

Counselor Ethics: CACREP Student Learning Objectives
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This article addresses several Student Learning Objectives (SLO) required in Ethics and Professional Orientation courses that are offered in training programs accredited by the Council for the Accreditation of Counseling and Related Education Programs (CACREP; 2008). The Appendix contains a list of CACREP Clinical Mental Health Counselor (CMHC) Standards addressed in the Richmond Graduate University's course titled CED 6123 (Ethical, Legal, and Professional Standards in Professional Counseling and Marriage and Family Therapy).

History and philosophy of the counseling profession (CACREP II.G.1.a.)

On October 4, 1957, the course of history changed when the Union of Soviet Socialist Republics (U.S.S.R.), commonly known as the Soviet Union, successfully launched the world's first artificial satellite. Sputnik I was about the size of a beach ball and took about 98 minutes to orbit the Earth on its elliptical path. Prompted by the launch of this satellite, people in the United States (U.S.) feared that education in the U.S.S.R. was superior to public education in the U.S. At that time, the majority of U.S. engineers, mathematicians, and scientists went into relatively well paying jobs in private industries rather than becoming teachers in public schools, a trend that caused concern that the U.S. was not training the next generation of engineers. As a result, the U.S. Congress reacted by enacting the National Defense Education Act (NDEA), which gave additional funding to schools and resulted in increased hiring of school counselors needed to help guide more students into courses related to mathematics and science. The legislation was signed into law by President Dwight Eisenhower on September 2, 1958. Title V of the federal law included provisions for the training of guidance counselors and the implementation of testing programs to identify gifted students. As a result, the school counseling movement was born.

On April 25, 1961, only four years after the launch of Sputnik I, the Soviet cosmonaut Yuri Gagarin became the first human in space, an event that further embarrassed the U.S. Within a month (May 25, 1961), the U.S. responded when President John F. Kennedy announced before a special joint session of Congress the goal of sending an American safely to the Moon before the end of the decade. On July 16, 1969, Apollo 11 was the first spaceflight that landed the first two humans on the Moon, resulting in the U.S. proclaiming itself winner of the space race that the U.S. had begun eight years earlier.

It was during the decade of the space race that a federal law was passed that helped to ensure the future employment of thousands of mental health professionals. On October 31, 1963, President Kennedy signed into law the Mental Retardation and Community Mental Health Centers Construction Act of 1963, also known by its shorter name, the Community Mental Health Act (CMHA). This federal law drastically altered the delivery of mental health services and inspired a new era of optimism in mental healthcare. By creating employment opportunities, the Community Mental Health Act was associated with growth in the fields of clinical psychology, clinical social work, and eventually, clinical mental health counseling. Although only half of the proposed mental health centers were ever built and none were fully funded (i.e., the act didn't provide money for long-term operations), the law led to deinstitutionalization of thousands of

mentally ill people who had been confined in state hospitals. For example, Milledgeville State Hospital, which was legislatively created in Georgia as a State Lunatic, Idiot, and Epileptic Asylum in 1837 and 130 years later renamed as Central State Hospital (1967), reached its peak census of 12,205 patients in 1965 as the world's largest insane asylum (Cranford, 1981). One of the goals of deinstitutionalization was reached in 2010, when the Georgia Department of Behavioral Health and Developmental Disabilities announced that the hospital would be closed to mental health patients (although the facility continues to care for adults with developmental disabilities, those in their nursing home, and those in the maximum security forensic unit).

Marcus Mosiah Garvey (1887-1940), a Jamaican political leader, publisher, journalist, entrepreneur, and distinguished orator, is often quoted as having said, "A people without the knowledge of their past history, origin and culture is like a tree without roots." The field of counseling has several roots in its history and has continued to change and develop its identity since its origins a century ago. One of the predecessors of the American Counseling Association (ACA), the National Vocational Guidance Association (NVGA), was founded in 1913 as the first career-guidance organization in the U.S. On its official website (<https://www.counseling.org/>), the ACA cites its own history as follows:

Four independent associations convened a joint convention in Los Angeles, CA in 1952: The National Vocational Guidance Association (NVGA), the National Association of Guidance and Counselor Trainers (NAGCT), the Student Personnel Association for Teacher Education (SPATE), and the American College Personnel Association, in hopes of providing a larger professional voice. They established the American Personnel and Guidance Association (APGA), later changing names in 1983 to the American Association of Counseling and Development. On July 1, 1992, the association changed its name to the American Counseling Association (ACA) to reflect the common bond among association members and to reinforce their unity of purpose. (ACA, 2018, p. 1)

In contrast to other mental health professions, which place more focus on the diagnosis and treatment of mental, emotional, and behavioral disorders, an underlying philosophy of the counseling profession involves a *wellness model*. As summarized by Myers and Sweeney (2007, p. 1), "Wellness is both a dynamic process of physical, mental, and spiritual optimization and integration and an outcome of that process." The first model of wellness-based counseling was probably the Wheel of Wellness developed by Sweeney and Witmer (1991) and Witmer and Sweeney (1992).¹ In their review of the literature from multiple disciplines, Myers, Sweeney, and Witmer (2000) concluded that wellness is

a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

The primary goal of the counseling profession is to help people accomplish wellness (Corey, Corey, Corey, & Callanan, 2015; Corey, Corey, & Cory, 2018; Remley & Herlihy, 2016). Counselors share with other mental health professionals the belief that primary prevention and early intervention are the most appropriate means in dealing with emotional and personal

problems. Implicit in the wellness model is an underlying assumption that the role of a counselor is to empower others to problem-solve independently. The wellness model of counseling is different from a more traditional clinical model of treatment. For example, with respect to working with clients with impairments, a clinician operating from a clinical perspective would focus on factors such as the diagnosis that is associated with the disability, the severity of the disability and the degree of impairment it may entail, and the treatment of the disability from a cultural and multidisciplinary clinical perspective. In contrast, when providing counseling to a client with severe physical and communication deficits, a counselor operating within a holistic and psychosocial model of health and wellness would acknowledge, embrace, and empower the abilities and strengths of their clients.

The term *professionalism* is usually associated with development of a professional identity; development of a professional code of ethics; formation of professional associations, credentialing bodies, and state regulatory boards, and involvement in prolonged political advocacy to create legislation. In 1975, the Commonwealth of Virginia passed the first regulatory act for professional counselors, and the state law was revised in 1976 to license counselors. Ten years later, the Georgia General Assembly passed Code 1981, § 43-7A-4 (currently enumerated as § 43-10A-4), enacted by Ga. L. 1984, p. 1406, § 1, which created the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. The members first appointed to the board under this chapter served their initial terms of office beginning September 1, 1985. The Georgia board issued its first counselor licenses on December 15, 1986. On October, 11, 2009, then California Gov. Arnold Schwarzenegger signed California Senate Bill 788 into law, making California the 50th and final state (along with the District of Columbia and Puerto Rico) to license professional counselors. California began regulating the practice of marriage and family therapy (MFT) in 1963² as a consumer protection. Prior to the establishment of counseling as a profession in California, people who wanted to provide mental health counseling pursued the MFT license, those who wanted to do school counseling earned the Pupil Personnel Services credential, and those who wanted to do career or rehabilitation counseling could practice without a license. With the 2016 passage of California Code of Regulations (CCR) §1820.7 (http://www.bbs.ca.gov/bd_activity/law_reg.shtml), California Licensed Professional Clinical Counselors (LPCC) are still in the process of defining their scope of practice (http://www.bbs.ca.gov/consumer/what_is.shtml).³

A professional license is not the same as a *business license*, known as an Occupational Tax Certificate. In most local jurisdictions, corporations and independent practitioners are required to have a business license, which expires on December 31 and which is renewed on January 1 of each year (usually with a 90 day “grace” period). In contrast to corporations or independent practitioners, employees of corporations (including non-profit corporations) are not required to have a business license (because the corporation pays the occupational tax based on the number of employees. Local jurisdictions include counties and incorporated cities within a county, in which case a city usually trumps a county. For example, a business in unincorporated Fulton County would apply for a Fulton County Occupational Tax Certificate, whereas a business in the City of Sandy Springs (which is located in Fulton County) would apply to the City of Sandy Springs. A business operating in several jurisdictions would be required to apply for business licenses in multiple jurisdictions (with the exception of businesses that operate on the basis of a state license). Fees (i.e., the occupational tax) for business licenses in most jurisdictions range

from as low as \$100.00 to as high as a few hundred dollars (based on gross receipts). Many urban cities have a flat rate professional license which, with the exception of high volume counseling practices, involves fees that are higher than if calculated on the basis of gross receipts. For example, the flat rate tax for professionals in the City of Sandy Springs, Georgia, would be approximately \$400.00, whereas a professional operating a business with less than \$100,000.00 annual gross receipts could submit a worksheet with calculations that could result in an occupational tax of less than \$200.00.

Professional roles, functions, and relationships with other human service providers, including strategies for interagency/interorganization collaboration and communications (CACREP II.G.1.b.)

During the 1990's, as medical practices and hospitals began transitioning to computerized storage medical records, there were increasing concerns about the security of records in these systems. Along with these concerns, some lawmakers were raising questions about whether or not people should be able to keep their health insurance when they lost their jobs. As a result of these concerns, Senator Ted Kennedy and Senator Nancy Kassebaum introduced a bill in Congress. Originally known as the Kennedy-Kassebaum Act, the name was changed to the Health Insurance Portability and Accountability Act (HIPAA; Pub. L. 104-191, 110 Stat. 1936). HIPAA was enacted on August 21, 1996 when President Bill Clinton signed the legislation into law. The act required the Secretary of Health and Human Services (HSS) to create standards that would protect individual health information by August 21, 1997. On September 11, 1997, the Secretary of Health and Human Services (HHS) submitted a report for review by Congress with a deadline of August 21, 1999. After Congress failed to meet that deadline, the HHS Secretary published the proposed standards in the *Federal Register* on November 3, 1999.

By August of 2000, the HIPAA Transaction and Code Sets Final Rule was Published, creating industry-wide standards for health data so that if data were exchanged, the same codes and identifiers would be used across all domains. The HIPAA Privacy Rule was first proposed on November 3, 1999 with the HIPAA Final Privacy Rule of HIPAA enacted on December 20, 2000, although corrections were made almost immediately.

In December of 2000, the HIPAA Privacy Final Rule was published. The Privacy Rule protected all information relating to an individual related to health, including (but not limited to): name, address, demographic, health plan numbers, photographs, social security numbers and email addresses. The act also requires the patient's signature to release any information except for treatment, payment, and health care operations. Compliance for the Transaction and Code Sets Final rule was set to October 15, 2002 (unless an extension was requested for 2003). Compliance for the Privacy standards was set for April 14, 2003, which was when HIPAA began to be implemented. April 14, 2003 is considered the most important date because this date was when HIPAA-covered entities were required to comply with the HIPAA Privacy Rule (When was HIPAA enacted, 2018).

The introduction of the HIPAA Enforcement Rule in 2006 gave the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) the power to enforce HIPAA. Since that time, HHS has had the authority to pursue financial penalties for non-compliance with HIPAA Rules. Depending on the severity of the violation, based on a four-tier system, each violation of HIPAA can cost from \$100.00 to \$50,000.00 depending on whether the violation occurred due to mistakes that would have been fixed had the party known its mistakes, or if it was due to willful neglect (HIPAA fines listed by year, (2019)). Criminal penalties can also be imposed if a party knowingly violates HIPAA, with penalties ranging from \$50,000.00 and one year in prison for minor infractions, up to \$250,000.00 and 10 years in prison if the information was intended to be sold, transferred, or used for personal gain or harm.

In February 2009, an additional provision was added to HIPAA as part of the American Recovery and Reinvestment Act. This provision, known as the Health Information Technology for Economic and Clinical Health (HITECH), made it necessary for entities to disclose when a breach occurred to those whom the breach affected. For example, HIPAA-compliant entities (e.g., hospitals, insurance companies, and practitioners) must HITECH also gave a hospital or practice 60 days to notify individuals of the breach.

HIPAA law provides federal oversight and regulation of hospitals; insurance companies; health maintenance organizations (HMO) managed care organizations (MCO); and any agency that creates, stores, or transmits personal health information (PHI). HIPAA also applies to health care professionals such as physicians, psychologists, mental health counselors, and other professionals who store or transmit PHI. The Family Educational Rights and Privacy Act of 1974 (FERPA) applies to public educational institutions and any private or parochial educational institutions that receive federal funding. There are some institutions that must comply with both HIPAA and FERPA. For example, the requirements of both sets of federal laws must be met by state university counseling centers that provide guidance counseling to students while also providing health care to students at the university.

Mental health counselors working within systems such as HMOs and MCOs may face unique ethical challenges. Corey et al. (2015) emphasize that the financial incentives inherent in managed care may tempt both the payer and the practitioner to engage in unethical practices. For example, managed care counselors may be asked to breach confidentiality by giving case reviewers too much personal information about clients. Another dilemma is sometimes created when a counselor is required to justify continued care by providing additional clinical information, which can then be used by the MCO to limit the amount of authorized care. When working with managed care clients, and especially when employed by HMOs that do not allow clients to continue receiving services beyond those authorized as clinically necessary by their case managers, a counselor's first step with clients involves creating and managing realistic expectations from the outset. For purposes of cost-containment and to maximize corporate profits, HMOs and MCOs narrow the client's choice of therapists, rely on less qualified providers to provide care, and use less qualified providers to conduct utilization reviews (UR) of care. Based on short-term treatment models, managed care companies limit and even deny access to long-term care. Because corporations typically base their practices on business ethics rather than professional ethics, therapists working for such corporations may find themselves in ethical quandaries. When faced with an ethical dilemma, a counselor is advised to consult with an

experienced colleague. When it appears that there is a conflict between an ethical and legal course to follow, a counselor's first course of action should be to consult with an attorney and a colleague (or a supervisor for trainees).

Asking a mental health counselor for legal advice can be more costly than asking an attorney for mental health counseling. Although it is always wise to obtain ongoing consultations with respected colleagues, who can discuss clinical and ethical aspects of cases, mental health professionals do not practice law nor can they provide privileged attorney-client consultations. When choosing an attorney for a consultation or for representation in a matter related to professional practice, licensure, or liability, choose one with appropriate education, training, and experience. For counselors-in-training and under supervision, a good place to start would be one's clinical supervisor, because the supervisor is ethically and legally responsible for the work of the supervisee. Clinical supervisors are familiar with attorneys with whom they have obtained legal advice. Another resource would be a State Bar Association, assuming that the attorney chosen has specific experience consulting with mental health professionals. The [State Bar of Georgia](#) is the mandatory bar association of lawyers admitted to practice in Georgia. Many national and State Professional Associations offer Legal Service Plans, which require annual fees that are quite reasonable when compared to the usual and customary hourly rates of the attorneys who provide consultations for members enrolled in the plans. In a very limited sense, these plans might be figuratively compared to "legal insurance" although they do not actually provide any indemnification of the member nor do they provide any real insurance in the true meaning of the term. In contrast, professional liability insurance carriers do provide a type of insurance and, not surprisingly, these carriers often have attorneys who provide legal consultations to insureds. It makes sense from a risk management perspective, because the liability insurance companies do not want claims filed against their insureds in the first place. In the event that a claim is filed, these same companies can provide representation and defense.

Homan (2016) offers a useful framework of choices for counselors who identify and recognize a perceived ethical violation or problem situation in an agency, system, or institution. This model can be useful for counselors working within managed care systems. Counselors can (1) change their perception by identifying the situation as acceptable, (2) recognize the situation as unacceptable and adjust themselves to the situation, (3) recognize the situation as unacceptable and do what they can do to change it, (4) or leave the situation, either by emotionally withdrawing or by physically leaving the agency or institution. As applied to working with managed care organizations (MCO), which are based on a business model of limiting the number of sessions that are paid by the client's underlying health insurance, counselors have at least four options: (1) viewing the situation as a reality within which counselors must maintain an ethical form of practice (accepting the acceptable), (2) recognizing the situation as unacceptable but learning to adapt (accepting the unacceptable), (3) filing appeals or joining an internal committee to change policies (changing the situation), and (4) providing a lawful notice of termination of the contractual relationship (withdrawing).

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 (CACREP II.G.1.c.)

Over 50 years ago, the American Psychiatric Association (1964) published *First Aid for Psychological Reactions in Disasters*, which foreshadowed more contemporary models of psychological first aid. By the 1970s, one important concept has included crisis intervention, which refers to the immediate and usually short-term psychological intervention that is focused on the two-fold process of assisting individuals in a crisis situation in (1) restoring equilibrium to their biopsychosocial functioning and (2) minimizing the potential for long-term psychological trauma (Aguilera, 1998; Jackson-Cherry & Erford, 2010). Over the subsequent decades, other disaster and trauma concepts have emerged, such as combat stress injury (CSI), incident command system (ICS), psychological debriefing (PD), critical incident stress debriefing (CISD), critical incident stress management (CISM), vicarious traumatization, compassion fatigue, and compassion satisfaction.

In response to the aftermath of the destruction of the World Trade Center in September 11, 2001, and in a collaboration between the American Red Cross and the American Counseling Association, counselors and other mental health professionals have volunteered their time in various local crises such as hurricane devastation, terrorist attacks, university shootings, and so forth. During this time, counselors and organizations of trauma professionals raised concerns over the depth and quality of counselors' disaster response preparation. Because counselors have an ethical responsibility to practice disaster response and trauma counseling only to the extent of their competence, counseling training programs have increasingly focused on better preparing mental health counselors for future demands that may be made on them.

Webber and Mascari (2009) have proposed six general guidelines to assist in ensuring compliance with CACREP (2008) standards related to competence in this area of practice. In order to integrate CACREP standards into training program objectives and course syllabi, these guidelines emphasize that counselor educators should know relevant organizations and government agencies and their purposes; understand the major principles of disaster response, trauma counseling, and crisis intervention; and understand the differences among these principles. For example, CISD was originally designed in 1983 by Jeffrey Mitchell (Mitchell, 1983; Mitchell & Everly, 1997; Mitchell, 2003). It is defined as "a specific, 7-phase, small group, supportive crisis intervention process" (Mitchell, 2008, p. 1). It is not considered a form of psychotherapy nor a substitute for psychotherapy. Instead, it is primarily designed for small, homogeneous groups who have encountered a powerful traumatic event (e.g., a flight crew who experienced an emergency landing of their commercial aircraft). The goal of CISD is designed to reduce distress and restore group cohesion and unit performance.

The American Red Cross (ARC) provides immediate response each year to more than 70,000 disasters, primarily fires and floods (<http://www.redcross.org/>). Founded by Clara Barton on May 21, 1881, the ARC is dedicated to serving people in need. Under the United States Department of Homeland Security, the Federal Emergency Management Agency (FEMA) is the government agency responsible for managing all phases of disasters from intervention through recovery. FEMA's online and certified on-site courses in trauma and disaster include Incident

Command System (ICS 100) and National Incident Management System (NIMS 700), which are often required for participation in state or federal disaster mental health response.

The Green Cross Academy of Traumatology's (Green Cross) mission is "to accredit training sites throughout the world, to certify traumatologists throughout the world, and to deploy traumatologists when and where requested throughout the world" (<https://greencross.org/>) through the Green Cross Assistance Program. Green Cross describes itself as "an international, humanitarian assistance, non-profit corporation, established in 1997 to bring together world leaders in the study of traumatology for the purpose of establishing and maintaining professionalism and high standards in the care of trauma victims and responders throughout the world" (<https://greencross.org/>). In responding to victims of trauma, Green Cross has developed a four-wave deployment process:

- Wave I (Days 1 – 10 following disaster): Crisis stabilization, mobilization of local Green Cross members in the vicinity of the disaster
- Wave II (Days 5 – 15): Stress management, social support, orientation of management
- Wave III (Days 10 – 20): All of the above, plus training, assessment, referral, and family resource development
- Wave IV (Days 15 – 40): All of the above, plus grief and loss counseling

The Association of Traumatic Stress Specialists (ATSS; 2016) describes itself on its website (<http://www.atss.info/>) as a worldwide "professional membership organization of individuals engaged in and committed to excellence in trauma services, response, and treatment." ATSS members provide services and treatment to victims of abuse, crime, disasters, terrorism, and war. According to the Mission Statement in the ATSS Code of Ethics, its mission is to organize, educate and professionally certify its worldwide membership in order to assist those affected by trauma.

The International Society for Traumatic Stress Studies (ISTSS) is an international, multidisciplinary, professional membership organization that promotes advancement and exchange of knowledge about severe stress and trauma (<https://www.istss.org/>). Post-traumatic stress can be associated with a variety of traumatic experiences such as child abuse, domestic violence, physical assault, terrorism, motor vehicle accidents, workplace accidents, and reactions to grief. Counselors interested in increasing their understanding of various types of post-traumatic stress may be interested in resources such as info-trauma's website (<http://www.info-trauma.org/en/about>), which includes examples of different kinds of symptoms and the impact they may have on an individual's behavior.

Self-care strategies appropriate to the counselor role (CACREP II.G.1.d.)

There are several dimensions of competence that are important in counseling. *Technical competence* is based in part on *knowledge* (the accumulation of information) and *proficiency* (the ability to apply knowledge to real life situations). In other words, technical competence requires knowledge ("in the head") and skills ("with the hands"). In contrast, *emotional competence* refers to one's emotional, psychological, and interpersonal functioning, which are often (albeit

sometimes inaccurately) assumed to be intact in anyone capable of functioning as a mental health professional (Doverspike, 2015). Stress (occupational and otherwise) can lead to distress, which can lead to loss of emotional competence, which can lead to impairment (often associated with the degree and duration of distress). *Occupational burnout*, which is usually considered to be the result of long-term and unresolvable job-related stress, represents a loss of emotional competence.

According to the *Oxford English Dictionary* (2014), the term *workaholic* first appeared in Canada as a satirical reference in the April 5, 1947 edition of *The Toronto Daily Star*: “If you are cursed with an unconquerable craving for work, call Workaholics Synonymous, and a reformed worker will aid you back to happy idleness.” In the fields of pastoral counseling and psychotherapy, the term *workaholic* is attributed to Wayne Oates, Ph.D. (1917-1999), who was a professor of psychology of religion and pastoral care at Southern Baptist Theological Seminary in Louisville, Kentucky. Popularizing the term in the title of his book, *Confessions of a Workaholic*, Oates described workaholism as “the compulsion or the uncontrollable need to work incessantly” (Oates, 1971, p. 11). Psychotherapist Bryan Robinson (2014), who has been described as one of the world’s leading experts on workaholism (Wright, 2016), differentiates two axes of workaholism: work initiation and work completion. Describing four major styles that may involve a blending, combining, or alternating of styles, Robinson associates workaholism with the behavior of procrastination. *Savoring workaholics* are those with low work initiation and low work completion, *attention-deficit workaholics* are those with high work initiation and low work completion, *bulimic workaholics* are those with low work initiation and high work completion, and *relentless workaholics* are those with high work initiation and high work completion.

In 1974, the German-born American psychologist Herbert Freudenberger (1926-1999) coined the term *burnout* when he became the first researcher to publish in a psychology-related journal a paper that used the term. Freudenberger’s paper was based on his observations of the volunteer staff (including himself) at a free clinic for drug addicts. He characterized burnout by a set of symptoms that includes exhaustion resulting from work’s excessive demands as well as physical symptoms such as headaches and sleeplessness, closed thinking, and “quickness to anger.” He observed that the burned out worker “looks, acts, and seems depressed” (p. 161). After the publication of Freudenberger’s original paper, interest in occupational burnout grew. In 1980, Herbert Freudenberger and Géraldine Richelson wrote the best selling paperback book titled *Burnout*. Because the phrase “burnt-out” was part of the title of a Graham Greene (1961) novel, *A Burnt-Out Case*, which dealt with a doctor working in the Belgian Congo with patients who had leprosy, the phrase may have been in use outside the psychology literature before Freudenberger employed it. Freudenberger’s contribution to the literature was in part forged by some of the early experiences in his life. When Hitler came to power in Germany in 1933, seven year old Hebert was sent to the United States, with his parents’ approval and false passport in hand. Traveling alone through multiple cities and countries, Freudenberger arrived in New York where he cared for himself until he was taken in by a relative.

Joinson (1992) coined the term *compassion fatigue* to describe the “loss of the ability to nurture” that was noted in some nurses in emergency department settings. For health professionals, compassion fatigue arises when providers have close interpersonal contact with a suffering

patient and their emotional boundaries become blurred to the point that the caregiver unconsciously assimilates the distress experienced by the patient (Bush, 2009). The internalization of patients' adversity may result in the healthcare professionals' feelings of self-blame, futility, or impotence, especially if these scenarios occur repeatedly over time. Figley (1995) subsequently identified compassion fatigue as a more user-friendly term to describe secondary traumatic stress disorder (STSD), an outcome of counter-transference whereby empathic caregivers indirectly experience the trauma of their patients. As Figley (1995) continued to observe this phenomenon in mental health workers, he explained: "There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care. Sometimes we feel we are losing our own sense of self to the clients we serve" (p. 1).

Self-care involves searching for positive life experiences that lead to zest, peace, excitement, and happiness (Skovolt, 2001). Myers, Sweeney, and Witmer (2000) borrow from the Adlerian perspective and identify five life tasks on their "wheel to wellness" that are a basic part of healthy functioning: spirituality, self-direction, work and leisure, friendship, and love. In the words attributed to St. Augustine of Hippo (354-430) "Fill yourselves first, and then only will you be able to give to others." As Craddock (1990) points out, "Some of us regard turning from evil to good a victory; only persons of extraordinary spiritual discernment can at times turn from good to the power necessary to resource the good" (p. 72). For contemporary counselors, self-care continues to be a popular topic of discussion in social media and on professional blogs (e.g., Shallcross, 2011). For example, Beaton (2013) describes a "Self-Care 360!" model consisting of the eight integrated components of exercise, nutrition, sleep, healthy relationships, stress management, work/life balance, self-appreciation, and social interaction.

Self-care is not the same as *self-indulgence*, which is defined as "excessive or unrestrained gratification of one's own appetites, desires, or whims" (Merriam-Webster, n.d.). Whereas self-indulgence usually involves short-term pleasure at the expense of long-term gain, self-care usually involves discipline that pays the long-term dividends of wellness.

From a different perspective, pastors Gunderson and Pray (2009) describe five leading causes of life. *Agency* refers to our capacity to act intentionally and to have moral awareness of our responsibility for what we do and why we do it. *Intergenerativity/blessing* means bestowing on others our approval or praise. When we honor those who come before us and we nurture those who come after us, we enliven and shape our own lives intergenerationally. *Connection* refers to our connections to one another and a sense of belonging to a community. Connections include not only intimate relationships and complex social relationships, but also our connections to the world of ideas as well as the healing presence of nature. *Coherence* involves having a sense of meaning and purpose. Coherence is how we make sense of life and how we order and perceive sometimes overwhelming experiences in life. *Hope* refers to our capacity to imagine a different and better future. It is not simple optimism or wishful thinking, but rather an ability to perceive a better future and the energy to do something to bring it about.

Counseling supervision models, practices, and processes (CACREP II.G.1.e.)

From an ethical and legal perspective, supervision is based on the principle of *respondet superior* (Latin: “let the master answer”), which is a legal doctrine that a party such as an employer is responsible for the acts of its agents. Within this context, supervisors are ultimately responsible, both ethically and legally, for the actions of their trainees. Supervisors bear *direct liability* for their actions toward the supervisee (e.g., providing adequate and timely feedback regarding the supervisee’s actions, progress, and areas in need of remediation). Supervisors also bear *indirect liability*, also known as *vicarious liability*, for their supervisees’ actions. It is for this reason that some legal analysts argue that “Supervision involves at least *twice* as much professional liability as does psychotherapy” (Harris, 2004).

Supervisors must be qualified in the practice of supervision and in the area of counseling being supervised. In other words, supervisors must have education, training, and supervised experience not only in providing supervision but also in the areas of practice that they are supervising. They are responsible for maintaining confidentiality of client information, checking on the progress of supervisees, being familiar with the caseloads of supervisees, and providing ongoing and timely feedback to supervisors and to training directors or departments. Ethical responsibilities of the supervisor include maintaining and modeling professional boundaries and ensuring confidentiality within the ethically and legally acceptable exceptions (e.g., such as mandated reporting).

Qualifications for being a supervisor do not always require a doctoral degree, but are usually based on the level of education and the number of years of post-license work experience (e.g., one year for doctoral level counselors and three years for master’s level counselors), continuing education, and sometimes additional certification. Various models of supervision are often related to the services that are being provided. For example, a client-centered approach to counseling may involve supervision that is relationally oriented, whereas a behavioral therapist’s supervisor may focus more on operationalizing and measuring goals, objectives, and interventions. In all cases, supervision must be properly documented. In most states, the supervisor and the supervisee are both required to maintain a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session. In most states (including Georgia), *individual supervision* is defined as being comprised of no more than two (2) supervisees, which actually and more properly should be termed *paired supervision* (i.e., one supervisor and no more than two supervisees). In most states (including Georgia), *group supervision* is defined as being comprised of no more than six (6) supervisees (Ga. Comp. R. & Regs. r. 135-5-.01). CACREP accreditation standards in counseling allow *triadic supervision*, which is defined as one supervisor meeting with two supervisees simultaneously, as a substitute for individual supervision (Borders, Brown, & Purgason, 2015). Triadic supervision is a fancy CACREP term for the older term known as paired supervision.

In a landmark survey of supervisees, Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999) found that 51% percent of 151 supervisees reported what they considered to be at least one ethical violation by their supervisor. In this study, which is often cited by its post-millennial

date that was merely a summary review by the primary author (i.e., Ladany, 2002), the most common ethical complaint reported by 33% of supervisees was that supervisors often do not provide adequate evaluations of the supervisee's counseling performance. Other common complaints of supervisees involved reports that supervisors didn't handle confidentiality appropriately (15%), never explained the roles of the supervisee and supervisor (9%), lacked competence with the clients the supervisee was treating (9%), didn't address how supervisee was to disclose student status (8%), didn't provide modeling or responding to ethical concerns (8%), and other concerns. In contrast to popular social media accounts of romantic encounters during supervision, Ladany et al. (1999, p. 464) found that in only two cases (1%) did supervisees report that their supervisors were inappropriate regarding sexual or romantic issues: "In one case, the issue pertained to the supervisee's work with clients and in the other case the supervisee noted that sexual issues 'demand attention.'"

With respect to the most common complaint among supervisees (i.e., lack of adequate evaluations of the supervisee's counseling performance), the ethics codes of most professions provide some guidance. If a counselor intern thinks that his or her supervision is inadequate, the counselor's first action should be to discuss these concerns with the supervisor (ACA, 2014, Section I.2.d.). In contrast, Ladany et al. (1999) found that only 35% of supervisees reported perceived ethical violations with their supervisors, whereas 84% of supervisees discussed their concerns with a peer or friend in the field. When potential conflicts arise among the needs of the supervisee, the needs of the client, and the needs of the program or agency, the ethical guidelines of the Association for Counselor Education and Supervision (ACES; 1993) offer a prioritized sequence in resolving conflicts. Because several of the ACES guidelines were incorporated into the 2005 and 2014 ACA Codes of Ethics, the 1993 ACES guidelines were never updated but rather were largely replaced by the ACES (2011) best practices in clinical supervision. However, the ACES (2011) best practices guidelines do not contain the prioritized sequence. For these reasons, the now obsolete ACES (1993) prioritized sequence guideline may be of interest only for historical reference:

3.20 Supervisors should use the following prioritized sequence in resolving conflicts among the needs of the client, the needs of the supervisee, and the needs of the program or agency. Insofar as the client must [sic] be protected, it should be understood that client welfare is usually subsumed in federal and state laws such that these statutes should be the first point of reference. Where laws and ethical standards are not present or are unclear, the good judgment of the supervisor should be guided by the following list.

- a. Relevant legal and ethical standards (e.g., duty to warn, state child abuse laws, etc.);
- b. Client welfare;
- c. Supervisee welfare;
- d. Supervisor welfare; and
- e. Program and/or agency service and administrative needs. (ACES, 1993, p. 9)

As a final note regarding supervision, supervisors are often asked to provide professional references for their supervisees who may be seeking new employment after graduation. When a prospective employer contacts the supervisor and asks for an opinion regarding the supervisee's suitability for a job opening, the supervisor should first ensure that he or she has written

authorization to disclose information to a third party. Assuming that the supervisor has proper authorization to communicate to a prospective employer, the supervisor should limit his or her disclosures to only those that can be made on the basis of the supervisor's knowledge of the trainee's supervised experience.

Professional organizations, including membership benefits, activities, services to members, and current issues (CACREP II.G.1.f.)

The ACA is the national professional association that represents the wide range of interests of counseling professionals. Benefits of membership include receiving periodic information, newsletters, and journals published by the organization so that members can keep abreast of ongoing developments in the field and be aware of professional development opportunities through state, regional, and national conferences. ACA members can also receive discounts on registration to the continuing education events sponsored by the association. With respect to the development of a professional identity, being a member of a professional association provides opportunities for networking and building relationships with other professionals in the field. ACA colleagues can provide professional role models for emerging professionals and can provide consultation opportunities for all levels of experience.

In Georgia, the Licensed Professional Counselors Association (LPCA) of Georgia is the state professional association (SPA) that provides opportunities for counselors to network and collaborate with other professionals and mentors. LPCA is a state chapter of the American Mental Health Counselors Association (AMHCA), which is a division of ACA. The organization holds an annual conference and provides continuing education workshops. LPCA provides legislative advocacy for the interests of counselors and has had successful efforts in mobilizing support for legislation to expand the scope of practice for counselors. For example, in 2016 LPCA supported SB319, which added *diagnosis* to the scope of practice for professional counselors.

In politics, money talks. SPA's pay lobbyists to advocate for legislation, but SPAs do not pay money to legislators directly because to do so would jeopardize the non-profit status of the SPA. Instead, SPAs create political action committees (PAC), which engage in the process of political fund-giving. PACs are required to have bylaws that are separate from the SPA's bylaws and PACs also have independent boards, which may be called a board of directors or board of trustees. Board members are generally active political givers and they are often required to contribute to the state association PAC. Active state PACs can be effective in influencing existing legislators and in funding campaigns of candidates who are campaigning for political offices at every level of national, state, and local government. An analysis of the Sunlight Foundation revealed that state-level PACs paid \$1.4 billion to candidates running for governor, attorney general, state legislative and other non-federal offices in various states (Wilson, 2013).

PACs exist on both state and national levels. PAC laws vary from state to state, with each state having its own unique campaign finance laws that govern the activities of that state's PACs. In most states, the secretary of state's office oversees the activities and filings of its state's PACs. State PACs are limited to contributing to campaigns for governor, state house and senate seats, and county level political offices, whereas national PACs support federal level candidates

running for Congress. Federal PACs are highly regulated and are required to following rules and regulations that are under the purview of the U.S. Federal Election Commission.

Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues (CACREP II.G.1.g.)

Accreditation refers to the process whereby a private nongovernmental agency or association grants public recognition to an institution or program of study that meets certain established qualifications and periodic evaluations. CACREP is the national organization responsible for the accreditation of counseling programs. CACREP provides accreditation to qualified training programs, whereas NBCC provides certification to qualified counselors. The American Personnel and Guidance Association (a predecessor of the American Counselor Association) and the Association for Counselor Education and Supervision (ACES) discussed cooperative accreditation efforts for setting standards in counseling training programs. This collaboration led to CACREP's establishment in 1981.

Registration involves a voluntary listing (or *registry*) of individuals who use a title and/or provide a service that an occupational group or local government believes is of benefit to require or encourage registration. Registration can exist on a local, state, or national level. An early form of professional regulation, registration has been largely relegated to history as certification and licensing have become the primary means of professional credentialing.

Certification refers to voluntary regulation by a private governing board. It is a non-statutory process by which an agency, private organization, or governmental body officially grants permission for an individual to use a title adopted by a profession, providing the individual has met certain predetermined professional qualifications. Certification usually exists on a national level but it can exist on a state level. In the field of counseling, the National Board for Certified Counselors (NBCC) is the organization that provides the primary form of national voluntary certification in the counseling profession. NBCC offers the National Certified Counselor (NCC) and three speciality certifications in addictions, clinical mental health, and school counseling. The NBCC also manages the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE). Additional information about the NBCC can be obtained from its website (<http://www.nbcc.org/>).

Licensing refers to regulation by a state government. More restrictive than certification, licensing grants individuals the legal right to use a title and to practice a profession provided he/she has met the minimum qualifications established by the profession, licensure prescribes who can and cannot practice a profession. In addition to graduate school education, prospective candidates for licensure must pass a national examination such as the NCE or the NCMHCE. In Georgia, the licensing board for counselors is known as the Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists (sometimes described simply as the "Composite Board"). Additional information about the Composite Board's rules and regulations can be obtained from its website (<http://sos.ga.gov/index.php/licensing/plb/43>). On a national level, the American Association of State Counseling Boards (AASCB) is the organization of state boards that regulate the practice of counseling (<http://www.aascb.org/>). Founded in 1985,

AASCB provides information about counseling licensing and regulation, test development, and standards for licensing. Contact information for licensing boards of each state are available at the ACA Knowledge Center (<https://www.counseling.org/knowledge-center/licensure-requirements/state-professional-counselor-licensure-boards>).

Portability, which is also described as *mobility* or *reciprocity*, refers to the ability to transfer a license to other jurisdictions in which a licensee desires to practice. By way of definition, *intra-jurisdictional* practice refers to practice within a state or jurisdiction, whereas *inter-jurisdictional* practice refers to practice outside of a state or jurisdiction. Because professional licensure is a state-based (intra-jurisdictional) rather than a national-based system, counselors are required to be licensed in each of the states in which they practice. Practitioners who practice in more than one state must obtain a license in each of the states in which they practice. With the advent of telemental health, increasing numbers of practitioners want to provide services to those who reside outside the jurisdictions in which the practitioners are licensed (i.e., inter-jurisdictional practice). An Agreement of Reciprocity (AOR) encourages states to enter into a cooperative agreement whereby any individual holding a license in one AOR participating jurisdiction may obtain a license to practice in another AOR participating jurisdiction. Entrance into the AOR is dependent on a state demonstrating that their requirements for licensure meet the standards required by other AOR participating jurisdictions. Under the reciprocity approach to mobility, for example, all licensed psychologists in AOR participating jurisdictions are eligible for licensure in all other AOR participating jurisdictions.

In order to reduce the barriers that restrict such movement among jurisdictions, licensure laws must have a high level of uniformity. One of the major obstacles to portability has been the variability among licensure requirements in different jurisdictions. Private organizations and state regulatory agencies have collaborated to establish uniform educational and training requirements for license portability. For example, in February 2015, the Association of State and Provincial Psychology Boards (ASPPB) released model language to facilitate the practice of telepsychology and temporary in-person psychology across jurisdictions. The model is known as the Psychology Interjurisdictional Compact (PSYPACT), and it is described as “an interstate compact designed to facilitate telehealth and temporary face-to-face practice of psychology across jurisdictional boundaries” (ASPPB, 2015, p. 1). It provides model language that by federal law was required to be passed as statutory law in at least seven states to become effective (Center for Connected Health Policy, 2015, p. 1). It became effective nationally in 2019.

On April 23rd, 2019, Georgia Governor Brian P. Kemp signed GA HB 26 into law, which made Georgia one of the first seven states to enter into an interstate compact known as the Psychology Interjurisdictional Compact (PSYPACT). Georgia joined seven other PSYPACT participating states, including Arizona, Utah, Nevada, Colorado, Nebraska, Missouri, and Illinois. PSYPACT legislation in Illinois (IL HB 1853) included an effective date of January 1, 2020, so Illinois did not join PSYPACT until that date. Because legislation in Georgia was effective upon approval by the Governor, Georgia became the next PSYPACT participating state required to make PSYPACT operational (Psychology Interjurisdictional Compact, 2019). This legislation amended Chapter 39 of Title 43 of the Official Code of Georgia Annotated (OCGA), creating a new law (39-32-22) that requires criminal background checks for licensure, establishes and provides for the privilege to practice telepsychology, provides for the temporary authorization to

practice by psychologists, and authorizes the State Board of Examiners of Psychologists to administer the compact. According to Janet Orwig, Chief Executive Officer of PSYPACT, as of March 5, 2021 Georgia had a total of 149 psychologists who held Authority to Practice Interjurisdictional Telepsychology (APIT) certificates and there are 15 states have enacted PSYPACT (Litton & Orwig, 2021).

In Georgia and in most other states, the only form of partial portability is through *endorsement*, in which a state licensing board accepts an existing license (from another state) as qualification for licensure as long as other requirements are also met. Other models of license portability include *federal licensure* (a single license granted and administered by the federal government), *national licensure* (universal licensing criteria set at the national level but administered by each individual state), and *mutual recognition* (cooperation and reciprocity among state regulatory boards). Mutual recognition requires that “the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee’s home state” (Wakefield, 2012). Mutual recognition can take the form of state *interstate compacts*, which according to federal law must be passed as a statutory law in at least seven states to become effective. For two decades, the nursing profession has led the way in using the mutual recognition model. In 1997, The National Council of State Boards of Nursing (NCSBN) Delegate Assembly’s adopted model Nurse Licensure Compact (NLC) legislation and rules (American Nurses Association, 2013). In 2000, the NLC was introduced and allows any Registered Nurse (RN) or Licensed Practical Nurse (LPC), who is a primary resident of a compact state, to hold one license that allows him or her to practice in any other compact state, although the nurse must comply with the laws of that state. As of 2018, a total of 26 state legislatures have authorized their respective states to participate in the NLC and half a dozen states have pending legislation (Wallis, 2015). Approved May 4, 2015, an Advanced Practice Registered Nurse (APRN) Compact “allows an APRN to hold one multistate license with a privilege to practice in other compact states. The APRN Compact will be implemented when 10 states have enacted legislation” (National Council of State Boards of Nursing, n.d.). APRN provides a summary of the key provisions of the compact (APRN, 2015a), as well as model APRN compact legislation (APRN, 2015b).

In contrast to the professions of nursing and psychology, the field of counseling has been described as having a “portability crisis” (Bray, 2015, p. 1). The portability problem in counseling is largely attributable to the fact that there are more than 45 different titles used by state licensing boards (ACA, 2017, p. 27). ACA and the American Association of State Counseling Boards (AASCB) have worked on two separate initiatives aimed at solidifying professional counselor identity and transforming licensure portability into a reality. In 2015, counseling licensure board representatives from Tennessee, Kentucky, Virginia, and West Virginia met at the 2015 ACA Conference in Orlando, Florida, to discuss an interstate compact for counselor licensure. On March 20, 2015, Kentucky and Tennessee signed the agreement and the other two states moved forward to implement the compact, which represents the first advancement of an interstate compact for reciprocity of counselor licensure within a geographic region.

On August 5, 2015, the American Mental Health Counselors Association (AMHCA), Association for Counselor Education and Supervision (ACES), and National Board for Certified

Counselors (NBCC) announced their joint endorsement of a plan for counselor licensure portability (Canady, 2015; National Board for Certified Counselors, n.d.). Their plan establishes a regulatory platform allowing licensed counselors to move between and practice in multiple states. Briefly, the AMHCA-ACES-NBCC proposal for portability standards for licensed counselors seeking licensure in another state included the following credentials: (1) possession of a counselor license for independent practice for at least two years; and (2) a degree from a clinically focused counselor preparation program accredited by CACREP, or certification as a National Certified Counselor, or fulfillment of standards adopted by a state counseling licensure board. The AMHCA-ACES-NBCC proposal laid the groundwork for a subsequent proposal in 2017, which included input from these three organizations and the American Association of State Counseling Boards.

In June 2016, the ACA Governing Council approved what has been self-described as the ACA Licensure Portability Model, which is less stringent than the AMHCA-ACES-NBCC portability proposal. The ACA Licensure Portability Model is summarized briefly as follows:

A counselor who is licensed at the independent practice level in their [sic] home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they [sic] are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of what state. (ACA, 2017, p. 27)

In April 2017, the American Association of State Counseling Boards, the Association for Counselor Education and Supervision, the American Mental Health Counselors Association, and the National Board for Certified Counselors issued a joint statement on a national counselor licensure endorsement process (AASCB, ACES, AMHCA, & NBCC, 2017). This proposal is more stringent than the ACA Licensure Portability Model. According to this joint statement by AASCB, ACES, AMHCA, and NBCC, any counselor licensed at the highest level of licensure for independent practice available in his or her state may obtain licensure in any other state or territory of the United States if all of the following criteria are met:

1. The licensee has engaged in ethical practice, with no disciplinary sanctions, for at least 5 years from the date of application for licensure endorsement.
2. The licensee has possessed the highest level of counselor licensure for independent practice for at least 3 years from the date of application for licensure endorsement.
3. The licensee has completed a jurisprudence or equivalent exam if required by the state regulatory body.
4. The licensee complies with ONE of the following:
 - a. Meets all academic, exam, and post-graduate supervised experience standards as adopted by the state counseling licensure board.
 - b. Holds the National Certified Counselor (NCC) credential, in good standing, as issued by the National Board of Certified Counselors (NBCC).
 - c. Holds a graduate-level degree from a program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).

In January 2019, ACA signed a contract with the Council of State Governments' (CSG) National Center for Interstate Compacts (NCIC) to conduct the work. NCIC has divided the project into three phases:

Phase I (January – August 2020): Development of the compact, including project research; creation and convening of an advisory group; drafting of proposed language; and feedback on the draft from stakeholder groups. The advisory group will consist of state legislators who are either licensed professional counselors or who have passed counselor friendly legislation; leaders in the counseling field and practicing counselors, executive directors of licensing boards, and attorneys for state licensing boards.

Phase II (September 2020 – March 2023): Implementation to develop a comprehensive online resource kit that serves as the principal information resource on the new compact; the development of a comprehensive legislative strategy; convening a national legislative briefing; tracking legislation regarding the compact; attendance at legislative hearings for the compact; and providing state briefings, as needed.

Phase III (April 2023 – September 2023): Establishment of the commission that will provide on-going coordination of the compact.

Notwithstanding the problems with portability of licensure in the field of counseling, some states have been moving forward with regard to the practice of telemental health. On July 1, 2021, Georgia enacted House Bill 395, which was known as “The Professional Counselors Licensure Compact.” Largely due to the efforts of LPCA, Georgia became the first state in the nation to pass counseling compact legislation. Because it is one of the first 10 states to enact the Compact, Georgia joins the Counseling Compact Commission as authorized by Georgia Law, “The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth Member State” (OCGA § 43-10A-51, Section 13 A.). The Counseling Compact Commission is the administrative body whose makeup consists of all States that have enacted the Compact. Under the terms of this Compact, the practice of Professional Counseling occurs in the State where the client is located at the time of the counseling services (OCGA § 43-10A-51, Section 1.). The “Home State” refers to the Member State that is the Licensee’s primary State of residence, whereas the “Remote State” refers to a Member State (other than the Home State) where a Licensee is exercising or seeking to exercise the Privilege to Practice. Under Georgia law (i.e., OCGA § 43-10A-51, Section 1, Subsection H), Compact practice is defined and regulated in “the State in which the client is located at the time.” Before the Counseling Compact can become effective nationally, it requires that a core group of 10 member states enact the legislation. As of July 1, 2021, Counseling Compact legislation has been enacted in two states— Georgia (the first state) and Maryland. The Compact is being drafted in Delaware and North Carolina, and legislation has been introduced in Tennessee and Nebraska (Marsalek, 2021).

Role and process of the professional counselor advocating on behalf of the profession (CACREP II.G.1.h.)

In some ways, the fate of a profession is in the hands of legislators, most of whom may have little or no understanding of the concerns of the profession. Although individual lobbying efforts are useful, counselors who unify their efforts have a greater voice by standing together than they do by standing alone. In addition to the traditional roles of counselors working as change agents or advisers, Corey et al. (2015) describe alternative counselor roles such as serving as advocates for the profession and educating members of the public about services that counselors offer. For example, a counselor might write public service articles in newsletters that include the counselor's name institutional affiliation. Advocacy efforts may also include speaking in public on behalf of a professional counseling association, writing blogs that describe advances in the practice of counseling, and submitting articles to professional journals devoted to the practice of counseling.

In the legislative arena, advocacy efforts on the part of counselors may include working within a state professional association of counselors to promoting policy changes. Advocacy efforts may also include writing letters to state and national legislators who support the profession of counseling, meeting with legislators to discuss legislative proposals, and working within legislative systems to change laws that affect the counseling profession. Advocacy also includes activities such as networking with state legislators during a counseling awareness day at the capitol, signing online petitions that advocate for greater access to campaign financing data, and providing anonymous donations to a political candidate campaigning for a state office.

There are many resources available for counselors who want to learn more about political advocacy and the legislative process. For information about how to track a bill through the Georgia General Assembly, see the Appendix of this article. To track a bill through the Georgia General Assembly, see the Legislative Page on the General Assembly's website (<http://www.legis.ga.gov/Legislation/en-US/Search.aspx>). To track proposed rules and regulations of various Georgia licensing and regulatory boards, see the Georgia Secretary of State's Professional Licensing Board's (PLB) Interested Parties list (<http://sos.ga.gov/plb/subscribe.htm>). In order to stay informed about proposed federal legislation, see the ACA's Government Affairs webpage (<https://www.counseling.org/government-affairs/actioncenter>).

It is important to maintain professional boundaries between advocating for the profession and providing counseling to clients. For example, whereas it may be appropriate for a counselor to write a magazine article that explains how professional counselors are trained, it would not be appropriate for a counselor to write a magazine article about a client. Similarly, appropriate advocacy efforts may include citing published research that supports the efficacy of a specific psychotherapy technique, whereas appropriate advocacy efforts do not include activities such as soliciting testimonials from clients regarding how helpful counseling has been. Likewise, appropriate advocacy efforts do not include asking clients to write letters supporting legislation beneficial to counselors, or asking clients for donations to political campaigns of legislators who are supportive of the profession. Such activities are clearly exploitative of clients and can result in erosion of the counseling relationship, harm to the client, and complaints to ethics committees

and licensing boards. Another example of an unethical behavior might include a counselor providing some part-time work for an underemployed client until stable employment can be found. Rather than blurring boundaries, conscientious counselors strive to empower others to problem-solve independently. At the same time, that same counselor might be involved in other professional activities that raise public awareness of concerns related to factors contributing to unemployment and influencing public policy makers with respect to legislation related to disabilities.

Whereas state licensing boards have the fiduciary duty to protect the public by regulating the practice of professional counselors, licensing boards do not write legislation on behalf of counselors. Lobbying organizations, as well as state and national professional associations are typically the strongest advocates of legislation that promotes the interests of a profession. For this reason, professionals unify their efforts in order to have a stronger voice that can be heard by legislators. ACA is the national organization that advocates for the broad interests of counselors. To use an old adage, “All politics is local.” For this reason, grassroots efforts at the local, municipal, and state levels make the most difference. On the state level, Licensed Professional Counselors Association (LPCA) of Georgia is the organization that advocates for legislative proposals on behalf of its members in Georgia. Additional information about LPCA can be obtained from its website (<http://www.lpcaga.org/>).

Advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients (CACREP II.G.1.i.)

Advocating for a profession is different than advocating for a client. Advocacy on behalf of clients requires knowledge of the cultural values of clients, awareness of community resources, and recognition of oppressive forces that create impede access to opportunities for clients.

Culturally sensitive counselors should consider the cultural values of the community where they work and the degree to which their counseling interventions are likely to advance the mental health of clients in the community. One of the most important dimensions underlying the ethics of multiculturalism is the *power differential* that exists between people who are privileged and those who are oppressed or who do not have access to societal resources. Power differential refers to the inherently greater influence and power that counselors and other professionals have as compared to those of the people they serve. A cornerstone of ethical awareness involves understanding the impact of power differentials, particularly with respect to protecting the rights of those who are in position of less power. There is a strange irony that the U.S. continues to be built on the backs of the very people whose access to the country’s resources are the most limited. With respect to addressing the realities of oppression, privilege, and social inequities, social justice has become known as a *fifth force* that entails a paradigm shift beyond the individual (Ratts & Pedersen, 2014).

The community approach is relevant to all communities, but it is particularly relevant to underserved communities. Cohen and Chemimi (2010, p. 5) use the metaphor of “moving upstream.” For example, rather than rescuing people who are drowning in a river after falling through a hole in the bridge, a community approach may involve fixing the hole in the bridge,

which will prevent people from ever falling into the river in the first place. Rather than merely working to change people who are affected by these conditions, conscientious counselors consider cultural, societal, and legislative ways of changing the conditions that affect people. When counselors identify institutional barriers that impede access or equity for those they serve, it is often appropriate to recognize the situation as unacceptable and do what they can do to change it. Appropriate activities include working within a system to create change for oppressed people, advocating policy changes that benefit underserved populations, and educating members of a community about services that counselors offer.

Homan (2016) offers a useful model for counselors who observe perceived unethical or inappropriate practices in an organization or institution. According to Homan, once a counselor identifies and recognizes a problem situation in an agency, system, or institution, it is the counselor's responsibility to respond. Appropriate responses can include options such as changing his or her perception by identifying the situation as acceptable, recognizing situation as unacceptable and do what he or she can do to change it, leaving the situation, either by emotionally withdrawing or by physically leaving the situation. Counselors also have a responsibility to alert their employers to institutional barriers or conditions that affect the people they serve. For example, according to Section D.1.h (Negative Conditions) of the ACA (2014) *Code of Ethics*, counselors should alert their employers of inappropriate policies and practices.

For counselors providing mental health services to clients, appropriate alternative roles include direct and indirect activities. Indirect advocacy includes activities such as advocating to state legislators about changes in state laws that affect underserved populations. Direct advocacy includes activities such as serving as a change agent for a client who wishes to achieve goals and aspirations in a new culture, or advising a client from an underserved population about community resources of which the client may not be aware. For example, if an immigrant client refuses to seek police assistance when he or she has been the victim of a crime, it may be helpful for the client's counselor to understand that the client may have negative feelings toward police because of his or her history of oppression. In such a case, the counselor may be able to provide the client with community resources that can provide civic education, assist with crime prevention, and provide support for reporting of crimes in which the client or others are victims. In contrast, appropriate roles for mental health counselors do not include activities such as providing legal representation to a client who may not be able to afford services of a private attorney, transporting clients in counselors' private vehicles, hiring clients who need employment, or other activities that would constitute blurring of professional role boundaries. With respect to assuming an advocacy role and voicing support for people suffering from severe and persistent mental illness, appropriate activities include making public statements advocating greater access to public education, health care, and societal resources. Counselors have opportunities to influence public opinion, public policy, and legislative proposals.

Ethical standards of professional organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling (CACREP II.G.1.j.)

Values are attitudes and beliefs of a person or group in which they have an emotional investment, either for or against something. Values provide direction for everyday living, whereas *ethics*

pertain to the beliefs we hold about what constitutes right conduct. Ethics may have either a religious or secular origin, whereas *morality* is concerned with perspectives of right conduct and an evaluation of actions on the basis of some broader cultural context or religious standards. *Ethical principles* are usually considered abstract ideals that are based on common values of a group, whereas *ethical standards* are usually considered the more concrete rules that are derived from principles. An *ethics code* is a compilation of ethical standards and principles. *Mandatory ethics*, also known as enforceable ethical standards (Fisher, 2013), refers to the ethical floor (Haas & Malouf, 2005), below which represents a violation of ethical standards. *Aspirational ethics* refers to the ethical ceiling toward the more abstract ethical principles on which standards are based. *Best-practices* reflect a striving toward ethical excellence in practice, whereas *mandatory compliance* refers to a practitioner working in a way that merely meets the minimal ethical standards. An underlying assumption of ethical risk management is that practitioners can avoid ethical pitfalls by striving for aspirational ethics (Doverspike, 2010, 2015). *Professionalism* bears some relationship to ethical behavior, yet it is possible to act unprofessionally and still not be acting unethically. For example, not returning emails or phone calls to colleagues in a timely manner would be considered unprofessional, whereas not returning a phone call to an actively suicidal client would be considered unethical. Counselors striving for professionalism are encouraged to strive for best practices based on aspirational ethical principles, knowledge of and compliance with enforceable ethical standards, and consequential thinking integrated with ongoing peer consultation (Doverspike, 2015).

The (ACA, 2014) *Code of Ethics* is the most recognized set of ethical standards that is considered the consensus for most professional counselors. According to the ACA website (<https://www.counseling.org/>), 19 out of 52 jurisdictions (including Puerto Rico and the District of Columbia) have adopted the ACA *Code of Ethics* into their jurisdiction's licensing board regulations. The National Board for Certified Counseling (NBCC), which is a private organization that administers the National Counselor Examination (NCE) and provides voluntary certification for counselors, also has a code of ethics. The NBCC (2016) *Code of Ethics* is comprised of 95 enforceable directives. Whereas the NBCC Code of Ethics contains only mandatory ethical standards, there ACA Code of Ethics contains both mandatory and Aspirational ethical principles. Counselors who are members of both organizations are required to comply with both sets of standards.

The ethics codes offered by most professional counseling organizations are precise and specific rather than broad and general (Corey, et al., 2015). Although ethical standards are written in black and white, most situations encountered in real life involve the gray areas. For this reason, counselors often face dilemmas in which they encounter conflicts between ethical principles and legal standards. An *ethical dilemma* exists when (1) reasonable choices exist between two or more courses of action, (2) each choice can be supported by ethical principles, (3) each choice of actions presents significant potential consequences, and (4) the selection of either course of action will compromise one of the ethical principles (Stone, 2005). When an ethical dilemma exists, which is more the rule than the exception, counselors must use some type of systematic decision making process to resolve the dilemma. To use an analogy, whereas ethical standards provide the *directions*, decision-making models provide *maps* (Klein, 2009). Ethical decision making models range from the very simple one and two step models to the more complex

multiple step models (Doverspike, 2015). In most ethical decision making models, when faced with an ethical dilemma, a counselor's first step should be to *identify the problem or dilemma*.

Because some ethical standards occasionally conflict with state laws, it is possible for counselors to act in a way that they consider to be ethical only to find out that they have violated a legal standard. For example, although most professional codes of ethics provide ethical justification for notification of an identifiable third party who is at risk of "serious and foreseeable harm" (AC A, 2014, p. 7) by a client who has voiced a clear threat of violence, such third party notifications may violate the confidentiality and psychotherapy privilege statutes of some states (e.g., *Garner v. Stone*, 1999). For example, consider the scenario that arises when a counselor determines that a client may be at risk for harming self or others. Although the novice counselor's impulsive reaction may be to notify or warn a third party, the counselor's first action should be to take reasonable steps necessary to prevent harm. As mentioned previously, when faced with a counseling situation in which it appears that there is a conflict between an ethical and legal course to follow, the first appropriate course of action before making a decision would be to consult with an attorney and a colleague.

Whereas the most significant major sanction that could be taken by the ethics committee of the state and national professional associations is expulsion or suspension of membership from the professional organization, the most significant consequence of a state licensing board investigation would be suspension or revocation of a license to practice the profession. In contrast, the most severe consequence of a civil suit (such as a malpractice lawsuit) would be a trial verdict or, more likely, a negotiated (i.e., out of court) monetary settlement. To prevail in a malpractice lawsuit, the plaintiff must prove four elements, which are sometimes known as the *Four Ds*: duty, dereliction, damages, and direct cause. *Duty* exists whenever a professional person establishes a professional relationship with another person, which in its most conservative interpretation involves the first contact between a counselor and a client. *Dereliction* of duty refers to a deviation from an acceptable standard of care, which typically involves some type of negligence that a practitioner can generally avoid by following clinical and ethical best practices. *Damages* usually equate to dollars in a civil lawsuit. *Direct cause*, technically termed proximate cause, is the most difficult element for a plaintiff to prove. It involves an event that is sufficiently related to an injury that it is held to be the cause of the injury. Proximate cause is usually determined by the "but for" test (i.e., but for the practitioner's action or inaction, the result would not have happened), although this test can be complicated and it is sometimes ineffective. As an example of a worst case scenario, consider what might happen if a licensed professional counselor were to provide an expert forensic opinion regarding child custody or change in visitation without evaluating the parental fitness of both parents. The most severe consequences could involve complaint to state and national professional organization's ethics committees (with the most severe consequence being loss of membership), a civil lawsuit alleging professional negligence (with the most severe consequence being a public trial verdict resulting in a large financial settlement), and a complaint to a state licensing board (with the most severe consequence being a public hearing resulting in loss of license).

According to Healthcare Providers Service Organization (HPSO) and CNA Financial Corporation. (2014), the average cost for a counseling professional to defend against a malpractice lawsuit is \$46,900.00—if the professional prevails. If the professional loses, the

average cost of a settlement payment is \$129,900.00, for a total of \$176,800.00. Many counselors have a misconception that only doctors get sued, which is not true. When a patient is injured, anyone and everyone who has seen the patient may be named in the suit, which means that a counselor may require legal representation for defense or simply to have his or her name removed from the suit. Many counselors believe that they are covered by their employer's insurance, which may be true. However, being a named insured on an employer's policy may have significant limitations in coverage, particularly if a complaint is filed with the professional's state licensing board. For counselors, the risk of having a licensing board complaint is approximately *23 times* higher than the risk of being named in a civil lawsuit (National Practitioner Data Bank, 2015). All of these reasons justify counselors having their own professional liability insurance policies with sufficient limits of coverage, including coverage for representation in licensing board complaints.

Professional liability insurance comes in two basic forms: *occurrence* and *claims-made*. Because of its lower initial cost, the majority of policies available are claims-made, which provides coverage only for incidents that occurred and were reported while you are insured with that carrier. Both the incident and the filing of the claim must happen while the policy is in effect. In other words, the claims-made policy covers incidents that are reported during the active policy period—or an extended reporting period—and that occur after a policy's *retroactive start date*. Claims through this form of coverage must meet both criteria for coverage to apply. A retroactive date is the specific date a policy's coverage begins. This date is generally the policy's effective date or a past date agreed on by the insured. If an incident occurs before the retroactive date, it won't be covered. If a counselor discontinues a claims-made policy, the counselor would not be covered for any suits filed later unless he or she pays for *tail coverage*, which refers to an extended reporting endorsement. Tail coverage is expensive—often three times the amount of an annual premium of a claims-made policy—but when discontinuing coverage under a claims-made policy, it would be essential to purchase tail coverage in order to be insured for any claims that could arise after discontinuing a claims-made policy. In contrast, *occurrence coverage* provides lifetime coverage for incidents that occurred while the policy was in effect, regardless of when the claim is filed. In other words, occurrence insurance covers losses that take place during a specific coverage period, regardless of when an incident is reported. For example, if a counselor had an occurrence-type policy in effect for the calendar year 2015, and a client or former files a claim in 2017 for an incident that occurred during 2015, the policy provides coverage for that claim, even if the counselor no longer has insurance with that carrier. Because liability claims are often filed more than a calendar year later after a service has been rendered, an occurrence-type policy provides a longer period of protection in this context. Unlike discontinuing coverage under a claims-made policy, a practitioner with an occurrence-type policy does not need to purchase tail coverage to be insured for any claims that could arise after discontinuing a claims-made policy.

Newly licensed counselors overwhelmingly purchase claims-made insurance because of its lower initial cost. However, the lower premiums on the front end of the policy are sometimes offset by the higher premiums once the policy reaches what is called the *mature rate*. Claims-made policies are cheaper than occurrence policies for the first several years of coverage because the potential for claims increases slowly as policy years accumulate. The first-year premium of a claims-made policy may be very inexpensive, such as 10% to 30% of the mature rate. The

premium then increases each year for a period such as 3 to 5 years until it reaches the mature rate. In comparing costs of malpractice insurance policies, counselors are advised to ask how much the premium will increase after the first year.

Foot notes

1. As Myers and Sweeney (2007) point out, the historical roots of wellness may actually be traced back over 2,000 years to the early teachings of the two daughters of Aesculapias, the ancient Greek god of healing. Panacea, the oldest daughter, believed that treating existing illness was the way to promote healing. Hygeia, her younger sister, believed that teaching positive ways of living was the way to help prevent illness.
2. In 1945, California became the first state to register social workers with the formation of the Board of Social Work Examiners. In 1963, the regulatory agency received the additional responsibility of administration of the Marriage, Family, and Child Counselor Act (later renamed the Social Worker and Marriage Counselor Act). With the new responsibilities, the board was renamed the Social Worker and Marriage Counselor Qualification Board. In 1970, a licensing program for Educational Psychologists was added to the board, inspiring a new name: the Board of Behavioral Science Examiners. The board took its current name, the Board of Behavioral Sciences, on January 1, 1997.
3. LPCC Treatment of Couples and Families (CCR §1820.7): LPCCs shall obtain Board confirmation of qualifications to treat couples and families, and shall provide a copy of this confirmation to: (1) Couple or family clients prior to commencement of treatment. (2) A marriage and family therapist intern or trainee prior to commencement of supervision. (3) Another LPCC or PCC intern gaining supervised experience to comply with requirements to treat couples or families prior to commencement of supervision.

References

Please note that some reference entries are written in APA (2010) *Publication Manual* (6th ed.) style, which provides more detail for print publications (e.g., such as location of publisher), whereas other reference entries are written in APA (2020) *Publication Manual* (7th ed.) style, which provides more detail for digital sources (e.g., such as name of website).

Aguilera, D. C. (1998). *Crisis intervention: Theory and methodology* (8th ed.). St Louis, MO: Mosby.

American Association of State Counseling Boards, the Association for Counselor Education and Supervision, the American Mental Health Counselors Association, and the National Board for Certified Counselors. (2017, April). *Joint statement on a national counselor licensure endorsement process*. Retrieved from <http://www.amhca.org/portability2017>

American Counseling Association. (2014). *ACA code of ethics*. <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf>

American Counseling Association. (2017, December). ACA licensing portability model. *Counseling Today*, 60(6), 27.

American Counseling Association. (2018). Our history [Official website]. <https://www.counseling.org/about-us/about-aca/our-history>

American Counseling Association. (2019, August 8). The interstate compact for portability. <http://tinyurl.com/vlh3gk2>

American Nurses Association, Congress on Nursing Practice and Economic Licensure Portability Workgroup. (2013, April). *Nursing licensure portability: Options and information for registered nurses*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Nursing-Licensure-Portability.pdf>

Association for Counselor Education and Supervision. (1993). Ethical guidelines for counseling supervisors. *Counselor Education and Supervision*, 34(3), 270-276.

Association for Counselor Education and Supervision. (2011). *Best practices in clinical supervision*. Alexandria, VA: Author. www.saces.org/resources/documents/aces_best_practices.doc

Association of State and Provincial Psychology Boards. (2015, February 23). *Psychology Interjurisdictional Compact (PSYPACT) announced*. Retrieved from <http://www.asppb.net/news/217917/Psychology-Interjurisdictional-Compact-PSYPACT-Announced.htm>

Association of Trauma Stress Specialists. (2016). *ATSS Code of Ethics*. Greenville, SC: Author.

American Psychiatric Association (1964). *First aid for psychological reactions in disasters*. Washington, DC: Author.

Beaton, B. (2013). Self-care 360. Retrieved from <https://www.drbeckybeaton.com/self-care-360.html>

Bennett, J. (2010, January 20). Central State closing to mental health patients. <http://www.gpb.org/news/2010/01/20/central-state-closing-to-mental-health-patients>.

Borders, L. D., Brown, J. B., & Purgason, L. L. (2015, November 10). Triadic supervision with practicum and internship counseling students: A peer supervision approach. *The Clinical Supervisor*, 34(2), 232-248.

Boyle, D. A. (2011). Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Issues in Nursing*, 16(1). http://www.medscape.com/viewarticle/745293_1

Bray, B. (2015, March 26). *Addressing counseling's portability crisis*. <http://ct.counseling.org/2015/03/addressing-counselings-portability-crisis/>

Bush, N. J. (2009, January). Compassion fatigue: Are you at risk? *Oncology Nursing Forum*, 36(1), 24-28. doi.org/10.1188/09.ONF.24-28

Canady, V. A. (2015, August 26). *AMHCA-endorsed licensing plan allows counselors more mobility*. <http://www.mentalhealthweeklynews.com/Article-Detail/amhca-endorsed-licensing-plan-allows-counselors-more-mobility.aspx>

Center for Connected Health Policy. (2015, March 10). *PSYFACT fact sheet*. <http://www.cchpca.org/psychology-interjurisdictional-compact-psypact>

Clark, M. A. (2016). Workaholism: It's not just long hours on the job [Blog post]. <http://www.apa.org/science/about/psa/2016/04/workaholism.aspx>

Corey, G., Corey, M. S., Corey, C., & Callanan, P. (2015). *Issues and ethics in the helping professions* (9th ed.). Stamford, CT: Cengage Learning.

Corey, G., Corey, M. S., & Corey, C. (2018). *Issues and ethics in the helping professions* (10th ed.). Boston, MA: Cengage Learning.

Council for Accreditation of Counseling and Related Educational Programs. (2008). 2009 Standards. <http://www.cacrep.org/2009standards.html>

Craddock, F. B. (1990). *Interpretation: A Bible commentary for teaching and preaching*. Louisville, KY: John Knox Press.

- Cranford, P. G. (1981). *But for the grace of God. Milledgeville: The inside story of the world's largest insane asylum*. Augusta, GA: Great Pyramid Press.
- Doverspike, W. F. (2010). Risk management. In I. B. Weiner & W. E. Craighead (Eds.), *Corsini's Encyclopedia of Psychology, Volume 4*, (4th ed.) (pp. 1469-1471). New York: John Wiley and Sons.
- Doverspike, W. F. (2015). *Risk management: Clinical, ethical, and legal guidelines for successful practice* (2nd ed.). Sarasota, FL: Professional Resource Press, Inc.
- Fisher, C. B. (2013). *Decoding the ethics code: A practical guide for psychologists* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Garner v. Stone*, No. 97A-320250-1 (Ga., DeKalb County Super. Ct.) Dec. 16, 1999.
- Ga. Comp. R. & Regs. r. 135-5-.01 (Associate Professional Counselors)
- Gunderson, Gary, & Pray, Larry M. (2009). *Leading causes of life: Five fundamentals to change the way you live your life*. Nashville, TN: Abingdon Press.
- Haas, L. J., & Malouf, J. L. (2005). *Keeping up the good work: A practitioner's guide to mental health ethics* (4th ed.). Sarasota, FL: Professional Resource Press.
- Harris, E. (2004, March 11). APAIT Workshop: Part I: Legal and Ethical Risk Management in Professional Psychological Practice. Workshop presented at the Annual Conference of the Georgia Psychological Association, Hilton Oceanfront Resort, Hilton Head Island, SC.
- Healthcare Providers Service Organization (HPSO) and CNA Financial Corporation. (2014, March). *Understanding counselor liability risk*. Hatboro, PA: Authors.
<http://www.hpso.com>
- HIPAA fines listed by year. (2019). Retrieved from <https://compliance-group.com/hipaa-fines-directory-year/>
- Homan, M. (2016). *Promoting community change: Making it happen in the real world* (6th ed.). Belmont, CA: Brooks/Cole, Cengage Learning.
- Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner-Routledge.
- Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues*, 30, 159–165. doi:10.1111/j.1540-4560.1974.tb00706.x
- Freudenberger, H., & Richelson, G. (1980). *Burn Out: The High Cost of High Achievement. What it is and how to survive it*. New York, NY: Bantam Books.

- Jackson-Cherry, L. R., & Erford, B. T. (2010). *Crisis intervention and prevention* (3rd ed.). New York, NY: Pearson Education, Inc.
- Joinson, C. (1992, April). Coping with compassion fatigue. *Nursing*, 22(4), 116-122.
- Klein, G. (2009). *Streetlights and shadows: Searching for the keys to adaptive decision making*. Cambridge, MA: The MIT Press.
- Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. *The Counseling Psychologist*, 27(3), 443-475.
- Ladany, N. (2002). Psychotherapy supervision: How dressed is the emperor? *Psychotherapy Bulletin*, 37(4), 14-18.
- Litton, S., & Orwig, J. (2021, March 6, 2021). *Telehealth/PSYPACT* [Plenary discussion]. Live Zoom webinar sponsored by the Georgia Psychological Association.
- Marsalek, D. N. (2021, April 5). Counseling compact update. *APA News*.
<https://www.counseling.org/news/aca-blogs/aca-government-affairs-blog/aca-government-affairs-blog/2021/04/05/counseling-compact-update>
- Merriam-Webster. (n.d.). Self-indulgence. In Merriam-Webster.com dictionary.
<http://unabridged.merriam-webster.com/>
- Meyers, L. (2020, April 8). Interstate compact plan provides hope for licensure portability. *Counseling Today*. <https://ct.counseling.org/2020/04/interstate-compact-plan-provides-hope-for-licensure-portability/>
- Mitchell, J. T. (1983). When disaster strikes...The Critical Incident Stress Debriefing. *Journal of Emergency Medical Services*, 8, 36-39.
- Mitchell, J. T (February 10, 2003). Crisis intervention & CISM: A research summary. Ellicott City, MD: International Critical Incident Stress Foundation. <https://www.icisf.org/wp-content/uploads/2013/04/Crisis-Intervention-and-CISM-A-Research-Summary.pdf>
- Mitchell, J. T. & Everly, G. S. (1997). The scientific evidence for critical incident stress management. *Journal of Emergency Medical Services*, 22(1), 86-93.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model. *Journal of Counseling and Development*, 78(3), 251-266.
- Myers, J. E., & Sweeney, T. J. (2007). *Wellness in counseling: An overview* (ACAPCD-09). Alexandria, VA: American Counseling Association.

- Mitchell, J. (2008, May 9) Critical incident stress debriefing. <http://www.info-trauma.org/flash/media-f/mitchellCriticalIncidentStressDebriefing.pdf>
- National Board for Certified Counselors. (n.d.). *AMHCA-ACES-NBCC portability standards for counselors*. http://www.nbcc.org/assets/eblast/AMHCA-ACES-NBCC_Portability_Plan.pdf
- National Board for Certified Counselors and Center for Credentialing and Education. (2016). Code of Ethics. <http://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf>
- National Council of State Boards of Nursing. (n.d.). APRN compact [Web page]. <https://www.ncsbn.org/aprn-compact.htm>
- National Council of State Boards of Nursing. (2015a, April). *The APRN compact: A summary of the key provisions*. https://www.ncsbn.org/Key_Provisions_of_New_APRN_Compact.pdf
- National Council of State Boards of Nursing. (2015b, May 4). *Model APRN compact legislation*. https://www.ncsbn.org/APRN_Compact_Final_050415.pdf
- National Practitioner Data Bank, U. S. Department of Health and Human Services. (2015). <https://www.npdb.hrsa.gov>
- Oates, W. E. (1971). *Confessions of a workaholic: The facts about work addiction*. New York, NY: World.
- Oxford English dictionary* (3rd.). (2014). New York, NY: Oxford University Press.
- Psychology Interjurisdictional Compact. (2019, April 23). Psychology interjurisdictional compact (PSYPACT) becomes operational [Press Release]. <https://www.asppb.net/news/448039/PSYPACT-becomes-Operational.htm>
- Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory and application* (4th ed.). Alexandria, VA: American Counseling Association.
- Remley, T. P., & Herlihy, B. (2016). *Ethical, legal, and professional issues in counseling* (5th ed.). Boston, MA: Pearson Education.
- Robinson, B. E. (2014). *Chained to the desk: A guidebook for workaholics, their partners and children, and the clinicians who treat them* (3rd ed.). New York, NY: NYU Press.
- Shallcross, L. (2011, January 17). Taking care of yourself as a counselor [Blog post]. <http://ct.counseling.org/2011/01/taking-care-of-yourself-as-a-counselor/>

- Skovolt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health practitioners*. Boston, MA: Allyn & Bacon.
- Stone, C. (2005). *School counseling principles: Ethics and law*. Alexandria, VA: American School Counselor Association.
- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology*, 47, 527-540.
- Wakefield, M. (2012, October 17). Remarks to the Tri-Regulator Symposium. HRSA Speech. Health Resources and Services Administration. Department of Health and Human Services. <https://www.hrsa.gov/about/news/speeches/2012/10172012symposium.html>
- Wakefield, M. (2013). *Health licensing board report to Congress*. (Requested by Senate Report 111- 66). Pg. 17. Posted April 23, 2013. <https://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>
- Wallis, L. (2015, September). The case for license portability. *The American Journal of Nursing*, 115(9), 18-19. doi: 10.1097/01.NAJ.0000471239.08080.fb
- Webber, J. M., & Mascari, J. B. (2009). Critical issues in implementing the new CSACREP standards for disaster, trauma, and crisis counseling. In G. R. Walz, J. C. Bleuer, & R. K. Yep (Eds.), *Compelling counseling interventions: VISTAs 2009* (pp. 125-138). Alexandria, VA: American Counseling Association. <https://www.counseling.org/Resources/Library/VISTAS/2009-V-Print/Article%2012%20Webber%20Mascari.pdf>
- When was HIPAA enacted? (2018, March 9). <https://www.hipaajournal.com/when-was-hipaa-enacted/>
- Wilson, R. (2013, September 16). Washington Post. State PACs contributed \$1.4 billion on to candidates running for governor, attorney general, state legislative, and other state-level office. <https://www.washingtonpost.com/>
- Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the lifespan. *Journal of Counseling and Development*, 71, 140-148.
- Wright, C. (2016, October 9). The truth about workaholism [Blog post]. Retrieved from <https://www.thefix.com/content/reckless-pursuit-being-busy>

Appendix A: Clinical Mental Health Counselor (CMHC) Standards

This list of CACREP Clinical Mental Health Counselor (CMHC) Standards includes the standards that are addressed in the Richmond Graduate University's course titled CED 6123 (Ethical, Legal, and Professional Standards in Professional Counseling and Marriage and Family Therapy).

- Ethical and legal considerations specifically related to the practice of clinical mental health counseling (CMHC A.2.)
- Professional organizations, preparation standards, and credentials relevant to the practice of clinical mental health counseling (CMHC A.4.)
- Professional issues that affect clinical mental health counselors (e.g., core provider status, expert witness status, access to and practice privileges within managed care systems) (CMHC A.7.)
- Professional issues relevant to the practice of clinical mental health counseling. (CMHC A.9.)
- Operation of an emergency management system within clinical mental health agencies and in the community. (CMHC A.10.)
- How living in a multicultural society affects clients who are seeking clinical mental health counseling services. (CMHC E.1.)
- Current literature that outlines theories, approaches, strategies, and techniques shown to be effective when working with specific populations of clients with mental and emotional disorders. (CMHC E.3.).

Appendix B: Tracking a Bill Through The General Assembly [Georgia]

Idea

Legislator sees need for a new law or changes in existing law and decides to introduce a bill.

Drafting

Legislator goes to Office of Legislative Counsel. There, attorney advises legislator on legal issues and drafts bill.

Introduction and First Reading

Legislator files bill with the Clerk of the House or Secretary of the Senate. On legislative day after filing, the bill is formally introduced. In chamber, the bill's title is read during period of first readings. Immediately after first reading, presiding officer assigns the bill to a standing committee.

Second Reading

In the House only, on the next legislative day, the Clerk of the House reads the bill's title (second reading) in chamber, although the actual bill is now in committee. In Senate, the second reading comes after the bill is reported favorably from committee.

Committee Action

The bill is considered by a committee. The bill's author and other legislators may testify. If the bill is controversial, public hearings may be held. Final Committee action is reported in a written report. Committee options are:

- Recommend Bill or Resolution Do Pass;
- Recommend Do NOT Pass;
- Recommend Do Pass with changes (amendments or substitutes);
- Hold Bill.

Third Reading and Passage

Clerk or Secretary prepares a General Calendar of bills favorably reported from committee.

- Legislation which was second read the day before is placed on a calendar in numeric order for floor action prior to the Rules Committee meeting to choose bills for consideration.
- After a certain point, set by rule, the Rules Committee meets and prepares a Rules Calendar for the next day's floor consideration from bills on General Calendar.
- The presiding officer calls up bills from the Rules Calendar for floor action in order as they appear on this calendar.

Once presiding officer calls bill up from Rules Calendar, Clerk or Secretary reads bill's title (third reading). Bill is now ready for floor debate, amendments, and voting. After debate, main question is called and members vote. If bill is approved by majority of total membership of that house, it is sent to the other house.

Transmittal to Other Chamber

The bill is passed if:

- If second chamber passes bill, it is returned to chamber where bill was introduced.
- If first chamber rejects changes and second chamber insists, a conference committee may be appointed. Committee report is accepted by both chambers.

The bill is enrolled and sent to the Governor (if requested). Otherwise, all enrolled bills sent to Governor following adjournment sine die.

Governor's Signature or Veto

Governor may sign the bill or do nothing, and the bill becomes law. Governor may veto the bill, which requires two-thirds of members of each house to override.

Act

Act and other laws enacted at the session are printed in the Georgia Laws series. Also, act is incorporated into the Official Code of Georgia Annotated. Act becomes effective the following July 1, unless a different effective date is provided in act.

Georgia General Assembly. (n.d.). Tracking a bill through the General Assembly. Retrieved from <http://www.legis.ga.gov/Legislation/en-US/default.aspx>

Appendix C: Correct Citation for Reference Entry

The reference entry correct citation styles for this document are illustrated below. Students should defer to the style preferences of their individual course instructors to determine whether the course instructor has preferences that are more specific than those shown below:

American Psychological Association

Doverspike, W. F. (2017). Counselor ethics: CACREP student learning objectives.
<http://drwilliamdoverspike.com/>

Chicago Manual of Style / Kate Turabian

Doverspike, William, “Counselor Ethics: CACREP Student Learning Objectives,” January 1, 2020. <http://drwilliamdoverspike.com/>

Note: According to the Chicago Manual of Style, blog posts are typically not included in bibliographies, but can be cited in the running text and/or notes. However, if a blog is cited frequently, you may include it in the bibliography.

Modern Language Association

Doverspike, William F. “Counselor Ethics: CACREP Student Learning Objectives.” 17 Jan. 2020 [Date accessed]

Note: MLA guidelines assume that readers can track down most online sources by entering the author, title, or other identifying information in a search engine or a database. Consequently, MLA does not require a URL in citations for online sources such as websites. However, some instructors still ask for it – double-check if your instructor requires it.

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Some content, citations, and references last updated 2022.

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