UNIT - 1

INTRODUCTION HISTORY AND TRENDS IN COUNSELLING

Historical Background :

1950s: Mid Century Legislations If one decade in history has to

be singled out for the most profound impact on counselors, it would be 1950s (Aubery). Major

highlights of this decade are given below:

- American Personnel & Guidance association was formed in 1952. It was concerned with

vocational,

educational and other personnel activities.

- Division 17

of Counseling Psychology, separate from guidance, was established. Previous division was guidance

and counseling and this new division was established to distinguish it from clinical psychology

division. This separation was partly affected by Veterans Administration and was influenced more by

the desire of APA members to work with normal people.

- National Defense Education Act (NDEA) of 1958 provided funds to strengthenschool guidance

programs and train school counselors.

- At that time

the most popular theories were psychoanalysis and insight oriented theories, trait- factor, and

client centered theories. This decade is also important for the development of new theories, such

as Behavioral, Cognitive and Learning theories.

- Extension of the earlier Vocational Rehabilitation Legislation acts

1954 is another important feature

of this decade. Other notable legislations include the Vocational Education Act of 1963, the 1968

amendments, and subsequent amendments.

- Rehabilitation acts helped provide financial support for an extensive program to educate rehabilitation counselors specialized in assisting the disabled. Since its inception, it has provided training to several thousand counselors.

1960s:

- The initial focus was on counseling as a developmental profession. Gilbert Wrenn set the tone for the decade and became one of the strongest counseling advocates. He wrote the widely influencing book The Counselor in a Changing World and worked to resolve developmental needs.
- This impact gradually declined as the decade continued because of 3 events: o Vietnam War

o Civil right movement

o Women's movement

- Each event pointed out needs within society and the main focus of that time was on crises counseling and other short-term interventions.
- Powerful influences of Humanistic theories of Maslow and Jourard.

- The period after World War II also saw a rapid expansion of community mental health services.

The 1963 Community Mental Health Centers Act authorized establishment of such centers. Abo ut

two thousand centers were expected to provide 5 essential services: o Inpatients

o Outpatient

o Partial hospitalization

o Emergency care

o Consultation

- In 1955 US Congress passed a Mental Health Study Act which opened opportunities for counselors

outside education. This study resulted in a report "Action for Mental Health" in 1961.

- Requirements of a comprehensive center: o Diagnosis

- Rehabilitation

- Pre-care and aftercare

- Training

- Research & evaluation

- The first decline in the number of patients in state mental hospitals was seen in 1955,

despite an increase in the number of admissions, and it was steady over the next 20 years. A

minimum of 5 services were required for establishment of such centers, while 5 optional services

were required to a mandated set of 12.

- The Community Mental Health Centers Amendments of 1975: Further amendments in 1978 set new

criteria for the establishment of such centre. It was essential to satisfy 6 initial services

(followup service was added to previous 5), then over 3 years these centers could phase in

gradually.

- Special services for children

- Special services for the elderly
- Preinstitutional screening & alternative treatment
- Follow-up for discharged persons
- Transitional living for discharged persons
- Alcoholism services
- Drug abuse services

- In 1996, the US Congress passed the Mental Health Insurance Parity Act.

1970s:

- Diversification in counseling settings: Before this time almost all counselors had been

employed ineducational settings, usually in public schools. Now they were hired in community mental

health centers. Rate of growth of school counselors declined from 6-10% (1960s) to 1- 3% (1960-70s).

- Community counselor could work in any setting, e.g., in child abuse centers, hospitals, organizations, etc.
- Consistent with this, there was an increase in counselor education programs. Counselor programs increased from 327 in 1964 to about 475 by 1980.
- Lewis and Lewis (1977) coined the term community counselor.

- Helping-skills programs: Helping-skills programs concentrated on communicationand relationship skills, and the emphasis was humanistic and eclectic.
- Guidelines for Master's (1973) and doctorate (1978) degrees in counseling were outlined

1980s:

- Counselor Licensure Movement was initiated for official approval of the profession and also to maintain standards of education in graduate degree programs.

- The National Board for Certified Counselors (NBCC) was formed in 1983. The NBCC developed a

standardized test and defined 8 major areas of knowledge: o Professional identity o Social and

cultural diversity

o Human growth and development

o Career development

o Helping relationships

o Group work

o Assessment

o Research and program evaluation

- By the end of the decade, there were approximately 17,000 professionals.

- By the years 2000, there were 31,342 nations (US) certified counselors.

- By 2001, 46 US states

had passed legislation to license counselors. A register was maintained of trained counselors.

1990s:

- In 1992, AACD changed its name to American Counseling Association (ACA) with 16 subdivisions.

The changed name better reflected the work of the members.

- Increased attention to counseling within a

pluralistic society: Multicultural issues were given due attention in a pluralistic society.

- There was a renowned interest within counseling on addressing issues related to the whole

person.

Counselors became more aware of social and environmental factors important tothe development and

maintenance of mental disorders and health. There was a gradual trend that there are several

factors which are important to the development of human beings, e.g., spiritual, socio-economic,

family, etc.

Recent Trends in Counseling

In 21st century, the counseling profession is impacted by globalization and technology. In the late

1980s and early 1990s, counseling extended to various new directions:

- Outreach services for the poor & homeless
- Outplacement services or middle-aged workers and senior executives
- Prevention and early intervention programs for alcohol and drug abusers
- Emerging concerns with retirees
- Stress management
- Sports & leisure counseling
- Multi-cultural counseling
- Globalization and technology

Definition of Counselling :

counselling is a contracted meeting between a client and a counsellor. The meeting happens at a set

time, in an agreed place, for the sole benefit of the client.

History of Counselling :

In the 1890's, German neurologist Sigmund Freud developed a theory later to be called

psychoanalysis, which allowed individuals to tell their problems to a 'psychoanalyst,'

an individual trained in interpreting the 'subconscious' , that part of our psyche that

we are not aware of but influences what we do. Freud played an important part in the history of

counselling, but the actual word "counselling" did not come into everyday language until the 1960's

Counselling really took off after the Second World War, in 1950's America. Most of the therapies we

hear about today can trace their origins back to a handful of psychologists and psychiatrists

(some of whom we will look at in this guide) who developed techniques and theories, sometimes referred to as ‘schools’ of therapy.

The word ‘school’ in counselling does not mean a building or campus. Rather it refers to how psychologists believe human beings develop their view of the world they live in and how they cope with it. The three schools are Psychoanalytical, Behaviourist, and Humanistic, which we will look at later in this guide.

There have been many developments in counselling since the 1950’s. A lot of research has taken place and this has given us a better understanding of what makes human beings think and act in certain ways. However most psychologists and counsellors would agree that we are a long way from fully understanding what makes each human being unique.

It is worth considering that counselling has rapidly developed since Freud's time with hew ideas an approaches emerging from the late 1800s to the present day.

Current Trends in the new millennium :

(1) , six trends regarding the future of psychology that will lead us into the 21s t century. These include psychotherapy integration, specialization, managing psychotherapy, expansion of the

scope of practice, cultural diversity, and psychotherapy without walls.. Studying

specific techniques as they relate to symptom reduction fails to take into account the participants— therapist and client.

(2) Psychotherapy integration focuses on core ingredients, such as the therapeutic alliance and

client expectancies. It also uses more sophisticated matching studies to formulate conceptions of

the right therapist for the right client in the right context as opposed to the right technique for the right problem. The trend toward specialization addresses the reality that the field of psychotherapy is highly competitive in a market of decreased governmental and insurance dollars as well as a geometrically increasing number of service providers. Specialization, an adaptation to the overpopulated and underfunded psychotherapy

market, will occur both in training and in the practice of psychotherapy In the training arena, there is a proliferation of specialty programs at the predoctoral and postdoctoral levels. The American Psychological Association (APA) has responded to the trend

toward specialization by forming the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), established in 1995 to review petitions requesting APA recognition for a specialty or proficiency. A specialty is defined as a field that requires comprehensive training, e.g., clinical psychology, health psychology, whereas a proficiency is defined as a more concrete skill, such as biofeedback and hypnosis. Debates about

the need for specialization in psychotherapy will continue. Specialization has its dangers; one of them is the potential exclusion of generalists in major shares of the psychotherapy market. There is also the potential danger of specialization in the training arena. With growing competition among professional training programs for students, more will begin to offer either specialty tracks or simply define themselves as a specialty

program. We must be careful not to sacrifice sound, comprehensive general training curricula for

flashy "faddish" specialization tracks. Managing psychotherapy is a major trend in mental-

health-service delivery. Many psychotherapists are losing their autonomy in clinical

decision- making and economic stability with the expansion of managed care. Despite

the many shortcomings of the system, managed care is the dominant economic force in health care

delivery and will continue to be so for many years. It is widely

accepted by the public and by mental-healthservice providers. Approximately 125 million Americans

are enrolled in managed

care programs. In a recent survey by Norcross, Orlinsky and Beutler, 60% of a sample of the

Division of Psychotherapy members of the APA were accepting managed care patients for more than a

year. Some of the more egregious sins of managed care will be rectified not only because of public

clamor, but because it is cost effective to the corporate entities. Since there is a dramatic

drop-off in the number of clients continuing treatment after just a few sessions, it is cost

effective to reduce drastically the amount of paper work presently required for the

intake of managed care clients. Similarly, the authorization process will also be

streamlined to reduce management costs, while more emphasis will be placed on utilization review.

Though managed care has been widely accepted by the public, certain aspects of it are not acceptable. Patients are demanding the right to due process of their grievances and the right to sue for mismanagement, negligence, and fraud. They also want the right to better access to specialists and the right to choose their own practitioner. These changes will occur. The future of the independent practice of psychotherapy will rely upon a variety of arrangements, including practitioners working for, or contracting with, managed care entities, models of independent practice, such as those described by Pipal (3), Kovacs (4), and privately owned and operated professional groups. Competition for mental health dollars will also expand the scope of practice. One dramatic example is the movement of psychologists to obtain prescription privileges. In 1996, the APA Council of Representatives formally endorsed model legislation and curriculum for prescriptive authority (5). Legislation has been introduced for prescriptive authority by several state associations and curricula are being implemented in several universities. Another "hot" new addition to traditional psychological

services is psychological coaching. It combines aspects of the psychotherapeutic relationship with

organizational techniques, such as skill development and performance enhancement, to assist clients

with everyday work and family problems. The realities of a changing population will force the

field of psychotherapy to address the issue of cultural diversity. Approximately one third of our

population consists of cultural minorities (6). Psychotherapy cannot survive without

addressing the needs of a diverse population as well as the development of relevant and accessible

services. Addressing cultural diversity requires focused effort on delineating the needs of

ethnic minorities. There are four primary reference groups: Native Americans, African Americans,

Asian Americans, and Hispanic AmericansLatinos (7). Currently, there is a rich variety of

resources already available to enhance training in cultural diversity (8-10) that will help to

foster culturally sensitive clinicians. However, psychotherapy

research lags far behind training in addressing cultural diversity. As an example, in a

recent article (11) I vigorously criticized a Division 12 task-force report on effective

psychotherapies,

a.k.a. empirically validated therapies, as "espousing empirically validated treatments for White

people" (p. 214). Its insensitivity to the issues of cultural diversity in the

formation of generalities as to whom to deliver what services was astounding. Watts

(10) notes four perspectives that can contribute to a psychology of human diversity: a)

population-specific psychologies, such as the psychology of women or

Asian-Americans; b) sociopolitical perspectives that expunge historical, economic, and system

analysis; c) crosscultural psychology; and d) ecological psychology. He identifies how each of

these perspectives facilitate theory and action. While research in diversity is in the embryonic

stage, Yutrzenka (7) does report that new cultural-inclusive theoretical models are being developed

as well as more culturally sensitive and culturally inclusive research designs and methodologies.

Dealing with violence, trauma and crises, the challenge of managed care, promoting wellness,

concern for social justice, greater emphasis on the use of technology and relationship :

Crisis is a ubiquitous experience, and all counselors will inevitably encounter a client who is

in crisis or has experienced a traumatic event. Thus, it is important for all counselors to have a basic understanding of crisis and trauma theories, assessment, and interventions. According to James (2008, p.1) [2], crisis is defined as “a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms.” A crisis can be described as a state of disequilibrium which occurs when a person has reached a state where their resources and coping mechanisms are stretched too far [3].

Individuals who experienced the crisis might have irrational beliefs toward self, others, and the world [18]. A disaster can be natural, such as a hurricane, tsunami, or tornado, or can be man-made, such as a mass shooting or terrorist attack. It is a sudden event that disrupts the functioning of a community or society and often results in human, material, or economic losses. Trauma is much more difficult to define as the term has often been used to describe almost any stressor experienced by an individual [4].

At the most basic level, trauma refers to the emotional response an individual has to an event that

was perceived to be physically or emotionally harmful. The Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5; American Psychiatric Association [APA], 2013) [5] lists a traumatic stressor as: exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event, witnessing, in person, the event(s) as it occurred others, learning that the traumatic event(s) occurred to a close family member or close friend..., experiencing repeated or extreme exposure to aversive details of the traumatic events(s). (e.g., first responders collecting human remains…) (p. 271). The traumatic event has “lasting adverse effects on an individual’s mental, physical, social, and spiritual wellbeing” (p.7) [6].

While crises are relatively brief events, a trauma response is more extreme, enduring and involves specific psychological and physiological responses (Levers, 2012). Cohen and Mannarino (2015) [19] reported that trauma exposure is correlated with increased risks of medical and mental health problems, such as PTSD, depression, anxiety, substance abuse, attempted suicide, and so forth. The effects of trauma are prolonged, as individuals may have recurrent experiences of the event, amplified arousal, negative thoughts, moods or feelings

and avoid thoughts, places, and memories related to the event [5]. While all traumas are caused by

a crisis, not all crises result in trauma [4, 17]. Crises and traumatic events are highly

subjective experiences from which people construct their own meaning. A person's response to a

crisis or traumatic event is often determined by factors such as time, cultural beliefs,

availability of social supports, and developmental stages [6]. For example, in some

cultures, the subjugation of women is a common practice, and the experience of domestic

violence is not necessarily considered to be a traumatic event.

Wellness is a positive state of being, brought about by the simultaneous, balanced, and synergistic

satisfaction of personal, relational, and collective needs. For wellness to take place in each one

of these domains, and for it to flourish at the intersection of them all, justice ought to be

present in each and every one of them. Wellness cannot flourish in the absence of justice, and

justice is devoid of meaning in the absence of wellness. We will demonstrate in this chapter the strength of the wellness – justice nexus, and we will offer recommendations for aligning counseling practices with the need to promote wellness and justice at the same time. The

first section of this chapter elucidates the connections between wellness and justice at the

personal, relational, and collective levels of analysis. In light of that background, the second section distills ethical dilemmas associated with prevailing counseling practices. We explore how dominant modes of practice contend with the need to advance wellness and justice at the personal, relational, and collective levels at the same time. Each practice is subjected to scrutiny for its success or failure in promoting wellness and justice. Following a critique of existing forms of counseling, the third section outlines innovative practices that may fulfill the requirement for promoting wellness and justice, at the same time, at all the levels. This is a high calling and not without obstacles or dilemmas. Hence, we subject our own recommendations to close scrutiny as well. We debate each recommendation and offer potential solutions to the various dilemmas we encounter along the way.

In recent years an increasing number of mental health professionals and scholars have presented convincing arguments in favor of a value-based approach to counseling. This perspective asserts that as counselors we bring a set of values to work, that if we don't challenge the societal status quo we tacitly support it, and the if we concentrate exclusively on

intra- psychic dynamics we run the risk of neglecting the social origins of suffering and distress. A great deal of scholarship has demonstrated that professionals cannot neutralize their personal values, that passivity in light of injustice amounts to complicity, and that the value of individualism reigns supreme in society and the mental health professions (Dokecki, 1996; Prilleltensky, 1994, 1997; Prilleltensky & Nelson, 2002; Wang, in press). In this chapter we go beyond well established critiques of dominant mental health practices: We strive to tackle the ethical dilemmas that stem from knowing that (a) we are value-laden professionals, (b) we wish to challenge the societal status quo, and (c) unless we address the societal sphere our efforts will be forever undermined by larger forces. But after a momentary celebration of our newly gained insights, a whole new set of questions and dilemmas arise: What right do we have as counselors to suggest to our clients to join a social cause? What responsibility do we have as professionals to address social causes of oppression when our training is primarily in helping individuals? What are the limits of our expertise when we try to work at the personal, relational, and collective levels at the same time?

These questions have been rarely asked. By framing wellness in light of justice and by linking personal satisfaction to relational and collective concerns we open a whole new field of ethical inquiry. All of a sudden it is no longer the sanctity of the relationship between counselor and client that is the sole refractor of ethical concerns, but the very context within which that relationship is situated. Our hope is that this chapter will challenge not only counselors who may need their consciousness raised, but also those of us who already understand the connection between

wellness and justice. With every new

realization there is a new ethical dilemma to contend with. We want to be explicit about the new dilemmas that arise from linking wellness with justice and from linking the personal with the relational and the collective.Technology can be a problem when it lets you avoid taking responsibility for your actions -- such as ‘ghosting’ someone instead of breaking up with them in person -- but it also gives us many different ways to build and maintain relationships, join communities, and express what we need from each other.” It leads to more offline interaction. Hampton would like to dispel the notion that the people who use technology the most are hiding in

their apartments to avoid personal contact. He says online conversations often lead to an in-person coffee or dinner date.

There is no evidence that digital interactions are replacing face-to-face interactions," he explains. "In fact, we have found that users of digital technology are also the heaviest users of public spaces, such as cafes, restaurants, and religious centers."

Those relationships are closer. Hampton found that users of Facebook had 9% more people they can confide in and discuss important topics with when compared with other Internet users. Regular users of cell phones and instant messaging also had more close ties.