The Art and Science of Mental Health Counseling

Mental health counseling is both an art and science. It is an art for mental health counselors to adjust to the demands of health care reform (such as managed care) and continue to provide high-quality mental health services. One of the challenges associated with this process is to maintain the philosophical core of mental health counseling (the developmental/preventative perspective) while continuing to be perceived as a viable provider for managed-care organizations, which tend to focus on symptom relief. In addition, it is an art for mental health counseling to make appropriate changes in its philosophical and theoretical orientation in response to current trends like postmodernism and issues relating to diversity.

Mental health counselors must strive to develop innovative, creative methods to address the challenges of the population that they serve (e.g., clients with mental disorders such as serious depression, schizophrenia, and substance abuse) and do so through the personal characteristics of patience, humbleness, kindness, and compassion. Clearly, for mental health counselors to be effective, they must become emotionally affected by their clients and the counseling process.

To be as effective as possible, however, the emotionally charged art of counseling must be balanced by a scientific perspective. Counselors can become overly enmeshed in their clients’ lives, which can obscure boundaries and undermine the professional objectivity that is essential. Numerous objective practices can contribute to the science of counseling, for example, assessment instruments, psychological tests, and the clinical interview. Qualitative and quantitative research strategies can also be useful in promoting the scientific perspective in mental health.
counseling. These assessment and research methodologies can help the mental health counselor stand back and evaluate what is going on in the counseling process, provide new direction for innovations in theory and practice, and determine the efficacy of the mental health services being offered.

**Professional Issues**

Mental health counseling is both a profession undertaken by mental health counselors and an amorphous job role performed by various members of the helping profession, such as counselors, psychologists, psychiatrists, psychiatric nurses, and social workers. Mental health counselors can be defined as individuals whose “primary affiliation and theoretical basis is counseling and not psychiatry, psychology, or social work” (Palmo, 1986, p. 41). The profession of mental health counselor is the fastest-growing segment of the mental health field (Dingman, 1988), with 57% of mental health agencies having a mental health counselor (Burtnett, 1986). Mental health counselors handle some of the most difficult cases, including crisis intervention (Ivey, 1989), and have therefore become an integral part of the mental health delivery system.

In 1976, the American Association for Counseling and Development (AACD)—now called the American Counseling Association (ACA)—created a special division called the American Mental Health Counselors Association (AMHCA). By 1985, the AMHCA had become the largest division of the ACA. In 1998, the AMHCA separated from the ACA (although it continues to be an ACA division) to promote the professional status of mental health counselors (Colangelo, 2009).

Since its inception, the AMHCA has embarked on numerous activities that have contributed to the professional identity of the mental health counselor. Its most important contributions include creating a code of ethics for mental health counselors, which was revised in 2010; publishing the Journal of Mental Health Counseling, which provides information regarding the theory, research, and practice of mental health counseling; spearheading a movement for mental health counselor licensure in all states; and establishing national standards for mental health counselor training.

By 2004, there were approximately 80,000 licensed mental health counselors (also called licensed professional counselors and clinical mental health counselors). Since 2009, all states and the District of Columbia, Guam, and Puerto Rico have had licensure laws for mental health counselors. In 1988, national preparation standards were established for mental health counselors to ensure adequate professional training and recognition in the health care delivery system (e.g., the eligibility of mental health counseling for third-party insurance reimbursement and participation in managed care; Smith & Robinson, 1995). The national clinical standards for mental health counselors are as follows. Individuals must graduate from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or has CACREP equivalency, have 3,000 hours of experience in the mental health field, have 100 hours of face-to-face supervision, adhere to the AMHCA standards of clinical practice and code of ethics, pass a national clinical exam, have work samples...
of counseling successfully reviewed (e.g., videotapes), and fulfill state licensure requirements (Smith & Robinson).

Mental health counselors work in a variety of settings, including private practice, community mental health centers, hospitals, alcohol and drug centers, social service agencies, and business and industry (Brooks & Gerstein, 1990). During the 1980s, there was an apparent shift in work settings for mental health counselors (Hershenson & Power, 1987). For example, in 1978, the highest percentage (39%) of AMHCA members worked in community mental health centers; 18% worked in private practice; and the remainder worked in a variety of other settings, including college counseling centers and as college teachers (Weikel & Taylor, 1979). In 1985, 22% of AMHCA members worked in private practice, 13% in private counseling centers; 13% in colleges and universities; only 11% in community mental health centers; and the rest in other settings, such as rehabilitation agencies and state and local government (Weikel, 1985). The trend toward private practice becoming the dominant work setting for AMHCA members continued in the 1990s (Brooks & Gerstein).

Several other studies have shown that a high percentage of mental health counselors work in substance abuse centers (Hosie, West, & MacKey, 1988; Richardson & Bradley, 1985). The largest percentage of professionals working in substance abuse centers hold a master's degree in counseling or a Master of Social Work (MSW) degree (Hosie et al.). In addition, mental health counselors are more likely to be program directors than are individuals from other disciplines (Hosie et al.).

It is imperative that mental health counseling continues to evolve in a manner that corresponds appropriately to the changing needs and challenges of society. Mental health counselors must continue to receive training in the diagnosis and treatment of mental disorders, and this training should emphasize a developmental/preventative perspective. It is also suggested that specialty skills (such as marriage and family counseling) can enhance the standing of mental health counselors within the health care community (Smith & Robinson, 1995). In an era of rapid change within the health care system, mental health counseling appears to be poised to receive greater acceptance and recognition. In this regard, mental health counseling appears to be a cost-effective alternative to other mental health delivery systems and therefore very attractive to managed-care organizations.

The Role and Function of Mental Health Counselors

Mental health counselors perform most of the same tasks as other mental health practitioners, such as marriage and family counselors, social workers, and psychologists (Nicholas, Gerstein, & Keller, 1988), including psychoeducational services, clinical or direct services, supervision, administration, program development, and consultation. Two tasks that mental health counselors do not tend to engage in are program evaluation and research, which are often performed by doctoral-level counselors and psychologists (Nicholas et al.).
Although mental health practitioners serve similar functions, their treatment philosophies vary from those of other practitioners (Brooks & Gerstein, 1990). Mental health counselors typically adopt a psychoeducational, developmental, and psychopathological point of view; marriage and family therapists use a systemic orientation; psychologists rely on a psychopathological frame of reference; and social workers adhere to a sociological perspective (Brooks & Gerstein). Mental health disciplines are also differentiated according to philosophical orientation: mental health counselors define themselves primarily within a developmental perspective, whereas psychologists adhere to a medical/therapeutic model and social workers focus on the environment (Ivey, 1989). According to Ginter (1996), the three philosophical pillars of mental health counseling are that counseling is contextually an interpersonal medium, it recognizes the importance of both prevention and remediation, and it has a developmental perspective.

There is a debate raging within the mental health profession regarding the validity of the developmental-preventative model versus the medical model, which emphasizes diagnosis and treatment (Messina, 1999). The developmental-preventative model can be traced to graduate training programs in mental health counseling. Messina suggested that the developmental-preventative legacy may be an inhibiting factor for the mental health profession. Clearly, managed care rewards clinicians who embrace the medical model. Mental health counselors who do not adhere to the medical model may be at a disadvantage in their ability to compete with psychologists and social workers, who promote their ability to diagnose and treat mental disorders. However, it would seem to be in the best interest of the managed care industry and mental health counselors to strike a balance between prevention and treatment. For example, managed care has emphasized symptom relief over comprehensive treatment of disorders, but tertiary prevention involves providing comprehensive treatment programs for disorders such as depression, thereby preventing future problems. Ongoing research and evaluation will be necessary to shape the identity of mental health counselors in the ever-changing landscape of mental health services.

Kelly (1996) looked to the future in terms of the role and function of mental health counselors. He suggested that mental health counselors are attempting to address three broad, interrelated challenges. First, mental health counselors are faced with asserting their right to be mental health service providers in a health care environment of shrinking resources. This challenge can be met only with continued support for mental health counseling licensure and recognition and its utilization by managed-care providers. A second challenge is to communicate accountability by documenting client improvement. Research and evaluation will play a key role in this process. And third, mental health counselors must effectively adjust to changes in the mental health field in terms of technology, diversity, and health care reform. The evolution and refinement of mental health counseling will enable this profession to continue to be a viable service in the mental health delivery system.

**Direct Intervention Strategies**

Central to the role and function of mental health counselors is providing direct and indirect intervention strategies. Mental health counselors provide direct counseling
services to clients with a wide range of mental disorders (West, Hosie, & MacKey, 1988). This section addresses two commonly used direct intervention strategies: counseling and crisis intervention.

**COUNSELING STRATEGIES** Mental health counselors use a wide range of direct counseling strategies, such as individual counseling, group counseling, marriage and family counseling, and substance abuse counseling (NeJedlo, Arredondo, & Benjamin, 1985; Spruill & Fong, 1990; West et al., 1988). In addition, a shift in emphasis appears to have taken place in mental health counseling from preventive approaches to the direct counseling services of individual, group, and family counseling (Spruill & Fong).

**CRISIS INTERVENTION SERVICES** Mental health counselors also provide crisis intervention services (Ivey, 1989; West et al., 1988). Crisis intervention is not the same as counseling, even though it is a helping strategy (George & Cristiani, 1995). Its focus is more narrow and superficial, its goals are more modest, and it has a briefer duration than counseling. The following is a four-step model for crisis intervention.

The first step is to determine whether the client is in crisis. To determine whether crisis intervention is necessary, the counselor must decide whether the client is experiencing a personal crisis. A crisis has been defined as

> the perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. Unless the person obtains relief, the crisis has the potential to cause severe affective, behavioral, and cognitive malfunctioning up to the point of instigating injurious or lethal behavior to oneself or others. (James & Gilliland, 2013, p. 8)

James and Gilliland (2013) and Puryear (1979) identified the following factors associated with a crisis:

1. The symptoms of stress result in psychological and physiological discomfort.
2. The client feels intense emotions such as feelings of inadequacy, helplessness, anxiety, panic, or agitation.
3. The client is more concerned with gaining relief from the symptom than with the problem that precipitated the symptom.
4. The client has a reduced ability to function efficiently.
5. The crisis is normally time limited but may develop into recurring long-term mental health problems.
6. Crises tend to be complex and difficult to resolve.
7. Crises represent both danger and opportunity for positive change.
The counselor should use listening skills during the initial phase of crisis intervention to gain a phenomenological understanding of the client (James & Gilliand, 2013). This can help the counselor determine whether the client is truly experiencing a crisis and enable the counselor to establish rapport and communicate support to the client.

The second step in crisis intervention involves assessment, using two separate procedures. First, the counselor must assess the severity of the crisis in terms of the potential for serious harm to the client or others. The primary goal of crisis intervention is to avoid a catastrophe in which someone would be seriously injured (James & Gilliand, 2013). The second assessment procedure involves determining whether the client is mentally able to take an active role in resolving the crisis situation. A useful tool in this process is a mental status exam (Othmer & Othmer, 1989), which can help determine whether the client is oriented to person, place, and time; free of hallucinations; and capable of coherent thinking. When a client does not appear to be capable of realistic decision making, the counselor may need to take a more active role in the crisis intervention process.

The third step in the crisis intervention model involves action. During a crisis, some form of action will usually be required to restore equilibrium to the client. Providing rest can be an important part of this process. For example, if the client is acutely suicidal, the counselor may work with family members to arrange for the client to be hospitalized. Once the client receives rest and equilibrium has been restored, counseling strategies can be implemented. The counselor can attempt to identify the precipitating factors associated with the crisis and help the client overcome these problems in the future.

The fourth and final step entails follow-up. Clients can have delayed reactions to a crisis, which may occur weeks or even months after the precipitating event (Cavanaugh, 1982). It is therefore important to arrange for appropriate follow-up counseling services.

The following *Personal Note* illustrates crisis intervention.

**A Personal Note**

Mary arrived at an outpatient mental health clinic where I was a psychologist and said that she was having trouble sleeping and wanted sleeping pills. She appeared agitated and tearful, and she spoke in monotone. It soon became clear that there was much more on her mind than her trouble with sleeping. She began to talk about an affair that her husband was having. She went on to say that because of her “religious beliefs,” it was necessary for her to kill her three children and herself. Mary reasoned that since her husband had an affair, he had lost his right to have any more contact with his family.

I asked Mary what religion would want her to kill herself and her children. At this point,
Indirect Intervention Strategies

Hershenson and Power (1987) have identified six indirect activities associated with the mental health counselor’s role and function. These can be considered indirect intervention strategies because they are an indirect form of treatment. An overview of these activities follows.

**PREVENTION** Prevention represents the inverse of coping with a crisis (Barclay, 1984). Prevention can be defined as a helping strategy used to avoid or minimize a potential problem (Gladding, 2001). Prevention of mental disorders and the promotion of mental health have been an integral part of the community mental health movement (Matus & Neuhring, 1979). An example of a preventive focus is the recent emphasis on “wellness” in the counseling literature. Meyers (2014b, p. 33) noted that “the essence of wellness is the integration of mind, body, and spirit” to promote holistic health, and healthy lifestyles and prevent the development of illness.

Hershenson and Power (1987) identified three types of prevention: primary, secondary, and tertiary.

1. **Primary prevention** evolved from the public health model. It refers to strengthening the resistance of a particular population and offsetting of harmful influences before they can make an impact (Caplan, 1964). Primary prevention takes place before a problem...
has manifested itself or when its symptoms are barely noticeable (Gilbert, 1982). It reduces the number of individuals requiring mental health services and is therefore an important aspect of any comprehensive human services program (Shaw & Goodyear, 1984). Unfortunately, primary prevention has historically taken a backseat to other strategies because resources are instead applied to people with existing problems.

2. **Secondary prevention** involves programs that attempt to identify individuals who are at risk for developing certain problems and then prescribe remedial activities to prevent those problems from occurring (McMurty, 1985). For example, there has been some interest in working with children of alcoholics to prevent them from becoming alcoholics.

3. **Tertiary prevention** attempts to avert further consequences of a problem that has already manifested itself (Hershenson & Power, 1987). The present mental health system puts most of its efforts into tertiary prevention, focusing on alleviating existing mental health problems.

Hage et al. (2007) have established 15 best-practice prevention guidelines that can be used by practitioners, researchers, and counselor educators. They noted that all 15 of the guidelines relate to one or more of the following principles:

- Stopping a problem before it occurs
- Delaying when a problem occurs
- Reducing the effects of a problem
- Strengthening attitudes, knowledge, and behaviors that promote physical and emotional well-being
- Promoting public policies that foster physical, social, and emotional well-being

Hage et al.’s (2007) 15 guidelines are comprehensive and clearly stated. Furthermore, they incorporate a multicultural/social justice perspective and provide standards that can be used to move the profession forward in terms of providing prevention services. These guidelines can be summarized as follows:

1. Prevention is associated with proactive interventions that reduce or eliminate risk factors and potential problems before they occur.

2. Preventive interventions should be based on theory and supported by empirically validated research.
3. Prevention initiatives should be culturally sensitive and have input from the target populations they serve.

4. Prevention interventions recognize that psychological distress is associated with both individual and contextual/systemic factors that undermine human growth and development.

5. Preventive strategies aim to reduce risk and increase strengths and protective factors across the life span.

6. Prevention recognizes the role of research in promoting the science of prevention (e.g., identifying social injustice associated with racism).

7. Prevention requires competencies in different research methodologies.

8. Prevention research recognizes the importance of environmental context to formulating appropriate prevention strategies (e.g., going beyond the individual and including a social-ecological perspective).

9. Prevention research considers ethical issues, including recognition of the potential negative impact of prevention interventions.

10. Prevention researchers consider the social justice implications of research findings (e.g., victims being blamed for their problems).

11. Prevention education and training promote knowledge, skills, and scholarship associated with prevention research and practice.

12. Prevention education and training include a focus on developing awareness, knowledge, and skills associated with prevention.

13. Prevention is associated with designing, promoting, and supporting systemic initiatives that reduce psychological distress and disability.

14. Prevention is associated with designing, promoting, and supporting institutional change to reduce psychological distress and promote well-being.

15. Prevention is directed at social-political advocacy that promotes health and well-being for a broad base of people (e.g., HIV-AIDS prevention).

Although prevention is clearly a recognized intervention in mental health counseling, it has not been adequately integrated into the training process or practice of mental health counselors (Kiselica & Look, 1993). The disparity between philosophy and
practice may be due in part to a lack of insight into the “what and how” of prevention. Apparently, mental health educators and providers lack a clear understanding of what prevention is and how a clinician can engage in this endeavor. In addition, mental health trainees appear to be more interested in remedial interventions, such as psychotherapy, than prevention. Kiselica and Look suggested that counselor educators should make a renewed effort to emphasize prevention and provide adequate training on it. They further urged mental health counselors to work together to make primary prevention the principal mode of intervention in counseling. In addition, these authors recommended that increased effort be directed at pursuing grant money for prevention and journals, such as the Journal of Mental Health Counseling, make articles on prevention a higher priority.

**ADVOCACY** Advocacy is another indirect intervention strategy used by mental health counselors. Advocacy means to plead the cause of another person and follow through with action in support of that cause (Myers, Sweeney, & White, 2002). “A mental health counselor-advocate is one who is the client’s supporter, the advisor, the champion, and if need be, the client’s representative in dealing with the court, the police, the social agency, and other organizations that affect one’s well-being” (Hershenson & Power, 1987, p. 246). Counselors should also advocate for the profession of counseling and for counselors (Myers et al.). In this way, advocacy can advance the cause of counseling so that more individuals can benefit from counseling services. Advocacy is an action-oriented form of intervention in which the counselor does something for the client. This can have a positive impact on the counseling relationship in that the client may perceive the counselor as someone who can get things done. Mental health counselors can function as advocates in many ways, such as working with a human services department to ensure that clients receive benefits to which they are entitled.

Hershenson and Power (1987) have identified the following advocacy skills as important to mental health counselors:

- **Timing.** Counselors must decide when to be an advocate and when to let the client take the initiative. As a basic rule, counselors should intervene when it becomes clear that the system is not working for the client or even appears to be working against the client.

- **Support.** Counselors must have the support of the system to be capable of working effectively with that system. In this vein, it is important for counselors not to alienate themselves from coworkers. Counselors are more successful when they work in a cooperative manner and avoid being perceived as blindly fighting for a cause that may sometimes be at cross-purposes with the interests of their colleagues.

- **Compromise.** To maintain support from the system, counselors should be flexible and willing to compromise. A give-and-take approach can also yield creative solutions to complex problems.
• **Communication.** Several communication skills can be useful in the role of advocate. It is important to be able to listen and communicate an understanding of different points of view regarding the client. Using these skills can promote a cooperative approach. Another communication skill that may be necessary is assertiveness. Occasionally, mental health counselors need to take an assertive position to obtain the desired results. Naturally, this must be done in a tactful, caring fashion to be effective.

**CONSULTING** Since the passage of the Community Mental Health Act in 1963, consultation has been an important aspect of the mental health worker's role and function (Kurpius, 1978). The act noted that consultation services were to become an essential part of community mental health programs of the future (Hershenson & Power, 1987). This legislation was viewed as an attempt to broaden mental health services to include more developmental and preventive approaches (Kurpius).

Caplan (1970) provided the following definition of **mental health consultation**:

A process of interaction between two professional persons—the consultant, who is a specialist, and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized competence. (p. 19)

Caplan's definition of mental health consultation has been broadened to include a professional consulting with a layperson, such as a counselor consulting with a parent (Hansen, Himes, & Meier, 1990). In addition, consultation can involve working with individuals, couples, groups, families, organizations, and larger systems such as communities (Brown, 1993).

Brown (1993) observed that although consultation holds an important role in the overall philosophy of counseling, it does not appear to be a high priority for counselor educators or counselors. Brown made several recommendations about how to increase the role that consultation plays in all aspects of the counseling profession, including mental health counseling. First, more effort needs to be made to integrate consultation into the counselor education curriculum in terms of coursework and fieldwork experiences (e.g., counseling and consultation should both be considered during treatment planning). Second, licensing and accreditation boards should ensure that individuals and programs show evidence of appropriate consultation skills and activities.

The lack of attention paid to consultation appears to parallel the underutilization of preventative services by mental health counselors (Albee & Ryan-Finn, 1993). It therefore seems imperative that prevention and consultation be linked so that counselors can gain a better understanding of how to promote prevention through consultation. Clearly, the interrelationship of theory, research, and practice regarding these concepts requires further development.
MEDIATION  Mediation is one of the newest roles of mental health counselors. Many states now offer mediation services to assist individuals who are going through a divorce (Hershenson & Power, 1987). Mediation has been defined as the “facilitation of an agreement between two or more disputing parties by an agreed-upon third party” (Witty, 1980, p. 4). It has the following components: Each party agrees to utilize the services of a mediator, the outcome is an agreement made by the disputants themselves, conflict resolution is cooperative instead of competitive, the focus is on “where we go from here” as opposed to on fault-finding, self-disclosure and empathy are promoted in place of deception and intimidation, decisions are self-imposed instead of imposed by others, and creative alternatives are promoted rather than win-or-lose positions (Kessler, 1979; Koopman, 1985).

Kessler (1979) described the actual process of mediation as being one of structured decision making that usually lasts one to three sessions. Hershenson and Power (1987) identified the following three steps that a mental health counselor could use to structure the mediation process:

1. The counselor initially provides the necessary structure by establishing a cooperative tone, setting the rules, obtaining a commitment to the process, and providing an overview of what is to come (Kessler).

2. In this strategic and planning phase, the mediator obtains an overview of the conflict by reviewing all pertinent information. Toward the end of this step, the mediator can begin to develop a specific plan of action with the disputants.

3. The third step is the problem-solving phase, in which the mediator works with the disputants to help them reach a specific agreement. The mediator may use a variety of tactics during this process, including negotiation, creative problem solving, joining meetings, and private caucuses. The final agreement is usually written out by the disputants so they will have a permanent record of the mediation process.

MENTORING  Mentoring is another relatively new role for mental health counselors. Mentoring has been defined as a process in which a trusted and experienced individual takes a direct interest in the development and education of a younger, less experienced individual (Krupp, 1982). Numerous studies have shown that mentoring has a positive impact on the mentor, the less experienced individual, and the organization involved (Lynch, 1980; Valliant, 1977). Several guidelines for establishing a mentoring relationship include voluntary participation, minimal rules and maximum freedom, shared and negotiated expectations between the mentor and the less experienced individual, and rewards for the mentor’s efforts (Farren, Gray, & Kaye, 1984).
**EDUCATION** The mental health counselor can also function as an educator, a role that may involve indirect and direct intervention strategies. Education is often an important factor in both types of strategies described in this section, as shown in the following examples:

- Counseling can help a client learn how to become more autonomous.
- Crisis intervention may teach a client how to avoid future crises.
- Prevention often occurs through programs that emphasize an educational component, such as parent education.
- Advocacy can teach a client how to be assertive without alienating others.
- Consultation may involve inservice training programs that teach special skills, such as how to avoid burnout.
- Mediation can help a client learn how to resolve conflicts in a cooperative fashion.
- Mentoring provides opportunities for a less experienced individual to learn from a more experienced person.

**Categories of Mental Health Services**

The majority of mental health services are directed at helping clients who are dealing with problems of living or who have mental disorders. This section provides an overview of the clinical issues associated with these two categories of problems.

**Problems of Living**

**Problems of living** have been defined as “aberrations and/or natural rough spots as one moves through the course of the life span development” (Hershenson & Power, 1987, p. 87). Typical problems of living that clients face include relationship difficulties, such as marital problems; lack of meaning in life, such as not feeling valued at work, and problems associated with stress, such as psychosomatic illness. Although mental disorders may contribute to problems of living, a client can experience these problems without having a recognized mental disorder.

Counseling is the primary treatment strategy used to help clients deal with problems of living. It can help clients deal with specific problems, prevent future problems, and cope with stress. Since problems of living typically do not involve mental disorders, the use of psychoactive drugs is usually not part of the treatment program.
Mental Disorders

A mental disorder can be broadly defined as a dysfunctional behavioral or psychological pattern associated with distress or disability (American Psychiatric Association, 2013). In 1984, the National Institute of Mental Health conducted an in-depth study of mental health problems in the United States (“Mental Disorders,” 1984). The study estimated that 40 million people in the United States experience mental health problems at any given time. More specifically it found that

- 1 in 5 adults suffered from a recognized mental disorder.
- the three most common disorders in order of incidence were anxiety, substance abuse, and depression.
- only 1 out of 5 people with a mental disorder had sought professional help. Those who did tended to seek help from someone at their church or from a family physician.
- women tended to suffer from phobias and depression, whereas men tended to have problems with alcohol and drugs and antisocial behavior.
- the rate of incidence of mental problems was higher for those under 45.
- college graduates tended to be less prone to mental disorders than were those who had not graduated from college.

The results of this survey suggest that a large percentage of Americans suffer from mental disorders. Another important implication is that when people experience mental problems, they tend not to utilize mental health services. Instead, they often turn to other professionals, such as physicians or members of the clergy. A challenge for mental health counselors has been to overcome the stigma often associated with mental health services so that individuals will seek help when they need it.

TREATING MENTAL DISORDERS Treatment approaches for mental disorders include the use of psychoactive drugs and counseling. Psychoactive drugs are used by psychiatrists primarily to treat psychosis, depression, and acute anxiety reactions. It is important to note that these medications do not cure a person of a mental disorder. They are used primarily to treat underlying brain chemistry dysfunctions and provide symptom relief, such as alleviating depression or anxiety. There are potential dangers, such as the possibility of clients becoming dependent on these medications, especially in the case of tranquilizers to treat anxiety. There can also be serious side effects, such as tardive dyskinesia, an irreversible neurological disorder that can result from the prolonged use of antipsychotic medications.
Although psychoactive medications can have drawbacks and inherent dangers, their benefits usually outweigh the risks. For example, a client who has schizophrenia who does not receive medication may be overwhelmed by threatening hallucinations, dangerous delusions, or a disruptive thought disorder. Although medication cannot remove these symptoms entirely, it can usually control them to the degree that the client can function in society. Antidepressant medications can also be an important aspect of a treatment program for severely depressed clients, who may require medication to be able to work and engage in daily activities. Medication can also be very useful in treating a severe anxiety reaction since it can reduce anxiety to a point where the client can cope.

Counseling can also play a vital role in the overall treatment program for mental disorders (see Chapter 9 on cognitive-behavioral approaches). Counseling may not be indicated until a client has been medically stabilized by the psychoactive medication. A client can be considered medically stable when the symptoms associated with the mental disorder have been reduced to the extent that the client is capable of actively engaging in the counseling process.

Counseling is often used to treat mental disorders that do not require medication. The counseling strategies used will vary according to the unique needs of the client and the clinical indicators associated with the particular mental disorder.

The following Personal Note describes some of the things I have learned about the treatment of mental disorders.

A Personal Note

Over the years, I have learned many important lessons from clients who had mental disorders. Several clients have said something in particular that I have never forgotten. As I reflect on these cases, their comments symbolize lessons that I learned from them. I will describe five of these cases, giving the client’s statement, a brief description of the situation, and the lesson I learned from each person.

**Client’s Statement:**

“Someone said pull my eyes out and I did.”

**Description of Client’s Situation:**

The client who made this statement was a 25-year-old male who was in jail for theft. A psychiatrist had been asked to make an evaluation because the client was acting strangely. The psychiatrist made a provisional diagnosis of schizophrenia and arranged to have the client admitted to a psychiatric hospital.

The client was not given any antipsychotic medication and was to be transferred to the

(Continued)
hospital the next day. That night, he began to hallucinate that he was hearing voices. A “voice” told him to take his eye out, and he did. Then a “voice” said to take the other eye out, and he took it out as well. He was standing and holding his two eyes when a jailer walked by and saw with horror what had happened. The client was immediately taken to a hospital and provided treatment. At the hospital, the client was diagnosed as schizophrenic. I met this man while I was at the hospital checking on several clients. He told me about the voices he had heard, asking him to take his eyes out when he was in jail.

**What I Learned:**

I learned that clients who are actively hallucinating can do serious harm to themselves. Antipsychotic medications must therefore be considered to help control the hallucinations and other psychotic symptoms.

**Client’s Statement:**

“Would you like to see the picture I painted?”

**Description of Client’s Situation:**

The client was a 23-year-old woman who had a long history of severe depression. I had been providing counseling for the client for about 1 year. Although she had weekly appointments, she often missed them. I was actually surprised when she did make an appointment because she always seemed so disoriented.

One day, the client walked into the counseling center and said she wanted to see me. She told me she had painted a self-portrait and asked if I would like to see it. I could not believe my eyes. She had painted the most beautiful painting I had ever seen!

**What I Learned:**

This client taught me never to “write off” a client. Regardless of how incapacitated I may think some clients are, I will always remember that they are still capable of doing fantastic things with their lives.

**Client’s Statement:**

“There were spiders crawling all over my face and voices telling me I was going to die. I was terrified!”

**Description of Client’s Situation:**

This was a 54-year-old female who had been an alcoholic for 26 years. The client had been on a drinking binge for 2 weeks and then experienced alcohol hallucinosis, in which she saw and felt spiders crawling on her face and heard terrifying voices. The client came to the counseling center the next day and said she would never drink again. I provided weekly counseling services for her over the next year. During that time, the client did not drink. She later moved to another city.

**What I Learned:**

I discovered that the prognosis for overcoming alcoholism is good when the client decides that the costs outweigh the rewards of use. During the first few sessions, it became clear to me that this client had decided that drinking was just not worth it anymore.

**Client’s Statement:**

“We just caught on fire.”
Description of Client’s Situation:
The client who made this statement was one of two brothers who had caught on fire when they were sniffing gasoline. Both had a history of inhalant abuse spanning a 5-year period. I had been seeing them in counseling for 2 years prior to their accident with gasoline. During the time I had worked with them, they had been hospitalized on numerous occasions for treatment of acute lead poisoning. On one occasion, one of the brothers had become psychotic during 8:00 a.m. rush-hour traffic, jumping out of a moving car and running down the street pounding on other cars.

What I Learned:
I learned several things from this case and similar cases involving inhalant dependency. First, I found that these individuals have a very difficult time attempting to overcome their dependency. My success rate has been very low with this population: Only 1 out of 5 stopped using inhalants while I worked with them.

I soon discovered that lead poisoning can produce serious side effects. For example, both of the brothers I worked with showed significant intellectual impairment. Their overall IQ scores on the Wechsler Adult Intelligence Scale dropped 15 and 20 points over a 12-month interval while they were using inhalants. I also discovered that gasoline sniffing can make a person psychotic. In addition, I learned that lead poisoning is very difficult to treat. I found out that when an individual inhales lead, the lead is absorbed into the bones as well as other parts of the body. Unfortunately, the lead tends to remain in the bones, gradually releasing lead into the body over a period of time, even if active abuse has stopped.

Client’s Statement:
“I got my meat, my flour, and my Jesus.”

Description of Client’s Situation:
This was the statement of a 45-year-old woman who had been suffering from chronic schizophrenia for 20 years. A residential program had just opened for people who were chronically mentally ill and who had no relatives to assist them. I asked the client whether she would like to be admitted into the program, and she said, “Yes.” Getting the client admitted was a very long and drawn-out process. It involved filling out numerous forms and dealing with other seemingly endless aspects of the bureaucracy. I was finally told that my client could get into the program. I couldn’t wait to tell her the good news.

When I told her she was accepted, she looked puzzled. She then smiled and told me that she didn’t want to go. She said, “I got my meat, my flour, and my Jesus.” When I asked her what she meant, she said she had plenty of meat to eat and flour to make bread. Then she turned on her portable radio and played a religious station featuring a preacher giving a high-powered sermon. She pointed to the radio, smiled, and said, “That’s my Jesus.”

What I Learned:
I learned that freedom is essential to human dignity. Whenever possible, people need to have freedom of choice and be able to act on those choices. My job as a counselor was simply to help create choices. When I did create choices for this client, it seemed to bring more meaning to her existence—an existence that she already had.
Strategies for Suicidal Clients

Mental health services must continually adapt to the changes in society. Three types of clients requiring increased efforts from mental health counselors and other members of the helping profession are suicidal clients, clients with substance abuse problems, and gerontological clients. To illustrate the contemporary issues and skills associated with mental health counseling, this section provides an overview of suicide, and the next two sections will cover substance abuse and gerontological counseling.

The rate of suicides per 100,000 people has increased over the past 40 years and has now leveled off. In 1950, there were 4.2 suicides per 100,000; in 1974, 10.9; in 1984, 12.8; 1996, 11.65; and 2009, 12.0 (American Association of Suicidology, 2012; NIMH, 1999; Shneidman, 1984). Suicide rates are high across all levels of society. Among girls, the gifted have the highest rate of suicide nationally and are therefore considered to be at especially high risk (Taylor, 1979).

Capuzzi and Nystul (1986) provided a comprehensive overview of suicide—causes, myths, and treatment strategies. The remainder of this section is adapted from that work.

Causes

Shneidman (1984) identified four theoretical perspectives for understanding the motivation for attempting suicide: sociological, psychodynamic, psychological, and constitutional or biochemical.

SOCIOLOGICAL Durkheim (1897) described sociological reasons for suicide that seem to have withstood the test of time. These reasons can be categorized as egoistic, when a person lacks a sense of belonging and therefore lacks a sense of purpose; altruistic, when a person is willing to die for a particular cause (e.g., Japanese kamikaze pilots); anomic, when a person believes his or her relationship with society has been shattered (e.g., after being fired from a job or experiencing racial oppression); and fatalistic, when a person feels society does not offer any hope for a better future (e.g., someone who feels trapped in poverty).

PSYCHODYNAMIC Freud (1933) emphasized the role of unconscious forces in personality dynamics. He believed that all people have an unconscious death wish that could contribute to suicidal behavior.

PSYCHOLOGICAL Shneidman (1976) provided a psychological perspective on suicide, suggesting that it is associated with the following psychological conditions: acute perturbation, when a person is in a heightened state of unhappiness; heightened inimicality, when a person has negative thoughts and feelings toward the self, such as self-hate and guilt; constriction of intellectual focus, when a person experiences a tunneling of thought processes, resulting in an inability to see viable options; and cessation, when a person believes that suicide will make his or her suffering stop.
The medical model suggests a link between depression and suicide and views depression as having an organic basis. In this model, therefore, suicide can be prevented by using psychoactive medication to restore an individual's biochemical balance.

### Myths About Suicide

Numerous myths are associated with suicide. The following are some of the myths and the facts that contradict them, as provided by Capuzzi and Nystul (1986) and James and Gilliand (2013):

- **Suicide is committed only by people with severe psychological problems.** Studies have shown that most individuals who commit suicide had not been diagnosed with a psychological disorder (Shneidman, Farberow, & Litman, 1976).

- **Suicide usually occurs without warning.** In fact, most suicides are preceded by warning signs. The nature of the warning signs may be a sudden change of behavior, self-destructive behavior, verbal threats of suicide, talk of hopelessness and despair, and depression.

- **People who are suicidal will always be prone to suicide.** In truth, most people who become suicidal do not remain in that state forever. They may be struggling through a temporary personal crisis. Once they work through the crisis, they may never be suicidal again.

- **Discussing suicide may cause the client to want to carry out the act.** The opposite is actually true. Talking with a caring person can often prevent suicide.

- **When a person has attempted suicide and pulls back from it, the danger is over.** Actually, the greatest period of danger is usually during the upswing period, when the person becomes energized following a severe depression and has the energy to commit suicide.

### Treatment Strategies

Capuzzi and Nystul (1986), Westefeld et al. (2000), Wong, Maffini, and Shin (2014), and Rogers and Russell (2014) provided an overview of treatment issues relating to suicide such as prevention, assessment, suicide risk factors, crisis intervention, postcrisis counseling, postintervention, and rational suicide.

**PREVENTION** Three types of prevention were described earlier in this chapter (primary, secondary, and tertiary). All three can be related to suicide. Primary
prevention focuses on individuals before they become suicidal, such as when an elementary school counselor makes classroom presentations on dealing with stress. In secondary prevention, the counselor attempts to recognize people who are at risk for suicide and provide the necessary assistance before their problems get worse. Tertiary prevention involves assisting people who are currently suicidal. For example, crisis intervention services like telephone hotlines have been used to prevent individuals from committing suicide (Lester, 1993).

Wong et al. (2014) suggested that clinicians utilize culturally relevant suicide prevention interventions, because risk factors and protective factors vary across cultures. "Cultural relevance refers to interventions that incorporate the cultural practices, beliefs, values, norms, and customs that form the core of a community" (Wong et al., p. 32). Wong et al. recommended that clinicians incorporate an ecological perspective in suicide prevention that extends beyond traditional psychotherapy and includes consultation, training, advocacy, and community outreach (e.g., promoting life skills training in high schools).

**ASSESSMENT** Assessment of potential suicidal behavior should be a comprehensive process involving standardized and nonstandardized assessment procedures and the clinical interview discussed in Chapter 4. Westefeld et al. (2000) identified assessment tools that have been developed to specifically assess suicide. Some of these assessment tools are the Suicide Ideation Scale (Rudd, 1989), designed primarily for college students; the Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983), based on Victor Frankl's (1959) existential theory; and the Fairy Tales Test (Orbach, Feshbach, Carlson, Glaubman, & Gross, 1983), which can be used with children.

Granello (2010a) provided 12 core principles that can be used to guide the process of suicide risk assessment. These 12 principles have been summarized as follows. Suicide risk assessment is unique for each person and is done in a cultural context. It is a process that is ongoing, complicated, and challenging and can be considered a form of treatment. Consultation and documentation are high priorities during suicide assessment. In addition, practitioners use clinical judgement, take threats seriously, when in doubt emphasize safety, and identify underlying messages associated with the suicidal ideations (e.g., a cry for help or attempt to control one's fate).

**SUICIDE RISK FACTORS** A number of empirically identified risk factors are associated with suicide (James & Gilliand, 2013; Westefeld et al., 2000; Wong et al., 2014):

**Mental Disorders** Several mental disorders have been associated with suicide, including depression, substance abuse, psychotic disorders, and personality disorders (especially borderline). Suicide, for example, can be an escape response to the sadness of depression. Wong et al. (2014) reported that depression is a poor predictor of suicide for Black American adolescents and adults as compared to their White
American counterparts. Impaired family relations is a more accurate predictor of suicide for Black American adolescents and adults (Wong et al.).

**Loss**  Loss can be a factor in any suicide. The breakup of a relationship or a divorce can trigger a suicide attempt. Multiple issues of loss can characterize the late adult stage: unwanted retirement, chronic illnesses and pain, and death of loved ones. Loss for seniors can, therefore, result in suicidal tendencies associated with lack of purpose and meaning, pain and suffering, and social-emotional isolation.

**History**  A history of past suicide attempts indicates a high risk for suicide. Suicide risk also increases if there is past family history of suicide, because it can be perceived by family members as a way of coping with mental problems such as depression. Another historical factor that may be associated with suicide is the contagion factor (i.e., being exposed to suicide may cause a person to be more prone to engaging in suicide).

**Diversity Issues**  Rogers and Russell (2014) noted that potential barriers to suicide assessment can occur when cultural factors are not considered (e.g., some cultures contend that discussing suicidal thoughts is shameful and taboo). Diversity factors like age, gender, culture, and sexual orientation can be associated with increased risk of suicide. Adolescents and adults over age 65 are at a higher risk of suicide than the general population. Gender statistics indicate that women attempt suicide at a much higher rate than men, although, surprisingly, men actually commit suicide 4.5 times more often than women. It is not clear what accounts for this discrepancy. Some have hypothesized that fatal suicides for women are often incorrectly reported as accidental deaths (Westefeld et al., 2000). Culture also plays a role in suicide. Native Americans have the highest suicide rates in the United States, estimated to be 1.6 to 4.2 times higher than the national average. Wong et al. (2014) noted that although Native American adolescents and young adults have the highest suicide rate of any cultural group, Native American seniors (ages 65–85) had lower rates of suicide in 2007 (7.58 per 100,000 individuals) than did White American seniors (16.08 per 100,000 individuals). The increased risk for suicide of Native American adolescents and young adults can be related to high rates of alcoholism and difficulty with acculturation and identity development. Sexual orientation has also been related to increased risk for suicide. This is especially true during adolescence, when gays and lesbians are 2 to 3 times more likely to die from suicide than are their heterosexual counterparts. A lack of public acceptance or tolerance of homosexual orientations can undermine identity development when adolescents need understanding and acceptance the most.

**MMPI**  MMPI does not stand for the commonly used personality inventory described in Chapter 4. Rather, MMPI is an acronym for *means, motive, plan,* and *intent* and can be used to identify risk factors associated with suicide.

The following *Personal Note* provides an example of how I used the MMPI to assess for suicide.
CRISIS INTERVENTION

The section on crisis intervention services earlier in this chapter provides guidelines for crisis intervention in terms of potential suicide. As was noted, the aim of crisis intervention is to take the necessary steps to avoid a catastrophe in which the client is seriously hurt.

Crisis intervention strategies used with suicidal clients include contracts, assistance from relatives, medication, counseling, and hospitalization. Suicide contracts, which are commonly used to prevent suicide, involve having clients sign a no-harm contract promising not to kill themselves and to let the counselor, a family member, or another concerned adult know if they become suicidal. No-harm contracts must be used in conjunction with other interventions (Hyldahl & Richardson, 2011). Family members can play an integral role in suicide intervention by providing social-emotional support to clients, monitoring clients for suicidal ideations, and helping clients obtain professional help as needed. Other suicide interventions include medication to treat mental disorders such as depression. Counseling involves encouraging ventilation to defuse the crisis and to promote psychological equilibrium. Hospitalization provides the safest means of preventing suicide and should be considered for acutely suicidal individuals.

Providing mental health services to a suicidal client can be a very challenging experience. Granello (2010b) provided a seven-step model that can be used to address suicide ideations. The seven steps are summarized as follows.

- Assess the degree of lethality to determine what is necessary to promote safety.
- Establish a positive therapeutic relationship.
- Encourage clients to tell their story regarding why they are considering suicide.
- Help clients manage their feelings.
• Promote alternatives, hope, social support, and resilience.
• Create an action-safety plan to address factors associated with suicidal ideations.
• Ensure appropriate follow-up care.

**POSTCRISIS COUNSELING** Postcrisis counseling can be conducted when an individual is no longer at high risk. It can help determine underlying reasons the client was suicidal and foster coping mechanisms to prevent future psychological problems. Dialectic behavior therapy (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), which was specifically designed to treat clients who have a history of suicidal ideations, is directed at teaching skills associated with suicide prevention, such as emotional regulation, interpersonal effectiveness, and distress tolerance. Beck’s (1986) cognitive therapy can also be a valuable approach to helping clients who have had a history of suicidal ideations (Tyrer et al., 1999).

**POSTINTERVENTION** Postintervention involves providing mental health assistance to bereaved individuals, families, and communities. The American Association of Suicidology (1990) identified the following postintervention strategies for suicide:

• Planning how schools and community agencies respond to suicide
• Providing opportunities to work through emotions such as grief, anger, and guilt associated with survivors of suicide
• Taking necessary steps to prevent contagion suicide (such as avoidance of glamorizing the suicide)
• Providing debriefing counseling for mental health staff involved

The following *Personal Note* provides additional insight into the suicide phenomenon.

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**A Personal Note**

When I was the psychologist for an Indian reservation, I provided mental health counseling to more than 100 clients who had attempted suicide. Most of these clients were female adolescents who had tried to kill themselves by taking large amounts of pills they found in a medicine cabinet.

The thing that surprised me about these clients was that nearly all of them truly seemed to

*(Continued)*
RATIONAL SUICIDE  Rational suicide, also referred to as hastened death and assisted suicide, may be the most controversial issue in suicidology. Rational suicide relates to a rational choice to hasten the end of one’s life. Hastened death can be requested in instances of terminal illness or insufferable pain.

Oregon’s Death with Dignity Act of 1999 (Oregon Act), as amended from the 1994 Oregon Act, has played a major role in the evolution of rational suicide. The Oregon Act legalizes physician-assisted suicide in Oregon. It includes conditions that must be met for physicians to participate in assisted suicide. For example, physicians must refer patients to state-licensed psychologists or psychiatrists if the patient appears to have a psychological or psychiatric condition such as depression that impairs judgment (Cohen, 2001). Care of the dying in Oregon appears to have improved since the Death with Dignity Act, which may represent a “wake-up call” to physicians to do a better job assisting individuals to prepare and move toward the end of their lives (Lee & Tolle, 1996). There appears to be an increasing interest in legislation similar to Oregon’s Death with Dignity Act, as Vermont and Washington State allow assisted suicide, and Montana allows it if a court order is obtained. Rational suicide involves health care workers, such as psychologists, in promoting the psychological means of achieving a death with dignity and meaning. The American Psychological Association’s (1997) position on rational suicide is as follows:

I would often use nontraditional approaches to counseling to help these clients overcome their preoccupation with suicide, death, and dying. For example, I might meet with them under a tree to awaken them to the beauty and innocence of life. During a session, we might stop and take time to hear a bird sing. Focusing on the wonder of nature helped clients shift from the negativity associated with their suicidal ideation and open their eyes to the simple, basic splendor of life that only nature can portray. The focus of counseling with these clients was to help them discover some personal meaning in life. Together, we worked to cultivate dreams and develop the means to turn those dreams into reality, a process that required intensive individual counseling and psychotherapy. In addition, I often utilized couples counseling and family therapy as an important facet of the overall treatment program.
The American Psychological Association does not advocate for or against assisted suicide. What psychologists do support is high quality end-of-life care and informed end-of-life decisions based on the correct assessment of the patient's mental capacity, social support systems, and degree of self-determination. (p. 1)

The APA provides guidelines regarding the role of mental health workers in rational suicide. These activities include providing support to the patient and family, ensuring that patients receive proper diagnosis and treatment for mental disorders, and assisting in determining whether patients' decisions regarding hastened death are rational.

Although rational suicide appears to offer a death with dignity and meaning, it involves numerous moral, religious, ethical, and legal issues, which have yet to be addressed. Additional research and evaluation are necessary to determine the implications for the role of mental health workers in rational suicide.

**Substance Abuse Counseling**

*Substance abuse counseling* is a specialty directed at the prevention and treatment of problems associated with alcohol and other substances. Substance abuse has become a major health problem in the United States as well as in many other countries. Alcoholism has been considered to be the third most prevalent US public health problem (Pattison & Kaufman, 1982). Among some cultures, such as Native American, alcoholism ranks first among all health problems (Herring, 1994). Illicit drug use is also widespread in American society, including among children and adolescents, as discussed in Chapter 11. A 1982 survey estimated that 32 million Americans smoked marijuana at least once a year, and 20 million used it once a month; over 12 million used cocaine once a year, and several million used a variety of drugs, such as tranquilizers and stimulants, without medical supervision (Polich, Ellickson, Reuter, & Kahan, 1984).

The result of the high prevalence of alcohol and drug use (not counting tobacco) is that approximately 40% of hospital admissions and 25% of deaths a year in the United States are related to substance abuse, costing society in excess of $300 billion a year, in addition to human suffering and losses in productivity (American Psychiatric Association, 1995). Approximately half of all highway fatalities involve alcohol, one third of all new AIDS cases are related to intravenous drug use, and 7.5% to 15% of pregnant women had recently used a drug (not counting alcohol) just prior to their first prenatal exam (American Psychiatric Association).

Substance abuse permeates all levels of society: Approximately one fifth of all Americans have a problem with alcohol or drug abuse at some time in their lives, and one third of all psychiatric patients have alcohol or drug abuse problems (Frances, 1988). Counselors can therefore expect to have to deal with problems relating to drug abuse regardless of the counseling setting in which they work.
This section provides an overview of substance abuse counseling, with information relating to diagnosis, special treatment issues, counseling goals, treatment strategies, and prevention of relapses. Since alcoholism is the most prevalent of these problems, particular attention is devoted to that issue.

**Diagnosis**

The DSM-5 (American Psychiatric Association, 2013) recognizes 10 classes of drugs that are included in substance-related disorders (e.g., alcohol, cannabis, hallucinogens, and opioids). The substance-related disorders are made up of two separate groups: substance use disorders and substance-induced disorders. A *substance use disorder* is characterized by a “pathological pattern of behaviors related to the use of the substance” resulting in significant problems for the individual (American Psychiatric Association, p. 483). *Substance-induced disorders* include “intoxication, withdrawal, and other substance/medication-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder”; American Psychiatric Association, p. 485).

Questionnaires can be part of the diagnostic process of determining whether a person is an alcoholic or has another substance abuse problem. One commonly used questionnaire is the Michigan Alcohol Screening Test (Selzer, 1971), which has 24 questions that require yes-or-no answers from the respondent.

There are some drawbacks to using the DSM system of diagnosis or a questionnaire to label a person as a substance abuser (e.g., alcohol use disorder), because these systems tend to have either-or definitions of alcoholism in that they provide a result that a client either is or is not an alcoholic. This type of definition could result in a counselor not providing needed services to a client with a borderline problem. Pattison and Kaufman (1982) rejected the either-or perspective and instead conceptualized alcoholism as a multivariant syndrome, which suggests that no two alcoholics are alike and that they manifest multiple patterns of dysfunctional use, varying personalities, numerous possibilities for adverse consequences, and various prognoses. Each individual thus requires a different type of treatment.

The multivariant position suggests that substance abuse should be thought of in terms of a continuum that begins with nonuse and can progress to moderate nonproblematic use, heavy nonproblematic use, heavy use with moderate problems, heavy use with serious problems, and then dependence with life and health problems (Lewis, Dana, & Blevins, 2011). The continuum model does not imply that people who develop problems will always move steadily along the continuum from left to right (Lewis et al.). The relationship to the continuum will vary from individual to individual. Some will stay at the same spot; others will move to the right, signifying more serious problems; and some will develop less severe problems, moving to the left on the continuum.

Counselors can estimate the place where a person is functioning on the continuum by determining the number of problems the person has experienced in relation to
substance abuse (Lewis et al., 2011). Valliant’s (1983) Problem-Drinking Scale can identify problems relating to drinking, including work-related problems, such as excessive tardiness or sick leave or being fired from work; family problems, such as complaints from family members or marital problems; legal problems, such as alcohol-related arrests; and health problems, such as medical disorders, blackouts, and tremors.

Special Treatment Issues

Most of the counseling theories and strategies described in this text can be applied to substance abuse counseling. At the same time, there are some special issues involved in working with this population. Lewis et al. (2011) provided the following guidelines for substance abuse counseling:

- Conceptualize substance abuse problems on a continuum from nonproblematic to problematic rather than in dichotomous, either-or terms.
- Use evidence-based practices.
- Maintain a respectful-positive approach.
- Recognize that advocacy is an important role for the counselor.
- Utilize a multicultural perspective recognizing the needs of diverse client populations.
- Provide an individualized treatment program in terms of goals, methods, and plans for change.
- Incorporate a multidimensional treatment program that includes social and environmental aspects associated with long-term recovery.

These guidelines provide a general theoretical framework for working with substance abuse clients. There are also some unique counseling goals and treatment strategies associated with substance abuse counseling.

Counseling Goals

Considerable debate exists in the literature as to whether the primary goal of alcohol abuse counseling should be abstinence or controlled drinking (Fisher, 1982; Marlatt, 1983; Sobell & Sobell, 1984). Proponents of abstinence align themselves with the disease model of alcoholism, contending that alcoholism is a chronic and progressive disease and that abstinence is therefore the only solution. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are among the proponents of this position. Supporters of controlled drinking, on the other hand, view alcoholism from a behavioral perspective, believing that it results from maladaptive learning.
Miller and Munoz (1982) noted that controlled drinking will be appropriate only for approximately 15% of all alcohol abusers and that certain conditions should preclude any consideration of controlled drinking as a treatment goal. These include clients who have a medical problem, such as a disease of the gastrointestinal system (e.g., liver disease), heart disease, or other conditions that may be made worse by drinking; who are pregnant or trying to become pregnant; who tend to lose control of their behavior when they drink; who have been physically addicted to alcohol; who take medication that is dangerous when combined with alcohol, such as antidepressants or tranquilizers; or who are currently abstaining successfully, particularly if there is a family history of alcoholism or a personal history of serious drinking problems.

Counselors who want to consider controlled drinking as a goal for a client should first receive specialized training. One approach that has received considerable attention, reporting a success rate between 60% and 80%, is behavioral self-control training (Miller, 1980). This program is educationally oriented and can be used in an outpatient setting. It involves a variety of behavioral techniques, including training the client to identify environmental cues that increase the frequency of drinking, to monitor drinking consumption, and to use self-reinforcement to control drinking rates.

Aside from the issue of abstinence versus controlled drinking, there are other, more specific goals that counselors should address when developing a comprehensive treatment program. Lewis et al. (2011) noted that substance abuse tends to be associated with social, psychological, family, and economic problems. With respect to the relationship of these problems to substance abuse, the authors identified the following goals that counselors could attempt to help clients with:

- Resolve legal problems.
- Attain stability in marriage and family.
- Establish and meet educational and career goals.
- Improve interpersonal and social skills.
- Enhance physical fitness and health.
- Develop effective coping mechanisms to deal with stress.
- Learn how to recognize and express feelings.
- Develop effective problem-solving and decision-making skills.
- Establish a social support system.
- Develop positive self-esteem and self-efficacy.
- Deal effectively with psychological issues such as anxiety and depression.
- Create recreational and social outlets.
- Adapt to challenges at work or school.
Treatment Strategies

Treatment approaches in substance abuse counseling vary according to the counselor's theoretical orientation as well as the goals established by the counselor and client. The following is an overview of some commonly used approaches.

THE MINNESOTA MODEL  The Minnesota model has been one of the most widely used forms of treatment for substance abuse. According to James and Gilliland (2013), there are two phases to the Minnesota model. The first phase involves assembling a comprehensive treatment team to evaluate and provide initial treatment pertaining to the client’s unique needs. The second phase typically involves an intensive, 28-day inpatient hospitalization directed at all aspects of the client’s substance abuse problem (e.g., education, recovery, and relapse prevention). In an era of managed care, a 28-day hospitalization is in most instances not a realistic component of a treatment plan. Most managed-care organizations are shifting to an emphasis on outpatient substance abuse treatment programs.

THE ALCOHOLICS ANONYMOUS (AA) MODEL  Since its founding in 1935, AA has grown into the most popular organization for the treatment of alcoholism and other substance abuse problems (Lê, Ingvarson, & Page, 1995). AA incorporates the disease model of alcoholism and is based on a 12-step program, which has a strong religious context. One of the strengths of AA is that it is run by individuals who have themselves struggled with substance dependence. In addition, it can be a place where people feel acceptance, hope, and encouragement. It is also a highly accessible model, with outlets available in almost every major city in the world.

There has been some concern that the efficacy of AA has not been established by empirical research and that its religiously oriented steps, such as admitting powerlessness, are inconsistent with counseling theory and practice are of some concern (Bristow-Braitman, 1995; Lê et al., 1995). Bristow-Braitman suggested that cognitive-behavioral counseling could be used to help reframe some AA concepts to make them more compatible with traditional counseling approaches. Nevertheless, professional counselors may benefit from a deeper understanding of AA to become more sensitive to the spiritual aspects of counseling and be more supportive of their clients who are attending AA.

THE MEDICAL MODEL  This approach also adheres to the disease model of alcoholism. Researchers are investigating the role of physiological factors (including brain function) in the etiology and treatment of substance abuse disorders (Ruden & Byalick, 1997). A number of neurotransmitters may be important in the addiction process (Lewis, et al., 2011). For example, dopamine is believed to influence learning, motor activity, reward, and reinforcement and has been associated with commonly used drugs like cocaine, marijuana, and nicotine (Lewis et al.). The dopamine hypothesis of addiction suggests that dopamine plays a key role in addiction by sending pleasure signals to the brain when it is stimulated by drugs such as cocaine (Volkow et al., 1997).
Medical treatments for substance abuse problems include Antabuse (disulfiram) and methadone (Ruden & Byalick, 1997). Antabuse is a form of aversive therapy that can be taken to prevent relapse in alcoholism. A person will experience anxiety, vomiting, nausea, and palpitations within minutes if alcohol is consumed. Methadone maintenance can be used to block the withdrawal symptoms associated with heroin addiction, while avoiding its euphoric effects. Detoxification centers can also be important in the treatment of substance abuse problems. The detoxification process allows patients to overcome potentially life-threatening withdrawal effects of alcohol and other drugs under medical supervision.

**COGNITIVE-BEHAVIORAL THERAPIES** A number of research studies that have focused on the role of cognitive-behavioral therapies in the acquisition of skills necessary to overcome alcohol abuse and dependence have confirmed that cognitive-behavioral therapies are effective treatments for substance abuse (especially alcohol-related problems) (American Psychiatric Association, 1995). Some of these cognitive-behavioral skills are self-control, interpersonal functioning, self-efficacy, alternative coping mechanisms, and relapse prevention.

**BEHAVIORAL THERAPIES** Two of the more common behavioral approaches used in substance abuse counseling are operant conditioning, used to reward behaviors associated with abstinence and punish those involved in substance abuse, and systematic desensitization and aversion training, which countercondition clients’ drug cravings (American Psychiatric Association, 1995).

**INDIVIDUAL PSYCHODYNAMIC/INTERPERSONAL THERAPIES** The American Psychiatric Association (1995) has provided some support for psychodynamic and interpersonal therapies in substance abuse counseling. The association noted that psychodynamic psychotherapy appears to help prevent relapse and newer, short-term forms of psychodynamic therapy (such as supportive-expressive therapy and interpersonal psychotherapy) have demonstrated efficacy in substance abuse counseling (American Psychiatric Association). These newer approaches focus on formulating supportive counseling relationships in which clients can learn the social skills necessary to overcome negative patterns of interpersonal functioning, which in turn decreases problems with substance abuse (Ruden & Byalick, 1997).

**GROUP THERAPIES** Lewis et al. (2011) suggested that group counseling has many advantages over other methods of substance abuse counseling. For example, it can provide an opportunity for group members to offer support and encouragement, generate problem-solving strategies, learn how to apply new skills such as assertiveness, and, when necessary, break through denial or other processes that interfere with recovery from substance abuse problems.

**FAMILY THERAPY** James and Gilliand (2013) contended that it is critical to involve the family in the treatment of substance abuse. Family therapy recognizes that the behavior of each family member must be understood from the perspective of the
family system. Drinking or the use of other drugs is therefore not an isolated event but an action that affects the overall functioning of the family.

The family therapy literature has provided numerous insights into the systemic nature of family behavior. For example, the concepts enabling and codependency imply that two individuals (one with a substance abuse problem such as drinking) could be dependent on maintaining an adversarial relationship regarding the abuse. In this situation it is common for the drinker and the concerned family member to both gain secondary gains from their codependency, thereby enabling the drinker to continue drinking (i.e., drinkers feel they have an excuse to drink when they “get griped at,” and concerned family members get sympathy from others for having to put up with the drinking).

Family therapy can also be used to overcome one of the most difficult barriers to treatment in substance abuse counseling: denial. It is very common for individuals to deny problems with alcohol or other drugs and resist treatment even when the problem is having a serious adverse effect on their health, family, social life, and work. When this occurs, Johnson’s (1986) family-intervention model can be used to help a family confront a family member with the realities of his or her substance abuse problem. This approach involves training family members to communicate in a clear, caring, and direct manner their concerns regarding how the substance abuse is affecting the individual and the family as a whole. The family-intervention model can be a powerful tool in overcoming denial and motivating the individual to seek help (James & Gilliand, 2013).

Stages of Change

Helping clients successfully engage in the change process is perhaps the most difficult, yet important, aspect of counseling. Unfortunately, little was known about how the change process works. This bleak situation has been addressed by the pioneering work of Prochaska, DiClemente, and associates on how the change process relates to overcoming addictive behaviors (Prochaska, 1984; Prochaska, DiClemente, & Norcross, 1992). Their transtheoretical model of change is based on the idea that both the cessation of problematic behaviors and the acquisition of healthier behaviors involve five stages of change: precontemplation, contemplation, preparation, action, and maintenance (Prochaska et al.). The following is an overview of these five stages of change and the implications they have for developing intervention strategies.

- **Precontemplation.** During the first stage, clients have no serious plans to engage in the change process. Resistance and denial are common reactions in the precontemplation stage.

- **Contemplation.** The second stage is characterized by clients being aware that they have a problem and are thinking about making changes but have not quite reached the point of making a commitment to do something. During the contemplation stage, clients seriously consider resolving their problems. They tend to weigh the pros and cons associated with potential changes to help with decision making.
Special Approaches and Settings

Part 3  |  Special Approaches and Settings

• **Preparation.** At the preparation stage, clients have unsuccessfully taken some action during the past year and plan to try to work on their problem during the next 30 days.

• **Action.** Clients have reached the action stage when they have made the necessary changes in their lives to successfully address a particular problem (e.g., they have stopped drinking for 1 day to 6 months).

• **Maintenance.** The maintenance stage is characterized by clients attempting to prevent relapse and to stabilize their gains. In substance abuse counseling, maintenance extends from 6 months to the rest of the client’s life.

Change is like the tide. It moves forward and backward as clients progress and relapse. Since clients tend to relapse, it is common to regress to earlier stages in the change process (Prochaska et al., 1992). Fortunately, people tend to learn from their mistakes, using what they learn to be more successful as they work their way back through the stages of change. One of the most important implications of the change model is the need to identify where clients are in terms of the change process and match their position with the appropriate form of intervention. For example, some evidence suggests that during the precontemplation and contemplation stages, experiential, cognitive, and psychoanalytic approaches are the most effective, whereas during the action and maintenance stages, existential and behavioral theories have the strongest efficacy (Prochaska et al.).

**Prevention of Relapses**

A comprehensive treatment program for substance abuse should include strategies to prevent or deal with a client’s relapse, or uncontrolled return to drug or alcohol use. The potential for relapse is a serious problem in substance abuse counseling. Some estimates suggest that 90% of all clients have a relapse within 4 years following treatment (Polich, Armor, & Braiker, 1981).

Several factors have been related to substance abuse relapse. Differences in the outcome of a substance abuse treatment program are related to the presence or absence of a mental disorder in addition to the substance abuse disorder (Svanum & McAdoo, 1989). Clients with no additional disorders tend to avoid relapse as long as they comply with after-care treatment, especially an exercise program; have a satisfactory job; and have an adequate living arrangement (Svanum & McAdoo). Clients with multiple mental disorders are more prone to relapse if their emotional disturbance continues after participation in a substance abuse program. Other factors such as exercise, work, or living conditions do not appear to be related to relapse for these clients. Since a substantial minority of substance abuse clients suffer from psychopathology, such as anxiety and depression (Mirin, Weiss, Michael, & Griffin, 1988), substance abuse programs should include careful screening and treatment for these disorders as part of relapse prevention.
A second factor related to substance abuse relapse is the lifestyle imbalance that can result from certain life events. The types of events that precipitate a relapse are negative emotional states (35%), interpersonal conflicts (16%), and social pressures (20%; Cummings, Gordon, & Marlatt, 1980). Lewis et al. (2011) incorporated Marlatt and Gordon’s (1985) model of relapse into the following description of how relapse can occur. A lifestyle imbalance can occur when a client experiences a particular problem, such as a setback at work or a relationship problem. The imbalance may cause the client to feel the need for immediate stress release, and the client may rationalize taking a drink by thinking, “I deserve a drink, with all that I’m going through.” At this point, the client may deny having a problem with alcohol and make apparently irrelevant decisions (AIDs). Lacking the necessary coping skills, the client will experience a decrease in self-efficacy, feeling unable to cope with the situation. This in turn will result in a slip—beginning to drink—creating an abstinence violation effect (AVE). The AVE further undermines the client’s self-efficacy, reducing self-confidence. The client may think, “I’m just a hopeless drunk.” Such negative thinking can create a self-fulfilling prophecy, leading to an increased probability of relapse. In this model, the key to preventing a relapse is to teach effective coping skills, such as stress management, that can increase self-efficacy and decrease the probability of relapse.

**Gerontological Counseling**

Medical advances and a drop in birth rates have resulted in a dramatic increase in the proportion of seniors throughout the world (Yen, 2009). Evidence of this global shift in demographics includes the following (Yen):

- Seniors currently comprise 8% of the 6.8 billion people in the world.
- Germany, Italy, Japan, and Monaco have the highest percentage of seniors (20% of their general populations).
- Since 2000, the percentage of seniors has increased by 23% to 516 million people (twice the growth rate of the general population).
- By 2050, 1 in 6 people in the world will be 65 or older (triple what they are now).

Baby boomers (individuals born between 1946 and 1964) account for the new wave of seniors in the United States (Maples & Abney, 2006). In 2006, 76 million US baby boomers were beginning to reach age 60 (approximately 40% of the adult population). Maples and Abney suggested these individuals would soon be in need of gerontological counseling services, from preretirement to end-of-life counseling.

Gerontological counseling represents an emerging specialty within the counseling profession. This section will address gerontological counseling from the perspective of successful aging, developmental issues, and counseling strategies.
Successful Aging

Sixty-five can be considered the chronological age when old age begins, and old age can be thought of as having three periods—young-old (65–74), old-old (75–84), and oldest-old (over 84)—each marked by distinct changes that occur throughout the aging process (Hooyman & Kiyak, 2005).

A major aim of gerontological counseling is to promote successful aging in older adults, including making successful transitions, overcoming stereotypes associated with ageism, encouraging personal strengths, and promoting lifestyle factors associated with longevity. Ponzo (1992) defined successful aging as “staying vital longer by reaching for and emphasizing the positive aspects of life, of seeing what is possible, instead of what is typical or expected” (p. 210).

Successful aging can involve adjusting to life transitions (such as from work to retirement), which can be thought of as turning points that occur between periods of stability within one's life (Goodman, Schlossberg, & Anderson, 2006). Transitions often require a person to journey into the unknown, take risks, adapt, and cope with fears. They can therefore be challenging times in one's life, often experienced as a crisis. Transitions can also create opportunities for personal discovery, renewal, and transcendence to heightened levels of existence.

Another challenge associated with successful aging can be the ageism associated with sexuality and definitions of beauty. Ageism comprises stereotypes regarding old age that contribute to negative attitudes (prejudice) and actions (discrimination; Hooyman & Kiyak, 2005). For example, sexual expression in older people can be met with prejudice (e.g., older people are asexual beings) and discrimination (e.g., restrictions regarding privacy in residential facilities). Women can face special challenges from ageism, especially as they transition into midlife and old age. It is not uncommon for women to struggle with self-esteem, anxiety, and depression associated with body image issues that result from unrealistic/healthy media messages (Saucier, 2004). Gerontological counselors can use feminist therapy, social justice/advocacy strategies, and other approaches to help older adults address issues associated with ageism.

Functional aging recognizes that definitions of aging vary according to the individual and the culture (Hooyman & Kiyak, 2005). Gerontological researchers like Hooyman and Kiyak and Maples and Abney (2006) have identified a number of personal strengths associated with successful aging, which have been incorporated into the following:

- Maintaining a positive attitude, or optimism, to promote a self-fulfilling prophecy of success
- Self-empowerment and self-efficacy to help seniors recognize the control they have over the aging process (e.g., engaging in healthy lifestyle habits)
- Creativity and wisdom to successfully navigate life's transitions
- Resiliency and self-esteem to provide strengths for overcoming adversity such as negativism associated with ageism
Buettner (2008) has researched “blue zones” associated with longevity (geographic regions where people live to 100 years or more), among them Loma Linda, California; Nicoya Peninsula, Costa Rica; Sardinia, Italy; and Okinawa, Japan. Through in-depth interviews with centenarians from these regions, Buettner and his colleagues identified nine key factors associated with longevity and successful aging (Blue Zones, 2015):

- Move naturally, as part of your daily routine.
- Have a sense of purpose in life.
- Avoid stress and find ways to relieve it.
- Avoid overeating (stop when 80% full).
- Eat a diet rich in vegetables and light on meat.
- Drink alcohol in moderation.
- Utilize a spiritual/belief system.
- Make family life a priority.
- Maintain a social network that supports a healthy lifestyle.

Developmental Issues

Gerontological counseling requires an understanding of human growth and development from the womb to the tomb. This section is a brief overview of some of the issues associated with physical, cognitive, and social and personality development of late adulthood.

PHYSICAL DEVELOPMENT

By early adulthood, most physical growth and maturation has occurred (Feldman, 2008). Senescence (the natural decline of all physical functions) follows this period of growth and plays a major role in the aging process. Physical ailments, restrictions in mobility, and problems with vision and hearing can be early signs of senescence. Older adults can also have increased risk of disease, such as cancer, due to reduced functioning of the immune system. And they can suffer from other chronic conditions, like arthritis and osteoporosis (thinning of bones); the latter affects approximately 25% of women over 60 (Feldman).

Fortunately, the process of senescence can be offset by healthy lifestyle habits like regular exercise, good diet, and refraining from smoking. Regular exercise is especially important for older adults because it can enhance physical, cognitive, and social emotional functioning. Fitness programs that address the special needs of older adults can include weight lifting for bone and muscle strength, aerobics (running, walking, or swimming) for cardiovascular conditioning, tai chi for balance, and yoga for flexibility of movement.

COGNITIVE DEVELOPMENT

Cognition is associated with intelligence, memory, and learning. Hooyman and Kiyak’s (2005) overview of cognition in older adults states that in most instances, intellectual functioning remains relatively consistent throughout old age. This is especially true for crystallized intelligence (verbal tasks),
with some decline experienced in terms of fluid intelligence (performance tasks). Problems with performance tasks may be related to noncognitive functions associated with perceptual, motor, and sensory skills, which tend to decline in old age. Cognition can be dramatically undermined by dementia associated with Alzheimer's disease and other medical conditions. Gerontological counselors can provide support to individuals stricken by these disorders and to their families.

Learning and memory are interrelated. Although difficulty with memory can be a common problem with older adults (e.g., trying to remember the name of something), intellectual stimulation and memory aids can enhance recall and promote learning. Learning is a lifelong endeavor. Healthy lifestyle habits, including regular exercise, can play an important role in promoting learning throughout the life span.

Wisdom can be defined as “expert knowledge in the practical aspects of life” (Feldman, 2008, p. 610). Wisdom is believed to be associated with contemplation, knowledge, and reflection on life experiences. Although research regarding wisdom is a relatively new science, several preliminary findings are beginning to emerge (Feldman). Older adults appear to be “wise thinkers” in terms of having superior skills in problem solving and analyzing complex situations from a number of perspectives. Older adults also appear to have more sophisticated skills in terms of “theory of mind”—being able to make accurate inferences about the mental states of others—because they are able to draw on past experiences in understanding the subtle nuances of human behavior.

SOCIAL AND PERSONALITY DEVELOPMENT Psychosocial factors are relatively stable through adulthood (Feldman, 2008), including a number of personal qualities that impact daily functioning, such as self-concept, self-confidence, affection, openness, agreeableness, conscientiousness, extroversion, and neuroticism. Well-being and happiness also tend to be relatively stable throughout the life span. Happiness is to a large degree associated with how well people are able to meet their basic needs—love, belonging, and self-esteem. External rewards like money and possessions do not appear to play a significant role in a person's happiness (Feldman).

Erikson (1963) suggested that the final stage of psychosocial developmental is ego integrity (having a sense of wholeness and completeness with life) versus despair. Older adults who are unable to derive meaning from life can feel regret and become prone to depression and suicide. The American Psychological Association (2014) noted that life review and reminiscence therapy can be used to help older adults integrate life experiences. Depression is the most common mental disorder in older adults (Hooyman & Kiyak, 2005). It can be associated with the following risk factors: female, unmarried, financial problems, multiple medical conditions, lack of social support, and family history of depression (Hooyman & Kikak). Men can also be at risk for depression and suicide, especially when cut off from their emotional support system (as in divorce or death of a spouse). Gerontological counselors can address mental disorders like depression in older adults through cognitive-behavioral counseling, life review and reminiscence therapy, managing medication issues, and monitoring for possible suicide (APA; Meyers, 2014a).
Briggs, Magnus, Lassiter, Patterson, and Smith (2011) noted that alcohol and drug abuse among adults 50 and over will triple by 2020 and that mental health practitioners need to be aware of the special needs of older adults regarding substance abuse assessment and treatment. These authors reported that substance abuse problems are often not recognized in older adults, because older adults tend to deny these problems due to feelings of shame and failure and concerns of loss of independence. Briggs et al. suggested that older adults with substance abuse problems require a multifaceted approach that is empathic and caring and not confrontational, addresses the special needs of older adults, and includes family support. In addition, they noted that older adults with substance abuse problems tend to respond positively to self-help groups and brief group counseling that includes cognitive behavioral strategies (e.g., motivational interviewing and brief advice).

Counseling Strategies
Gerontological counseling has come of age; it represents an important emerging counseling specialty (Maples & Abney, 2006; Meyers, 2014a). Meyers suggested that gerontological counselors address special issues of aging, such as dealing with loss and concerns regarding autonomy and independence. Chatters and Zalaquett (2013) recommended that gerontological counseling be comprehensive and strength based, emphasizing the positive aspects of aging and assisting clients to make life changes to promote successful aging. In addition, the APA (2014) identified the following positive aspects of aging on social/emotional development that may be addressed in counseling:

- Use of wisdom and life experiences to cope with challenges such as dealing with loss
- Enhanced plasticity of personality (ability to adapt and adjust to life circumstances)
- Making the most of their remaining years by developing emotionally meaningful goals and positive social networks necessary to achieve these goals

Although psychotherapy can be very effective with older adults, they often find it difficult to seek out mental health services because of misconceptions about counseling and psychotherapy (Hooyman & Kiyak, 2005). The APA (2014) and Meyers (2014a) suggested that gerontological counselors incorporate a narrative perspective (e.g., life review and reminiscence therapy) to overcome the negative stigma many older adults have about mental health services and promote cultural sensitivity (e.g., exploring cultural belief systems and indigenous healing practices). Many other existing counseling theories, such as existential therapy, can also be adapted to gerontological counseling. The following Personal Note is an example of gerontological counseling.
LEGAL/ETHICAL ISSUES AND CLINICAL CHALLENGES  Legal/ethical issues and clinical challenges should be considered when providing counseling and psychological services to clients with end-of-life (EOL) issues. The recently revised American Counseling Association’s (ACA, 2014) code of ethics addresses EOL issues associated with confidentiality as follows. Counselors who become aware of clients wanting to hasten their deaths have the option of maintaining confidentiality depending on applicable laws and the circumstances of the situation. In these instances, the counselor should consult with professionals, including legal experts, to determine appropriate action regarding confidentiality.

The ACA (2014) code of ethics also provides information on a number of other topics that can impact clients with EOL issues, including client welfare and professional competency:

- **Client welfare.** The primary responsibility of counselors is to promote the dignity and welfare of the client.

- **Professional competency.** Counselors should practice only within the realm of their competence or obtain additional education, training, and supervision necessary to perform these
tasks. Counselors who do not have or are unable to obtain the competencies necessary to assist clients should work with clients to obtain appropriate referral sources.

Werth and Crow (2009) identified particular clinical challenges associated with counseling EOL clients. They noted that correct diagnosis and treatment of mental disorders is an important aspect of EOL care. For example, grief is a common emotional response to death and dying. When necessary, counselors can assist dying individuals and their loved ones with the grieving process. Addressing spiritual/religious issues can be an important part of this process. Counselors can engage in other interventions associated with EOL care, such as facilitating meaningful communication between the dying person and family members.

**Guidelines for Gerontological Counseling**

Older adults face a number of challenges associated with successful aging. The overall aim of gerontological counseling is to promote successful aging in terms of adjusting to transitions; overcoming stereotypes associated with ageism; fostering personal strengths; encouraging lifestyle factors associated with longevity; promoting optimal physical, cognitive, social, and personality development; and coping successfully with EOL issues.

The following guidelines for gerontological counseling incorporated information from APA (2014) and Meyers (2014a):

1. Obtain accurate knowledge about adult development and aging, including an awareness of positive aspects of aging such as the enhanced plasticity of personality (the ability to adapt and adjust to life circumstances).

2. Utilize culturally sensitive interventions, such as life review and reminiscence therapy, to overcome negative stigmas of mental health services, integrate life experiences, explore cultural beliefs systems, and identify indigenous healing practices.

3. Establish counseling goals and strategies to address the special needs of older adults, such as using creative arts in individual and group counseling to awaken social interest and overcome isolation and loneliness.

4. Utilize social justice/advocacy strategies with older adults to combat negative societal forces like ageism, prejudice, and discrimination.

5. Utilize cognitive-behavioral therapy and other approaches to promote personal strengths associated with successful aging (e.g., self-empowerment, positive attitude and optimism, and resiliency).
6. Promote lifestyle factors associated with longevity, including exercise, proper diet, meaning in life, social-family relationships, and reduced levels of stress.

7. Be cognizant of the role that spirituality and religion can play in the lives of seniors, especially when faced with EOL issues.

8. Promote preventative strategies, such as screening for possible medical and mental health issues (e.g., depression and dementia), that may require further evaluation and treatment.

9. Be aware of ethical codes and legal issues that may impact counseling of older adults (e.g., EOL care and elder abuse and neglect).

10. Be enriched by the wisdom of older adults. They have much to teach us about life.

**Trends and Perspectives**

Several trends have affected all aspects of the counseling profession, including mental health counseling. This section reviews mental health counseling trends and perspectives relating to postmodernism, the Internet, ecosystemic issues, diversity issues, and issues relating to managed care.

**Postmodernism**

Postmodernism is a force that is reshaping the manner in which mental health counseling is conceptualized and practiced (see the special 1994 issue of *Journal of Mental Health Counseling, 16*(1), on constructivist and ecosystemic views; D'Andrea, 2000; Gutterman, 1996). Postmodernism can be understood by contrasting its key concepts with those of modernism. Modernists view the “self” as autonomous and independent. It therefore follows from a modernist perspective that problems like depression are caused by internal struggles (e.g., intrapsychic conflicts). The modernist view of the world is objective, and it has a fixed understanding of knowledge and reality. Modernist research methodology tends to be quantitative, focusing on testing observable, measurable hypotheses. The assessment of clients’ problems is based on cause-and-effect relationships with a focus on content over process (e.g., irrational and dysfunctional thinking causes depression and must therefore be analyzed in terms of its content). Goal setting and interventions are generated by mutual agreement between the counselor and client and are reflected in the major modernist counseling theories and approaches.

Postmodern thought takes a broader view of the self to include interpersonal, systemic, and sociocultural forces. Psychological problems, knowledge, and reality
are viewed subjectively from a phenomenological perspective and are understood within the context in which they are presented (the sociocultural milieu). Assessment of clients’ problems emphasizes process over content, with a focus on relational/contextual perspectives. Goal setting and intervention strategies often involve exploring clients’ narratives and stories and working together to co-construct new stories that generate personal meaning. Postmodernist research and evaluation methods tend to be qualitative, whereby the counselor and client function as co-investigators interested in discovering patterns of meaning that can generate insight and understanding. Table 15.1 summarizes the major concepts that differentiate modern from postmodern perspectives. The following Personal Note is an example of how I engaged in a postmodern approach to counseling.

A Personal Note

I was a psychologist providing in-patient care in a hospital. My client was a 25-year-old Navajo woman, Martha, whose mother had died 2 months earlier. She was admitted to the hospital by an emergency room doctor who had diagnosed major depression with psychotic features. The ER doctor used traditional diagnostic procedures that are by their nature grounded in modernism (e.g., a fixed-objective view of reality). The doctor gave Martha the diagnosis “with psychotic features” because she had concluded that Martha was hearing voices and had lost contact with reality (she was conversing with her deceased mother). The ER doctor agreed to hold off on prescribing antipsychotic medication for Martha’s voices until I could do a psychological consult.

At the time I saw Martha, I had been working on the Navajo reservation for 2 years as a psychologist with the Indian Health Service. By this time, I had become sensitized to some of the unique aspects of the Navajo culture, such as the role of medicine men in promoting mental health and healing. I was also aware of how attitudes, customs, and values shaped my clients’ views of reality. I was, therefore, very open to Martha’s story when she shared that she regularly conversed with her deceased mother. She asked me if I believed her when she said she often talked with her mother. I responded that it did not matter what I believed; it only mattered what made sense to her.

I worked with Martha, assisting her with her depression and grief, over a period of 2 weeks. With the support of her family, Martha was able to move on and let go of her sadness. In time, her story became one of hope and optimism versus one of sadness, despair, and loss. I believe that my relationship with her and the resulting therapeutic alliance was fostered by my openness to her experience. Clinical experiences such as this have made me aware of the importance of maintaining a postmodern phenomenological perspective in counseling.
Mental Health Counseling, the Internet, and Technology-Assisted Counseling

The use of the Internet and other forms of technology-assisted counseling appear to be increasing (Sude, 2013).

Gutterman and Kirk (1999) identified Internet tools and resources that can be helpful to mental health counselors:

- **Email** can be used in a variety of ways, including for communication among practitioners and provision of mental health counseling services. Internet counseling has advantages and disadvantages. Advantages include easy access (e.g., clients can log on whenever they have time and are not restricted in terms of travel); disadvantages include difficulty in reviewing a counselor's credentials, the limited opportunity to develop a personal relationship between counselor and client, and reduced control over confidentiality. The National Board for Certified Counselors (NBCC) Standards for the Ethical Practice of Web Counseling (1997) was created to address potential ethical-legal issues relating to Internet counseling.

- **Chat rooms** are especially popular as a self-help group format to provide opportunities for two or more clients to share mental health information with each other in a manner that is not restricted by time or distance.

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<th>View of the self</th>
<th>Modern Views</th>
<th>Postmodern Views</th>
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<td>View of knowledge and reality</td>
<td>Autonomous, independent self</td>
<td>Relational/contextual self</td>
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<td>Fixed-objective concept of knowledge and reality</td>
<td>Phenomenological perspective; subjective/relative concept of knowledge and reality</td>
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<td>Assessment of client’s problems</td>
<td>Etiology of problems is intrapsychic, with a focus on cause-effect and content (e.g., how cognitions affect emotions).</td>
<td>Etiology of problems emphasizes process over content and is focused on relational/contextual perspectives.</td>
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<td>Goal setting and interventions</td>
<td>Goals are mutually agreed on between counselor and client, as reflected in the major counseling theories.</td>
<td>Goals and interventions evolve from exploring client’s narratives resulting in co-construction of new stories that generate personal meaning.</td>
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• **Websites** can disseminate information regarding mental health services. The American Counseling Association established its website in 1996 (http://www.counseling.org).

• **Search engines** can help clients and counselors locate information on the Internet. Mental Health Net (http://www.mentalhelp.net) had over 93,000 mental health listings as of 1999.

• **Web rings** have been created to facilitate interdisciplinary communication between laypeople and professionals.

• **Online communities** provide opportunities for individuals to visit sites that feature interactive services. Visitors are encouraged to visit often and get to know other users with common interests. There are a number of online communities developed for mental health professionals, such as Behavior Online: The Mental Health and Behavior Science Meeting Place (http://www.behavior.net).

• **Scholarly publications and professional newsletters** can be accessed through the Internet.

• **Education and training opportunities** are available on the Internet. Most professional organizations offer continuing education opportunities on the Internet, and many universities utilize the Internet for distance education programs, which in some instances include graduate coursework in mental health counseling.

The Internet is an active versus passive form of communication whereby all voices can be heard and can ultimately influence any field of endeavor, with the result that the knowledge base for various professions, including mental health counseling, is now more fluid and diversified. Mental health professionals are using the Internet to address all aspects of professional activity from theory to research to practice. Gutterman and Kirk (1999), for example, used the Internet to solicit feedback regarding the development of an article subsequently published in the *Journal of Mental Health Counseling*. The possibilities seem limitless regarding the impact of the Internet not only on shaping professions like mental health counseling but on influencing all other aspects of human existence.

Sude (2013) noted that there has been an increased use of cell phones and other mobile devices by mental health practitioners to create communication options with their clients. For example, text messaging (which can include videos and pictures) can be used to schedule appointments and provide other administrative services and to give clients support and assistance with interventions (Sude). Warren (2012) noted that mobile mind mapping provides clients with visual aids they can use to assess information as an adjunct to therapy. Warren suggested that mobile mind-mapping applications (such as SimpleMind and Thinking Space) have been used in
rational-emotive behavior therapy (e.g., clients use apps to download a list of rational responses they can utilize when they experience an adverse event).

Although technology-assisted counseling can be useful for scheduling and other counseling-related tasks, there are ethical and clinical concerns regarding these emerging technologies. For example, Sude (2013) identified ethical and clinical concerns relating to text messaging such as confidentiality and problems with service delivery (e.g., difficulty establishing rapport outside of a face-to-face relationship and responding appropriately to crises). Professional organizations, such as the American Counseling Association and the Mental Health Counseling Association, have addressed ethical issues relating to technology-assisted counseling in their ethical codes. Clearly, mental health practitioners need appropriate training and competencies regarding the use of technology-assisted counseling.

**Ecosystemic Mental Health Counseling**

Sherrard and Amatea (1994) defined ecosystemic mental health counseling as an approach that “enlarges the field of inquiry and intervention from the individual to the couple, the family, and the larger sociocultural contexts that constitute the individual's environment” (p. 3). This approach appears to be an attempt to incorporate the major concepts of postmodernism into a new conceptualization of the role and function of the mental health counselor. Ecosystemic mental health counseling acknowledges the vital role that narrative psychology and counseling as storytelling play in the counseling process (Becvar & Becvar, 1994). The role of the mental health counselor is directed at exploring the linguistic and language systems of the client, resulting in a shift from managing lives to managing conversations (Daniels & White, 1994).

Postmodern thought offers an opportunity for effective integration of theoretical positions in mental health counseling. Fong and Lease (1994), for example, suggested that the ecosystemic perspective effectively translates systemic concepts (widely used in marriage and family counseling) into individual and group mental health counseling. Rigazio-DiGilio (1994) addressed the need to integrate theories of development into counseling theories and provided an in-depth description of how Piaget's theory of cognitive development can be integrated into ecosystemic mental health counseling. Gutterman (1996) noted that solution-focused counseling was derived from current trends in brief counseling and postmodernism/social constructionism and that solution-focused counseling provides a theoretical framework that can crystallize and bring into focus the unique professional identity of mental health counselors.

Postmodern trends such as ecosystemic mental health counseling are exciting new dimensions of mental health counseling. They appear to offer considerable promise for new paradigms in conceptualizing the counseling process. Postmodern trends can help create treatment programs that are more comprehensive and holistic in nature and that encourage awareness of and sensitivity to issues of diversity, such as sociocultural forces and gender. Future research activities will need to be directed at the efficacy of postmodern trends as they are integrated into the role and function of mental health counselors.
Diversity Issues

Mental health counseling is attempting to embrace all aspects of diversity—age, gender, culture, sexual orientation, socioeconomic status, race, ethnicity, and spirituality—so that counselors can sensitively and effectively provide mental health services to clients. Kohn-Wood and Hooper (2014) and Locke (1993) recommended that mental health counselors increase their efforts to respond to the immense challenges that diversity issues pose in the delivery of mental health services. Mental health counselors can address these challenges by promoting culturally sensitive competencies regarding assessment, diagnosis, and treatment and advocating for sociopolitical policy change relating to access, utilization of services, and service delivery (Kohn-Wood & Hooper). Kohn-Wood and Hooper also suggested that multidisciplinary teams (e.g., mental health specialists working directly with primary care practitioners) could be utilized to promote multicultural competency in health care settings.

The following personal note provides an example of mental health practitioners working collaboratively with primary care physicians and other health care workers.

A Personal Note

As a professor at New Mexico State University, I was the coordinator for the CACREP-accredited mental health counseling program and oversaw the master’s degree practicum and internship programs. One of the most noteworthy clinical placements involved our master’s and doctoral students working directly with primary care physicians who were residents in family medicine. Our students provided consulting (from a multicultural perspective) to the medical staff regarding possible mental health issues and psychological factors that could promote health and wellness. It was especially rewarding when the physicians reported that our students were perceived to be an integral part of their treatment team.

This outstanding clinical placement was made possible by a training grant by Dr. Eve Adams, an associate professor in our department. I believe this innovative clinical placement worked because it was a mutually beneficial experience bringing together expertise in psychological and physical health. Collaboratively, these professionals were able to promote mental health and wellness from a holistic perspective.

The Patient-Centered Culturally Sensitive Health Care Model (PC-CSHC) was developed in an attempt to incorporate a culturally sensitive perspective into the treatment of low-income, racially diverse patients (Tucker et al., 2007). Training health care staff and patients in the PC-CSHC Model has a positive effect on the health care physical environment, enhances the behaviors and attitudes of health care staff and patients, and promotes positive health care outcomes in patients (Tucker et al.). Staff are encouraged to display attitudes and behaviors that are culturally sensitive.
(including modifying health care environments to make patients more comfortable), and patients are empowered to engage in healthy lifestyle behaviors.

The Multi-Level Model of Psychotherapy, Social Justice, and Human Rights (MLM) addresses mental health issues of immigrants from a multicultural/social justice perspective (Bemak & Chung, 2008a). The MLM appears to be an example of culturally sensitive interventions that may be adapted to other multicultural populations. Its five levels are as follows:

- **Level 1: Mental health education.** Psychoeducational interventions are used to help orient immigrant clients to counseling and mental health services.

- **Level 2: Individual, group, and family counseling.** Counselors are encouraged to adapt traditional counseling strategies to the unique needs of clients from a multicultural perspective.

- **Level 3: Cultural empowerment.** Social justice, advocacy, and other interventions are used to help immigrant clients achieve bicultural status (e.g., transition into the mainstream of society while maintaining cultural heritage as desired).

- **Level 4: Integrating of traditional and Western healing.** Counselors communicate a respect for traditional and Western forms of healing.

- **Level 5: Addressing social justice and human rights issues.** Counselors work with immigrant clients to ensure equal opportunity and access to community resources.

Cultural issues are critical in all phases of counseling. Substance abuse counseling, for example, illustrates the importance of cultural issues in mental health counseling. Acculturation, sources of stress, and beliefs and attitudes regarding substance use are important cultural factors that contribute to the development and treatment of substance abuse (Terrell, 1993). In terms of the stress experienced during the acculturation process and as a result of conflicting cultural values regarding substance use, acculturation can play a role in the development of substance abuse. An example can be seen in the stress experienced by Native Americans who move from a reservation to an urban area. Beliefs and attitudes regarding substance abuse can also play a role in treatment. For example, African Americans may resist investing themselves in substance abuse treatment that adheres to the medical model, contending that substance abuse is not a disease but a condition based on personal choice (Terrell).

Gender is another important diversity consideration in mental health counseling. Most treatment modalities for substance abuse counseling have been based on a male model of alcoholism (McDonough & Russell, 1994). Research is beginning to suggest that women alcoholics have special needs relating to relationship expectations, development issues, and societal stigma. For example, some Hispanic females feel a strong cultural
sanction against alcohol use, which could make it difficult for them to admit to a problem and seek help from mental health services (Terrell, 1993). The relationship of gender and depression is another diversity issue. An international review of the literature on the prevalence of depression in males and females shows that women have higher rates of depression compared to men (2:1); women also suffer from more serious, profound depression at higher rates (the ratio of women to men with major depression is between 3:1 and 4:1), while rates of bipolar (manic/depressive) disorders appear to be similar for men and women (Culberston, 1997). Several factors could contribute to the different rates of major depression for women and men (Culberston). Women tend to seek out mental health services more than men, and there is some indication that men tend to “self-medicate” with alcohol and other drugs to deal with problems such as depression. Biological differences in men and women and sociopolitical forces, such as child care demands and less economic support, could also contribute to higher rates of depression in women than in men.

Clients with disabilities are an often neglected but important population that requires careful attention from mental health counselors (Helwig & Holicky, 1994). Clients with physical disabilities, such as spinal cord injuries, are prone to substance abuse problems (Helwig & Holicky). Although approximately half of these individuals have symptomatology associated with substance abuse, rehabilitation counseling tends to focus on helping the client adjust to the disability rather than on recognizing and treating the substance abuse. Helwig and Holicky suggested that substance abuse problems should be addressed first to facilitate clients’ ability to deal with the challenges of their disability.

Spirituality (which may or not include religion) is now being addressed in the diversity literature (Bishop, 1995). Conceptualized as a developmental construct endemic to all people that is directed at addressing questions basic to one’s existence (Ingersoll, 1995), spirituality has been supported in recent research for the positive role that it and religion can play in mental and physical health (Koenig, 1997; Richards & Bergin, 1997; Witmer & Sweeney, 1995). People turn to spiritual values as an important source of strength and support in times of great need (Miranti & Burke, 1995), a tendency that becomes stronger especially as people get older. A number of other factors make spirituality a particularly attractive dimension of the counseling process, including the following (Richards & Bergin):

- It fosters a secure sense of identity that promotes resiliency and helps alleviate stress and anxiety.
- It provides a sense of purpose and meaning to all phases of life, including death.
- It encourages positive feelings and thoughts like hope, healing, optimism, and forgiveness.
- It provides a support system through such activities as church involvement.
• It fosters processes like prayer and meditation that promote healing through activities such as communion with a "higher power."

• It encourages healthy lifestyles.

**Managed Care**

Managed care is here to stay, along with its advantages and limitations (Lawless, Ginter, & Kelly, 1999). Some of the advantages include the control of the costs of mental health services and establishment of standards of practice to ensure quality. Constraints are time limits for treatment of disorders, overuse of medication in treatment programs, and reduced access to inpatient treatment. Managed care is essentially an attempt by health organizations to control medical costs (Pipal, 1995). Its overall aim is to help clients achieve their premorbid levels of functioning and to obtain symptom relief; managed care has little interest in developmental or preventive enhancement (Pipal).

Mental health counselors and other health care professionals have had to become providers to managed-care organizations in order to access clients’ insurance programs, which are still evolving under the health care reform movement. Two facets of managed care that have directly affected the delivery of mental health services are an emphasis on diagnosis and a preference for time-limited, solution-focused sessions. Mental health counselors (and other practitioners) therefore often feel under pressure to conform to managed care's expectations in order to remain approved providers. This can produce behaviors that are clearly ethical violations (Bachrach, 1995; Pipal, 1995), such as making improper diagnoses to gain authorization for services, not ensuring clients’ confidentiality through communication with managed-care personnel, providing inadequate services owing to restriction on the number of sessions (usually fewer than six), and providing services beyond the scope of one's practice.

Some suggest that the advent of managed care requires changes in the counseling process and mental health delivery system (Wagner & Gartner, 1996). Therapists need to function as coaches or teachers and act as catalysts for change (Wagner & Gartner). In this mode, clients learn skills from a variety of individuals and practice what they learn in their everyday life experiences. The working-through phase of counseling therefore occurs outside of counseling. In addition, counseling becomes more of an open-ended process involving intermittent or episodic care (Wagner & Gartner). The therapist and client together work within the constraints of managed care to address the client’s needs as efficiently as possible (e.g., the client may sign up for a certain number of sessions to treat a substance abuse problem and attempt to seek other assistance at a later date). One facet of counseling that does not seem to need to change is the nature of the therapeutic alliance: It is essential for counselors to maintain a positive counseling relationship as advocated by Carl Rogers and others (Wagner & Gartner).
Managed care poses many challenges to the mental health counselor and other health practitioners. In an era of increasing pressures for cost containment, it is becoming difficult to provide services that are consistent with the basic standards of practice and that are in the client's best interests. Former surgeon general C. Everett Koop voiced this concern when he noted that too much emphasis has been put on the economic/political pressures of health care with too little attention paid to the ethical imperatives for health care reform (Bachrach, 1995).

### SUMMARY

Mental health counseling is both an amorphous job role performed by various members of the helping profession and an emerging profession for individuals who identify themselves as mental health counselors. Professional issues relating to mental health counselors include professional affiliation and certification requirements.

The role and function of mental health counselors are to provide direct and indirect counseling services to clients who have either problems of living or mental disorders. Mental health counselors can provide specialized services to a wide range of clients, including suicidal clients, clients with substance abuse problems, and gerontological clients.

### PERSONAL EXPLORATION

1. What do you think are the major challenges and opportunities associated with mental health counseling, and would you consider entering this profession?

2. What do you believe are the key issues associated with substance abuse, and how should mental health counselors address these issues?

3. How can the concept of stages of change be useful in treating substance abuse and other mental health problems?

4. What is your opinion of rational (or physician-assisted) suicide?

5. How would you feel about working with older adults?

6. What do you think is the most important thing to do in a crisis?

7. How can mental health counselors engage in social advocacy?

8. What are the warning signs of suicide, and what would you do if you became aware of someone having these signs?

9. What are your views on providing mental health counseling via the Internet or using other forms of technology to provide mental health counseling?

10. What are some physical, cognitive, and social-emotional changes that occur with aging?
LEARNING ACTIVITIES

1. Apply some of the guidelines for gerontological counseling in your interactions with seniors.

2. How could you apply the factors associated with successful aging in your life?

WEBSITES

