

Counselor Ethics: CACREP Student Learning Objectives
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Updated 08-18-2017

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 (USSR), commonly known as the Soviet Union, successfully launched the world's first artificial satellite. Sputnik I was roughly 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 feared that education in the USSR was superior to public education in the United States (US). At that time, the majority of US engineers, mathematicians, and scientists went into relatively well paid jobs in private industries rather than becoming public school teachers, a trend that caused concern that the US 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 in the United States was born.

Four years after the shock of Sputnik I, on April 25, 1961, the Soviet cosmonaut Yuri Gagarin became the first human in space, further embarrassing the US. Within a month (May 25, 1961), the US 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 US proclaiming itself winner of the space race that the US 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 (CMA). 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).

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; Remley & Herlihy, 2016). Counselors share with other mental health professionals the belief that primary prevention and early intervention are considered to be 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. With respect to seeing 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.

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, the National Vocational Guidance Association (NVGA), was founded in 1913 as the first career-guidance organization in the US. On its official website (<https://www.counseling.org/>), the American Counseling Association (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, 2017, p. 1)

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. 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

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

The Health Insurance Portability and Accountability Act (HIPAA; Pub. L. 104-191, 110 Stat. 1936) is a federal law that was enacted August 21, 1996 and signed by President Bill Clinton. HIPAA is also known as the Kennedy-Kassebaum Health Insurance Portability and Accountability Act (HIPAA-Public Law 104-191). The 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. A dilemma is sometimes created when a counselor is required to provide additional clinical information to justify continued care, because the information can be used by the MCO to limit the amount of authorized care. When working with managed care clients or in 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 limits and even denies 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).

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. The 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 unacceptable), (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.)

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.

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.

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" (<http://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” (<http://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., 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). 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, Herbert Freudenberger 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.

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).

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

From an ethical and legal perspective, supervision is based on the principle of *respondere 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.

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 was reviewed at its 10 year anniversary (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 much [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 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 supporting 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. 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>).

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

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 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>).

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 in the US. CACREP provides accreditation to qualified training programs, whereas NBCC provides certification to qualified counselors.

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 who 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.

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 to write a magazine article about a client. Whereas it appropriate advocacy efforts may include citing published research that supports the efficacy of a specific psychotherapy technique, 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 impediments to 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 US 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, 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 the ACA (2014) Code of Ethics Section D.1.h (Negative Conditions), 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 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 American Counseling Association (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

Rica and the District of Columbia) have adopted the *ACA Code of Ethics* into their jurisdiction's licensing board regulations. The National Board of 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, the 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" (American Counseling Association, 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 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 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. 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).

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.

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**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

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 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 [Blog post]. Retrieved from <http://drwilliamdoverspike.com/>

Chicago Manual of Style / Kate Turabian

Doverspike, William, “Counselor Ethics: CACREP Student Learning Objectives” (blog), August 17, 2017. <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.” Web blog post. 17 Aug. 2017 [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.