risk population for suicidal intent. This population may have varying ideas regarding counseling, and the clinician should address them as needed.
- Counselors should respect the client, know diseases and normal aging processes, and be able to offer resources within the community to the client.

2.6.4 Adolescents

Adolescence occurs between 10 and 20 years of age and is a time of significant developmental transitions, including physical changes (e.g., hormonal changes and biological development affecting cognition and self-concept). In addition, the social self is very important during this time, with increasing value on peer groups for solidifying self-concept.

- Issues that may present when counseling adolescents include eating disorders, substance abuse, depression, anxiety, and behavioral problems (including sexually risky behaviors).

2.6.5 International Students

International students are those who leave their home country to pursue higher education in the United States. Over the past three decades U.S. higher education has experienced a notable growth in enrollment numbers to over 765,000. Students enrolling in U.S. institutions for the first time increased 6.5% between 2010 and 2010 (Institute of International Education, 2013).

- Counselors working with international students should be knowledgeable about difficulties in transitioning (e.g., language difficulties, discrimination, monetary issues, isolation, and cultural differences, culture shock, acculturation) and anything else that may hamper the efficacy of counseling. International students may suffer from depression, anxiety, and feeling powerless. Positive factors for these students include host-family bonds, desire to learn the native language, family support, and institutional support.
- **Culture shock** involves having to transition to a foreign environment by adjusting to the new foods, customs, language, and so on. Four phases of culture shock have been proposed (Pedersen, 1995):
  - ***Honeymoon Phase.*** Involves hopefulness, excitement, and captivation of the new culture.
  - ***Crisis or Disintegration Phase.*** Involves the individual being frustrated or let down by cultural aspects that were at first fascinating.
  - ***Reorientation and Reintegration Phase.*** Involves reintegrating into the new culture by viewing both the good and bad of the culture.
  - ***Adaptation or Resolution Phase.*** Feelings of belonging to multiple cultures and having a sense of well-being.
- As noted, acculturation occurs when an individual comes into contact with a new culture and experiences changes in their own beliefs or actions. Acculturative stress occurs when acculturation causes a person to decompensate either physically, mentally, or socially.
- Other stressors that international students might encounter include language differences that might affect academics and social functioning, racism, and lack of social support. Further, there may be additional stress toward the end of an academic career as individuals decide whether to remain in the host country after graduation.
- International students may not seek counseling for fear the government may find out about their issues and force the student to return home, may assume any somatic complaints are a physical problem only, or may perceive a stigma for seeking help.

2.6.6 Practice Multiple-Choice Items: Counseling Other Cultural Groups

1. Feelings of hopefulness and captivation of a new culture are part of the __________ phase of culture shock.
   a. Crisis
   b. Honeymoon
   c. Reorientation
   d. Resolution
2. A cultural group that typically deals with issues with eating disorders and sexually risky behaviors is
   a. international students.
   b. the elderly.
   c. transgender individuals.
   d. adolescents.
3. *Intersexed* is defined as an individual who
   a. is two-spirited.
   b. lives as the opposite sex without biological intervention.
   c. alters their biology.
   d. possesses both male and female genitalia
4. Some of the unique issues affecting __________ clients are grief, loss, physical challenges, and terminal illness.
   a. adolescent
   b. elderly
   c. transgender individuals
   d. international clients
5. Counselors should advocate for
   a. reparative therapy.
   b. acceptance of sexual minorities.
   c. pain therapy.
   d. conversion therapy.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** d; **3.** d; **4.** b; **5.** b.

2.7 CRISIS, TRAUMA, AND SPECIALIZED INTERVENTIONS

When a person experiences a crisis, the person is going through an intense time of distress when normal stress management and solution-finding skills are not adequate for the situation—that is, the perceived or actual stressors exceed perceived or actual resources. Although a crisis is considered short-term, a **trauma** consists of a longer-term crisis for which there is no resolution or balance of stressors and available resources. This section highlights various crises and traumas, including aggression, child abuse, intimate partner violence, and divorce and separation; it also provides treatment information for crisis intervention, trauma counseling, suicide intervention, conflict resolution, peer mediation, and addictions counseling.

2.7.1 Aggression

Aggression involves actions taken with the goal of inflicting harm. Aggression can be verbal, physical, or relational. *Relational aggression*, or harm within the context of a social group, is receiving increased attention in the counseling literature. Examples of aggression include verbal insults, hate crimes, physical injury, gossiping, and bullying.

- A **microaggression** involves an aggressive act against a minority, such as men and women of color. These acts

are not necessarily overtly violent but rather more insidious acts that build up and occur within everyday social interactions. Eventually, accumulated microaggressions lead individuals to feel they do not belong.

- **Violence** is a focused intent to cause harm. Violence may be premeditated or occur on the spur of the moment. It is thought that perpetrators of violence act out to deal with their feelings of anger, shame, and humiliation. Violence occurs in a series of steps, starting from the act of humiliation that causes an eventual perpetrator to feel disconnected from society around him; this leads to intense self-consciousness, then to destructive behaviors and ineffective boundaries.
- Warning signs of violence include (Thompson, 2004) feelings of rejection, history as a violence victim, disciplinary problems, fear of ridicule, academic problems, portrayal of violence in artwork or writing, serious threats of violence toward others, intolerance, gang membership, substance abuse, and access to a weapon.

2.7.2 Child Abuse

Although specific legal definitions range from state to state, the broad definition of **child abuse** involves harm to an individual under the age of 18 years, caused by either exploitation, neglect, or physical, sexual, or emotional abuse. The Child Abuse Prevention and Treatment Act (CAPTA) adds to the definitions list by including caregiver lack of action to combat and prevent possible or actual harm or death of one under the age of 18 years. Professional counselors are mandated to report suspected child abuse.

- **Neglect**, the most prevalent type of abuse, involves not taking care of a child's needs, either physically (e.g., food, housing, proper care/supervision), medically (e.g., not providing needed treatments), educationally (e.g., not supplying schooling or not enrolling a qualified student in special education), or emotionally (e.g., lack of affection or being around abuse and turmoil or substance abuse). An important distinction to note is that families who are financially unable to support themselves are distinguished from those who have the money but decide not to use it.
- **Physical abuse** involves causing injury and harm in the form of bruising; sprained muscles; broken bones; burns; cuts; being shaken, hit, or thrown; asphyxiation; and genital mutilation. This is the easiest type of abuse to show, and any injury caused to a child, regardless of motivation, is considered abuse.
- **Sexual abuse** involves any sexual activity with a child, even if there is no direct touching. This includes exposing oneself, exposing children to pornography, touching of genitalia (by adult to child or vice versa), intercourse, sexual assault, and sodomy. **Sexual exploitation** is defined as forcing a child into prostitution or pornography.
- Across abuse report types, there is approximately equal prevalence by gender, and approximately 55% of abuse victims are younger than 8 years old. Approximately 80% of known child abusers are parents (U.S. Department of Health and Human Services, 2007).

2.7.3 Intimate Partner Violence

Intimate partner violence (IPV), a predominant form of adult domestic violence, is defined as any behavior that is physically, emotionally, or sexually abusive in nature and used to gain authority over one's relationship with an intimate partner. Marriages, intimate relationships, families, and dating couples may experience domestic violence, as may heterosexual or same-sex couples. Women are victims more often than males.

- A cycle of violence may be noted in abusive relationships, including tension buildup; the actual abuse occurrence; and then the honeymoon phase, which occurs less and less frequently in abusive relationships as they progress.
- A risk factor for IPV survivors is previous abuse, often occurring in childhood. Other risks include lack of healthy self-esteem, low educational level, isolation from social supports, and lack of friends, family, and neighbors. Relationships with violence may have certain characteristics, such as strife or fighting within the marriage, a dominant male, low healthy functioning within the family, fostering of dependence emotionally, rigid adherence to traditional gender roles, and a need for control and authority. Inability to leave the situation may be due to fear for children and losing custody of them, intellectualizing abuser behavior, worry about employment, and lack of financial resources or shelter.
- Consequences of IPV for the survivor include physical injury, isolation, depression and anxiety symptoms, academic and occupational problems, risky behaviors (e.g., unprotected sexual activity, unwanted pregnancies, rape, and substance abuse), and eating disorders, to name a few.

2.7.4 Divorce and Separation

Separation is a legal process that allows couples to remain legally married while living separate lives. This often precedes **divorce**, which is the formal, legal termination of a marriage with no death of either individual involved. **Annulment** is the formal voiding of a marriage. Causes of divorce vary from extramarital affairs, irreconcilable differences, abuse, money, mood disturbances like depression or anxiety, and fighting to differences on how to raise the children, clashing personalities, ineffective communication, sexual incompatibility, and differing expectations of gender roles. Rich (2002) defined four phases of divorce:

- ***Shock and disbelief.*** Counselors can help clients talk about issues and reality testing.
- ***Initial adjustment.*** Can include practical adjustments to the first set of changes triggered by divorce, such as moving, family changes, and legal proceedings.
- ***Active reorganization.*** Occurs after finalization of legal proceedings and involves connecting with new

individuals for socialization, be it friends or perhaps a new romantic interest.

- ***Life reformation.*** Accepting and integrating one's former and current lives.

Children may be affected by divorce as well, and professional counselors should watch for changes in daily activities (e.g., eating, sleeping, interacting with others) and mental health issues (e.g., depression, suicidality, anxiety, academic difficulties, behavioral problems).

2.7.5 Crisis Intervention

Five forms of crises may warrant intervention from a professional counselor. These include (a) developmental crises (i.e., crises due to normal lifespan events such as childbirth, marriage, graduation, and aging); (b) environmental crises (i.e., those due to natural or human-made events such as an economic downturn, disease, natural disasters, famine, and fire); (c) existential crises (i.e., crises due to realizations concerning one's meaning and purpose in life that cause internal strife, conflict, or anxiety); (d) situational crises (i.e., those due to an unexpected circumstance outside of one's control, such as being fired, being a victim of a violent crime, or experiencing the death of a loved one); and (e) psychiatric crises (i.e., those due to substance abuse or issues with mental health). James and Gilliland (2013) outlined steps in crisis intervention:

- ***Define the problem.*** Discover how the client conceptualizes the event and to what extent it is perceived as a crisis and not simply an obstacle. Rely on Rogerian skills (see Chapter 5) and validate the client's point of view. Examine how serious the crisis is, the client's emotional state, any impairment to client behavior or cognitions, and any potential threats the client may exhibit to harm self or others.
- ***Ensure client safety.*** It is an ongoing process to ensure that both the client and individuals affiliated with the client are safe mentally and physically. Follow the ethical duty to report if harm to self or others is determined. Some basic universal actions that help ensure client safety are to be in touch with law enforcement, individuals in the medical field, and local child protective services (CPS) staff and to work toward creating a plan of action for the client to follow.
- ***Provide support.*** A counselor should provide support to the client in crisis regardless of what the actual event is or how the client's beliefs or worldview may differ from his or hers. Use skills such as unconditional positive regard and empathy.
- ***Examine alternatives.*** Help the client to make decisions he or she may find overwhelming or unable to make at the present time. Work with clients on a list of different ways to manage a situation and help them to choose the most appropriate action while making sure to empower, and not railroad, the client.
- ***Make plans.*** Do this after examining the alternatives. Help the client to discover a support system (e.g., among family, friends, community) and to come up with uplifting behaviors (e.g., exercise, journaling). It is important for the client to establish a sense of control by being involved in devising these plans.
- ***Obtain commitment.*** Ensure that the client will stick to the plan and commit to a reasonable action that begins to get life back on track.

2.7.6 Trauma Counseling

Trauma may result from a one-time occurrence, such as a violent crime or natural disaster, or from being in a prolonged stressful situation, such as combat or a chronic illness. Experiencing a trauma overwhelms an individual and steals power and control, resulting in helplessness and questions of purpose.

- Posttraumatic stress disorder (PTSD) symptoms can present in the primary victim of a trauma but may also present vicariously in secondary victims, or those who were not directly involved or who were merely bystanders. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychiatric Association, 2013) specifies symptoms of PTSD as hypervigilance; change in sleep patterns; intrusive thoughts; flashbacks; numbness; memory issues; avoiding places, triggers, or people that remind the individual of the trauma; mood disturbance; and problems with focus. These symptoms present soon after the trauma and last longer than a month.

Judith Herman, author of *Trauma and Recovery* (1997), believes healing from a psychologically traumatic situation occurs in three phases that are ongoing, and are not necessarily ever completed but rather integrated into one's life and sometimes reworked:

- ***Establishment of safety.*** Diagnosis, client empowerment to return control, and client opportunity for decision making are critical pieces of this first phase. Opportunities for prevention of symptom worsening and treatment of existing issues should occur. Complex PTSD may also present in this phase, often rooted in a repressed or long-lasting event, with symptomology including insomnia, eating disorders, interpersonal relationship issues, drug or alcohol abuse, and mood disturbances such as anxiety or depression. Reduction of isolation and ensuring the physical well-being of the survivor is important. Counselors should assess whether the threat of harm is past or still lurking in the future and come up with a safety plan. Counselors should also be aware of the need for a reduction in feelings of fear and should encourage the client to be aware that treatment for trauma is not a quick fix but rather a longer process requiring extended work. Every facet of an individual is affected by trauma, including behavior, cognition, physical presentation, social aspects, emotional aspects, and spiritual aspects. Crisis intervention, treatment of symptoms, and increasing client knowledge are key in this phase.

- ***Remembrance and mourning.*** This phase involves the client working with a counselor to tell the story of the trauma, to remember the details and make it more reality oriented and less surreal. The client should always maintain control and monitor any bodily symptoms that occur during this draining process. Particular attention should be paid to proper techniques and possible medications that are effective for the various symptoms present following a trauma. Individuals may seek to get even with the perpetrator of the event or resist mourning. If the survivor focuses on the perpetrator, however, then the focus of the survivor is always on the one who inflicted harm.
- ***Reconnection with ordinary life.*** Individuals in this phase begin to reintegrate into a more regular existence and find purpose in the new normal. Survivors may benefit from participation in groups focused on interpersonal relationships and groups that focus on where they want to be in the future. Outreach and advocacy also may be desired activities for the client.

2.7.7 Suicide Intervention

Taking one's own life, whether intentional or not, is **suicide**. Unintentional suicides occur when a cry for help results in accidental death, such as when a person takes many pills in the hope that friends and family will intervene.

- Most suicides occur within either end of the spectrum of life, meaning 35 years and younger or 65 years and older. Males are four times more likely to commit suicide than women, although women attempt suicide more often. Whites and Native Americans are the most likely races/ethnicities to attempt and complete suicide (Centers for Disease Control, 2011).

Professional counselors should do the following for suicidal clients:

- Assess clients for risk and immediate danger to self that would warrant hospitalization without delay within the least restrictive environment. Factors to look for involving immediate suicide risk include suicidal intent that is specific and in place for a long duration, active planning, and a very fatal suicide plan.
- Remove the method of harm delivery (e.g., pills, gun) and access to method (e.g., hanging). Supply a safe environment for the client until the risk is over.
- If the risk is very high and the client is not cooperative, *involuntary hospitalization* may be needed. *Voluntary hospitalization* is possible when the client agrees to go into a care facility for treatment.
- For less severe cases with less serious intent, counselors may help clients to create a check-in system with members of their social network to keep isolation to a minimum and/or engage the client in a *no suicide contract*, which clients sign in agreement to call a suicide hotline or other support source in the event of increased suicidal ideation or pain. Professional counselors only engage in contracting with those who understand exactly what the contract entails and will follow through with their commitment.

2.7.8 Conflict Resolution

Conflict resolution is the way individuals seek resolution to interpersonal differences and usually involves negotiating, mediating, facilitating, and arbitrating. The goal is to keep the risk of violent acts to a minimum. *Win-win* situations are the ideal ending to conflicts, providing a benefit to both parties. Conflict resolution begins with a discussion of what each person believes is the root of the issue and takes several forms:

- **Negotiation** involves compromise by involved individuals. **Power negotiations** occur when individuals vie to have the strongest influence on the outcome and may involve deceitful tactics such as relaying false information and cheating. **Rights negotiations** involve the legality of what is right and uses norms, policies, and rules. **Interest-based negotiations** involve the process of finding a commonality between the individuals involved. **Transformation-based negotiations** deal with promoting empowerment and recognition of involved persons. **Empowerment** elevates people's sense of what they can do and their personal value. **Recognition** deals with being able to connect to the situation and engage in true listening.
- **Mediation** is the use of an objective, uninvolved person to help with conflict resolution with the goal of working toward determining specific desires and good solutions. This may be a voluntary process or mandated by a court. (Section 2.7.9 provides more detail on peer mediation.)
- **Facilitation** is the use of counseling-related skills, especially in groups, to analyze the conflict, find compromise and solutions, and elicit commitment among individuals.
- **Arbitration** is the use of a third party to make decisions that resolve a conflict for the involved individuals. Arbitration may be binding, which means there is no extra legal action, or nonbinding, which warrants further action.
- **Med-arb** uses both mediation and arbitration. The objective individual listens to both sides, problem-solves to incorporate mediation, and then lets individuals make the final decision. It is often used for divorces or child custody cases, during which counselors may be called in to give their perceptions of the case.
- Not every form or technique will work for every client, so counselors should tailor their choices to each situation.

2.7.9 Peer Mediation

Peer mediation, used frequently in the school system, involves an objective third-party individual who helps individuals to negotiate, compromise, and problem-solve when issues arise. Peer mediation attempts to instill better conflict resolution skills in students.

- The three stages of peer mediation include (a) making operational decisions, (b) introducing the program to

stakeholders (e.g., faculty and staff), and (c) obtaining support for its use. Peer mediation is similar to mediation (see Section 2.7.7), which is when individuals come together to lessen conflict between two parties.

- Steps to peer mediation are as follows:
  - Supply a safe environment for each party to talk about their perception of the issue.
  - Get all individuals to look at what they consider the main problem, then strive to reach some commonality.
  - With all parties, develop a few ways to solve the problem and explain why each way is needed.
  - Help individuals to see each other's side or perspective.
  - Help individuals to come up with a compromise solution to the problem, and get a commitment from all persons to see the solution through.

2.7.10 Addictions Counseling

Valente (2009) defines **addiction** as "a preoccupation and dependence on a drug or process, resulting in increased tolerance, withdrawal, and repeated patterns of relapse" (p. 4). Individuals may be addicted to substances, either illegal or legal, which can be pills, alcohol, cigarettes, or caffeine, or they may be addicted to a process, which can be eating, being online, having sex, or gambling.

- Regardless of the type of addiction, being addicted has certain characteristics, including increased tolerance to the substance or process of choice, withdrawal symptoms, an unjustifiable compulsion for acting on the addiction (e.g., pills taken when not medically necessary), and previous attempts to decrease involvement level or quit entirely that have not met with success. A functioning impairment may occur economically, interpersonally, within the family, physically, on the job, and at school.
- Addictions counseling attempts to reduce the dependence of the person on the addiction by helping the person to stop engaging in addictive behaviors and then to reduce or eliminate relapses and impairment. Professional counselors may use various therapeutic techniques, provide coping skills, educate regarding addictions, and discuss a prevention plan concerning relapses with the client. This plan can include discussing the triggers that led up to the relapse and any emotions or environments that affected them. Twelve Step program attendance is typically encouraged in addictions counseling.
- Counselors also engage in **harm reduction**, which is the view that addiction is a health issue and that there are physical risks to abuse. Harm reduction and risk reduction are accomplished through education and managed use.
- Assessing an individual who is coming in for services requires taking a look at the client's willingness to change, access to medical and mental health services, current crises, and whether acute treatment such as detox or hospitalization in a psychiatric facility is needed. Biopsychosocial intake evaluations are often administered with a history of family, jobs, interpersonal relationships, schooling, medical needs, and so forth. Comorbidity may be present, meaning the individual has an addiction plus another disorder (i.e., dual diagnosis). Domestic violence may be of concern as well, so proper steps must be taken to ensure safety of all individuals involved. As always, a counselor should never practice outside of his or her competency range and if necessary should refer clients to practitioners with more expertise.

2.7.11 Practice Multiple-Choice Items: Crisis, Trauma, and Specialized Interventions

1. (A) __________ is an intense, generally short-term, time of distress in which a person's normal stress management skills are inadequate.
   a. Trauma
   b. Crisis
   c. Conflict
   d. Neglect
2. All of the following are considered forms of child abuse EXCEPT
   a. neglect.
   b. physical abuse.
   c. sexual abuse.
   d. separation.
3. Behavior that is used to gain authority over one's relationship with an intimate partner is
   a. neglect.
   b. trauma.
   c. sexual exploitation.
   d. intimate partner violence.
4. The use of an uninvolved person to help with conflict resolution is
   a. mediation.
   b. facilitation.
   c. negotiation.
   d. litigation.
5. Aggression can take the form of each of the following EXCEPT
   a. verbal abuse.
   b. hate crimes.
   c. bullying.
   d. alcoholism.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** b; **2.** d; **3.** d; **4.** a; **5.** d.

2.8 ADDITIONAL CONSIDERATIONS IN MULTICULTURAL COUNSELING PRACTICE

This final section highlights specialized theories that apply to cross-cultural populations: motivational interviewing, feminist theory, social identity theory, social influence model, and sociometry.

2.8.1 Motivational Interviewing

Motivational interviewing (MI), in contrast to the popular focus on pathology and a forceful confrontation-based model known as the **Minnesota Model (MM)**, takes a more respectful and person-centered, yet distinctly directive, approach used initially in addictions counseling. MI is heavily supported by research, unlike MM, which has much less supporting research in two main areas: first, what had previously been seen as client resistance to be conquered is now seen as a working part of the therapeutic relationship.

MI practitioners try to elicit awareness of incongruence between actions and goals (Lewis & Osborn, 2004).

- As MI is a briefer model focused on solutions, an acronym, **FRAMES**, was developed to guide timely and effective interventions (Lewis & Osborn, 2004):
  - ***F: Feedback.*** Give pertinent and immediate input on what is happening.
  - ***R: Responsibility.*** Clients are in charge of their modifications and should take ownership of the process.
  - ***A: Advice.*** Provide direction on client situations.
  - ***M: Menu.*** Offer a menu of various treatment opportunities.
  - ***E: Empathy.*** As MI is based on Rogerian principles (see Chapter 5), displaying this understanding is key.
  - ***S: Self-Efficacy.*** The client's perception of his or her ability to overcome challenges effectively is another important component of this model.
- Another acronym, which has its roots in MI, is **OARES**, which outlines MI techniques:
  - ***O: Open-Ended Questions.*** Open-ended questions will draw out more information from the client.
  - ***A: Affirm.*** Encourages the client to change behaviors.
  - ***R: Reflective Listening.*** Shows the counselor is tracking the client.
  - ***E: Elicit Self-Motivational Statements.*** To foster an environment in which the client can feel more comfortable changing and can make goals to move toward a desired behavior.
  - ***S: Summarize.*** Shows the counselor understands the client.
- When a client is leaning toward a decision to change, it is important that the professional counselor become more directive and proactive with the client.

2.8.2 Feminist Theory

Feminist theory, which began as a political movement, is generally concerned with equality of women. This theory is not heavily technique-laden, but rather promotes values taken from the areas of multiculturalism, politics, and social advocacy. Those who espouse a feminist viewpoint want equality for all individuals and are interested in eliminating sexism. Feminist-theory practitioners are critical of classical theories that typically analyze individuals from only the male perspective, and feminist clinicians also find fault with "gendercentric" psychological developmental models that operate on the assumption that males and females advance differently.

- Practitioners of feminist theory should be well aware of their values and should be able to have a cooperative, empowering relationship with the client, viewing them as an important and capable person in the process. Feminist theory does not focus on the pathology in a person but examines the social and political environment within which a person operates.
- The main beliefs of feminist theory include the following:
  - Males and females are equal politically, socially, and economically.
  - The patriarchal male oppresses women in society.
  - At root, people are political.
  - Rather than mental health issues and other difficulties being the result of pathology, the issues stem more from the skills a person uses to cope with their world.
  - Value-free therapy is not possible.
  - The counselor must establish a relationship that promotes equality between counselor and client.
- Several distinct phases exist within feminist doctrine:
  - ***Liberal feminism.*** This marks the beginning of the feminist movement in the 18th and 19th centuries when this view sprang to life in response to discrimination against women. Liberal feminism focuses on human rights and the desire to be treated, like men, as "rational" human beings. This movement touts accomplishments such as women's eventual participation in medical and mental health studies and also the incorporation of women into the voting population.
  - ***Radical feminism.*** Emerging in the 1960s and continuing through the 1980s, this particular phase focused on discrimination against women in capitalism, particularly white middle-class women, and was the building block for feminist therapy. A book written by author Betty Friedan (1963) entitled *The Feminine Mystique* brought awareness to feminism and sparked discussions worldwide. Also during this time period, birth control pills were introduced, enabling women to choose for themselves their path either to or away from motherhood.
  - ***Cultural feminism.*** Workplace environment, politics, sexual identity, and sexual harassment of women were the particular concentration of this movement, which began in the mid-1980s. In addition, females were studied to determine how their life experiences were distinct due merely to the fact that they are women. Cultural feminism looks at styles of management in the workplace as well, comparing them to male authority styles.
  - ***Women of color feminism.*** Promotes embracing all women regardless of the color of their skin.
  - ***Black feminism.*** Puts forth that African American women are the targets of both sexism and racism.
  - ***Social feminism.*** Focuses on the whole of society, which pertains to particulars such as women's roles

and careers, race, capitalism in a patriarchal context, socioeconomic status, ethnicity, culture, and the financial realm.
  - ***Ecofeminism.*** The beliefs that women understand the balance between humans and nature better than men do and that men hurt both women and the environment.
- Feminist counseling is concerned with empowering women to become more aware of their place in society and the various means through which success has been impeded. Women are not seen as being pathological in nature. This holistic counseling theory focuses on raising the quality of life and looks at many issues, such as oppression, body image, abuse, independence, power discrepancies, roles, and sexual identity.

2.8.3 Social Identity Theory

Based on social psychology, **social identity theory** was created to understand discrimination within groups. This theory puts forth the idea that people sort themselves into groups on the basis of similar characteristics, such as ethnicity or gender. The basis for social identity is categorization, identification, and comparison. Categorization refers to how social groups are labeled and assessed according to group member characteristics. Prestige, or social value, is identified by comparing persons against other groups, and then persons choose a group to identify with based on social comparison results.

- **Self-categorization** is an important piece of social identity theory. The "self" is seen as an object to be classified into membership in a social group that gives worth to the person. People are categorized into groups as a result of birth characteristics (e.g., sex, race); however, some group memberships are chosen.
- The **in-group** is the group to which an individual feels similar, and the **out-group** is the group to which the person feels least similar. The in-group is viewed positively, and the out-group is viewed negatively and may be the object of discrimination.
- Theories similar to social identity theory include the social identity theory of leadership, self-categorization theory, optimal distinctiveness theory, and the social identity model of deindividuation.

2.8.4 Social Influence Model

The **social influence model** was created by Stanley Strong (1968) and encompassed two counselor pieces: (a) *credibility* or the expertise and trustworthiness of the counselor and (b) *interpersonal attractiveness*, or how the counselor shows the client that the counselor likes and has commonalities with him or her. This theory, based on social psychology, asserts that if counselors are viewed as having expertise and being attractive, they will have greater influence on the client.

- Increasing client perceptions of counselors' expertise can be done by showing proof of expertise by displaying credentials, behaving competently, and having a solid reputation.
- Trustworthiness can be increased by being honest and open. Attractiveness can be increased when the client feels commonalities exist between client and counselor, which is primarily accomplished through appropriate self-disclosure.

2.8.5 Sociometry

Sociometry gauges the extent of relationship among people or groups, or how people relate to one another, via a **sociogram**, which is a scientific, visual way to analyze and display these relationships. Sociometry was developed by Jacob Moreno.

- Two important principles for scientific testing of sociometry are spontaneity, which is the appropriate response to new situations, and creativity, which interfaces with spontaneity. Most persons have varying levels of these two factors; rarely are they equal.
- Methodology and technique in sociometry vary. Sociograms may be used to see connections or disconnections among individuals, using arrows and symbols, and can be reanalyzed to discover any progress.
- A *near-sociometric test* is conducted in a hypothetical situation and will have no action taken following the results. A **sociometric test** studies actual behavior, as opposed to *psychometric tests*, which infer ideas from similar behaviors. Researchers should know that reliability and validity of sociometric tests are not thought of in the traditional sense.

2.8.6 Practice Multiple-Choice Items: Additional Considerations in Multicultural Counseling Practice

1. The social influence model espouses that a counselor should have __________ for maximum influence.
a. equity
b. creativity
c. spontaneity
d. credibility

2. Two forms of feminism are women of color feminism and Black feminism. What is the difference between the two?
a. There is no difference.
b. Women of color feminism embraces all women, regardless of color, and Black feminism focuses mainly on the oppression of African American women.
c. Women of color feminism embraces all women except Caucasians, and Black feminism was the main movement in the 1980s and focused on career.
d. Women of color feminism focuses on the oppression of African American women, and Black feminism embraces all women, regardless of color.

3. Motivational interviewing is mainly based on a Rogerian counseling style, but
a. is also directive.
b. focuses heavily on transference and countertransference.

c. is highly confrontational.
d. focuses on the source of problems.

4. Each of the following is correct concerning the acronym OARES, from motivational interviewing, EXCEPT
a. O = Open-Ended Questions.
b. A = Action.
c. R = Reflective Listening.
d. S = Summarize.

5. Motivational interviewing has been primarily used in
a. addictions counseling.
b. feminist counseling.
c. supervision.
d. sociometry.

Click here to take an automatically-graded version of this self-check quiz.

Answer Key: **1.** d; **2.** b; **3.** a; **4.** b; **5.** a.

2.9 KEY POINTS FOR CHAPTER 2: SOCIAL AND CULTURAL DIVERSITY

- Social and cultural diversity, or multiculturalism, is an important consideration of the counseling relationship, as all counselor–client pairs are multicultural in some manner. The degree to which all counseling is considered multicultural depends on how broadly culture is defined.
- Multiculturalism is considered the fourth force of counseling, whereas social advocacy is considered the fifth force of counseling.
- Being familiar with the tripartite model of counseling and working to facilitate one's multicultural counseling competency is an ethical imperative.
- The three components of the tripartite model are counselor awareness of one's own cultural values and biases, counselor awareness of the client's worldview, and culturally appropriate intervention strategies. Each of these components is described in terms of attitudes and beliefs, knowledge and skills.
- Communication patterns are significant cultural considerations. Although traditional counseling theories and interventions rely heavily on verbal communication, nonverbal communication is the predominant form of communication across cultures. Counselors must be aware of types of nonverbal communication, including context communication, paralanguage, kinesics, chronemics, and proxemics.
- Worldview has been conceptualized primarily in two ways: (a) the intersection of locus of responsibility and locus of control and (b) the combinational features of views of human nature, relationship to nature, sense of time, activity, and social relationships.
- Each cultural group has an underlying power structure imbued with oppression experiences: racism for race, ethnocentrism for ethnicity, classism for socioeconomic status, sexism for gender, heterosexism for sexual orientation, ableism for ability status, and so forth.
- Several forms of racial prejudice can occur in multicultural counseling and include color blindness (ignoring race), color consciousness (focusing predominantly on race), and colorism (more favorable treatment of those with lighter skin).
- Research indicates that androgyny, or the combination of masculine and feminine characteristics, is the most psychologically ideal.
- The major types of world religions are Buddhism, Christianity, Confucianism, Hinduism, Islam, Judaism, and Taoism.
- Social justice involves the belief that individuals are to advocate for others to address issues of cultural privilege and oppression. It includes four components: equity, access, participation, and harmony.
- Individuals can be oppressed by having experiences or labels imposed on them or by being deprived of experiences or labels. Three levels of oppression are primary (individual acts of oppression), secondary (benefits individuals receive based on others' acts of oppression), and tertiary (internalized oppression).
- Racism can be overt or covert, intentional or unintentional, and occur at three levels: individual, institutional, and cultural.
- Resilience is an important characteristic to assess for and foster in individuals who experience oppression.
- For each cultural group that constitutes our identity, there is likely an identity development process. Identity development processes occur within social interactions with others who both identify with the cultural group membership and those outside of the membership.
- Individuals experiencing various identity development processes typically go through the following statuses: unawareness/denial, conflict/anxiety, retreat into own group and cautious interaction, integration of one's cultural identity with other identities and factors, and advocacy.
- Cross published the first racial identity development model, and Helms's White and people of color racial identity development models are the most widely cited.
- Gender identity development models tend to focus on women becoming aware of sexism and working to eliminate it in society.
- Cass's sexual identity development model is well known and has been expanded to examine social and environmental processes for individuals of all sexual orientations.
- The prominent racial/ethnic groups in the United States are (from largest to smallest) Whites/European Americans, Latin Americans, African Americans, Asian Americans, Multiracial Americans, Native Americans, and Arab Americans.
- Some of the common cultural values across racial/ethnic groups involve the concepts of family, gender roles, time orientation, harmony with nature, communication patterns, and spirituality.
- International students face culture shock and acculturative stress, which affects their psychological and academic functioning.

- A crisis is an intense time of distress during which perceived resources are insufficient to deal with perceived or actual stressors. Some methods for intervening in crises include defining the problem, ensuring safety, providing support, examining alternative actions, making plans, and obtaining commitment from the client.
- A trauma seems to be more pervasive than a crisis, with long-term psychological consequences likely involving PTSD symptoms. The three stages associated with trauma recovery are (a) establishing safety for the survivor, (b) remembering the trauma and mourning associated losses, and (c) reconnecting and finding meaning.
- Child abuse and intimate partner violence are two prominent trauma experiences. Child abuse involves child neglect (e.g., not caring for a child's physical, educational, or emotional needs), physical abuse (e.g., physical injury, genital mutilation), and sexual abuse (e.g., direct touching, sexual exploitation, exposure to sexually inappropriate material).
- Intimate partner violence tends to follow a cycle, beginning with tension building, the abuse or battering incident, and then the honeymoon phase.
- The five major forms of conflict resolution are negotiation, mediation, facilitation, arbitration, and mediation-arbitration (med-arb).
- Addictions counseling involves several interventions, including Twelve Step self-help groups, motivational interviewing, harm reduction methods, relapse prevention, and family and group counseling.
- Some of the primary principles of feminist theory are that (a) personal matters are political endeavors that promote equity, particularly among genders, (b) sexism exists in society as evidenced in a patriarchal system, and (c) the counseling relationship should be collaborative and egalitarian.