

Reaffirming the Unique Identity of Counseling Psychology: Opting for the “Road Less Traveled By”

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Chwalisz's (2003 [this issue]) call to adopt the evidence-based practice model provides an opportunity for counseling psychologists to reexamine both their commitment to the scientist-practitioner model and their unique professional identity. In this reaction, the author offers her critique of several assumptions underlying the evidence-based approach and presents her position that a shift to the evidence-based worldview would move the field further away from its roots as a specialty, including its particular commitment to prevention, multiculturalism, and social justice. A set of standards or competencies to advance counseling psychologists' commitments to a prevention-oriented, social justice approach is needed to guide counseling training, practice, and research. In addition, significant barriers to the implementation of a prevention-oriented agenda in counseling psychology will need to be overcome.

I took the one less traveled by,
And that has made all the difference.

—Robert Frost

Despite debate regarding the value and meaning of the scientist-practitioner model (e.g., Gelso, 1979), the commitment of graduate counseling programs to this vision of training has not wavered. Chwalisz's (2003 [this issue]) disagreement regarding the exact meaning of the scientist-practitioner model serves as fodder to argue for a shift from the scientist-practitioner framework to an evidence-based practice approach for counseling psychology training, research, and practice. Her article provides an opportunity for counseling psychologists to reexamine not only our commitment to the scientist-practitioner model, so long regarded as a hallmark of the field, but also an aspect of our unique professional identity. In recent years, the identity of counseling psychologists has focused less on issues of health and adaptation within social systems and concerned itself more with the etiology of pathology. The movement toward a focus on disease and distress rather than health and well-being (Holden & Black, 1999) runs counter to the unique perspective of the professional practice of counseling psychology originally developed at the Boulder

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conference in 1949 and reiterated and further articulated at the 1987 Georgia conference on the Future of Counseling Psychology.

The following reaction will briefly discuss some of the philosophical strengths of the evidence-based practice approach as laid out by Chwalisz (2003). I will also present my position that a shift to the evidence-based worldview would ultimately move the field further away from its roots as a specialty, including its particular commitment to prevention, multiculturalism, and social justice. Finally, I will discuss implications for the field of counseling.

Part of the larger context for this discussion is the tension that exists within counseling psychology between two paths: a one-on-one, remedial, and medically oriented approach largely circumscribed by the managed care environment; and an approach grounded in the social and cultural context emphasizing prevention, advocacy, and social change (e.g., Sue, 2001; Vera & Speight, 2003). In many ways, the first path is the way of least resistance, because the field of counseling psychology has already begun a movement in this direction, and continued advancement means closer alliances with both the medical establishment and clinical psychology and a perceived increase in status for the field.

The second path, on the other hand, which might be said to be the "road less traveled by," involves the more difficult task of challenging the status quo and requires facing the enormous complexity surrounding issues of oppression and discrimination as well as the demands of tailoring our interventions to diverse issues and cultural contexts. One could rightly argue that presenting just two mutually exclusive options is far too simplistic and that on some level both approaches are needed, addressing immediate needs of individuals and creating systemic change within groups, organizations, and institutions. However, I maintain that on a philosophical level, each is distinct, and the reality of limited resources as well as the strong pull of larger societal forces (e.g., a for-profit health care system) toward a medically oriented approach means that fundamentally, we must actively and consciously opt for one of the two paths outlined above, which will then intentionally form the theoretical foundation for our training, research, and interventions.

PHILOSOPHICAL STRENGTHS OF CHWALISZ'S EVIDENCE-BASED PRACTICE APPROACH

Despite my objection to Chwalisz's (2003) call for a "shift from training scientist-practitioners to training *evidence-based practitioners*" (p. 499), which will be explored in more depth below, her commentary aptly challenges counseling psychologists to face several shortcomings of the current

scientist-practitioner model of training. The shortcomings include the failure to model and truly integrate science and practice as well as to adequately measure program outcomes; the adoption of an “extreme positivist approach” in our research and teaching, which she rightly argues has “exacerbated the scientist-practitioner split;” and our disregard for the “processes and knowledge” acquired through practice. While the brevity of my reaction does not allow for a full discussion of each of the weaknesses outlined by Chwalisz, continued dialogue among counseling psychologists about issues related to identity and the integration of science and practice is vital to strengthen and clarify the scientist-practitioner approach.

The challenge to adopt expanded notions of scientific evidence is the most compelling of the limitations of the scientist-practitioner model discussed by Chwalisz (2003). The bias within counseling psychology toward controlled, experimental research continues unabated despite general philosophical support for a shift to a variety of research methods. However, as reflected by Heppner, Kivlighna, and Wampold (1999), “Methodological diversity is essential for important advances in the field of counseling and development” (p. 11). Such diversity is also consistent with the fundamental tenets of our field, which has emphasized respect for the personal, subjective experience of the client and multifaceted approaches to knowing.

A further strength of Chwalisz’s (2003) commentary is her acknowledgement of the need to extend controlled empirical research to real-world settings and her call for the development of specific standards to evaluate the value of each contribution. As reflected by Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001) in their discussion of evidence-based practice with children and adolescents, “The central problem is that treatments that have been validated in efficacy studies cannot be assumed to be effective when implemented under routine practice conditions” (p. 1186). Hoagwood et al. argued for the introduction of clinic and community intervention development models that attend to “nuisance characteristics” of practice settings. Their recommendation parallels Chwalisz’s suggestion that training programs adopt the model of practice research networks as they exist in the United Kingdom. I applaud this suggestion and invite further commentary regarding implementation of such networks.

In sum, Chwalisz’s (2003) recommendation to extend studies of effectiveness of treatments and services to practice settings and her well articulated argument for a broader range of evidence to support psychological activities are strengths of her treatise and effectively counter a number of significant objections to the evidence-based approach (Carter, 2002; Corrie & Callahan, 2000; Hausman, 2002; Hoagwood et al., 2001). Several other objections to the evidence-based practice approach will be discussed in the next section, along with my view that a shift to the evidence-based practice model would

ultimately move the field away from the very tenets that make counseling psychology a unique specialty.

OBJECTIONS TO CHWALISZ'S EVIDENCE-BASED MODEL OF TRAINING

In her commentary, Chwalisz (2003) maintains, "Perhaps for the first time since the inception of the scientist-practitioner model, science is of immediate relevance to practitioners" (p. 498). While this declaration is an overstatement, it does highlight a movement in counseling psychology toward grounding our work in scientific evidence and best practices. The trend toward further integration of science and practice will only strengthen our training, research, and interventions as well as provide for better implementation of the scientist-practitioner model. I strongly support a closer connection between science and practice; that being said, I have two major objections that largely address underlying assumptions in Chwalisz's call for a transition to the evidence-based model.

My first objection concerns the almost complete lack of attention in the evidence-based approach, as Chwalisz (2003) presents it, to the importance of counselor relationship and client variables (i.e., common factors) that have been recognized as being important for significant progress in psychotherapy (Weinberger, 1995). The second criticism relates to her assumption that counseling psychologists must further align with the health care delivery system (i.e., medical model) or suffer negative results. A related objection I have is her assertion that by embracing the medical model, counseling psychologists will somehow increase their ability to effect changes in the health care system.

Lack of Attention to the Counselor and Client Variables

Near the end of Chwalisz's (2003) commentary she alludes to counselor relationship and client variables (i.e., common factors) in psychotherapy. She recognizes that early in the psychotherapy training process, coursework and practicum "*could* [italics added] incorporate quantitative . . . research methods and findings . . . related to identifying and elucidating the therapeutic common factors" (p.519). Furthermore, she suggests that "utilizing and gathering evidence related to client and therapist variables and technique selection" will be incorporated into coursework and practicum, as students advance in their training (p. 519). While her statements exhibit awareness of the potential impact of counselor and client variables in therapy, their brevity within the larger context of Chwalisz's lengthy discussion of identifying and

expanding effective treatments appears to minimize the significance of such variables. For example, she identifies the context for evidence-based practice as the modern managed care environment and the need to be “concerned with providing clients with more positive outcomes in a more efficient manner” (p. 498). The steps she provides for evidence-based practice begin with “a specific clinical question” related to “the care of a patient or group of patients” and ultimately lead to the development of “treatment guidelines being based on both research evidence and clinical consensus” (p. 514). Chwalisz’s lack of attention to counselor and client variables is a major weakness of the evidence-based practice approach and probably one that is not easily remedied, given the model’s focus on evaluation of evidence, treatment efficacy, and guideline development.

The crucial role of the client-counselor relationship in the process of client change has been widely recognized. Across a broad variety of counseling theories, a number of counselor-mediated common factors (e.g., empathy, caring, warmth) have been identified as important for significant progress in therapy (Lambert & Ogles, 2003). Likewise, a constellation of client variables, such as severity of symptoms, sociodemographic characteristics, personality (e.g., ego strength), and interpersonal variables (e.g., attachment patterns) are said to account for a significant percentage of therapeutic outcome variance (Clarkin & Levy, 2003). In addition, relationship-mediated variables have been identified by multicultural counseling theorists and researchers as “essential to bridging potential barriers when the client and counselor are ethnically and/or culturally different” (Atkinson, Bui, & Mori, 2001, p. 548). A number of important ethnic and cultural factors that impact the client-counselor relationship have also been recognized, including language similarity, racial/ethnic similarity, racial/ethnic identity compatibility, and mental health belief similarity. In their critique of the empirically supported treatment movement, Atkinson et al. (2001) suggested that ethnic and cultural factors account for at least as much or perhaps more of the variance in psychotherapy outcome with culturally diverse clients as the treatment provided.

Alignment With the Medical Model

Chwalisz’s (2003) support for the medical model of treatment is puzzling given the existence of comprehensive reviews of the psychotherapy research, such as Wampold’s (2001), which find little evidence to recommend a disease-focused, medically oriented approach to therapy. Chwalisz urges counseling psychologists to “embrace” the health care system (i.e., medical model), lest we be left behind by “a system that is moving ahead without us” (p. 515). Furthermore, she argues that should counseling psychology fail to further align

with the health care system, the inevitable result will be “restricting roles and decreasing opportunities” (p. 498) for members of the field, while joining with the medical model will result in tremendous “growth” and “expansion of opportunities” (p. 499). Finally, Chwalisz maintains, “It is to our advantage to speak the same language and be accepted as contributing members of the health care system,” and only then will we “be able to effect changes in the system consistent with our values—from the inside” (p. 515). In sum, she entreats counseling psychologists to fully assume the identity of a medically oriented profession or face evaporating influence and potential economic self-deterioration.

Most of us are well aware of changes that have contributed to confusion about the unique role of counseling psychologists, such as the decline of traditional fee-for-service activities, the influence of accountability in managed care, and the emphasis on training and licensure of master’s-level practitioners. The range of social, economic, and professional changes present a significant challenge to the profession (and dare I say opportunity) to develop a clearer professional identity and new models of training. As counseling psychologists stand at the intersection between two very different directions, a remedial and medically oriented approach and a social, contextual approach that emphasizes broader roles for counseling psychologists (e.g., prevention, advocacy, and social change), the question becomes, Which direction shall we go?

One important way, it seems to me, to begin to answer the question of identity is to briefly review what have been traditionally identified as specialty areas in the profession of counseling psychology. Counseling psychologists have distinguished themselves from other specialty areas (e.g., clinical psychology) by a focus on activities promoting the optimal development for individuals, groups and systems (Meara et al., 1988). Historically, the counseling psychology field has also demonstrated strong commitments to addressing major societal needs (e.g., underserved populations) and those undergoing life transitions, often resulting from rapid social change (Sue, Bingham, Burke-Porches, & Vasquez, 1999). In recent years, counseling psychologists have also taken an active leadership role in the areas of multicultural issues (Heppner, Casas, Carter, & Stone, 2000) and prevention (Romano & Hage, 2000). Given these particular domains of counseling psychology, further movement in the direction of the medical model would result in a rejection of some of the very things that make the profession of counseling psychology a unique specialty.

Indeed, Albee (2000) has argued that counseling psychologists have already moved too far in the direction of the medical model (i.e., “sold their souls to the devil”) and are now “stuck in a blind alley blocked by a for-profit health care system, a corporate world where the only concern is for the bot-

tom line” (p. 248). Albee faulted the Boulder model for its “uncritical acceptance of the medical model” and for moving the counseling psychology field away from a social model aimed at reduction of poverty. In many ways, I agree with his conclusion, given the lack of emphasis in counseling psychology training programs on preparing students to engage in systemic change processes. However, it is worth noting that Baker and Benjamin’s (2000) review of the Boulder conference proceedings pointed out that the theme of prevention was “echoed throughout Boulder, and a philosophy of understanding normal persons in the context of the environment in which they lived was often repeated” (p. 245). Hence, the scientist-practitioner model emerged out of a framework that included a view of people as healthy and emphasized a developmental perspective along with the work of prevention (i.e., the specific role of counseling psychologists). It is the social-developmental, contextual perspective, as found within the scientist-practitioner framework, that we must embrace if we are to remain true to our roots and unique identity as counseling psychologists.

A final point concerns Chwalisz’s (2003) assumption that to be truly effective in changing the health care system, counseling psychologists must work from within the system. It is true that we have an important role to play in shaping and directing health service delivery. However, given counseling psychologists’ status as a numerical minority relative to other fields (i.e., clinical psychology), further alignment with the health care system would inevitably result in an increase in counseling psychologists’ economic dependence on the system and a reduction in their ability to positively shape policy concerning what services are worthy of being supported (Helms, 2003).

CONCLUDING REMARKS

As counseling psychology continues the difficult task of redefining the roles and identity of its members in response to significant societal changes, I urge leaders to move toward a deeper affirmation of the commitment of counseling psychology to prevention, multiculturalism, and social justice. Such a commitment seems the only tenable option, given the fact that traditional mental health services systems have failed to significantly reduce the effects of debilitating social and emotional distress in the vast majority of the population of the United States (U.S. Department of Health and Human Services, 2000). For example, as few as 20% of children with serious mental health needs actually receive the help they need from service providers (Hoagwood & Koretz, 1996). If counseling psychologists are to truly make an impact in addressing social needs, as noted by Cowen and Work (1988), we must move away from a model of care (i.e., the medical model) that is often costly, time-

consuming, culture-bound, and available to few. Instead, we need to recommit ourselves to addressing the needs of the most vulnerable (e.g., children, youth, people living in poverty, older adults) and search for ways to collaborate with schools and governmental and community organizations, not just at the level of providing individuals with life skills or better coping mechanisms for dealing with existing problems but at the level of systemic change. Such collaborations also present a new research agenda for counseling psychologists (Braebeck, Walsh, Kenny, & Comilang, 1997).

In closing, Parham's (2001) words provide a vision for the challenges ahead, in doing the difficult work of shaping our future as part of the counseling psychology field: "We must be bold enough to challenge inequity, brave enough to speak out against social injustice, and visionary enough to believe we can change our condition as a people if we put our collective energies forward" (p. 881).

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