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Medicalizing Developments in Counsellor Education? Counselling and Counselling Psychology Students' Views
L'évolution vers la médicalisation de la formation en counseling : les points de vue d'étudiants en counseling et en psychologie du counseling

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ABSTRACT

Counsellors have historically endorsed pluralistic approaches to practice. However, recent medicalizing trends now often shape how they are paid, regulated, and administered. The experiences and views of graduate students in counsellor education with respect to this pluralism and medicalization have not been studied. In an effort to better understand their experiences and how they reconciled (or anticipated reconciling) medicalizing expectations (e.g., use of diagnoses and evidence-based treatments) with other aspects of their learning, we conducted a nationwide survey of Canadian graduate students and recent graduates of master's-level counsellor education programs (N = 68). We also conducted in-depth follow-up interviews (n = 9) with self-nominating survey respondents. Our interest was with representing the tensions and complexities in our participants' reported experiences, so we used the mapping procedures of Adele Clarke's (2005) situational analysis. We discuss the implications we associate with these mapped tensions and complexities as they relate to curricular and other aspects of counsellor education.

RÉSUMÉ

Par le passé, les conseillers et conseillères ont toujours préconisé des approches pluralistes de la pratique. Cependant, les récentes tendances vers la médicalisation influencent les modes de rémunération, de réglementation et de gestion. Aucune étude n'avait encore porté sur les expériences et les points de vue des universitaires diplômés des programmes de formation des conseillers en ce qui concerne ce pluralisme et cette approche médicalisée. Afin de mieux comprendre leurs expériences et la façon dont ils concilient (ou prévoient concilier) les perspectives de médicalisation (p. ex. le recours aux diagnostics et aux traitements fondés sur des données probantes) et d'autres aspects de leur formation, nous avons mené un sondage national auprès d'étudiants universitaires canadiens (N = 68) et de récents diplômés de maîtrise inscrits à des programmes de formation des conseillers. Nous avons également effectué un suivi sous forme d'entrevues approfondies (n = 9) auprès de répondants au sondage ayant librement accepté d'être choisis à cette fin. Nous nous sommes intéressés à la représentation des tensions et des éléments complexes observables dans les expériences rapportées par nos participants, et pour ce faire, nous avons eu recours aux procédures de cartographie préconisées dans l'analyse des situations

chez Adele Clarke (2005). Nous discutons des implications ainsi associées aux tensions et aux éléments complexes cartographiés, ainsi que de leur lien avec le programme d'études et d'autres aspects de la formation des conseillers.

> "The narrative of suffering should be viewed as the outcome of the extraordinary convergence between the different actors positioned in the field of mental health." (Illouz, 2007, p. 63)

Historically, counselling,[1] counselling psychology,[2] and counsellor education[3] have undergone major changes. Over the past 50 years, Canada's professional counselling organization has witnessed three illustrative name changes: it began as the Canadian Guidance and Counselling Association, then became the Canadian Counselling Association, and today is named the Canadian Counselling and Psychotherapy Association. The public's understandings of counselling and the concerns presented in counselling have similarly changed, particularly as the popular media change their representations of what we do in ways that have an influence on clients' self-understandings and presentations to counsellors (Furedi, 2004; Illouz, 2008).

One feature of practice, however, has been on the rise (Appignanesi, 2011; Gray, 2013): critics of medicalization have argued that a growing number of clients' everyday concerns (e.g., bereavement, Bandini, 2015; grief, Kofod, 2015; sleeplessness, Moloney, Konrad, & Zimmer, 2011; sexual desire, Kamens, 2011; gender variance, Drescher, 2015, and Lev, 2006; shyness, Aho, 2010, and Scott, 2006) have become increasingly most authoritatively understood when approached as medical diagnoses found in the *Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition* (DSM-5; American Psychiatric Association, 2013). Allan Frances, the former chair of the fourth edition of this manual, expressed concerns about "diagnostic exuberance" in the *DSM-5* summed up by his book's title: *Saving Normal* (2013). His concerns about medicalization echo earlier critiques of an increasing trend of medically classifying formerly normal aspects of the human condition (e.g., Conrad, 2007; Moss & Teghtsoonian, 2008; Rapley, Moncrieff, & Dillon, 2011).

In Canada and elsewhere, recent efforts to promote mental health literacy have enabled greater recognition of the symptoms of mental disorders, extending to knowledge of mental health treatments and prevention activities (Kutcher, Bagnell, & Wei, 2015; McLuckie, Kutcher, Wei, & Weaver, 2014). These efforts, along with media campaigns, accelerate concerns raised by Canadian philosopher Ian Hacking (1995) regarding the "looping effects" of expert knowledge in the public domain, effects that medical sociologists beyond Canada have cited as promoting a "diagnose and treat" logic (Conrad, 2007; Jutel, 2011).

Historically and culturally, counsellors have responded to client concerns that focused on life problems, decision-making, and relational difficulties—not psychiatric conditions or mental disorders (e.g., Robertson & Paterson, 1983). However, fuzzy medicalized boundaries have been developing between clients' everyday concerns and what is now understood as mental health knowledge—changes

related to financing the publicly and privately funded mental health services in which counsellors frequently work.

A diagnose and treat logic has increasingly come to inform the administration of mental health services. In Canada, employee assistance programs often require clients to present with diagnosable mental disorders to receive services beyond initial consultations (Csiernik & Csiernik, 2012), while counselling services on Canadian postsecondary campuses are increasingly based on diagnosable disorders needing treatment (Nunes et al., 2014). These Canadian developments parallel those occurring elsewhere for insurance companies (Pilecki, Clegg, & McKay, 2011), employee and family assistance programs (Sharar, 2009), and other forms of third-party funding (Miller, 2004; Pilecki et al., 2011). Counsellors are often expected to use brief treatment models (Sharar, 2009) and evidence-based approaches (Ferraro, 2016; Tanenbaum, 2005) primarily focused on symptom reduction (Eriksen & Kress, 2005; Gazzola, Smith, King-Andrews, & Kearney, 2010; Goodheart, 2010; Linton, Russett, & Taleff, 2008). Counselling, whether publicly (e.g., Canadian Alliance on Mental Illness and Mental Health, 2016; Health Canada, 2016) or privately funded (Miller, 2004) tends to be funded and administered as a health service.

In our national study, we analyzed graduate student survey and interview responses regarding their counsellor education. From this study, we report on our use of the mapping procedures of situational analysis (Clarke, 2005) to make sense of complexities and tensions that students associated with medicalizing trends in counsellor education, and we offer implications for practice. Situational analysis normally is used to provoke new forms of theorizing and dialogue, and so our aim here is to heuristically depict the situation of medicalizing influences in Canadian counsellor education. In other words, our maps are not intended to provide a general overview of the prevalence of medicalizing influences in Canadian counsellor education.

BACKGROUND TO OUR STUDY

Counsellor education primarily has been offered on a pluralistic basis (cf. Cooper & McLeod, 2010), meaning that students are taught differing theoretical orientations to practice that may or may not align with a medicalized orientation to practice. The counselling programs of interest in this study were those whose graduates would seek professional credentials with counselling and psychotherapy organizations at the provincial or national level (e.g., the British Columbia Association of Clinical Counsellors or the Canadian Counselling and Psychotherapy Association [CCPA], respectively), without excluding those who could also register as master's-level psychologists in those provinces where this is possible. Some counsellor educators, such as Chwalisz (2003), have welcomed a medicalizing direction: "It is to counseling psychology's advantage to speak the same language as medicine and for its practitioners to be accepted as contributing members of the health care system" (p. 515). In this study, medicalization refers

to an expected use of *DSM-5* diagnoses, evidence-based interventions, and other standardized procedures for treating conditions that in other contexts may not be understood and addressed on medical terms (Conrad, 2007). As some critics have argued (e.g., Conrad, 2007; Eriksen & Kress, 2006; Ferraro, 2016; Frances, 2013; Moss & Teghtsoonian, 2008; Nylund, 2000; Rapley et al., 2011), a medicalized orientation to counselling is a growing part of today's pluralistic landscape of professional counselling. Our interest is where and how this orientation arises and how students in Canadian graduate counsellor education programs respond to it.

Students of counselling are invited to conceptually and practically try on quite varied orientations to practice (e.g., Wedding & Corsini, 2013) with which they may later professionally self-identify. They might, for example, adopt systemic, feminist, or narrative orientations that see them focus on client concerns as either occurring outside of or between people, while those who adopt cognitive or psychodynamic orientations may focus on concerns as occurring within individuals. Turning to other aspects of their training, students learn social justice, linguistic, and cultural sensitivities to counsel in contextually relevant ways. Our research interests were how such elements of counsellor education are experienced and addressed by students should they encounter medicalized (Conrad, 2007) expectations in their professional education. Other researchers have cited how differences in counselling orientation can become consequential in varied professional service contexts in which students complete practica, or where graduates take up employment (Eriksen & Kress, 2006). How much a medicalized orientation to counselling is expected varies by context and, where it is expected (e.g., settings requiring diagnoses), counsellors' responses can vary as well (e.g., Strong, Gaete, Sametband, French, & Eeson, 2012). The status quo—as evidenced by curricular documents, textbooks, the professional research literature, and current regulatory practices—suggests that a pluralistic approach is still the most prevalent in Canadian counsellor education (Strong, Ross, Chondros, & Sesma-Vazquez, 2015). However, this evidence has not come from the people most directly affected by the counsellor education trends (i.e., medicalization) we have been describing: the students.

Beyond course and instructor evaluations or program-exit feedback, students' experiences of counsellor education programs are seldom a research focus (Protivnak & Foss, 2009), especially for students at the master's level (Furr & Carroll, 2003; Gaubatz & Vera, 2006). Studies evaluating students' learning using instruments developed by counsellor educators are common (e.g., Mullen, Uwamahoro, Blount, & Lambie, 2015) and usually aligned with curricular expectations monitored by professional accreditation bodies (Barrio Minton, Wachter Morris, & Yaites, 2014). In circumstances where counselling student experiences have been solicited, the hermeneutic focus has been to converge on common meanings (Chang, 2011) and on particular aspects or stages of their learning (Dickson & Jepsen, 2007; Woodside, Oberman, Cole, & Carruth, 2007). Finer grain distinctions associated with aspects of graduate education have been examined, with counselling students offering perspectives on critical incidents (e.g., Furr & Carroll, 2003; Howard, Inman, & Altman, 2006). By focusing on common or

discrete experiences, the literature about the student counsellor experience tends to pass over the complexities and tensions inherent in that education. Our focus is instead on where and how tensions can arise for counselling students in instances where medicalized expectations may arise in their learning.

An example of medicalizing tensions may occur as students balance a relational orientation with the need for a diagnostically informed, evidence-based practice. Such tensions need not be seen as either/or dilemmas (e.g., maintain a strong therapeutic alliance versus adhere to evidence-based intervention protocols with fidelity), though students can feel challenged in balancing their approach. In another instance, graduate counselling students initially forge a congruent sense of professional identity by choosing a fitting theoretical orientation (Auxier, Hughes, & Kline, 2003). However, this choice can retrospectively seem idealized when the exigencies of professional practice become evident (Moss, Gibson, & Dollarhide, 2014).

A student preferring existential or feminist ideas of practice, for example, may end up in a practicum where only cognitive-behavioural therapy (CBT) is used. Some scholars have bemoaned both a narrowing and a medicalizing of theoretical orientations within counselling (Hansen, 2007; Rapley et al., 2011) and clinical psychology (Elkins, 2009; Heatherington et al., 2012). As counselling has become increasingly regulated and administered as a form of health practice, controversies have been highlighted both within counsellor education (Eriksen & Kress, 2006; Hansen, 2007) and beyond the counselling profession (Tanenbaum, 2005).

"Medicalizing tensions," as we will be identifying and representing them in this study, refer to possible dilemmas counselling students may face in learning and making "accountable" choices. Regardless of their preferred orientations to practice, counsellors and counselling students are frequently faced with administrative and other requirements that they use *DSM-5* diagnoses and evidence-based treatments (Mozdzierz, Peluso, & Lisiecki, 2011). For some counsellors, this has meant responding to these requirements or "tensions" in ethically questionable ways (cf. Moses, 2000; Strong et al., 2012). Wanting to learn more about how (not if) such tensions might feature in graduate counsellor education, we sought students' and recent graduates' views of these potential tensions as they relate to classroom and practicum learning experiences to map their presence and to learn how students responded to such tensions.

METHOD

Following our university's ethical approval, we conducted our qualitative study using a combination of electronic surveys ($N = 68$) and follow-up audio-recorded and transcribed telephone interviews ($n = 9$). We obtained our data from current and recently graduated (i.e., within five years of program completion) Canadian students in master's-level counsellor education programs (normally housed in counselling psychology and educational psychology departments) who were, or had the option to be, affiliated with a professional counselling and psychotherapy

association—social work, psychiatric nursing, pastoral, and family counselling programs were not included in the study. Participants were recruited over a 16-month period (Fall 2013–Winter 2015) through e-mails to counsellor education program administrators, professors who were members of a counsellor educators' chapter electronic mailing list, or to a student members' electronic mailing list for the Canadian Counselling and Psychotherapy Association. Copies of our survey and interview protocol questions, as well as demographic details describing our sample, can be found in Appendices A, B, and C, respectively.

With respect to our student survey participants (who were part of a broader study in which counsellor educators and other stakeholders in counsellor education also participated), 42 current and 26 recently graduated students, predominantly from Ontario, Alberta, and British Columbia, completed our online survey (loaded onto SurveyGizmo). The survey data provided an initial means to examine the extent to which these students and recent graduates reported medicalized features in their programs of study. As this study was not a comparative analysis, the quantitative statistics of survey responses were not meaningful to our research question. For example, while almost 65% of students reported no (32.4%) or little (32.4%) discussion of *DSM* diagnoses, approximately 43% reported no (20.6%) or little (22.1%) discussion of evidence-based interventions to address diagnosed conditions. Asked if they experienced any tensions (feeling "pulled in different directions") between medicalized and other approaches to counselling they had been learning, 13.2% of responding students reported experiencing a lot of tension, with 29.4% reporting some tension, 35.3% reporting a little tension, and 22.1% reporting no tension.

Similarly, when asked, "Were tensions or contradictions between medicalized and other approaches to counselling discussed within your master's degree education?" 50% reported that such tensions had been discussed (12% said a lot, 38% said some). In practice settings, students and recent graduates reported medicalized tensions associated with counselling at a comparable rate. We also interviewed nine self-selecting, master's-level counselling students and recent graduates whose words we recorded, transcribed, and analyzed. This analysis yielded themes consistent with our analyses of the survey data; in other words, the same patterns of meaning were found in our open-ended survey responses as were found in the nine qualitative interview transcripts.

Our analytic interest in this study was in where and how students experienced and addressed medicalizing tensions when they did arise in their learning. Given our relatively small, self-selecting sample of survey and interview participants, it is beyond the scope of this study to comment on the prevalence or general nature of these tensions for counselling students. Instead we sought preliminary insights into students' and graduates' experiences and responses when they identified medicalizing tensions in their professional learning. Participants in the current study were in (or had graduated from) graduate programs in counselling or counselling psychology. Other counselling program students/graduates (e.g., clinical social workers, marriage and family therapists) were not included in the study.

In a prior document review of Canadian counselling program websites, accessible curricula, and recent textbooks, our results indicated that medicalizing features of graduate counsellor education were evident and often illustrated semantic tensions (e.g., that a website might speak of humanistic counselling practices, while later talking about training in psychiatric diagnoses), but not in ways that might be considered exclusory (Strong et al., 2015). Our aim with our analyses of survey and interview data, however, was to learn from the *situation* of students' experiences of tensions between medicalized and other features of their education. In reviewing our situational analysis (Clarke, 2005) maps that follow, we aim to offer unique ways of zooming in and out from data like that obtained from our surveys, interviews, and prior document reviews (e.g., curricula, websites, textbooks; Strong et al., 2015).

We analyzed the textual data from responses to the open-ended questions in our surveys and from our transcribed interviews, using Adele Clarke's (2005) situational analysis method. *Situational analysis* (SA) is a relatively new adaptation of grounded theory that aims to map, rather than reduce, complexities and tensions in varied kinds of data. Informed by postmodern notions of knowledge (Gergen, 2009), in SA there is no convergent account or correct representation of experience to be drawn from human situations, like graduate-level counsellor education. The aim in SA is not to map data for proportional or even proximal accuracy; thus, we make no claim that our maps accurately represent graduate-level counsellor education in Canada. Where earlier grounded theory (Glaser & Strauss, 1967) was used to inductively develop new theory, SA maps aim to generate new forms of theorizing (Clarke, 2005) regarding complex situations. Our additional aim was to develop maps useful for generating further professional conversations on counsellor education.

Clarke's pivotal study using SA involved examining American responses to the arrival of the "morning-after" pill, a contentious development for which no social consensus was understood to be forthcoming. In doing SA, many salient elements can make up a situation, so SA can be useful for representing value-based and other differences in complex and sometimes contested situations, such as counsellor education. No formal consensus has developed among counsellors and counsellor educators regarding medicalization, and for us this makes it a situation worth exploring for possible differences articulated by students.

As a first stage in analyzing our survey and transcribed interview data, we initially focused on identifying commonly reported semantic elements (e.g., words and stories) in ways similar to the constant comparison procedures of traditional grounded theory (e.g., Glaser & Strauss, 1967). Elements were those identifiable and commonly reported details that came up in response to our survey and interview questions. Thus, students raised elements of their classroom and practicum learning that gave us a starting point for mapping where they cited tensions associated with what we have previously described as medicalization. However, tensions do not exist in isolation, and part of the mapping challenge in SA is to bring out possible differences between elements (e.g., practicing from preferred

and evidence-supported ideas) and discourse differences over a common element (e.g., "practicing in client-centred ways").

The mapping procedures of SA offer unique ways to depict and reflect upon what is at stake for different actors in any situation. For example, while agreeing on a common ethics of practice, counsellors use diverse orientations to practice, some which do not align with the medicalized orientation described earlier. This can be seen when, for example, a counsellor chooses a strengths-focused approach in a setting focused on diagnosing and treating psychiatric symptoms. Medicalizing tensions become evident for that counsellor in elements reported to us such as case management meetings, required record-keeping, and so on. How graduate students in counselling reconcile such elements of their learning with possible medicalizing influences on that learning is part of how they exercise their personal influence in becoming professionals.

Adapting notions from science and technology studies (e.g., Latour, 2013), "actors" in SA are not only humans influencing situations. Other influences beyond educators, supervisors, and students reportedly influenced processes and outcomes in counsellor education. For example, there were variable expectations around use of *DSM-5* diagnoses and evidence-based treatments within courses and practica. In SA, such expectations can be seen to have material influence (or "agency"; Clarke, 2005). Thus, to stay with this example, our analyses focused on how such expectations translate to actions such as completing records at practica sites, or how psychiatric discourse might animate classroom or supervisory discussions, or how clients present their concerns in psychiatric discourse to a counsellor who understands those concerns differently. In SA it is important to map elements and relationships, to show what collectively shapes a situation (in this case medicalizing tensions in counsellor education), using maps to zoom in to represent microdetailed relations between actors and elements, or to zoom out to not lose sight of the situation's "big picture."

RESULTS

Our Mapped Analyses

Starting with the "big picture," we developed a "Social Worlds/Arenas" map, used to portray collectives of individuals engaged in and having something at stake in the situation (i.e., *social worlds*) and the *arena(s)* of counselling where medicalizing may feature. For instance, a Medical Health Arena may be populated by the social worlds of clinicians, epidemiologists, government bodies, advocacy/human rights movements, media, professional organizations, health policy/research organizations, pharmaceutical companies, and so on (see Clarke, 2005, p. 120)—all of whom have a stake in shaping this arena. Social worlds, as mapped in SA, derive from the symbolic interactionist ideas that Clarke's mentor, Anselm Strauss (1979), brought to grounded theory (cf. Glaser & Strauss, 1967). To symbolic interactionists, meaning develops through different social interactions over events, intentions, and objects that may be of relevance and salience to those engaged in shaping

developments in a social world or arena. In the present study, many groups had a stake in the meaning and development of counsellor education. In SA, groups like students are social worlds, inside which one finds what Clarke (2005) referred to as "universes of discourse"— in this case, different possible ways that counsellor education could be understood and related to. Arenas are spheres of common interest where social worlds interact to shape processes and outcomes, and these interactions get particularly interesting when arenas overlap, as was the case in our research. In constructing our Social Worlds/Arenas map, we drew on a prior review of counsellor education curricula, textbooks, and research from an earlier phase of our study (Strong et al., 2015). Our first map (Figure 1) represents the Social Worlds/Arenas that we determined to be relevant to students' interactions with medicalizing influences in counsellor education. We continually revisited and reworked this map over the course of our research to include additional social worlds that we identified from our survey and interview data.

For analytic purposes, medicalized counsellor education is identified as a world that is also central to the social world of counselling students and recent graduates. These worlds are depicted as occurring at the intersection of four major arenas: psychology, psychiatry, counselling psychology, and counsellor education (generally speaking). Inside each of these arenas are distinct yet related elements of potential analytic interest, with varying social worlds interacting around these elements. For example, the psychiatry arena is influential in that counsellors (and by extension counselling students in practice settings) are often paid and their roles/functions administered according to a couple of key elements: the psychiatric diagnoses of

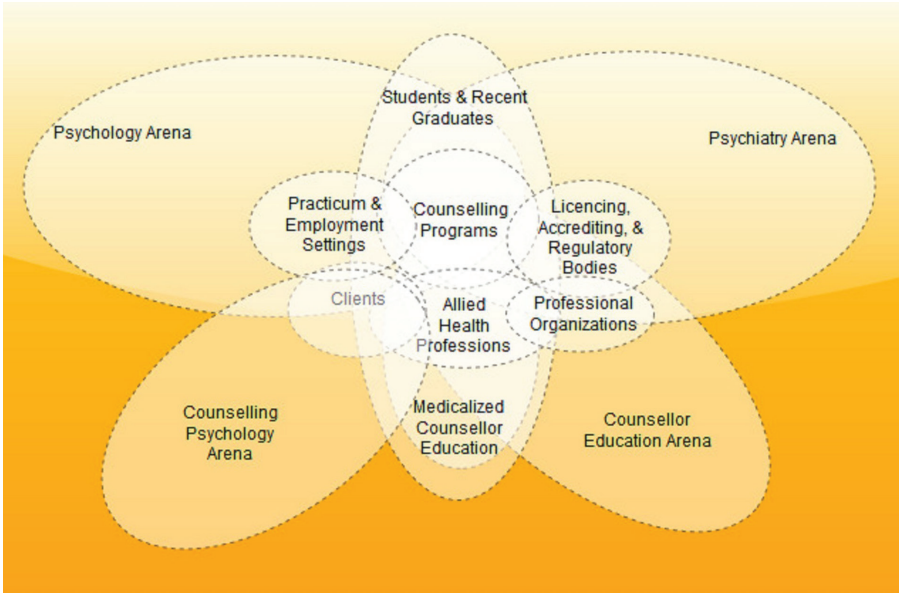

Figure 1. Social worlds/arenas map of medicalized counsellor education

their clients and counsellors' use of evidence-based interventions. Thus, to stay relevant in meeting such practicum site requirements and shifting professional regulations, counsellor education has been adjusting to such medicalizing expectations from psychiatry while retaining its pluralistic traditions (Cooper & McLeod, 2010; Eriksen & Kress, 2006).

Counsellor education students usually require courses in psychology for admission, while deriving some of their course content (e.g., psychopathology) from psychology. However, counselling psychology is very much its own arena, and can be seen as distinct from psychology, particularly given that some counsellor education programs (like ours) are academically housed in accredited counselling psychology doctoral programs. While clearly distinct from clinical or other specializations in psychology (Bedi, Klubben, & Barker, 2012), counselling psychology is partly a "healthcare" discipline (Young & Nicol, 2007), and its practitioners adhere to the same ethics and related professional expectations as other psychologists—expectations that can differ from those of the Canadian Counselling and Psychotherapy Association (CCPA). Counsellor education can similarly be seen as a distinct arena, given such things as having its own CCPA chapter, a somewhat common curriculum across Canada, and a focus on master's-level professional training. In short, these arenas are home to many social worlds, while the arenas have considerable points of overlap as we illustrate with our first map, which aims to show interactions relevant to medicalizing developments in counsellor education.

Some medicalizing influences can seem remote and of modest consequence. For example, the "social world" involving professional regulation of counselling is overseen in some Canadian provinces as a health practice, according to recent CCPA (2015) documents. How such regulation translates to front-line counselling, let alone to counsellor education, was beyond our scope to assess in this study. Other social worlds depicted can be seen to more plausibly interact with counsellor education in ways consistent with a medicalized approach. The "insurance world," through public or private funding for mental health services, can play a key role administratively in how practice is to be accountably conducted. For example, a common employer of counsellor education graduates (or students completing supervised practica) are mental health agencies whose funding and administration are often based on use of *DSM-5* diagnosed conditions and evidence-based treatments. Students, not infrequently, also undertake their supervised practica in such agencies. We also identified a few other "stakeholders" whose influence was referred to by our participants and in the research literatures. For example, clients increasingly present their concerns in psychiatric discourse, having "Googled" the evidence-based interventions they should receive in counselling (cf. Illouz, 2008; Strong et al., 2015). Similarly, counsellors (and counselling students) also take up roles on interdisciplinary health teams, where medically focused interactions are common. While an article-length discussion could easily follow from our Social Worlds/Arenas map, our interest is more with illustrating how this map can be used to identify worlds and arenas having something at stake in a situation like counsellor education.

Relational Analyses Mapping

Counselling students experience, and participate as actors in, these intersecting and overlapping arenas and worlds through varied symbolic interactions. Analytically, symbols were the "elements" we identified from verbatim student responses to our surveys and interviews; what they told us was relevant to their experiences and interactions with possible medicalizing influences in learning to become counsellors. In many respects, the second of the maps we developed was arrived at in ways familiar to grounded theory researchers (e.g., Charmaz, 2005; Glaser & Strauss, 1967) who inductively derive themes or codes from otherwise disparate words in a corpus of textual data. First we needed to identify discrete meaning units—elements—and then, through research team discussions, go from a "messy map" for these elements to ordered maps enabling our relational analyses. "Messiness" is what science and technology studies theorist John Law (2004) suggested researchers overcome with their methods of analysis, in ways that are inescapably reflexive. Consistent with SA's focus on generative theorizing, it is the role of SA researchers (e.g., two of us are graduate students in counselling psychology programs) to use maps to reflexively zoom in and zoom out on salient features of their analyses—but it is a salience resulting from their own interpretive map- and claims-making. Our relational analysis map (Figure 2) presents one such example of us bringing an analytic order to students' survey and interview responses.

We chose to categorize our relational analyses according to the degree of dilemma we associated with what students told us vis-à-vis elements of their graduate counsellor education. The relational analysis map in Figure 2 selectively

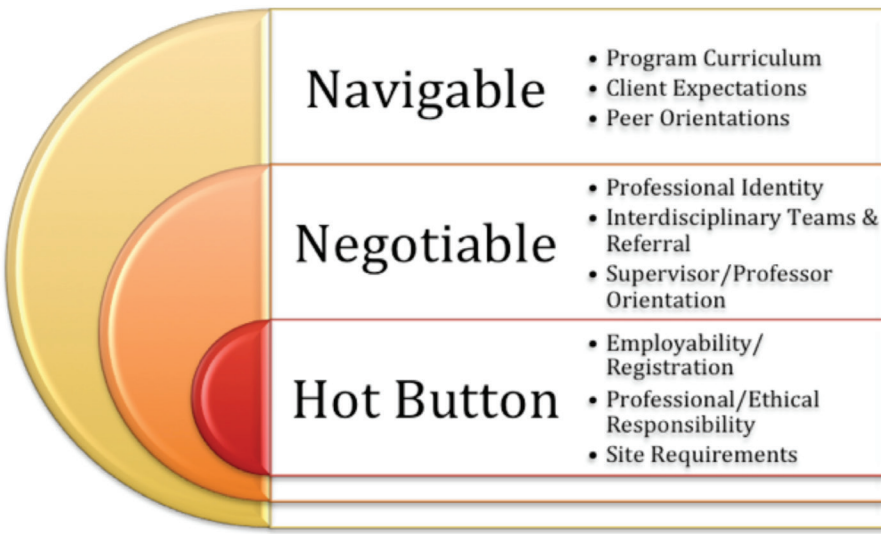

Figure 2. Simplified relational analysis map of navigable, negotiable, and "hot button" tensions for counsellor education students

reflects such differences by degree according to whether a potential dilemma was *navigable* (meaning students could easily accept it and practice "around" it), *negotiable* (meaning that they would try to address the dilemma by, for example, negotiating with an instructor or supervisor), or *hot button* (potential, non-negotiable dilemma for them in their learning that could be highly stressful and have career-ending implications). Given the variability across graduate counsellor education programs, we are not claiming that these categories are generalizable, only that student responses indicated that they perceived or related to these elements as navigable, negotiable, and potentially hot button. Our research focus was primarily on the "hot button" issues, as these pointed to issues counsellors could potentially address with curricular or program revisions. Negotiable issues are those that can invite discussable differences, if such differences are welcomed by instructors and supervisors.

Looking more closely at our relational analysis map above, we remind readers that the maps of SA can be used to zoom in or out depending on the desired analytic focus. Our initial messy map (derived from the survey and interview data) presented hundreds of potentially analyzable elements—particularly those that could be categorized as navigable and, less frequently, negotiable. We itemize examples for each category of element and, while space will not allow us to list them all here, for each element our analyses link back to verbatim comments that guided us in our categorizing. Before we do this, however, we will digress and talk about SA's third kind of map: discourse positions maps. We later return to our relational analysis map to show how different discourse positions were used to contest elements we consider "hot button."

Discourse Positions Map

The third general kind of map used in SA aims to map differences in discourse used by student respondents. To discourse theorists and analysts (e.g., Potter, 1996), discourses are distinct systems of meaning brought to salient elements of life, and they animate what Rose (2006) referred to as the "politics of life itself." Such differences in discourse—be they over theoretical orientations in counselling or other cultural ways of sense-making—can be mapped as discourse "positions" (Harré & van Langenhove, 1999). Mapping discourse positions is similar to the practice of externalizing a story or discourse in narrative therapy (White & Epston, 1990)—it enables people to linguistically separate themselves from the implicit meanings and values that they have internalized and may have been previously acting from without awareness. Mapping discourse differences so that people can reflect upon and possibly modify discourse positions has been helpful in different forms of conflict resolution (Moghaddam, Harré, & Lee, 2007; Monk, Sinclair, & Smith, 2004). Our discourse positions map helped us zoom out to represent different discourse positions we could generally identify in counsellor education, and helped us zoom in on the discourse differences evident in the negotiable and hot button elements identified in our relational analyses map. Turning to the map in Figure 3, we want to highlight how varied the discourse positions can be when

it comes to medicalizing influences on counsellor education. While medicalization could be understood as a discourse in its own right, in this study we have chosen to make it a central element in our analyses, focusing on differences in discourse used to relate to medicalized counsellor education.

The discourse positions mapped in Figure 3 show, in effect, where actors may be "coming from" as they influence counsellor education—in other words, the positions show how differently this education may be understood and addressed. For example, along with other counsellor educators (e.g., Cooper & McLeod, 2010), we are positioned in "Pluralist Discourse," meaning that, when understanding or interacting "from" that discourse, we relate to counsellor education as consisting of diverse orientations—and that this is not a problem. Contrast this position, however, with a "Mental Health Administration Discourse," and such pluralism about the names for client concerns and what can be done to address those concerns is problematic. Some of us also practice from a couple and family

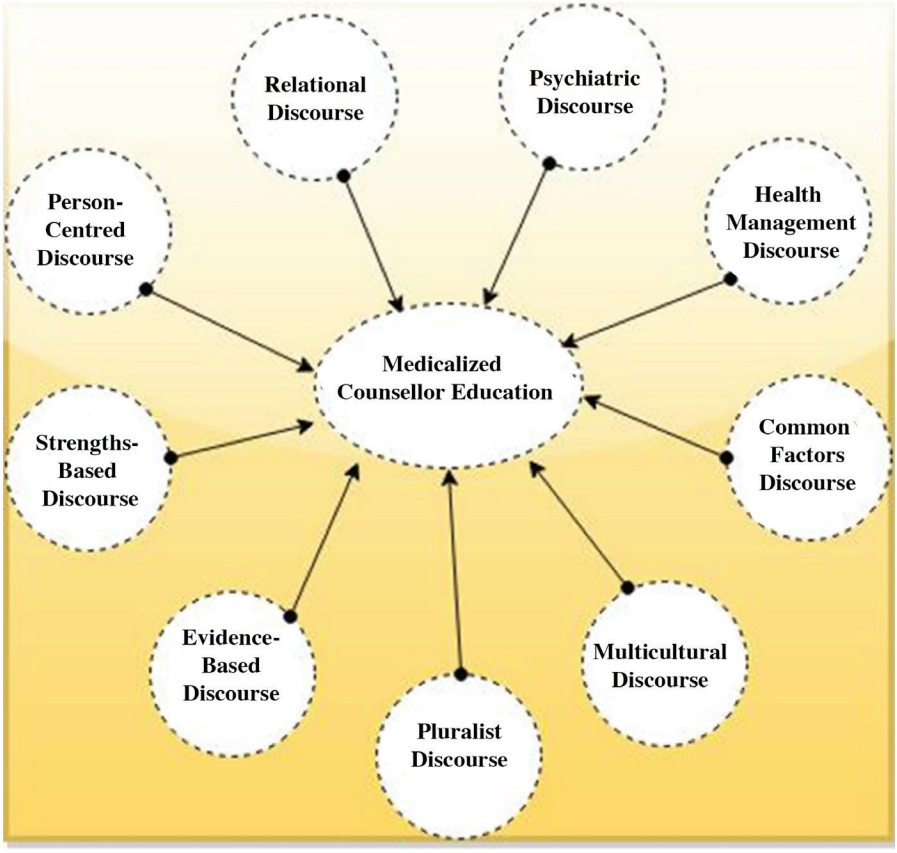

Figure 3. General discourse positions map: medicalized counsellor education

therapy orientation where "Relational Discourse" positions us to assess and address concerns in relational or systemic ways, where our humanist colleagues may understand and respond from a more individualistic "Person-Centred Discourse" position. Our point in mapping such discourse positions in this way is to illustrate how differently practitioners can relate to counsellor education and to show that these differences in discourse positions are not always readily synthesized into one common approach to counsellor education. Instead, they can produce differences in positioning on elements in counsellor education.

We would now like to selectively revisit, or zoom in on, one of the elements students identified as "hot button" as identified in our earlier relational analysis map (the navigable, negotiable, and hot button map). Recall that we categorized an element as hot button when students identified it as a potential, non-negotiable dilemma in their learning that could be highly stressful and have career-ending implications. The particular hot button element we have chosen to zoom in on, in Figure 4, is "competency." The quotation marks around this element relate to the different discourse positions that can sometimes be at odds and produce dilemmas for students when "competency" is invoked as part of having their counselling knowledge and skills evaluated (e.g., as "site requirements").

By zooming in on competency as an issue, we are not suggesting that the other two identified hot button issues (site requirements and employability) are insignificant for students. Instead, we use this final map to exemplify how differences in discourse positions can make a particular element "hot button." Competency

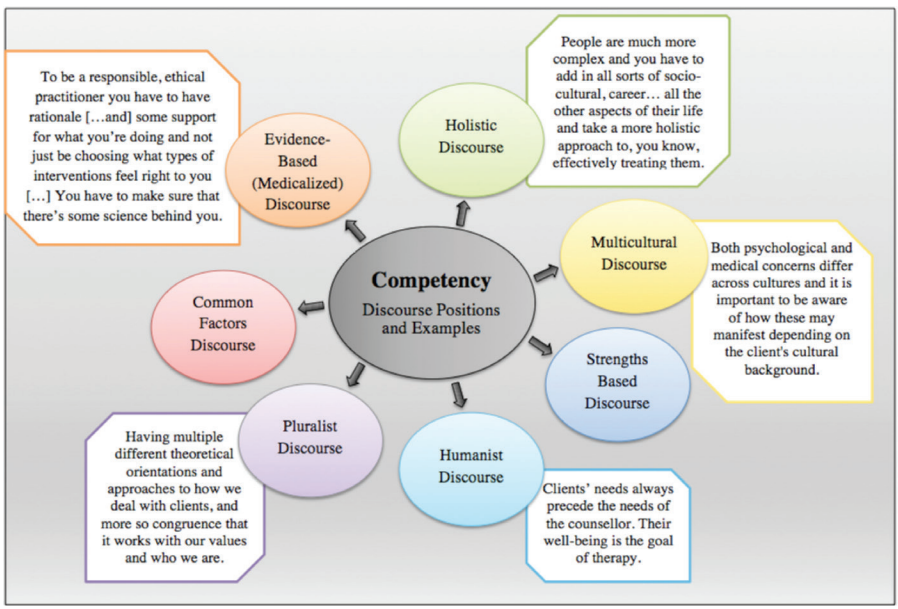

Figure 4. Student tensions associated with competency

was a recurring concern for students, partly because it could be so differently defined and used as a basis for evaluation in their learning. What Figure 4 illustrates are the key discourse positions students encounter within their classroom and practica learning that relate to competency, depending on the extent to which counsellor education is medicalized. For example, how do students reconcile an evidence-based intervention discourse that focuses on standardized implementation of interventions for a *DSM-5* diagnosed condition with a discourse focused on multicultural competence? Or how do they reconcile a pluralistic discourse of practice (e.g., incorporating strengths-focused ideas and relationally oriented family systems ideas) with a view of competence that focuses on "correct diagnosis and treatment" of psychopathology? What makes such differences over "competency" hot button comes through in student comments we heard and show on the map in Figure 4.

While there were many other tensions that students experienced as "navigable" or "negotiable," two remaining "hot button" elements of graduate counsellor education merit further attention, given what students told us. Specifically, students described practica site requirements as a source of considerable tension. As many counsellor educators will recognize, there can be a dearth of adequate placements for students, and matching students with supervisors and practicum settings can be a challenge. But, the settings themselves are often where students first encounter the institutional realities of practice, including medicalized expectations (e.g., diagnostic and symptom-focused record-keeping, use of diagnostic language, and evidence-based interventions). Gaps between classroom learning and front-line practice can vary, but when students join a medicalized setting, the requirements—given their exposure to other orientations to practice—can be threatening.

A related hot button issue extends beyond the students' in-program learning (classroom and practica) to the eventual graduates' employability—meeting market expectations they feel they must prepare for. While these job expectations can also vary greatly, employing organizations have had to structure themselves to be fundable, and that often can require expected use of medicalized approaches to counselling. Counselling services and counselling practice within different settings, however, hardly have uniform expectations, as we found in previous research (Strong et al., 2012). Still, students are rightly concerned about how their graduate education positions them for employment, while also equipping them with ways of competent practice through which they can address clients' concerns.

DISCUSSION

> In my experience a less medicalized approach to counselling seems to have been better-received and more effective with clients I have worked with. Thus, it is my preference to stay away from a medicalized approach. That said … I have begun to accept that following a more medicalized approach may be the only way I am able to make a respectable living as a counsellor. (Student responding to interview question)

We chose to study how students experienced, navigated, and negotiated a growing influence of medicalization within their graduate counsellor education. Medicalization refers to what Conrad (2007) described as a diagnose and treat logic that is central to medical practice. The ripple effects outward on society and the helping professions have been cited in prominent public media (Appignanesi, 2011; Frances, 2012). In counselling, medicalization has been on the rise, as use of *DSM-5* diagnoses and corresponding evidence-based interventions have become common administrative requirements of practice (Greenberg, 2013; Strong & Busch, 2013). Our aim was to learn from graduate students how medicalizing aspects feature in their education, an education that straddles campus and supervised counselling practica settings. Specifically, we listened for tensions they associated with medicalized features of their learning, with a particular ear for where such tensions challenged them—in navigable, negotiable, and "hot button" dilemmas. The kinds of professional judgements students are learning to make, such as how to respond to clients and supervisors in the immediacies of conversations with either, present normal learning challenges. Though schooled in orientations to practice that focus on issues not associated with a medicalizing focus—such as social justice, meaning, client strengths, and systemic influences—these other aspects of their learning need not necessarily raise tensions or dilemmas for students of counselling. However, given recent controversies over the *DSM-5* (Frances, 2013) and social concerns about increasing medicalization (Illouz, 2008; Rapley et al., 2011), we wanted to hear their views on how medicalization might have featured in learning to become a counsellor.

The mapping procedures of SA offered a unique way of orienting to the complexities and possible tensions in how medicalization may feature in graduate counsellor education. From a relatively small, self-selecting sample of graduate students and recent graduates unequally distributed across Canada, we mapped their survey and interview responses in ways that aimed to highlight where medicalization featured in their education and how they experienced its influence. Zooming out, our maps helped to bring out a general sense of the different social worlds interacting on a counsellor education that, with respect to medicalization, varied considerably across programs in terms of influence. Zooming in, we identified three "hot button" elements students related to a medicalized counsellor education, mapping in detail the discourse differences that made one element (Competency) "hot button," while describing other discourse differences more generally for the other hot button elements (employability, professionalism, and site requirements).

Trends come and go in counselling and counsellor education, and whether medicalization of counselling will endure as a trend remains to be seen. However, if clinical psychologists have been concerned that the theoretical orientations in graduate education are narrowing (Heatherington et al., 2012) to a medicalized orientation, then perhaps counsellor educators should be similarly mindful, though our research indicates no current need for alarm. Instead, students told us about potential elements of their education where they encounter tensions or dilemmas that we have categorized as "hot button." Behind these hot button elements are

discourse differences over what is expected of students as medicalized aspects of counselling become salient in particular contexts and with particular authorities in counselling students' education. Where a medicalized view of counselling prevails, students having learned other orientations to counselling can experience tensions or dilemmas that can be difficult to reconcile.

We approached our SA mapping of medicalized counsellor education with modest hopes and a heuristic intent. Our student/recent graduate sample was small and self-selecting, and so we make no claims regarding their representativeness as students or recent graduates of Canadian counsellor education. Our aim was to hear from students how concerns about medicalizing trends in counselling (e.g., Cooper & McLeod, 2010; Rapley et al., 2011) might have translated to their learning experiences, and at best we got glimmers of where such trends fostered tensions. Students still get immersed in a pluralistic education, learning many orientations to practice while preparing for the exigencies of employment as a counsellor. Even on counselling's front-lines there can be ambivalence to, if not creative or occasional covert defiance of, a medicalizing direction that sees practice exclusively conducted from psychiatric diagnoses and evidence-based interventions for treating them (Simblett, 2013; Strong et al., 2012). For students, however, the circumstances and stakes are different; it can be problematic to show ambivalence or "creativity" should medicalization feature in expected learning.

In terms of implications following from our study, we think our "tension buttons" classification of participants' responses to our survey and interview questions merits further consideration and conversation by counsellor educators and supervisors. In learning and supervisory conversations, considerable institutional power differences are at play. Students acquire a sense of what tensions are navigable, negotiable, or "hot button" in their learning interactions, including those with other students. Instructors and supervisors might engage students' understandable and strategic deference when they instead want to collaboratively name and discuss these tensions, as part of facilitating the students' developing clinical and institutional judgement (cf. Gaete Silva, 2014).

Gaining a sense from students about what they find to be "hot button" tensions, indicating what is negotiable or acceptable between students and instructors or supervisors with respect to ideas and practices, and sharing senses of navigable tensions that require no further negotiation—these are common pedagogical and supervisory practices. However, revisiting these practices can be particularly important as students experience and address tensions such as "competency," "employability," and "site requirements," though other "hot buttons" might be salient for students in other situations. While medicalization may be one influence on counselling students' education, other influences (e.g., client use of mental health apps) may also present tensions for students to understand and address in their professional development and client services. Thus, we encourage counsellor educators and students to monitor and discuss such potential developments.

The students and recent graduates of counselling programs who responded to our surveys and interviews indicated that their learning encompasses diverse

models and considerations that can sometimes be at odds with a medicalized orientation to counselling. Typically, they can navigate and negotiate when they encounter a medicalized orientation, but some elements of their education—such as competency, site requirements, professionalism, and employability—can present challenging dilemmas not so readily negotiable. Such elements are worthy of pedagogical consideration, particularly for how students can best prepared to face the possible dilemmas associated with these elements of their education.

Notes

1 We use CCPA's (2011) definition of counselling as "a relational process based upon the ethical use of specific professional competencies to facilitate human change. Counselling addresses wellness, relationships, personal growth, career development, mental health, and psychological illness or distress. The counselling process is characterized by the application of cognitive, affective, expressive, somatic, spiritual, developmental, behavioural, learning, and systemic principles" (https://www.ccpa-accp.ca/profession/).

2 See the definition of counselling psychology that was proposed by the Canadian Psychological Association's Counselling Section executive (CPA, 2009) and formally adopted in 2009 by the CPA Board of Directors (http://www.cpa.ca/aboutcpa/cpasections/counsellingpsychology).

3 Counsellor education refers to processes related to teaching, supervision, and research (CCPA, n.d.), and in this study is used as an umbrella term encompassing both counselling and counselling psychology.

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Appendix A
Medicalizing Tensions in Counsellor Education: Student and Recent Graduate Survey

Counsellors in Canada have traditionally helped clients using diverse approaches to counselling practice. We are interested in how counselling and counsellor education may be affected by a trend toward *medicalization.* At its most basic, medicalization refers to ways in which human problems come to be "defined in medical terms, described using medical language, understood through the adoption of a medical framework, or 'treated' with a medical intervention" (Conrad, 2007, p. 5). We would also add that in the context of counselling, medicalization may include:

- Use of psychiatric diagnoses, standardized interventions and/or evidence-based treatment
- Client problems assessed as psychiatric symptoms or biological/neurological disorders
- Clients presenting their concerns and expecting "treatment" in psychiatric ways
- "Treatment" requiring adherence to manualized, evidence-based intervention protocols
- Counselling regulated, funded, and administered as a health/mental health service

Our definition is somewhat open-ended because a medicalized approach to counselling has been evolving in multifaceted ways—as a form or logical extension of medical practice.

The primary aim of this study is to examine how medicalization may feature in counsellor education programs at the master's level. Secondarily, we look at how students, new graduates, instructors and program administrators, and other key stakeholders deal with possible tensions between medicalized and other approaches to counselling.

As current students or recent graduates of master's-level programs in counselling we would appreciate your participation in completing this survey. The questions which follow are a mix of single-answer questions that can be answered by the drop-down fields and open-ended questions. It will likely take approximately 15–20 minutes to complete.

I. Demographic Questions

1. Please select your province or territory of practice:

Alberta	Northwest Territories	Quebec
British Columbia	Nova Scotia	Saskatchewan
Manitoba	Nunavut	Yukon
New Brunswick	Ontario	
Newfoundland	Prince Edward Island	

2. Please select the option that best describes you:
   a) Current student in a counselling psychology master's program
   b) Graduated from a counselling psychology master's program 0–2 years ago
   c) Graduated from a counselling psychology master's program 2–5 years ago

3. In what practice setting do you primarily work as a counsellor or practicum student?
   a) Public or community mental health agency
   b) Educational setting
   c) Private practice (independent or group practice)
   d) Employee Assistance Program
   e) Hospital, outpatient, or health care setting
   f) Other (please specify in Comments section below_____)
4. What are your primary orientations to counselling practice? (e.g., Rogerian, CBT, Solution-focused. Rank-order: 1 as *most-used* to 3 as *least-used*).
   1 _____
   2 _____
   3 _____

II. Extent of Medicalization

Considering the description of *medicalization* offered above …

1. In your practicum or work setting, to what extent do your record-keeping or forms require the use of medicalized or psychiatric terms (e.g., DSM diagnoses)? (*Not at all, Only a little, Some, A lot*)
   Comments: _____
2. In your practicum or work setting, to what extent are you expected to focus on symptoms (e.g., monitoring symptom severity or creating a symptom-based treatment plan)? (*Not at all, Only a little, Some, A lot*)
   Comments: _____
3. In your practicum or work setting, to what extent do your colleagues/classmates and supervisors describe their work with clients using medicalized or psychiatric terms? (*Not at all, Only a little, Some, A lot*)
   Comments: _____
4. In your practicum or work setting, to what extent do your clients present their concerns to you using medicalized or psychiatric terms (e.g., DSM diagnoses)? (*Not at all, Only a little, Some, A lot*)
   Comments: _____
5. If you do use psychiatric diagnoses in your work as a counsellor, to what extent are you expected to choose your approach/interventions according to the evidence that supports their effectiveness in addressing the diagnosed conditions? (*Not at all, Only a little, Some, A lot*)
   Comments: _____
6. During your master's degree education, was a medical or psychiatric approach discussed in your coursework as a distinct approach to counselling? (*Yes, No*)
   Comments: _____
7. During your master's degree education, to what extent was counselling presented as a *healthcare* profession? (*Not at all, Only a little, Some, A lot*)
   Please explain in what ways counselling was presented as a healthcare profession, or as some other type of profession: _____
8. During your master's degree education, how much training or coursework did you receive in the following topics?
   a. Diagnosis: (*Not at all, Only a little, Some, A lot*)
   Comments: _____
   b. Psychopharmacology (medications): (*Not at all, Only a little, Some, A lot*)
   Comments: _____
   c. Evidence-based treatments for diagnosed conditions: (*Not at all, Only a little, Some, A lot*)
   Comments: _____
9. During your master's degree education, to what extent was evidence-based treatment emphasized as part of effective or ethical practice? (*Not at all, Only a little, Some, A lot*)
   Please explain: _____

10. Considering the description of *medicalization* offered above, please comment on how you may have noticed medicalization featured within your training or coursework in the following subjects/topics:

a. Therapeutic relationship/alliance:
b. Theories of counselling:
c. Ethics:
d. Interventions (or specific modalities/techniques):
e. Research methods:
f. Assessment:
g. Multicultural counselling:
h. Other (please explain):

III. Managing Tensions

We are interested in how medicalized approaches to counselling may exist in *tension* with other approaches to counselling (e.g., pluralism; feminist counselling; family therapy), and how these tensions are managed. Tensions, as we are interested in them, arise when counsellors feel torn when trying to reconcile medicalized with other approaches to counselling for any reason.

11. During your master's degree education, did you sense any tensions or being "pulled in different directions" between medicalized approaches and other approaches to counselling? These tensions could have been between different courses or instructors or within the same course.
(*Not at all, Only a little, Some, A lot*)

Please identify any tensions, explaining how they featured in your master's courses or program:

12. What did you do to manage, resolve, reduce, or cope with these tensions as a master's student in counselling?

13. Were tensions or contradictions between medicalized and other approaches to counselling *discussed* within your master's degree education? (*Not at all, Only a little, Some, A lot*)

In what ways were they discussed (or not discussed)?

14. In your current practicum or work setting, do you experience any tensions or being "pulled in different directions" between medicalized expectations (e.g., in forms/record-keeping, psychiatric language, emphasis on diagnosis, symptom management, or evidence-based treatment) and other approaches to counselling? (*Not at all, Only a little, Some, A lot*)

Please explain: (Could either leave as "Comments" or add "Please explain" to end of question).

15. What do you do to manage, resolve, reduce, or cope with these tensions?

16. If clients or colleagues present client concerns—and what to do about those concerns—in medicalized ways, how do you typically respond?

17. Based on your training and experience as a counsellor, in what ways do you foresee the practice of counselling being influenced in the future by medicalizing tensions?

Please provide any further comments on what we have been describing as "medicalizing tensions" related to either counsellor education or counselling practice that you may wish to offer:

If you are willing to be contacted by telephone for a 30–60 minute interview exploring these topics in more depth, please provide your first name and e-mail address or telephone number below:

_____

We would like to ensure we obtain the perspective of relevant key stakeholders for our study of medicalizing tensions in counsellor education. In your opinion, who in your community might be the most relevant individuals to contact about this topic?

_____
_____
_____

Thank you very much for your participation.

If you would like to participate in a draw for a $100 Chapters electronic gift certificate, please provide your e-mail address: _____

Appendix B
Semistructured Interview Questions—Students and Recent Graduates

Medicalization, as we are using this term in our research, refers to a view of counselling focused on "diagnosing and treating" mental disorders. Our questions of you are developed to better understand how medicalization may have occurred or been expected in your graduate education and supervised training as a counsellor. Your answers to the questions which follow will help us understand the circumstances and extent to which you may have experienced or been influenced by a "diagnose and treat" approach to counselling as a graduate student of counselling.

1. Please begin by sharing what drew you to graduate education focused on helping you become a counsellor. To what extent, if at all, was a diagnose-and-treat approach to counselling part of what drew you to becoming a counsellor?
2. If use of DSM-5 diagnoses and evidence-based interventions were part of your training and instruction, how were reasons for their use explained to you by your instructors or supervisors? How well, in your estimation, were you trained in their use?
3. Given what you understand is typical practice for counsellors, across different settings in which they might practice, how important is it for you to (a) understand and competently use DSM diagnoses and evidence-based interventions, and (b) exclusively use DSM diagnoses and evidence-based interventions in today's counselling practice? Please elaborate on your answers for each of *a* and *b*.
4. What is (are) your preferred approach(es) to counselling clients? Describe how you see your approach(es) to counselling relate, if at all, to a diagnose (i.e., using the DSM diagnoses) and treat approach.
5. Which approaches to counselling were you most exposed to in your graduate education? Where (if at all) was a medicalized diagnose-and-treat approach to counselling part of your learning about these approaches?
6. To what extent did you learn about, and/or were expected to use, DSM diagnoses and evidence-based interventions during your graduate education? In which courses were you most exposed to this medicalized approach to counselling, and how was this approach presented?
7. Within your graduate education, how were DSM diagnoses and evidence-based interventions presented given the broader ranges of approaches to practice used by counsellors? When comparisons were made to these other approaches, how were they presented?
8. How did DSM diagnoses and evidence-based interventions feature in your practicum experiences and practice-oriented classes? In your practicum placement(s), please describe any ways that a diagnose-and-treat approach related to your counselling. To what extent had your coursework prepared you for any counselling of this kind?
9. Some approaches to counselling (systemic, feminist, narrative) do not use diagnoses and evidence-based interventions. If you learned about these approaches in your counsellor education and supervision, how were these approaches presented with respect to a medicalized approach?
10. Where do you feel a medicalized approach is most useful or least useful in your practice as a counsellor? (elaborate on both answers)
11. How do you work with clients who come to you already having a DSM diagnosis? (And how frequently does this occur?)
12. If your primary approach to practice does not include a medicalized (diagnose and treat) approach, how were you trained and supervised to work with your primary approach as well as with others' expectations (clients' and practice settings') pertaining to offering medicalized service?
13. Please share any more thoughts you have about how a medicalized (diagnose and treat) approach to counselling featured as part of your graduate education as a counsellor. Speak to any education, training, and supervision you wished you had with respect to medicalized aspects of counselling or its influence on your approach(es) to counselling.

Appendix C
Survey and Interview Participant Demographics

	Survey Responses Raw value (*n*) followed by percentage* (%) *unless it corresponds to a small *n*	**Individual Interviews**
Province or territory	Alberta (*n* = 16; 23.50%); New Brunswick (*n* = 1; 1.50%); Nova Scotia (*n* = 1; 1.50%); British Columbia (*n* = 16; 23.50%); Newfoundland (*n* = 2; 2.90%); Quebec (*n* = 3; 4.40%); Manitoba (*n* = 3; 4.40%); Ontario (*n* = 26; 38.20%)	Alberta (*n* = 2); Nova Scotia (*n* = 1); British Columbia (*n* = 3); Quebec (*n* = 1); Ontario (*n* = 2)
Current status in the program	Graduated from a Counselling Psychology master's program 2–5 years ago (*n* = 9; 13.20%)	Graduated from a Counselling Psychology master's program 2–5 years ago (*n* = 2)
	Graduated from a Counselling Psychology master's program 0–2 years ago (*n* = 17; 25%)	Graduated from a Counselling Psychology master's program 0–2 years ago (*n* = 1)
	Current student in a Counselling Psychology master's program (*n* = 42; 61.80%)	Current student in a Counselling Psychology master's program (*n* = 6)
In what practice setting do you primarily work as a counsellor or practicum student?	Educational setting (*n* = 27; 39.7%);	Educational setting (*n* = 3);
	Public or community mental health agency (*n* = 25; 36.8%);	Community mental health agency (*n* = 3);
	Private practice (independent or group practice 2–5 years ago (*n* = 1; 1.5%);	Hospital, outpatient, or health care setting (*n* = 1);
	Employee Assistance Program (*n* = 1; 1.5%);	Other (*n* = 2)
	Hospital, putpatient, or health care setting (*n* = 6; 8.8%);	
	Other (*n* = 8; 11.8%)	

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