

The Historical Development of Community and Clinical Mental Health Counseling In the United States

Toplum ve Klinik Ruh Sağlığı Psikolojik Danışmanlığının Amerika Birleşik Devletleri'ndeki Tarihsel Gelişimi

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Abstract: This article presents an overview of the historical development and the current status of community and clinical mental health counseling in the United States. It begins with relevance to the counseling profession in Turkey, followed by significant individuals, actions, and events that took place during each of the decades reviewed. The article concludes with concerns at the present and hopes for the future.

Keywords: community counseling, mental health counseling, profession, history, education

Öz: Bu makale, Amerika Birleşik Devletleri'nde toplum ve klinik ruh sağlığı psikolojik danışmanlığının tarihsel gelişimi ve günümüzdeki durumu üzerine genel bir bakış açısını sunmaktadır. Türkiye'deki psikolojik danışma ve rehberlik ile ilişkilendirilerek başlayan yazı, toplum ve klinik ruh sağlığı psikolojik danışmanlığının başlangıcından itibaren onlu yıllar halindeki gelişimi, alandaki önemli kişilerden, toplumsal hareketlerden ve olaylardan söz edilerek aktarılmıştır. Makale, toplum ve klinik ruh sağlığı psikolojik danışmanlığı ile ilgili günümüzdeki sorunlar ve gelecek için umutlardan söz ederek bitirilmiştir.

Anahtar Sözcükler: toplum psikolojik danışmanlığı, ruh sağlığı psikolojik danışmanlığı, meslek, tarih, eğitim

In several countries around the world (e. g., Kenya, Turkey, and the United States), the profession of counseling began in schools (Kimemia, Korkut, & Smith, 2004). Thus, counselors built a professional identity separate from other professionals and workers who provided guidance, counseling, and mental health services, such as religious leaders, indigenous helpers, psychiatrists, psychologists, and social workers. Historically, the unique professional identity of counselors was based upon the use of preventive services and developmental theories and research to guide their work.

However, in the United States, significant economic, cultural, and social changes resulted in widespread recognition of a specialty, community and clinical mental health counseling, distinct from psychiatry and psychology. At certain times in American history, the demand for community counseling rose above the supply of well-trained professionals available to provide services. Many professional counselors who had been trained to work in schools began to seek additional training to work in other settings in the community. Although the resultant proliferation of community counselors

met the need, issues of differences in training and professional boundaries emerged. While mental health knowledge and research is of higher quality than ever before, many new challenges have emerged. Sharing similarities and differences among professionals in counseling helps all of us to formulate new ideas and hope for addressing increasingly complex situations and issues. While it is important to acknowledge and consider distinct differences within the countries and communities in which we work, aspirations to meet human potential and to limit human suffering are goals for many professionals.

The purpose of this article is to provide professionals in Turkey with a historical development of community and clinical mental health counseling to advance their own understanding, prevent mistakes, and to compare and contrast developments in the United States with their own vision for the future of Professional Counseling in Turkey.

Background

In 1997 the American Counseling Association (ACA) Governing Council defined specialty within the profession of counseling. "A Professional Counseling

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Specialty is narrowly focused, requiring advanced knowledge in the field founded on the premise that all Professional Counselors must first meet the requirements for the general practice of professional counseling” (ACA, 1997; Myers & Sweeney, 2001, p. 50). Yet, the American Mental Health Counselor Association (AMHCA), a division of ACA, stated as its mission, “To enhance the profession of clinical mental health counseling through licensing, advocacy, education and professional development” (AMHCA, 2012). For many years the counseling profession has tried to remain a cohesive group of professionals despite attempts by various factions to split off into their own specialty area of practice and identity.

The adoption of the 2009 Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2008) Clinical Mental Health Counseling program objectives and standards demonstrates a significant joining of what was previously somewhat divisive efforts among professional counselors identifying as: a) community counselors, b) community mental health counselors, c) clinical mental health counselors, or d) professional counselors. The new title for all CACREP accredited programs, formally known as Community Counseling or Mental Health Counseling, is now known as Clinical Mental Health Counseling. With this evolution it is important to record and preserve the historical development of this specialty within the counseling profession, particularly among those concerned with a loss of emphasis on “community” with the adoption of the word “clinical.” This article seeks to preserve the historical development of what is known today as Clinical Mental Health Counseling for those whose own communities strive toward providing similar services.

Origins in the United States

The beginning of clinical mental health counseling is best described through an understanding of the development of the counseling profession overall. From its inception, counseling was interdisciplinary as pioneers engaged in the social reform movement at the turn of the 20th century. Reformers focused on humanitarian concerns, child and adult welfare, public education and guidance, legal reform, and the influx of immigrants to the United States. Although early pioneers published information on moral education and developing interpersonal skills, “no mention of counseling was made in the professional literature until 1931” (Aubrey, 1983, p. 78).

The Reconstruction Era (1865-1877) in the United States followed the Civil War and marked an increased need for a specialized workforce and a new

awareness of the need for vocational guidance. In 1881, Salmon Richards recommended that vocational assistance be offered in every town to those who may need it (Guindon, 2011, p. 38). Pioneers believed that individuals could develop more fully when they were directed or guided. In May 1908, Frank Parsons presented a report that described systematic guidance procedures. His landmark book, *Choosing a Vocation*, published in 1909, had an immediate impact and Parsons became known as the “Father of Vocational Guidance.”

Parsons trained counselors and managers for Young Mens Christian Associations (YMCAs), schools, colleges, and businesses, believing that the best conditions for vocational success occurred when career choices were based on matching personal traits and job factors. His work, a revolutionary idea at the time, paved the way for matching individuals’ skills and abilities with work settings. Later, E. G. Williamson and his colleagues at the University of Minnesota developed a trait and factor theory that led to the publication of *How to Counsel Students* in 1939. This theory, also known as the Minnesota point of view, grew out of Frank Parson’s work. Williamson’s work became the first formalized approach to counseling; it could be used with issues other than vocational decision making. In the same year as Parsons’ publication *Choosing a Vocation* was released, Clifford W. Beers published an autobiographical account of his experience as a patient in mental institutions (Beers, 1908). The American public took great interest, many of who were shocked by the conditions of which he wrote, and began to focus on humane mental health care. Efforts eventually lead to the development of what later became known as the National Mental Health Association. Concurrent to these events, those trained as social workers were working with the poor, psychology was developing and solidifying itself as a distinct profession, psychiatrists were changing the way the mentally ill were treated, and educators were studying humanistic educational approaches (Guindon, 2011, p. 37-38).

1940s

In December of 1941, Carl Rogers was invited up to Minnesota to talk to Psy Chi, the honorary psychological society. His talk was on the “newer concepts of counseling” beginning with “outmoded methods of counseling” in which he “listed advice, persuasion, manipulation, and suggestion” (Rogers, n.d.). Rogers stated that he knew he “was not just speaking for everyone” and that he “seem(ed) to be saying something quite new and different” when he

finished sharing some of the new ideas and “there was just a furor of discussion, and questions, and attack and agreement” (Rogers, n.d.). Perhaps the greatest person of influence on the development of the counseling profession, distinct from either psychology or vocational guidance, was the work of Carl Rogers. His first book *Counseling and Psychotherapy* (1942) challenged the trait and factor approach of Parsons and Williamson. Rogers also challenged the assumptions and theories of Freud’s psychoanalysis. He advocated for new approaches and techniques to honor the individuals’ ability to make life choices, believing that, given certain conditions, individuals would naturally choose health and wellness. Rogers’ work influenced the direction that vocational guidance, education, and psychotherapy took by infusing a humanistic, person-centered orientation to counseling.

Another event that initiated widespread impact on the counseling profession was World War II. Women went to work in men’s positions when the men went to serve in the war. This led to a widespread perspective change about the work that women were capable of performing. New ideas about women’s potential were emphasized and focus turned to efforts for the greater good of society. When disabled soldiers returned from the war, the need for group counseling services soared. As part of efforts to assist with the effects of war on soldiers and their loved ones, the Veteran’s Administration (VA) provided financial aid to students for counselor training. Through the U. S. Office of Education, the federal government funded higher education training for counselors as well. In 1946, the National Institute of Mental Health (NIMH) was established and the National Mental Health Act provided funding for research, training and to assist states in prevention, diagnosis, and treatment of people with mental disorders (NIH, 2011).

1950s

The federal government had significant influence during the decade of the 1950s resulting in tremendous cultural advancement for professional counseling. In 1954, the Vocational Rehabilitation Act mandated counseling services and training funds for work with the disabled, including those with mental disabilities. In 1958, the National Defense Education Act (NDEA) allocated funding for the development of talented students in the United States. The federal government was particularly interested in identifying and optimizing math and science performance in secondary schools, in part motivated by the Space Race and the Russian launching of Sputnik. Title V of NDEA provided grants for counseling services in schools and for training school and career counselors

in institutions of higher education (U. S. Department of Education, 2012). As a result, the number of counselors in schools increased dramatically (Gladding & Newsome, 2010).

In 1952, the American Psychiatric Association (APA) published the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM marked the start of the modern mental illness diagnosis and classification system. A new era of treatment emerged with the release of antipsychotic medications for use with the mentally ill. Concurrently, there were groups of mental health professionals who wanted to work with clients with normal, development concerns rather than the psychopathological concerns treated by clinical psychologists. Many key theorists and scholars emerged and disseminated new information during this time; humanistic approaches and lifespan development knowledge grew considerably. Two key organizations were established. The American Personnel and Guidance Association (APGA) was created to meet the needs of those interested in guidance, counseling, and personnel, and the American Psychological Association chartered Division 17, the Division of Counseling Psychology. Many like-minded professionals held membership in both. Those who identified with a focus on mental health began to differentiate from those who identified with a focus on mental illness; those with a working belief that the client was a partner in the healing process began to differentiate from those who treated patients with a clinician-imposed cure (Brooks and Weikel, 1996; Gladding & Newsome, 2010).

1960s

Prior to the 1960s, the settings most commonly associated with counseling were schools and universities. The Community Mental Health Centers Act of 1963, one of the most sweeping and significant acts dealing with mental health needs of Americans, mandated the creation of mental health centers in over 2,000 locations (Guindon, 2011, p. 41). The new law provided funding for the delivery of preventive mental health interventions, direct counseling, outreach, substance abuse treatment, and many other services in communities (MacCluskie & Ingersoll, 2001; Scileppi, Teed, & Torres, 2000). Master’s and doctoral level counselors filled many of these positions that increased their visibility and viability as health care professionals. During this time effective antipsychotic medications were created and many patients were released from inpatient mental hospitals. This also allowed patients to receive treatment in outpatient centers while living in local communities.

Beginning in the 1940s and highlighted in the political unrest of the 1960s, individuals demonstrated greater desire for freedom and personal autonomy. The Civil Rights Movement, the Vietnam War, and the Women's Movement drew attention to the need for theories and professional services that addressed the whole of a community. The spirit of social reform efforts of the past was alive and continued in those identifying as counselors.

1970s

In 1975, the federal government expanded the original Community Mental Health Centers Act to mandate a total of twelve services as compared to the original five. According to Kottler and Brown (2000), "At one time 80 percent of all students enrolled in counseling programs were following a school-based employment track" (p. 33). The 1970s saw an influx of students who wanted to be trained to work outside of the school systems as community and mental health counselors; there were job positions to fill. Responding to this need, counselor education programs began preparing students to work in community settings, with most community counseling programs beginning after 1970 (Hershenson & Berger, 2001). The term "community counselor" was introduced in the 1970s (Lewis, Lewis, Daniels, & D'Andrea, 2003) and came to describe those counselors who worked outside of education settings. Concurrently, some counselors used the term "mental health counselor" to signify their specialization. During the 1970s there were many individuals prepared at either master's or doctoral level, worked in community agencies and other settings, and delivered a wide variety of services similar to more established mental health care professionals (i.e., psychiatry, psychology, social work). The need for credentialing was identified. Virginia was the first state to license professional counselors in 1976, Arkansas and Alabama followed shortly thereafter, and the Licensed Professional Counselor (LPC) became a reality (Gladding, 1997; Smith & Robinson, 1995).

The AMHCA was formed in 1976, chartered by APGA and became one of its largest divisions. AMHCA and the Association for Counselor Education and Supervision (ACES) formed a Joint Committee on Education and Training for Mental Health Counselors in 1978 (AMHCA, 1978). This was followed, in 1979, by the National Academy of Certified Clinical Mental Health Counselors appointing a task force to develop a system of counselor preparation that was competency based. Also during this time Egan (1970, 1975), Ivey (1971), and Carkhuff (1971) and his colleagues (Carkhuff & Anthony, 1979) outlined

training in basic attending, listening, and counseling skills that continue to be in use today (Guindon, 2011, p. 42).

The Community Mental Health Extension Act of 1978 required new centers to provide six services with the addition of gradual phasing in of six more services over their initial three years of operation. The first six services were screening, consultation/education, inpatient, outpatient, emergency, and follow-up of discharged inpatients. The remaining six services included partial hospitalization, children's services, elderly services, transitional halfway houses, and alcohol abuse services, and drug abuse services (Gibson & Mitchell, 2008). The Act of 1978 was a continued effort by the federal government to support mental health services while states and communities prepared for the intended taking over of responsibility for mental health care (Smith & Robinson, 1995). The money saved in state hospitals from deinstitutionalization was intended to go into community mental health care. Unfortunately, lack of adequate and advanced planning on all levels: federal, state, and local, lead to a result that was less than what had been idealized. In many states and communities the money was redirected elsewhere in political decisions. In other communities the boundaries of care were unrealistically defined, services were not effectively evaluated, and planning efforts in conjunction with state leaders largely failed (Frank & Glied, 2006; MacCluskie & Ingersoll, 2001). Nonetheless, results of such efforts lead to greater acceptance of people with mental illness, and greater opportunities for those who preferred outpatient treatment (Smith & Robinson, 1995).

1980s

In 1981, CACREP was created and APGA established the National Board for Certified Counselors (NBCC). In 1983 APGA changed its name to the American Counseling Association (ACA). This change was significant because it "reflect(ed) the changing demographics of its membership and the settings in which (counselors) worked" (Herr, 1985, p. 395). In the same year, ACES oversaw a Committee on Community Counseling (Hershenson & Berger, 2001). The committee proposed that community counseling be viewed as a process and an orientation, rather than as a specialized work setting (Hayes, 1984). It was suggested that community counselors take into account the effects of the community environment on individuals and seek to empower individuals by serving as advocates, thus, affecting the community as a whole. Training of community counselors emphasized the delivery of

preventive and rehabilitative services to a diverse clientele, and graduates of community counseling programs were employed in various positions and settings (Hershenson & Berger, 2001).

Throughout the 1980s, no definitive criterion for community counseling programs was provided in the CACREP standards; instead, it was left up to each counseling program to define its own area of specialization (Hershenson & Berger, 2001). Consequently, there was a great deal of variation in course titles and content. During this decade differences between community counseling programs and mental health counseling programs were being defined by training programs. Between 1986 and 1987 AMHCA adopted a set of comprehensive training standards for mental health counselors (AMHCA, 1993). These training standards required at least 60 semester credit hours of graduate work and a minimum of 1,000 clock hours of clinical supervision. These standards for the specialty of mental health counseling were adopted by CACREP in 1988 (AMHCA, 1993).

Another highlight of the 1980s was the intensity of discussions surrounding the challenges of working with differences among individuals including: gender, ethnicity, sexual orientation, and cultural groups (Gladding & Newsome, 2010). Increased emphasis on human development enriched classroom training environments as well as the awareness that comprehensive counseling theories had come largely from white males of European descent. Earlier in the decade, Carol Gilligan's (1982) landmark research on the development of moral values in females significantly challenged theories and practices that applied "universal" theories to women.

Economically, the 1980s saw an expanded private insurance coverage of mental health services, giving most Americans the financial ability to obtain mental health care provided by a range of professionals and institutions. This growth in the funding available for mental health services also encouraged institutions and individuals to provide the services that this funding would then reimburse. Expanded private insurance coverage led to the development of a large and competitive market for mental health professionals. This expansion of supply, in turn, generated growth in mental health spending, growth that became viewed as extreme (Frank & Glied, 2006). By the late 1980s mental health care outdistanced most other areas of medical care in spending growth and the market responded. The 1990s brought on the era of managed care. Concurrently, during the 1980s a new president's administration led to the repeal of the budgetary authorizations of the Mental Health Systems Act.

1990s

The managed care idea that swept the American health care system was also enacted to deal with the escalating costs of mental health care during this time. Managed behavioral health organizations (MBHOs) introduced price competition, significantly affecting the economic prospects of mental health professionals and institutions. As a result, mental health spending decreased and professional incomes across mental health providers fell. MBHOs used pricing strategies in combination with explicit management efforts in order to accomplish these results (Frank & Glied, 2006). Costs were reduced while the number of people receiving services expanded. Access to mental health care, overall, benefited consumers (Frank & Glied, 2006). Legislative policy sought to extend insurance coverage held by a majority of Americans to mental illness, so that treatment of mental disorders could be thought of like other "illnesses."

For the first time in 1992, counseling was included in the health care human resource statistics compiled by NIMH, who, previously, had only named psychiatry, psychology, and social work (Gladding & Newsome, 2010). However, there was more work to do; counselors wanted equitable reimbursement for services. So in 1993, using the CACREP standards and ACA policy as starting points, AMHCA adopted a comprehensive set of national standards for mental health counselors who delivered clinical services. These national standards were designed to enable the mental health counselor to satisfy requirements of third-party payers, particularly multistate insurance companies, and to pave the way for greater reciprocity among state regulatory bodies. During this time a necessary debate ensued among counselor educators, community counselors, and mental health counselors. At the core of the debate was a driving need to strengthen the identity of the profession. Some counselor educators and those academic programs with community counseling curriculum identified strongly with a professional identity rooted in wellness and the developmental view of human functioning. A strengths philosophy was emphasized versus an illness or deficits philosophy. Co-construction of goals between the counselor and client was prized and contrasted in the literature with psychiatry and psychology, whose philosophy was based upon a medical, expert-focused model of care.

Those who identified most strongly with the mental health counselor title voiced strong concerns related to the inequities among mental health professions. In 1993, the Certified Clinical Mental Health Counselor (CCMHC) credential that was originally created by AMHCA was absorbed into the NBCC credentialing

process where it remains today. AMHCA's clinical standards recognized and incorporated the CCMHC credential as an important means for recognizing that a Clinical Mental Health Counselor has met independent clinical practice standards. The next task to address became the significant differences that existed among state counselor licensure laws, as well as among educational and training programs.

During its evolution, community counseling has been defined in several different ways. Early in its formation, community counseling was viewed as counseling that took place in any setting other than schools or universities. Prior to the establishment of the 1994 CACREP standards, concern was expressed about the lack of a clear definition of community counseling and the lack of consistency across programs (Cowger, Hinkle, DeRidder, & Erk, 1991). Hershenson, Power, and Waldo's definition was published in 1996 and provided some clarity. Hershenson et al. defined community counseling as "the application of counseling principles and practices in agency, organizational, or individual practice settings that are located in and interact with their surrounding community" (p. 26). They suggested that community counseling was based on the following suppositions: a) the focus of assessment and intervention needs to include the community as well as the clients, b) interventions should take a proactive, health-promoting approach that emphasized learning and empowerment, c) interventions based on the principle of building on strengths, which include client and community resources, d) community counselors working with specific populations or with particular issues using skills developed by other counseling specialties, and e) central functions of community counselors included counseling, coordinating, consulting, educating, programming, and advocacy (Hershenson et al., 1996).

These statements appear to be fairly straightforward; however, this approach to care represented a fundamentally different concept of health care. Community counselors and others advocated for *health care*, rather than treatment of disorders, abnormalities, or disease amelioration. Many counselor educators and leaders were focused on a philosophy of care and the importance of recognizing the continuum of care. The health care industry was only beginning to consider the possibility of *health care* in the 1990s as an economically beneficial approach to the nation's illness-related expenditures. Others were focused on the competition for health care dollars within the illness-based infrastructure that had been built. Mental health counselors advocated for the need to be acknowledged

as a profession worthy of the status afforded other mental health care providers. This included basic knowledge and skills in the diagnosis and treatment of mental disorders as a part of their core coursework, in addition to the preventive, developmental, holistic, and multidisciplinary emphases.

2000s

During the 2000s, the convergence of greater scrutiny of mental health reimbursement, the call for updating CACREP standards for graduate programs, and the need to address problems in counselor licensure portability motivated ACA, AMHCA, CACREP, and counselor educators to engage in, at times, controversial debates around the future of professional counseling, professional identity, and counselor education program requirements. Professional literature proliferated during this time on topics such as: the role of the DSM in professional counseling; multiculturalism, diversity, and social justice; new theories and approaches highlighting the limits of reductionistic thinking and modernist theories; developmental and educational psychology research; and brain imaging and other efforts to explain mental health disorders organically. The pharmaceutical industry was very strong and psychotropic medications exploded in use. To begin to dissect the complexity of issues, the basic structure and tools in the provision of American health care are reviewed next.

The DSM, Fourth Edition, Text Revision (DSM-IV-TR) was published in May 2000 to correct errors and update and change diagnostic codes to reflect the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The three main goals or purposes of the DSM-IV-TR were 1) to provide a helpful guide to clinical practice, 2) to facilitate research and improve communication among clinicians and researchers, and 3) to improve the collection of clinical information and as an educational tool for teaching psychopathology (APA, 2000, p. xxiii).

The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) is a medical classification that provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Under this system, every health condition can be assigned to a unique category and given code. The ICD is published by the World Health Organization [WHO] (n.d.) and used worldwide for morbidity and mortality statistics, systems of reimbursement, and automated decision

support in medicine. This system was designed to promote international comparability in the collection, processing, classification, and presentation of this information. The ICD-9-CM edition is the official coding system of the United States used to track morbidity and mortality of diseases. The system is maintained by the federal government and also used to code diagnoses for reimbursement in medical care. The ICD-9-CM was created by the U.S. National Center for Health Statistics (NCHS, 2006) and used in assigning diagnostic and procedure codes associated with inpatient, outpatient, and physician services.

Counselors working directly within the mental health care reimbursement system and identifying as mental health counselors had many concerns. Their arguments centered on the argument that in order to be respected within the current system, they must be qualified to practice on the continuum of mental health services. In addition to the rich tradition of focusing on mental health prevention and normal development, counselor training program graduates needed to be competent at the other end of the mental health continuum in particular. Arguments were made to support coursework in DSM diagnosis, abnormal psychology, psychopharmacology, substance abuse, and crisis intervention according to current trends in mental health disorder treatment.

At the same time, leaders identifying as professional counselors argued in favor of a unified profession with division membership rather than specialties severing to become individual professions (Myers, 1995). Others were in favor of retaining emphasis on the preventive, developmental, holistic, and multidisciplinary emphases that defined the history of the profession and expressed concern for increased emphasis on the DSM (Hansen, 2003). During this time Lewis, Lewis, Daniels, and D'Andrea (2003) produced a view of community counseling as "a comprehensive helping framework of intervention strategies and services that promotes the personal development and well-being of all individuals and communities: (p. 6)." Their model of community counseling comprised four service components: a) indirect community services, b) indirect client services, c) direct community services, and d) indirect community services, and was widely accepted. According to Lewis et al. (2003), effective community counselors reflect an awareness of society's effects on its members. They strive to understand the unique needs and experiences of people from diverse backgrounds and seek to prevent debilitating problems that occur in the community. Clients are viewed holistically, possessing strengths, resources, and limitations (Lewis et al., 2003, p. 19-20).

The community counseling definitions provided by both Hershenson et al. (1996) and Lewis et al. (2003) address the fact that community counselors perform a broad range of therapeutic interventions among diverse client populations and in a variety of settings. Community counselors embraced multifaceted approaches that promote prevention, early intervention, and wellness, taking into account the client, the community, and the interactions between the two (Hershenson et al., 1996; Lewis et al., 2003).

In 2001, Dr. Bruce Wampold authored *The Great Psychotherapy Debate: Models, Methods, and Findings*. The book contained comprehensive reviews of the research on psychotherapy, disputing the commonly held view that benefits are derived from the specific ingredients contained in a given treatment (medical model). A major premise of his extensive analysis of research finding was the impact of the person of the counselor on counseling outcomes. Near the end of his research findings he presented three choices for counselors. From his point of view, he stated that counselors could 1) choose to create something new in contrast to the pervasive medical model of care, 2) join forces in the competition as providers of care using the medical model, or 3) provide care using what he termed, the Contextual Model, a general factors approach (Wampold, 2001).

On January 11, 2006, an initial summit convened at the American Association of State Counseling Boards Annual Conference to discuss what steps needed to be taken to ensure a healthy and strong future for the counseling profession (ACA, 2010). This was followed by a meeting in Montréal at the ACA's 2006 Annual Conference and Exposition; a group of 20 delegates from a wide range of counseling organizations met to identify and discuss issues related to the issue of professional identity. After four years of discussing, planning, collaborating, and meeting, 30 delegates reached consensus on a common definition of counseling as part of the 20/20 initiative: A Vision for the Future of Counseling (ACA, 2010). The ACA Governing Council passed a resolution formally recognizing CACREP as the accrediting agency for counselor education programs. Many state licensure boards were using the curriculum from CACREP-accredited mental health counseling programs for the standard coursework requirements for licensure. The culmination of these major forces working together resulted in a major change in counselor education programs and cohesion for the profession (ACA, 2010).

CACREP Standards go through rigorous review and revision every seven years. Toward this end, CACREP worked with state licensure boards and

20/20 ACA delegates resulting in a draft of standards implemented in 2009. The result was a decision to combine community counseling and mental health counseling CACREP programs into a new accredited program called Clinical Mental Health Counseling. Beginning in 2009, programs seeking accreditation through CACREP must choose to meet the standards or not be accredited. These events signaled the end of the professional identity crisis and specialization debate.

Implications for the Future

A few years into the 2010 decade, many new challenges face the specialty of clinical mental health counseling. Foremost, questions remain unanswered in training programs regarding one's ability to learn the entire spectrum of mental and emotional functioning from health to illness, while retaining the unique training philosophy of a preventive and developmental lens of human functioning. Economically, the supply of counselors and other mental health professionals is greater than ever before, changing foci to concerns about demand, compensation and competition for services. Secondly, the complexity of psychological disturbances on the mental illness end of the continuum, as well as efforts to seek greater mental health in the absence of illness is exponentially changing as individuals spend more and more time interacting with technology. Many Americans now seek opportunities through technology that were previously unavailable (e.g., communicating via real-time video, instant mobile communication access 24 hours per day, automated interaction for customer services, working in one's home). Individuals are able to easily and immediately access information about a virtually unlimited number of topics, with varying levels of quality. Practitioners express concern that research findings produced from traditionally-valued methods will fall further behind in their ability to inform practice. For example, how or when will findings produced from high quality methodology offer clinically useful information for an adult victim of childhood incest discovering

defamation of her character through relatives' use of social media? What foundational and specialized knowledge is needed to understand and work with the complexities of human life today?

Next, there are specific topics that practitioners are encountering. Wesley J. Erwin, a professor of counseling and student affairs at Minnesota State University Moorhead, conducted a sample of 224 counselors in private practice and community agencies, asking them about emerging issues in counseling and their feelings of competence related to those issues (cited in Rollins, 2008). The following received the most support as emerging issues and areas for additional training: a) internet addiction/abuse, b) internet sexual predators, c) working with racially/ethnically diverse clients, d) wars in Iraq/Afghanistan, and e) working with elderly clients (cited in Rollins, 2008). Lastly, if mental health is a continuum with high-level wellness on one end and severe and persistent mental illness on the other, most individuals can improve the quality of their lives through mental health services at some point in their lives. The profession of counseling and the specialty of clinical mental health counseling continues to hope that the United States will move toward greater emphasis on preventative mental health services in their investments toward long-term mental health for all.

Conclusion

Community counseling in the United States began with educators, social activists, and others whose actions were instrumental in the development of the profession of counseling as a whole. At times throughout the past 50 years, the specialty of community and clinical mental health counseling has met and overcome significant challenges. As American counselors face new challenges, it is hoped that counselors in Turkey will offer unique perspectives for our consideration and adaptation, while also considering and finding ways to adapt our information to the unique history, culture, and progress of Turkey.

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