Comment

In Response to Brooks and Gerstein: Mental Health Counseling Is More Diverse Than You Imply

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Current and past presidents of the Washington Mental Health Counselors Association respond to Brooks and Gerstein's (1990) article "Counselor Credentialing and Interprofessional Collaboration." They question whether descriptions of mental health counseling practices and standards contained in that article apply to the majority of mental health counseling practitioners.

"Counselor Credentialing and Interprofessional Collaboration" (Brooks & Gerstein, 1990), an article published in the May/June issue of the *Journal of Counseling & Development*, reveals a number of perspectives on the field of mental health counseling that we find incompatible with our experience as private counseling practitioners and as presidents of the Washington Mental Health Counselors Association. We are particularly concerned that leaders of the American Mental Health Counselors Association (AMHCA) have overestimated the homogeneity of its membership, and as a result, are pursuing a course that does not represent the whole spectrum of work settings, philosophical orientations, and subspecialties of mental health counseling found within its ranks.

INCOMPLETE DATA PROVIDED

Part of our concern is based on the statement by Brooks and Gerstein that private practice is the dominant work setting for both AMHCA and AACD members. Although this statement is technically correct, we believe it is misleading because it fails to acknowledge data that indicate just how few mental health counselors actually are engaged in private practice.

Data contained in *Leadership Update* (1990), a newsletter distributed to state, regional, and national counseling leaders by AACD, show that more AMHCA members work in private practice than in any of the other 22 work settings tabulated. Still, only 36% of the AMHCA membership actually work in private practice. In an earlier article another AMHCA leader misstated the number of counselors in private practice by at least 29% when he said, "Today, the majority [of AMHCA members] are working in private practice (22%)" (Weikel, 1985, p. 459).

Consistent with the perception that most of its members are engaged in private practice and utilize the clinical model, the Governing Council of AMHCA unilaterally endorsed the Certified Clinical Mental Health Counselor (CCMHC) credential as the standard for all counselors in private practice. The implications of this action are not clear unless one has access to the AACD data previously cited. Only then does it become apparent that 2.5% of the AACD membership and less than 12% of the AMHCA membership possess this clinically oriented subspecialty credential. It is most disturbing to us that such a small minority of mental health counselors have established a narrow standard of practice for only 36% of the AMHCA membership but have failed to create a relevant standard for 64% of the AMHCA membership employed in other work settings.

Although Brooks and Gerstein accurately stated that private practice also is the dominant work setting for AACD members in general, they again failed to report that only 17% of the total AACD membership are engaged in private practice. Of these, the majority (56%) do not belong to AMHCA and, in all likelihood, had no say in defining or establishing this standard of practice.

NOT ALL MENTAL HEALTH COUNSELORS ARE CLINICALLY ORIENTED

By advocating the CCMHC examination and standards, AMHCA apparently presumes that most of its members utilize the clinical model, work primarily with clients possessing psychiatric diagnoses, and intend to acquire the CCMHC credential. Again, this presumption does not match our personal experience as counselors nor does it seem to match the experience of the members in our state AMHCA branch.

During our respective terms of office, we have collected input from the vast majority of our membership via letters, phone calls, membership meetings, workshops, round table discussions, and formal surveys. We discovered that most members reject the clinical model for two reasons. First, they have difficulty identifying with the term *clinical*, which the *Random House Dictionary of the English Language* (Flexner & Hauck, 1987) defined as "concern with or based on actual observation and treatment of disease in patients . . . " (p. 387). The medical and disease connotations

associated with this term undermine our members' strong developmental orientation and their belief that clients are basically healthy individuals, precepts that Brooks and Gerstein acknowledge are the foundation of professional counseling.

Second, a large majority of our members were not oriented to the clinical model during their graduate training programs. The results of a survey conducted by the senior author of this article (Metcalf, 1988) revealed that only 28% of our members believe their professional education adequately prepared them to diagnose psychopathology and treat it from a clinical perspective. An additional 46% acquired these skills through on-the-job experience or continuing education, and the remainder simply did not use them in their particular work settings.

Most of our members do not believe the clinical model represents the whole spectrum of their counseling activities. Although they counsel clients with clinical diagnoses, they generally do so by focusing on strengths rather than psychopathology. Their case loads also contain a sizable portion of healthy clients seeking guidance in a variety of personal growth and developmental areas such as education, communication, relationships, careers, marriage, parenting, divorce, life crises, grief and loss, retirement, aging, and death and dying.

Washington counselors also have strongly resisted acquiring the CCMHC credential. Out of approximately 1800 mental health counselors who achieved Washington state mental health counselor certification, only 6 simultaneously possess the CCMHC credential. When a small handful of clinically oriented mental health counselors in our state attempted to impose the CCMHC examination and many of its standards on all professional counselors seeking Washington state certification, only 6% of our membership who provided written input to the Department of Licensing supported the proposed criteria. The "generic" or multidisciplinary emphasis of the National Certified Counselor (NCC) credential, held by 369 Washington counselors (National Directory of Certified Counselors, 1988), has more appeal for our members than the CCMHC credential, which many associate with treating more severely impaired clients.

This perception of the CCMHC credential was further reinforced by Washington State Department of Licensing personnel, who presented a comparison of the CCMHC competency-based and the NCC knowledge-based examinations (Department of Licensing, 1988) at a public forum 2½ years ago. Their analysis revealed that the NCC examination contained 200 questions, with an equal number of questions distributed throughout each of the eight content areas recommended in standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

The CCMHC examination included 150 questions, although they were unequally distributed among nine content areas. Three content areas were overemphasized, including (1) the helping relationship, (2) group dynamics, process, and counseling, and (3) treatment of actual cases, a category of clinical application added to the eight CACREP content areas. These three categories represented almost two-thirds of the entire CCMHC examination, with the remaining questions scattered among six other content areas.

Their analysis also revealed that the CCMHC examination virtually omitted two of the CACREP content areas, including (1) life-style and career development and (2) research and evaluation. These areas, essential in the counselor's ability to understand the client world as well as choose and evaluate effective interventions, reportedly warranted only two questions each in the CCMHC examination! As a result of the analysis, Department of Licensing administrators eventually revised or rescinded a number of regulations previously authorizing exclusive use of the CCMHC examination for testing purposes in the Washington state certification process.

Brooks and Gerstein bemoaned the fact that most state credentialing boards fail to evaluate the clinical competency of applicants, and cited studies they hope might eventually lead us closer to evaluating counselors' performance. Loesch and Vacc (1988), authors of one study they cited, however, stated in their findings that "in creating a competency-based examination, it is necessary to have a comprehensive, consensually agreed-upon set of competencies to serve as the basis for the examination. Clearly, no such set of competencies exists in the counseling profession" (p. 17).

We are convinced that competency-based examinations in the field of counseling are premature at this time. Therefore, we are gravely concerned about the cavalier attitude of those who disdain well-developed, psychometrically defensible, knowledge-based examinations in favor of competency-based examinations. We also question whether the field of counseling, which incorporates a variety of incompatible theories and methods, will ever evolve to the stage where counselors can agree upon the one *right* way to conduct intake interviews, evaluate clients, develop and implement intervention plans, confront client defenses, assess progress, terminate counseling relationships, or perform the plethora of other tasks encountered within a typical counseling practice.

PROPOSED INCREASES IN STANDARDS AND THEIR POTENTIAL IMPACT

In addition, Brooks and Gerstein discussed current trends of making educational and supervisory standards more extensive and stringent. These trends presumably are based on the assumption that longer educational and supervisory periods necessarily result in increased competency, an assumption that has not been adequately substantiated, in our opinion. We believe such trends have been fostered and supported by AMHCA as a means of enhancing counselor credibility and reducing reluctance to grant third-party reimbursement for counselors who engage in independent private practice. While some increases in education and supervision may eventually prove beneficial, we believe increases should be based on convincing empirical evidence rather than mere desires for added status and financial gain.

We also are concerned about the possible impact substantial increases in education or postgraduate supervision might have on the field of mental health counseling. One area of particular concern is the ability of mental health counseling to attract minorities and financially disadvantaged students to the profession. (Our own state branch of AACD has only an estimated 2%–3% minority population.) As members of a helping profession, we cannot ignore the fact that pricing any group out of the "marketplace" (the field of practitioners) is an exclusionary, discriminatory tactic that exacerbates the problem of achieving balanced ethnic and multicultural representation within the field. This tactic may also effectively diminish competition, which, hopefully, is not a hidden agenda behind the current drive for increased standards.

Another possible implication of increased standards is the potential unavailability of postgraduate internship sites. The state of Washington, like most western states, still possesses a rural character throughout much of its geographical region. Opportunities for acquiring 3000 or more hours of meaningful, postgraduate, supervised employment within clinical settings are very limited outside a few major metropolitan areas.

In our opinion, proposed increases in standards need to be carefully studied to determine their potential impact on the mental health counseling profession before requiring further commitments from those seeking to enter the field. As the time and cost of meeting additional standards continue to increase and begin to parallel the investment made by doctoral level psychologists, one wonders why prospective graduate students would seriously consider pursuing a master's degree in mental health counseling. What an ironic tragedy it would be if efforts to seek parity with licensed psychologists backfire and diminish our ranks rather than enhance them.

CONCLUSIONS AND RECOMMENDATIONS

Assuming the perspective and experience of Washington state mental health counselors are not unique, it would behoove the leaders and members of AMHCA and its state branches to review the composition of their collective memberships and seriously explore whether the needs and interests of all members are being met within their organizational structures. If current goals, policies, and standards fail to represent the needs of the entire membership, leaders and members must initiate open-minded dialogues in an effort to bring about necessary changes.

Some of the changes we anticipate members might want implemented include:

1. Modifying the current standard of practice to incorporate the full spectrum of work settings, philosophical orientations, client populations, and subspecialties found within the field of mental health counseling;
2. Modifying the CCMHC examination so questions are evenly balanced among its content areas;
3. Converting the CCMHC examination to a measure of counseling-related information and skills rather than competencies until such time that a set of comprehensive, consensually agreed-upon competencies have been established and can serve as a basis for examination; or adding a knowledge-based clinical component to the NCC examination;
4. Measuring proposed increases in standards against their impact on the entire AMHCA membership;
5. Increasing educational or supervisory requirements only if warranted by empirical evidence;
6. Acknowledging that proposed increases in standards potentially affect more AACD members than AMHCA members and seeking input from leaders of other AACD divisions before implementing further increases.

As the last item implies, leaders of other AACD divisions need to determine whether their members who are engaged in private practice have been adversely affected by AMHCA standards. In the event that this has occurred, division leaders must work with AMHCA to ensure that the needs of all AACD members engaged in private practice are addressed.

We encourage counselors to reaffirm during their discussions with AMHCA leaders the health and wellness philosophy that has set counseling apart from other mental health disciplines. Counselors, in our opinion, should be cautious about disavowing their historical roots or randomly increasing their clinical standards in the hope of gaining acceptance from insurance companies and well-established mental health professions that may gain financially by withholding recognition. As members of the counseling profession, we must remember that the whole health care system in the United States is in flux. It could be very shortsighted to revamp the nature of counseling so that it fits traditional service delivery models when these models may soon become obsolete.

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