On-Campus Clinical Training in Counselor Education

By: Jane E. Myers and Alfred W. Smith

Article:

Experiential training in on-campus clinics is an important component of professional preparation for both counselors and psychologists. Similarities between counseling and psychology training clinics are explored and implications for counselor education discussed.

Continuing interest in quality training in counselor education is reflected in a variety of ways, including the development, continued examination, and on-going process of revision of the Council for Accreditation of Counseling and Related Educational Programs' (CACREP) accreditation standards (CACREP, 1994). These standards include reference to didactic as well as experiential training elements. Experiential training can be provided either on-campus or in off-campus sites where supervision is available. The standards specify that clinical (i.e., experiential) instruction be provided in a "laboratory that is conducive to modeling, demonstration, and training" (CACREP, 1994, p. 53). From this statement, one may conjecture that on-campus laboratories, or facilities in which basic counseling skills can be taught, practiced, and observed, are a routine component of counselor preparation programs. Yet, when the authors set out to determine the state-of-the-art relative to on-campus clinical training, a paucity of information emerged.

One point of confusion in discussing on-campus training is that the facility, type of experience, supervision provided, and staff involved may vary across programs, yet these terms are often used interchangeably. The reference in the 1994 CACREP standards to a "counseling laboratory" (p. 53) is followed by a description of the physical resources for training rather than the type of instruction to be provided. Other parts of the standards address the nature of the training and supervision required.

The term laboratory is defined in the glossary to the 1988 standards as "a curricular experience which provides both observation and participation in specific activities" (CACREP, 1988, p. 23). Laboratory is not defined in the 1994 standards, which includes a definition of clinical instruction not included in the earlier standards. Clinical instruction refers to "all supervised coursework within which the student has the opportunity to engage in a broad range of clinical activities similar to those performed by a professional counselor. This includes all practica and internships completed within a student's program" (CACREP, 1994, p. 100). The specificity of the standards for clinical training leads to the assumption that many, if not most, counselor education programs have some type of on-campus experiential training. What has not been studied is the nature of these training experiences, the facilities in which they are implemented, and the various challenges that may arise in the process of providing on-campus training in the spirit of the standards.

Although counselor educators have not published studies in this area, clinical and counseling psychologists have been grappling with issues related to on-campus training clinics for many years. Based on similarities in clinical training across disciplines, counselor education programs operating clinical training facilities may encounter the variety and type of issues identified by psychologists in relation to their clinics. Although differences in clinical training between counseling and psychology exist, it is potentially useful to learn from the experiences of psychology training programs, possibly benefit from their successes, and avoid repeating obvious mistakes.

Relevant psychology literature was identified through personal contact with American Psychological Association (APA) and American Counseling Association (ACA) librarians and computer searches of the PsycLIT and ERIC/CAPS databases. The key words counseling, counselor education, psychology, and marriage and family were paired for each database search with the following key words: clinics, training clinics, clinical training, accreditation, standards, practicum, internship, supervision, legal, ethical, and ethics. Most citations identified through use of these key-word pairings reflected theoretical models and approaches to supervision, with relatively few citations that addressed developments in on-campus clinical training. Psychology clinics were clearly predominant in the literature. No citations were found that discussed training clinics in counselor education or marriage and family programs. Citations most often occurred in the Journal of Counseling Psychology, the Counseling Psychologist, the Journal for Professional Psychology, Professional Psychology: Research and Practice, and Counselor Education and Supervision.

In this article, findings from the literature are synthesized and the areas that offer the most potential for informing counselor educators in the development, implementation, and refinement of on-campus clinical training laboratories are identified. The intent of this article is to increase awareness of the issues and stimulate needed research and improvements in counselor preparation. The topics that seem most relevant to this effort are the role of the clinic in the preparation of psychologists, the accreditation standards and clinical instruction in counseling, and issues in psychology training clinics (e.g., purpose of the clinic, legal and ethical issues, and miscellaneous issues such as finding, evaluation of programs, administration and supervision issues).

THE ROLE OF THE CLINIC
Psychology Model
The use of a "clinic" has a long tradition in the preparation of clinical psychologists. The 1966 Chicago Conference on the Preparation of Clinical Psychologists resulted in clear acknowledgment of the central importance of the psychological clinic in training (Jarmon & Halgin, 1987). Within the Chicago model, clinics are an integral part of clinical training programs, providing a campus-based setting for the provision of services and the execution of research (Hoch, Ross, & Winder, 1966). The use of the in-house setting provides psychology students with a uniform experience supporting the integration of research and practice according to the scientist-professional model (Jarmon & Halgin, 1987). Since 1966, most clinical psychology doctoral programs have established and maintained in-house clinics for preinternship training of students.

The APA accreditation standards were reviewed to determine what specific requirements exist relative to in-house psychology clinics. The Criteria for Accreditation, Doctoral Training Programs and Internships in Professional Psychology (APA, 1989), specify that "adequate facilities" be provided "... in relation to program goals," to include "... observational facilities, and laboratory space for studies of individuals and small groups" (APA, 1989, p. 15). The authors were unable to find references in the APA standards for the word "clinic" or any more specific definition of "clinic" or "laboratory." The standards state that "Practicum training is a field experience, usually taken for academic credit, often on campus. The practicum provides for student experiences with client problems and learning of relevant psychological skills. The practicum is intended to prepare the student for internship..." (APA, 1989, p. 16).

The APA standards do not specify that "actual clients" be seen in the clinic, rather than using the clinic for demonstration and practice as may be the case in many counselor education clinics. It seems that the most, if not all, in-house psychology clinics recruit actual clients, however. This conclusion is based on the fact that the issue is not addressed directly in the psychology literature; rather, studies of in-house psychology clinics assume that actual clients are necessary for appropriate preinternship training of psychologists (Jarmon & Halgin, 1987). The most extensive study was completed by Halgin (1986) and included a follow-up study of 198 clients who had terminated after three sessions (59 or 30% responded), a survey of 35 clinical graduate students (23 or 66% responded), and a survey of 94 clinic directors (43 or 46% responded). The primary concerns relative to clients included a discrepancy between perceptions of clients and therapists concerning reasons for termination, and a concern on the part of some clients that treatment by a trainee resulted in a lower quality of service.

Clinical graduates were questioned concerning their attitudes toward clinical research, with most expressing concern about any project that might adversely affect or intrude upon the therapy process. Clinic directors were questioned about data collection and assessment procedures, the type and number of research projects completed in their clinic, and obstacles to clinical research. Directors reported a lack of interest in research on the part of both faculty and students.

Counselor Education Model

Similar to clinical psychology, philosophical discussions of models of professional preparation in counseling have been held repeatedly among counselor educators. Such discussions, beginning in the 1940s, led to the development of standards for counselor preparation (Sheeley, cited in Sweeney, 1992). Because these standards include on-campus clinical training, it is relevant to consider how the standards evolved and what they currently describe as the "model" for clinical preparation in counselor education.

The first attempts to establish standards for clinical instruction in counseling occurred in the late 1950s and early 1960s, with adoption of training standards by the Association for Counselor Education and Supervision (ACES) in the late 1960s (Sweeney, 1992). These standards were adopted by ACA (then the American Personnel and Guidance Association, APGA) in 1979 (APGA, 1979). The 1979 standards included a section on clinical instruction which, according to a search of available archival data, remained essentially identical to the first draft of the standards written by Robert Stripling in 1979 (Wittmer, 1994). A comparison of the 1979 standards to the new CACREP standards (CACREP, 1994) reveals only minor changes in a few words with no changes in content or intent of the standards over this 15 year time period (Wittmer, 1994).

The latest professional preparation standards for counselors, published in the Accreditation Standards and Procedures Manual (CACREP, 1994), include standards for preparation in clinical instruction (Section III). With respect to a counseling laboratory (Section III, D), the standards specify that "... a counseling laboratory that is conducive to modeling, demonstration, and training is available and used for clinical instruction." (p.53). The CACREP standards reveal a clear mandate to counselor education programs seeking accreditation to provide appropriate clinical instruction. Given the importance of clinical instruction in counselor education, it is interesting that on-campus clinics have not been addressed in the literature, either from a philosophical or research perspective. The databased articles that exist have failed to consider the clinical component of the CACREP standards, focusing instead on issues such as concerns of graduate students (Stickle & Schnacke, 1984), and increases in program requirements necessary to meet the standards (Cecil & Comas, 1986). Additionally, only in the most recent edition of the Hollis and Wantz directory of counselor education programs has information concerning the availability or nature of counseling laboratory training facilities been included (Hollis & Wantz, 1993).

The remainder of this article reviews literature relative to psychology training clinics as a step toward encouraging similar research and dialogue within counselor education concerning laboratory training.

ISSUES IN ON-CAMPUS TRAINING

The major issues that emerge in the literature of psychology training clinics may be summarized in three major areas: purpose of the clinic, legal and ethical issues, and administrative issues such as management, and supervision of services, funding, and evaluation of programs. The issues discussed here were considered in-depth at a 1989 APA symposium on the role of on-campus clinics in the training of psychologists. The presenters (i.e., Hailey, 1989; Parvin, 1989; Spruill, 1989) were all members of the APA clinic directors network whose presentations included personal observations and research summaries.

Purpose of the Clinic

The most enduring and perhaps elusive concern presented in the clinic literature relates to the purpose of the clinic (Hailey, 1989). Although it may seem that training is the clear and obvious (or only) choice for the existence of a clinic, Serafica and Harway (1980), in a survey of 63 psychology department clinics, found that priorities were for community services, student educational needs, faculty teaching, and research, in that order.

The most significant question to be answered is whether the primary purpose of the clinic is training or service. As noted above, psychology clinics were established to provide on-campus clinical experiences where faculty could supervise the development of clinical skills and the integration of clinical interventions with research. In order to provide direct clinical experiences, clients are needed. Whereas maintaining the highest standards of training is essential for program accreditation and the reputation of the clinical program, providing "professional and respected clinical service is very important, or the clinic would lose both clients and referrals" (Halgin, 1986, p. 134).

A variety of professional and ethical conflicts arise when programs attempt to address both training and services simultaneously. Although Spruill (1989) reported that 67% (n= 146 of 218 surveyed) of psychology clinic directors consider training to be their primary mission followed by community mental health services and research, the nature of the issues obscures the distinction between these purposes. The difficulties become clear when considering issues such as the type of clientele to be served, the nature of training needs of student clinicians, expertise of faculty supervisors, and responsibility to the client and the public.

Clinic clientele may include both university students and persons living in the surrounding community. The range of clientele in the university setting may be somewhat restricted, resulting in a homogeneous population of young persons with intellectual sophistication and accomplishments (Halgin, 1986). When community clients are recruited and the clinic operates according to the university calendar, decisions must be made concerning the provision of client services over term breaks and holidays. These decisions are especially important when facilities are locked or when utilities must be turned off while the university is closed. In addition, during term breaks, student clinicians may be unavailable to see clients and faculty may be unavailable for supervision. If community service is a priority, formal arrangements must be made with community mental health agencies regarding emergency services and clients must be informed of these procedures.

Clinicians' training needs may affect decisions regarding which clients or types of presenting problems to accept, how to handle waiting lists, and how to conduct intakes and screening (Cross, 1989). Training needs can affect decisions regarding termination or referral. The needs of the client and those of the clinician-in-training may conflict (Hailey, 1989; Halgin, 1986). For example, reassignment of clients may result from completion of treatment plans, practica or internships, client-counselor incompatibility, or other reasons, regardless of the client's desire to remain in treatment for additional or continuing problems (Robison, Hutchinson, Barrick, & Uhl, 1986). Halgin (1986) noted that only 8% of clients seen three or more times indicated that having a successful termination, leading to the conclusion that the academic schedule of training likely resulted in truncated therapies.

The nature of supervision also affects both training and services. When specific skills (e.g., cognitive-behavior therapy) are to be taught, faculty members with the identified expertise will typically teach and supervise students in the acquisition of these skills. When clients are recruited for clinical practice as a result of a class assignment, it is possible to screen and select only those clients most appropriate for the training experience. On the other hand, when clients are recruited to fulfill the mental health services component of clinic operations, it may be difficult or impossible to accurately pair client needs with clinician-in-training skills and faculty expertise. Hence, faculty members may supervise students working with clients whose presenting problems are outside the student's or faculty member's areas of clinical expertise. Although consultation with colleagues or psychiatric consultation may help to expand the range of clientele, interventions, and services in the clinic, Halgin (1986) noted that most clinics do not operate on such a consultation model.

Ultimately, the responsibility to the client becomes both a professional responsibility and an ethical issue, especially when training is considered to be the primary purpose of the clinic facility. Clinics that operate in state-supported institutions may be viewed by clients and the public as needing to be more responsive to the community at large, regardless of the specific nature of training needs.

Implementing the scientist-professional model makes clinical research training a priority (Goldfried, 1984). Yet, numerous problems and complexities result when attempting to integrate research and services (Halgin, 1986; Todd, Jacobus & Boland, 1992). These obstacles can range from difficulties in the standardization of record keeping to therapist reluctance to participate in research. Among the 23 responding clinical trainees in Halgin's (1986) survey, 25% "forgot" to complete research forms while another 25% simply refused to participate in the collection of research data. Reasons cited included a lack of commitment to clinical research, lack of faculty models for participating in clinical research, fear of manipulating clients, fear of biasing clients toward certain presenting issues, and anxiety related to evaluation. Halgin concluded that changes in attitude are required to help trainees view research in the clinic as both exciting and nonthreatening, and within their professional and ethical responsibilities.

Ethical and Legal Issues
A variety of ethical and legal issues arise when providing an on-campus laboratory that treats community clients. These issues are not easily categorized, nor are they easily resolved. Clinics operating in publicly funded institutions serving the community face ethical dilemmas when services provided conflict with the priorities for training, clinic policies, university schedules, or faculty and student research agendas. For example, whether clinics in public institutions refuse to serve clients whose needs do not fit their training or research priorities has not been determined (Parvin, 1989).

When clients are assessed fees as part of clinic operating policies, a determination of whether free services may be provided to clients participating in research must be made. If services are requested after the termination of the research, clinic policies may not provide for additional free services. In addition, questions related to supervision, automatic acceptance of the client, and related issues surface (Hailey, 1989).

Parvin (1989) emphasized that training clinics provide modeling for students of professional mental health care. Therefore, it is important to have clinic policies as well as operating procedures reviewed by an attorney. Policies need to be developed to address each of the three purposes of the clinic, with special attention to possible conflicts that may arise. For example, whereas extensive case notes may be helpful in supervision, such notes could prove harmful to a client if subpoenaed for court purposes (Hailey, 1989). Retention of records is an important consideration both for legal protection and for the development of research databases (Todd, et al., 1992). Procedures for assuring the confidentiality of clients need to be clearly specified, in writing, when case records are maintained. Also, student clinicians must be provided with specific training in appropriate case record maintenance.

Guidelines for handling potentially dangerous or suicidal clients are necessary in clinics, and these procedures need to be available to all student clinicians and supervising faculty. Concern for ethical, professional, and effective practice speaks to the need for a licensed professional to be available when clients are seen by student clinicians. In addition, to guard against the possibility of litigation involving student clinicians, some university attorneys have recommended that a licensed psychologist be available on site during the times when clients are seen in the clinic (Cross, 1989). In departments where this is not possible, professional liability and possible allegations of negligence must be considered.

Insurance payments can lead to additional legal and ethical issues, particularly if supervisors sign-off for work performed by students. Such sign-offs may be viewed by third-party-payors as insurance fraud (Cross, 1989; Hailey, 1989). Insurance for faculty and students working in clinics is essential because litigation is always possible. The availability of supervision may be inadequate for such sign-offs, particularly when supervisory sessions are not documented. Such documentation could protect the supervisor and supervisee. Because the university may be liable when clinical services are provided, professional and legal criteria for services must be closely monitored (Parvin, 1989). Community mental health agencies deal with these concerns, in part, through full-time staff with service as well as administrative duties assigned to work in clinical settings.

Administrative Clinic Issues

Administrative issues identified in the literature include management and supervision of clinic programs, including the clinic director's role, funding, and evaluation. Management of clinic programs most often is accomplished by an assigned director, either full or part time, who is a member of the department faculty. The role of this director frequently is open to question and in need of clarification. Although the director is responsible for overall clinic operation, other faculty engage in supervision in the clinic. The director, typically a nontenure-track faculty member, may have little control over other faculty or the setting of policies to guide client service or student supervision. This could include documentation of client service through case notes, documentation of supervision, and related issues that can affect the legal liability of the director (Hailey, 1989; Spruill, 1989). Sometimes the director is expected to provide supervisory coverage for absent faculty members, even if the supervisor lacks expertise related to a particular client or training approach in use. Tenure-track psychology faculty are reluctant to devote time to supervision as the academic reward system does not define this activity as "scholarly productivity" (Cross, 1989), leaving the clinic director to provide the majority of trainee supervision in the clinic.

Priorities assigned to clinical work, research, and course work may place the director in conflict with departmental faculty. In fact, it is common for directors to complain that faculty, department chairs, and deans provide little support for their needs. Galassi and Moss (1986), in a study of the Council of Counseling Psychology Programs, found that 62.5% of clinic directors have release time for their duties (equivalent to one or more courses), yet the demands of the job create excessive commitments of their time. Hailey (1989), whose research was noted earlier, reported that most psychology clinic directors indicate that they feel overwhelmed. A second administrative concern is funding for in-house clinics. Sources of funds for clinic operation include university and department budgets, grants, endowments, contributions, lab fees from students, and fees for services from clients. Outside funding is increasingly sought by psychology clinics, as university administrators increasingly expect clinics to generate all or some of their budgetary needs (Hailey, 1989). These needs include equipment maintenance and purchases that may be relatively expensive.

In-house psychology clinic budgets vary from almost nothing to more than a million dollars, the latter being for clinics that serve as comprehensive mental health facilities within a catchment area (Spruill, 11989). Spruill noted that client services fees, which contribute to the support of many clinics, vary from free to $100 per hour, however the modal and median figures were $5.00 per hour.

A third administrative issue identified in the literature is the need to evaluate the clinic as a training site (Edelstein, 1985). In particular, a standardized approach for evaluating competencies, such as clinical treatment, assessment, and research, should be developed for use in on-campus clinics. Obstacles to effective evaluation include resource constraints, staff resistance, technological limitations, and the need for better measures (Stevenson & Norcross, 1985). The significance of these obstacles is reflected in earlier findings that only 54% of clinics had done program evaluations and only 7% had written an evaluation report (Serafica & Harway, 1980).

IMPLICATIONS FOR COUNSELOR EDUCATION

It is timely for counselor educators to study the development and implementation of on-campus clinics. In fact, research in this area is long overdue. Counselor educators may begin to identify common issues in counseling clinics when they begin to network concerning issues related to on-campus laboratories.

The many issues that have emerged in psychology training clinics may be salient in counseling laboratories as well. Counselor educators and administrators can study these issues and learn from the experiences of psychologists in addressing them. The need to clarify the mission of the clinic -- training, research, services, or all three -- is a major concern. Once identified, these purposes must be integrated and policies and procedures developed (or revised, in the case of existing laboratories) that maximize the achievement of the clinic mission. Resolution of ethical and legal issues in clinic operations may require creative solutions as well as consultation with university attorneys. Consultation with ACA, the National Board for Certified Counselors (NBCC), or

state licensure board ethics committees may be helpful. As counselor educators network to share information about their clinics, it is possible that some will emerge as models for managing these difficult concerns.

The Association for Counselor Education and Supervision (ACES) has a vital role to play in stimulating interaction among counselor educators and providing a forum for consideration of on-campus clinical training. Initial steps taken by ACES members (all in 1992) include developing the Directors of Clinical Training and Clinics (DCTC) Interest Network, conducting a seven-session think tank sponsored by the DCTC Network at the ACES convention in San Antonio, and obtaining funding for a survey to establish baseline data concerning on-campus clinics. In addition, the proceedings of the think tank were published by the American Counseling Association in 1994 (Myers, 1994).

IMPLICATIONS FOR RESEARCH

Given the lack of literature concerning on-campus clinics in counselor education, basic descriptive research projects would be helpful. The survey funded by ACES (Myers & Smith, 1993) is an important first step in establishing a baseline for future study, as the number of programs that have clinical training facilities and the array of training components is not known. This survey, plus data gathered by Hollis and Wantz for their 1993 directory, should provide a base for additional questions concerning clinic operation. These questions include, but are not limited to, consideration of the physical facilities for clinics (e.g., number of rooms for individual and group counseling), provisions for supervision (e.g., live observation, audio and videotape capabilities), policies that guide clinic operation (e.g., confidentiality, emergencies), faculty participation in the clinic, and the role of the director.

The implications addressed in this article are based on the experiences of psychology training clinics. It is possible that counselor training laboratories differ in unknown ways from clinics in other training programs. It is important to determine the differences that may exist, as well as any problems or challenges presented as a result of the unique aspects of counselor preparation. A related area for research is the identification of "model" clinical training programs in counseling. Descriptions of such programs could guide the efforts of counseling departments in developing and restructuring their on-campus clinical training programs.

It is timely to examine the CACREP requirements for on-campus laboratories with a goal toward modifying the standards to reflect the highest quality of professional training. Research relating the standards to current practices in on-campus clinical training as well as student outcomes (i.e., counselor effectiveness) is needed. Determination of the specific types of training facilities and programs that provide the most proficient counselors will likely be the impetus to either change or strengthen the standards as now written.

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