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Counseling in New Orleans 10 Years After Hurricane Katrina: A Commentary on the Aftermath, Recovery and the Future

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Theodore P. Remley, Jr.

Ten years after Hurricane Katrina, the counseling profession in New Orleans has changed. The author, along with a group of counseling and other mental health professionals who were providing services at the time of the hurricane and still working in the city 10 years later, provided their impressions of counseling in New Orleans a decade after the storm. The population of New Orleans and the presenting problems of clients shifted after Hurricane Katrina. The residents have required help from counselors, supervisors, counselor educators and agency administrators in order to adapt to new challenges. The need for counselors to possess skills in trauma counseling was one of the lessons learned from the disaster. Agency administrators also advised using caution after a disaster when considering funding offers and research study proposals. While it may be impossible to prepare thoroughly for each unique disaster, Hurricane Katrina taught counseling professionals in New Orleans that after a disaster, flexibility and creativity are required to survive.

Keywords: **Hurricane Katrina, mental health, trauma, disaster, counselor educator**

Pausing to assess counseling and other mental health services in New Orleans 10 years after Hurricane Katrina has been a worthwhile endeavor. Many people are curious about what has happened to New Orleans since the hurricane, and counselors are particularly interested in how counseling and other mental health services have changed. The unique challenges due to Hurricane Katrina faced by New Orleans counselors who live and work in the city have not been forgotten or put aside since the storm.

The state of counseling and other mental health services in New Orleans a decade after the hurricane are presented in this article along with some of my own observations. This article does not report a qualitative study, but instead offers a summary of the impressions of counseling and other mental health services from a select group of professionals who were providing services at the time of Hurricane Katrina and still working in mental health agencies in New Orleans 10 years later. Rather

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TPC Editor Note: Earlier this year I was in the wonderful city of New Orleans and realized it was the 10th anniversary of Hurricane Katrina. In 2005 I was involved with operations at the National Board for Certified Counselors that sent 240 National Certified Counselors to New Orleans and the surrounding area to provide direct crisis counseling and disaster relief. Having done similar work in New York City following the attacks in 2011, I found myself reflecting on what it might be like 10 years later in the Crescent City from a counseling perspective. Of course I immediately thought to contact Dr. Ted Remley, who was living in New Orleans and teaching in counselor education at the time of the storm. I knew that his personal perspective would be invaluable, leading me to ask him to write this commentary about his reflections on mental health services in New Orleans today. Dr. Remley returned to the city last year to teach in a doctoral program in counselor education and supervision. His many years of experience and astute vision of the global process of counseling have resulted in the following personal analysis. It is my hope that this article is commemorative of the challenges that all mental health workers experienced during and after Hurricane Katrina, and the heroic services they provided during a time of extreme stress and loss. — J. Scott Hinkle, NCC

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than presenting only my observations of the state of counseling in New Orleans today, I asked several others to share their impressions and I have attempted to summarize their experiences.

Scholars have examined the aftermath of Hurricane Katrina and studied numerous aspects of the results of the devastating storm (Chan, Lowe, Weber, & Rhodes, 2015; Wang et al., 2007; Weisler, Barbee, & Townsend, 2006). Specific areas of investigation have included a school-based disaster recovery program for children (Walker, 2008), the precipitation of suicide (Kessler, Galea, Jones, & Parker, 2006), the disruption of mental health treatment (Wang et al., 2008), and the differences between people who were displaced and those who returned to New Orleans (Priebe, 2014). Analyses have been completed of leadership in the city (Gohl, Barclay, Vidaurri, Newby, & Arquette, 2015), the restructured education system (Lazarchik, 2015), the social capital and repopulation of New Orleans (Rackin & Weil, 2015), and tourism (Thomas, 2014; Vernet, 2015). Similarly, to obtain an up-close and personal perspective of the changes in counseling and other mental health services, I contacted professionals who were working in mental health agencies in the New Orleans area before or at the time of Hurricane Katrina and were still at a local agency today. These individuals also had a perspective and analysis regarding the effects of the hurricane, having had a major role in the continuation of counseling services at their agencies after the storm. And, like all residents of New Orleans, they also had to rebuild their personal lives following the hurricane.

The Changed City

New Orleans 10 years after Hurricane Katrina is different from the New Orleans that existed in August 2005. While the French Quarter, Uptown and other affluent neighborhoods appear hardly changed, at a deeper level the city is not the same as it was before the hurricane. The most obvious change, aside from the areas where houses are still boarded up and abandoned, is the population. New Orleans now holds 93% of the number of people it had prior to Hurricane Katrina (Shrinath, Mack, & Plyer, 2014). However, it is important to note that for several months after Hurricane Katrina, the city was still covered in floodwaters and had almost no people. Although the population has been reduced by 7%, a number of people living in New Orleans are new to the city. Many residents who lived in New Orleans before Hurricane Katrina did not return. The population loss affected the day-to-day lives of both the people who relocated to other areas of the United States and those who stayed behind and lost contact with relatives, friends and neighbors. Shrinath et al. (2014) provided a review of the changes in the New Orleans population that have occurred since Hurricane Katrina based on data provided by the U.S. Census Bureau. Overall, the population has become smaller, older, more educated and a bit poorer. In addition, New Orleans is now more Hispanic and Caucasian, and less African American.

New Orleans public schools have largely been replaced since Hurricane Katrina with charter schools, which nine out of 10 students now attend (Khadaroo, 2014). Many schools now contract with agencies that provide mental health counseling at school, significantly altering the role of traditional school counselors, and in some cases, replacing them. Today, counselors working as mental health counselors in schools in New Orleans are called upon to diagnose and treat emotional and mental disorders and to be much more involved in family counseling than school counselors were in the past. Consequently, traditional school counselors have been forced to interface with contracted mental health counselors and redefine their roles and responsibilities.

Implications for Counselors and Counselor Educators in New Orleans

One of the facts that counselors learned from Hurricane Katrina is that the demographics of a population will likely change after a disaster (Arendt & Alesch, 2014). Counselors will need to shift from serving one population to another, and will be required to learn new skills. Following a disaster, administrators will need to provide continuing education for counselors so that they can learn new skills, and counselor educators will need to prepare graduate students for work in disaster environments.

Changes in the median age of New Orleans citizens after the hurricane have resulted in an older population, fewer children and more people living alone, which have had a significant impact on counselors providing services in the city today. Counselors with little to no expertise in providing services for elderly, isolated clients have had to be educated on new skills. In fact, many counselors who previously worked with children are now counseling older adults with different needs.

Prior to Hurricane Katrina, few schoolchildren had access to mental health counseling to the extent that they do in today's charter schools. Counselor educators in New Orleans now prepare counselors who wish to work in schools for both the traditional role of school counselors in parochial or public schools and for the new role of school mental health counselors for those positions in agencies that contract to provide services in charter schools.

Counselors in New Orleans served a population challenged by poverty prior to Hurricane Katrina and continue to provide services to people who are impoverished at a much higher rate than people living in many other areas of the United States. Counseling individuals living in poverty requires special skills in order to serve their needs (Ratts & Pedersen, 2014). As a result, universities in New Orleans are required to prepare their graduates to understand and serve clients of poverty. Moreover, a report issued in the fall of 2012 by The Data Center, an independent research organization in New Orleans, indicated that 37% of the people in New Orleans live in *asset poverty*, defined as not having enough funds to support a household for 3 months if the main source of income was lost (Shrinath et al., 2014). Asset poverty has particularly severe implications in New Orleans because evacuations from hurricanes are necessary every few years and require funds or credit. Counselors in New Orleans who provide services to poor clients must help their clients prepare for hurricane evacuation despite not having needed financial resources. This narrative is told countless times during each evacuation maneuver.

My Story in Brief

I am a counselor educator and was one of the counseling professionals in New Orleans who chose to relocate after Hurricane Katrina. While such decisions are complicated and are motivated by multiple factors, the primary concerns that led to my departure were that the university where I was working, like all entities in New Orleans, was unstable and experiencing severe financial stress, and I was caring for my elderly mother who needed regular medical attention that was not readily available in the city after the hurricane. I resigned from the university in New Orleans in May 2006, almost a year after the hurricane, and relocated to another state to teach in a counselor education program. I had the opportunity to return to New Orleans eight years later and assumed my current position as a counselor education professor in 2014. When I left New Orleans in 2006, I was sad to be leaving my colleagues and friends, quite apprehensive about my professional future, financially vulnerable, and concerned about health care for my family members as well as myself. When I returned eight years

later, I was happy to be returning to my circle of friends, delighted to be welcomed by colleagues, comfortable with my professional future, financially secure, and confident that health care was readily available in New Orleans. When I returned, I found a city that was different in many ways since the hurricane, and a city that also was much the same.

The differences in New Orleans 10 years after Hurricane Katrina, from a personal perspective, were both subtle and striking. After living with my family temporarily in the mountains of Georgia, my return to New Orleans for a visit about two months after the storm was astonishing. Public services were limited. On the other hand, the city was functioning. People were going to work, utilities had been restored, and residents who had returned were doing their best to resume the lives they had known prior to the storm. I experienced many personal challenges, which included repairing my hurricane-damaged home, finding daily care for my elderly mother, and hosting friends for a year who had lost their home in the flood that followed the hurricane. During these challenges, I remained aware and thankful that my burdens were far fewer than those of many of my neighbors, friends and fellow residents.

New Orleans 10 Years Later: My Perspective

My personal impressions of New Orleans 10 years after the storm are generally positive, but there are many scars for those living in the aftermath of the storm. When I returned in 2014, one of my friends who had not left and was still living in the city said, "After Hurricane Katrina, *everything* changed" (Anonymous, personal communication, August 1, 2014). He said his friends were gone, he no longer had his job, his children and their families had relocated out of state, and everything seemed a mess. His reaction was not unique. Much has been written about the hardships faced by people after Hurricane Katrina, particularly by the poor and uneducated, but many of the stories of professional mental health workers living in the city at the time of the storm have not been told. For the past decade, counselors in New Orleans have been serving the citizens, including counselors who lost their homes in the flood after the storm.

For me, day-to-day life in New Orleans 10 years after Hurricane Katrina appears to be much what it was before the disaster. There is still too much poverty and crime. Although in the French Quarter one can hardly see any differences a decade later, a drive through the Ninth Ward or the community of Lakeview near Lake Pontchartrain shows the devastating aftermath of the hurricane.

Changes in Mental Health Services in New Orleans Since Hurricane Katrina

In an effort to encourage the mental health professionals I contacted to be forthright and free from inhibition in their responses, no individuals or agencies are identified; and because of this degree of privacy, only general information is provided. Mental health professionals who were still working at agencies in New Orleans and responded to my questions included counselors, psychologists and social workers in public and private nonprofit agencies that provide a wide array of counseling and other mental health services to all levels of the population. I was able to obtain informal, personal responses to a series of questions from eight mental health professionals who were working in counseling and other mental health agencies before Hurricane Katrina and are still working in agencies a decade later. The information, perspectives and comments they provided helped paint a picture of mental health services in New Orleans today.

It is telling in itself that I was able to locate only a few mental health professionals who were still working in the same agencies in New Orleans 10 years after Hurricane Katrina. The agencies

themselves have changed substantially. Although some have flourished, many have decreased in size and a number have ceased to exist. Staff turnover in New Orleans mental health agencies has been significant. Almost all top-level administration positions are held by different people, mental health practitioners have come and gone, and the number of staff members has generally decreased. I contacted the largest governmental mental health agency in the city in an effort to find a person who had been working there at the time of Hurricane Katrina and was still there. Not one administrator or mental health professional fit the criteria; there had been a 100% staff turnover in the past 10 years.

Agency differences 10 years after the hurricane. When asked to compare and contrast the current circumstances at the agencies with the situation 10 years before, the mental health professionals provided a variety of responses. Most agencies are operating 10 years after the disaster in a fashion similar to what they were doing prior to the hurricane. For an agency to have survived after Hurricane Katrina is, in itself, notable. All agencies were closed for several months during the evacuation of the city and some did not reopen for a significant period of time. In several agencies, as might be expected, the services shifted to dealing with trauma, with two agencies now specializing in trauma recovery. Several professionals reported that counseling and other mental health services after the storm were less often provided by licensed mental health professionals. For example, mental health interns who were completing their degree programs, as well as individuals who had completed their degrees and were working toward licensure, were often providing services. These changes might suggest that the quality of counseling services had been compromised in New Orleans. Certainly counselor educators and counselor supervisors have experienced an added burden of preparing new counselors to *hit the road running* (i.e., be better prepared to deliver professional counseling services earlier in their careers than what might normally be expected). Counseling supervisors have had to closely monitor the work of neophyte professionals to ensure that counseling services are of high quality.

One counseling agency experienced tremendous growth, morphing from a small agency with three part-time mental health professionals to an agency with over 50 mental health providers who are either licensed or working toward licensure. Such significant growth can test an organization's capacity to function effectively. Administrators at this agency have been challenged to find and hire competent counselors with the needed expertise to serve the population.

Three agency professionals indicated that they have been more focused on evidence-based mental health practices since Hurricane Katrina. They did not indicate why this change had occurred, but it is notable that such a change did become part of the agencies' practices. It is likely that governmental and private funding agencies required grant recipients to demonstrate engagement in mental health practices that were evidence-based.

Client needs after the hurricane. Mental health professionals reported significant shifts in the populations that they served prior to Hurricane Katrina and afterward. Several reported that the number of services for individuals suffering from trauma had significantly increased, not only from the hurricane, but also from other types of crises, including sexual trauma and other forms of violence.

One agency professional who served primarily indigent clients indicated a significant rise in the demand for free or reduced-cost services from families in households with incomes below $20,000 per year. At this particular agency, 25% of the clients came from families with incomes between zero and $8,000 per year. At the other extreme, an agency that served a more affluent population had an

increase in the number of young adult clients who moved to New Orleans to take jobs assisting in the city's recovery. Consequently, counselors at agencies have had to adjust to serving clientele they may not have worked with in the past. Agency administrators have had to provide significant in-service training to help counselors adjust to changing client needs.

Mental health professionals reported serving more Hispanic clients and indicated that attention-deficit/hyperactivity disorder and depression and anxiety issues have become more prevalent. Several agency professionals indicated that since Hurricane Katrina, they have served more clients in general, and specifically more children. In addition, some counselors who had never counseled children received in-service education in counseling children and adolescents. Currently, there is a need in the city for counselors who are bilingual and can provide counseling services in Spanish.

Changes in professional-to-client ratios since Hurricane Katrina. Five mental health professionals indicated that their agencies had established a maximum number of clients that each professional could serve in order to ensure that those who were served would receive high quality services. Some agencies established waiting lists and began offering more group services in order to avoid overburdening their professional staff.

Those agencies that had found it financially necessary to decrease their staff had correspondingly decreased the number of clients served. One mental health professional commented that challenges with Medicaid and health insurance reimbursement had made it difficult to afford the number of licensed mental health professionals needed. Agency administrators have had to protect their counselors from stress and burnout as client demand has increased and the number of staff has decreased. Administrators have met this challenge by reducing the number of clients on counselors' caseloads, establishing waiting lists and offering more group services. The shift to more group services implies that competent group counseling skills and experiences are needed in New Orleans.

Government funding since the hurricane. When asked whether their agencies had received state or federal funding to support them since Hurricane Katrina, most professionals indicated that their agencies had received such funds. Agency administrators reported receiving funds from a local parish government agency that distributes funds from the federal government (specifically, from the U.S. Department of Housing and Urban Development and the Substance Abuse and Mental Health Services Administration). Some agency administrators also reported receiving funding from the American Red Cross, United Way, and local foundations and charities. Three agencies reported receiving Federal Emergency Management Agency funds for operating costs and reconstruction after the hurricane.

How Would Agencies Be Different if Hurricane Katrina Had Not Happened?

Mental health professionals were asked how they believed their agencies would be different today if Hurricane Katrina had not happened. Responses varied. Two mental health professionals said that if the hurricane had not occurred, their agencies would have continued to struggle financially, indicating that the hurricane had brought at least a degree of relief from financial problems. Perhaps the outside funding that flows into an area after a natural disaster can infuse funds into financially struggling counseling agencies, allowing them to continue to operate when they might not have been able to do so if the disaster had not occurred.

Several mental health professionals reported that because of Hurricane Katrina, agency personnel had learned a great deal and certainly would be able to handle any similar type of natural disaster in a better fashion if one should occur in the future. Today's counseling graduate students are being taught disaster, crisis and emergency response counseling procedures, as required by the Council for Accreditation of Counseling and Related Educational Programs (2009) in their counselor preparation curriculum. However, most counselors completed their graduate training prior to the time that these standards were implemented, requiring in-service training in post-disaster operations.

Most agency personnel reported that their agencies had benefitted from having experienced Hurricane Katrina. One mental health professional indicated that if not for the hurricane, the agency would not have a close relationship with area schools, would lack evidence-based practices devoted to psychological trauma, and would be wanting in innovation and creativity. Another said that the agency would not have grown as much. Two mental health professionals suggested that Hurricane Katrina had provided their agencies with national attention that allowed the agencies to become leaders in their areas of specialization, which included juvenile justice and trauma. One mental health professional said that without the hurricane, the agency would not have been tested or trained in the following areas: crisis management, grief and loss due to a natural disaster, management of post-traumatic stress disorder, and how to counsel when the counselor is experiencing similar stressors. Lastly, another counseling professional indicated that staff would not have received trauma recovery training if Hurricane Katrina had not occurred.

Recommendations for Mental Health Agencies

Mental health professionals who provided information for my personal analysis offered recommendations for counselors who must contend with a disaster. They also gave recommendations to agency personnel for preparing for a disaster.

Recommendations on Contending With a Disaster

Three mental health professionals suggested that perhaps preparing for specific disasters is impossible, while there was agreement that agencies should be prepared to deal with emotional trauma in the event of a natural disaster. Two mental health professionals suggested that planning for the possibility of a disaster would most likely not be productive. One mental health professional said that "preparing for the next disaster based on experiences from Hurricane Katrina would be like preparing for the next war based on experiences from the last one." This mental health professional added that all disasters are unique and that it would do no good to base disaster recovery plans on what New Orleans experienced as a result of Hurricane Katrina. Another mental health professional emphasized that being flexible is essential, so that programs can be developed to meet the needs of the community.

Although no amount of disaster preparation can help counseling agencies prepare for all possible challenges, perhaps the best response to disasters is to be flexible, creative and practical, taking on each problem as it is encountered. One mental health professional cautioned that agencies should be prepared not only to treat clients with post-traumatic stress disorder resulting from the disaster, but also to treat trauma symptoms that stem from unresolved trauma from childhood or past life experiences that surface after the newer trauma caused by a recent disaster. The concept that mental health agencies should always be prepared to deal with the trauma that follows a natural disaster was universally voiced by mental health professionals. In addition, self-care for counselors has become

a popular topic in the professional literature (Alvarez, 2015; Ohrt & Cunningham, 2012; Thompson, Frick, & Trice-Black, 2011; Witt & McNichols, 2014), and mental health workers in New Orleans emphasized assessment of trauma among counselors for up to two years after a disaster.

The most significant disagreement among mental health professionals concerned whether it is advisable to join in collaborative efforts or partnerships with other agencies after a disaster. While one mental health professional said that collaboration is a key to recovery, and two counselors supported this idea, another mental health professional said that collaborative partnerships have the potential to support incompetence and ruin inter-organizational relationships. A third mental health professional warned that mental health agencies should not chase or accept time-limited funding after a disaster, and should not expand services based on funding that will soon disappear.

One mental health professional indicated that collaboration was touted as the best recovery tool by many after Hurricane Katrina and acknowledged that the concept of collaboration after a disaster could be a *win-win* for organizations leveraging their collective expertise into post-disaster response and recovery. This mental health professional said that organizations outside the community often want to create a collaborative partnership after a disaster by providing trauma intervention or counselors for a local agency at no cost. However, such offers could possibly be exploitive. Often the intervention offered is not evidence-based, and the outside organization wants to use the agency as a way to increase its own credibility or perhaps raise funds because its employees are responding to the needs of the community after a disaster. Furthermore, this mental health professional warned that university professors who want to conduct research are often more interested in increasing their scholarship productivity than helping a mental health agency recover from a disaster. Counselor educators should of course avoid exploiting disaster situations for the sole purpose of increasing their research publications. Counseling agency administrators need to be cautious after a disaster when they are approached about participating in proposed research or service projects.

One mental health professional gave the following advice regarding response to outside organizations or individuals who want to help after a disaster:

> I would create *collaboratives* that are measured in three or six month intervals when every party can check in and decide if the partnership is still working for them. The more difficult questions can come when one of the collaborative partners is not working to their potential, or is undermining the project unintentionally or intentionally. These are often ugly and very difficult situations to solve, and I don’t have much advice on these situations other than to be transparent and honest and to communicate your concerns with leadership when you see these situations on the horizon. (Anonymous, personal communication, May 28, 2015)

This mental health professional suggested asking hard questions of potential collaborative partners, including, “What’s in it for you? What’s in it for us? How long will you be around? What’s your long-term plan after one or two years? How do we continue this after you are gone? How will your success be measured? Who do you report to and what’s their expectation of this collaborative?”

Recommendations on Preparing for a Disaster

Mental health professionals offered a host of general and specific recommendations regarding how agencies should prepare to face a disaster like Hurricane Katrina in the event that such a disaster should occur. General recommendations included ensuring that an agency is well-managed before a

disaster if it is to survive the aftermath. Mental health agencies need to develop strong collaborative relationships with other agencies prior to an emergency. Putting into place evidence-based mental health practices provides a strong foundation for moving forward after a disaster. Staff members need to be flexible in their problem-solving because a culture of flexibility, in contrast to rigidity, helps agencies survive disasters.

Specific advice regarding preparing to survive a disaster such as Hurricane Katrina included the following: create an inventory of equipment to help report losses; operate within financial limitations; create a disaster plan that includes specific actions for before, during and after the disaster; create electronic records and have a server outside the area of operation; cross-train office staff; create and test a disaster communication plan; employ a staff grant writer; and create emergency plans for clients. This advice should be beneficial to counselor educators who teach classes in which disaster counseling topics are addressed.

Conclusions

After reviewing the demographics of New Orleans 10 years after the hurricane and communicating with eight mental health professionals who were working in the city prior to the hurricane, I offer the following observations. Overall, most mental health agencies have maintained the level of services they were providing before Hurricane Katrina, although some have actually expanded. Before Hurricane Katrina, there were not enough counseling and other mental health services for poor and middle-class families in New Orleans, and the same situation continues to exist 10 years after the storm.

A focus and specialty has emerged in most mental health agencies in New Orleans since Hurricane Katrina around issues of trauma. Consequently, the study of trauma has become quite popular in the professional literature (see Alvarez, 2009; Brown-Rice, 2013; Buss, Warren, & Horton, 2015; Cohen et al., 2009; Fernandez & Short, 2014; Hudspeth, 2015; Jones & Cureton, 2014; Jaycox et al., 2010; Langley et al., 2013; Parker & Henfield, 2012; Tosone, Bauwens, & Glassman, 2014). As one mental health professional pointed out, a natural disaster not only precipitates the distress resulting from the crisis experiences, but also brings unresolved prior trauma to the surface for many clients. Since trauma is likely to be a significant focus of mental health agencies after a disaster, disaster preparedness plans should include the education of all staff members on counseling trauma victims.

It appears that mental health agency personnel in other locations who want to learn from the experiences of practitioners who dealt with the aftermath of Hurricane Katrina in New Orleans should consider the advice given by several mental health professionals with whom I communicated—prepare to be flexible in case disaster occurs. Perhaps counselors and administrators who have leadership skills that include creativity and flexibility would be ideal for agencies after disasters have occurred, as opposed to those who have a high need for structure or who have trouble operating without clear procedural guidelines.

While partnerships and collaborative arrangements have the potential for helping mental health agencies survive and even prosper after a disaster, such arrangements should be evaluated carefully prior to agreement. Leaders in one of the New Orleans agencies attributed their growth and expansion to collaborative relationships and partnerships. However, several other mental health professionals appeared to have had negative experiences with collaborative arrangements and recommended that such offers be viewed with caution. Accepting time-limited financial support also

can lead to problems if agencies expand their services based on temporary support and must then scale back after financial resources disappear.

The most important lesson I learned from interviewing agency administrators in New Orleans who have been at their agencies for the 10 years since Hurricane Katrina was that it would have been impossible to prepare for the aftermath of the storm. As a result, it is important after a disaster for counselors and administrators to assess their unique situation, determine what counseling services are needed, provide in-service training when necessary, avoid relying on short-term funding to plan for the future, and pay attention to the self-care of counselors. New Orleans is unique and Hurricane Katrina's flooding of the city was a unique event. Several mental health professionals indicated that assessing the needs of the community after the storm and responding to those needs, as well as caring for the well-being of their employees, were critical aspects of their successful survival.

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Bereavement Experience of Female Military Spousal Suicide Survivors: Utilizing Lazarus' Cognitive Stress Theory

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The purpose of this study was to explore the relationship of five variables—primary appraisal, secondary appraisal, coping skills, social support and stigma—to bereavement among women whose military spouses had completed suicide. Four correlations to bereavement (primary appraisal, secondary appraisal, coping skills and stigma) were significant. Hierarchical multiple regression analysis assessed the overall relationship of bereavement (the criterion variable) to the five predictor variables, along with the unique contribution of each predictor variable. In the regression, five of six models (all except Model 4) showed significance. The dissertation on which this manuscript is based has the following practical implications: statistically significant correlations between bereavement and constructs of Lazarus' Cognitive Model of Stress (LCMS), as well as the significance of Lazarus' construct of primary appraisal within Model 6, indicate that LCMS holds promise for understanding symptoms of bereavement in women whose military spouses have completed suicide.

Keywords: **suicide, bereavement, military, spouse, Lazarus**

Reports indicate that suicides in the U.S. military surged to a record number of 349 in 2013. This figure far exceeds the 295 American combat deaths in Afghanistan in 2012 and compares with the 201 military suicides in 2011 (National Institute of Mental Health [NIMH], 2013). Some private experts predict that the trend will worsen this year (Miles, 2010).

From 2008–2010, the Army reported the highest number of suicides (n = 182) among active duty troops; whereas the Navy and Air Force reported 60 and 59 respectively (National Institute of Mental Health [NIMH], 2013). The Marine Corps had the largest percentage increase in suicides in a period of 2 years (Lamorie, 2011). U.S. veterans accounted for 20% of the more than 30,000 suicide deaths in the United States in 2009. Between 2003 and 2009, approximately 6,000 veterans committed suicide annually, an average of 18 suicides each day (Congressional Quarterly, 2010; Miles, 2010). During the 2009 fiscal year, 707 members of the veteran population committed suicide, and another 10,665 made unsuccessful suicide attempts (Miles, 2010). Certain experiences of military service members (e.g., exposure to violence, act of killing the enemy, risk of injury, exposure to trauma) increase suicidal tendencies (Zamorski, 2011).

For every person who completes suicide, an estimated 20 people experience trauma related to the death (NIMH, 2010). This suggests that from the 349 military suicides in 2013, approximately 7,000 people have experienced related trauma. Suicide survivors are family members and friends whose lives significantly change because of the suicide of a loved one (Andriessen, 2009; Jordan & McIntosh, 2011; McIntosh, 1993). Survivors of suicide may have higher risk for a variety of psychological complications, including elevated rates of complicated grief and even reactive suicide (Agerbo, 2005).

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It is also important to note that suicide survivors might not differ significantly from other bereaved groups regarding general mental health, depression, post-traumatic stress disorder symptoms and anxiety (Sveen & Walby, 2008). Examining the impact of suicide on surviving military family members may provide important information on minimizing negative consequences, including possible survivor suicide.

Military deaths are often sudden, unexpected, traumatic and/or violent in nature, and the family is conditioned to anticipate these types of deaths. In contrast, death by suicide is not anticipated and might not be handled well among military families (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Suicide within the military culture is a traumatic as well as a unique experience. Service members and their families struggle with the visible and invisible wounds of war and the aftermath that combat deaths leave for the survivors. When a service member's trauma leads to suicide, the military community is less trained and conditioned to process the grief than when death occurs as a direct result of military service (Zhang & Jia, 2009).

Stress plays a role in the grief process within the military culture when it relates to suicide. The chief identifying feature of military culture is warfare, which in turn leads to the claiming of human lives (Siebrecht, 2011). Siebrecht argued that bereavement can only be overcome if people adopt a more rational attitude and grant death its natural place in life. Association with the military ensures that most families will have to experience some form of bereavement and many forms of loss during times of war (Audoin-Rouzeau & Becker, 2002). Military men and woman are less equipped than the general population when it comes to their culture's acceptance of outward demonstration or sharing of the emotional experience of grief (Doka, 2005).

Stigma

Historically, the stigma of suicide has been present in society (Cvinar, 2005). The biggest obstacles that families with members who have completed suicide confront are acts of informal social disapproval. The surviving family may be suspected of being partly blameworthy in a suicide death and consequently may be subjected to informal isolation and shunning (Bleed, 2007). The stigma of suicide can be subtle. It can be manifested in overt actions taken against the survivors (i.e., placing blame on the family), as well as by omitted actions (i.e., not receiving life insurance), which are probably far more common. When people experience the untimely loss of a family member, there can be feelings of being offended, wounded or abandoned (Neimeyer & Jordan, 2002). The stigmatization experienced by survivors may complicate their bereavement process (Cvinar, 2005; Jordan, 2001; McIntosh, 1993). This complexity results in communication issues, social isolation, projection of guilt, blaming of others and scapegoating (Harwood, Hawton, Hope, & Jacoby, 2002; Lindemann & Greer, 1953). There is a lack of research in the professional literature addressing the grief of surviving military family members impacted by the death, including suicide, of a loved one (Lamorie, 2011).

Suicide and Bereavement

Jordan (2001) researched suicide bereavement and concluded that there are several underlying reasons that it differs from other types of mourning. Jordan summarized that "there is considerable evidence that suicide survivors are viewed more negatively by others and by themselves" (p. 93) and that suicide "is distinct in three significant ways: the thematic content of grief, the social processes surrounding the survivor, and the impact suicide has on family systems" (p. 91). In reviewing the social processes surrounding suicide, Jordan's analysis supports those of Worden (1991) and Ness and Pfeffer (1990), saying that "there is considerable evidence that survivors feel more isolated

and stigmatized than other mourners, and may be viewed more negatively by others in their social network" (p. 93). Most traumatic death survivors will face questions regarding their own culpability in their loved one's decision to take his or her own life. Survivors may find themselves repeatedly pondering missed warning signs and risk factors (Parrish & Tunkle, 2005). Four primary factors that distinguish the complexities of suicide bereavement for families include stigma, questions about reasons, issues of remorse and guilt, and various logistical and legal factors unique to suicide that necessarily influence the events and processes following death (Minois,1999). The question of *why* often comes up given the pervasive sense that suicide is a preventable event. This line of thought can often define the grief process. Combined with factors of shock from the sudden, often violent nature of the death, these questions are virtually unavoidable. In some cases, answers to questions of *why* may never be forthcoming or satisfactory (Steel, Dunlavy, Stillman, & Pape, 2011). Among military families, bereavement is complex. A military death often has circumstances not normally found in the civilian world. It is most likely unexpected, potentially traumatic, occurring in another country, publicized by the media, and enveloped in the commitment to duty and country. Surviving family members of military personnel are often parents, siblings, grandparents and spouses. Military widows are young, often with young families, and are living at a duty station, far away from family and longtime friends (Katzenell, Ash, Tapia, Campino, & Glassberg, 2012).

Bereavement in the Military Culture

Bereavement is a part of the military culture but is often misinterpreted as a weakness that will elicit limited outside support. Military men and women in general are uninformed about the cultural acceptability of outwardly demonstrating their grief or sharing the emotional experience of the loss (Doka, 2005). Although traditional mental health treatments predominantly encourage emotional vulnerability, the military culture values emotional toughness (Kang, Natelson, Mahan, Lee, & Murphy, 2003) and stigmatizes mental illness (Doka, 2005). These attitudes can often deter service members from seeking assistance that could help them to overcome physical and mental health issues. Military culture affects the impact of suicide on families. Each spouse and family has a different bereavement process, and this process is influenced by stigma, social support and ability to cope. In the U.S. military, these issues can be a hindrance to seeking services and can lead to feelings of isolation, which in turn are a risk factor for suicide (Christensen & Yaffe, 2012).

Conceptual Framework

The conceptual framework of Lazarus' Cognitive Model of Stress (LCMS) was used to frame this study. The underlying construct of this model states that times of uncertainty and difficulty may assist in understanding a person's ability and capacity to cope with the suicide of a loved one. In general, when people encounter a difficult situation, they employ strategies for dealing with and lessening perceived stress (Groomes & Leahy, 2002).

LCMS (Lazarus & Folkman, 1984) has served as a useful lens for examining the interaction between a person and situational demands. Burton, Farley, and Rhea (2009) used LCMS to frame a study of the relationship between level of perceived stress and extent of physical symptoms of stress, or somatization, among spouses of deployed versus non-deployed servicemen. Eberhardt and associates (2006) examined Lazarus and Folkman's 1984 stress theory regarding the ways that stress mediators and perceived social support may affect anxiety (as a stress response). The above studies show the usefulness of LCMS in depicting the impact of stress and coping on perceived anxiety, acceptance, ability to lead mentally and physically satisfactory lives, and perception of social support.

LCMS includes primary appraisal, secondary appraisal, coping and perceived social support. Stress is defined as a person's relationship to his or her environment, specifically a relationship that the person perceives as exceeding his or her resources and endangering well-being. This model supports that the person and the environment are in a dynamic, reciprocal and multidimensional relationship. This conceptualization suggests that people's perception of stress is related to the way they evaluate, appraise and cope with difficulties.

Stress can be measured by the way an individual appraises a specific encounter. Lazarus and Folkman (1984) presented two types of appraisal. The first is primary appraisal, defined as an individual's expressed concern in terms of harm, loss, threat or challenge. Harm and loss appraisals refer to loss or damage that has already taken place; threat appraisal refers to harm or loss that has not yet occurred (i.e., anticipatory loss); and challenge appraisal refers to the opportunity for mastery or growth (Lazarus & Folkman, 1984). The second type is secondary appraisal, defined as the focus on what the individual can do to overcome or prevent harm. Lazarus and Folkman suggested that an appraisal of threat is associated with coping resources that can mediate the relationship between stressful events (e.g., loss of spouse to suicide) and outcomes (e.g., ability to seek mental health services).

Coping resources are the personal factors that people use to help them manage situations that are appraised as stressful (Lazarus & Folkman, 1984). Coping resources can be available to the person during the grief process or can be obtained as needed. This fact suggests that the grief process following a suicide is stressful and imposes demands on coping as the bereavement process evolves. Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as exceeding the resources of the person" (p. 141). Coping is a dynamic process that is called into action whenever people are faced with a situation that requires them to engage in some special effort to manage that situation (Lazarus & Folkman, 1984). The ability to cope impacts a person's bereavement process, and the ways and ability to cope vary with each individual. Stigma and the amount of perceived social support also influence the ability to cope (Bandura, 1997). These variables impact the bereavement process, especially with the added variable of death by suicide.

Social support can strengthen an individual's position against the stressor and reduce the level of threat (Lazarus, 1996). Research suggests there are specific reasons why survivors do not seek out social support. McMenamy, Jordan, and Mitchell (2008) identified depression and a lack of energy as substantial barriers to obtaining social support.

People who experience a traumatic event are more likely to perceive barriers and not request medical and mental health services due to this lack of energy, lack of trust in professionals and depression (Amaya-Jackson et al., 1999). Provini, Everett, and Pfeffer (2000) stated that the stigma and social isolation that survivors experience can interfere with seeking social support and the willingness of social support networks to come to the aid of the survivor. A lack of social support can increase depression, a lack of energy to complete daily tasks and isolation. Limited social support is especially common for suicide survivors. Shame and guilt surrounding a suicide can impact survivors' ability to seek social support; however, high social support can be linked to positive mental health.

Barriers to Bereavement

Many suicide survivors struggle with questions about the meaning of life and death, report feeling more isolated and stigmatized, and have greater feelings of abandonment and anger compared with

other sudden death survivors (Callahan, 2000). Moreover, the feeling of relief from no longer having to worry about the deceased may distinguish survivors of suicide from survivors of other types of sudden death (Jordan, 2001). Experiencing suicide in one's family increases risks for family members' mental health and family relationships (Jordan, 2001). Despite the frequency of suicide, there is limited research focusing on the needs of surviving spouses (Miers, Abbott, & Springer, 2012).

The family system in which the spouses existed as a couple is destabilized by suicide, but the survivor must continue to function. Tasks that were carried out in the relationship must now be carried out by the survivor (Murray, Terry, Vance, Battistutta, & Connolly, 2000). Cerel, Jordan, and Duberstein (2008) stated that because suicide occurs within families, the focus on the aftermath of suicide within families and the impact on the spouse are important areas to investigate in order to determine exactly how to help survivors. Helping survivors to address practical, economic and legal issues, in addition to providing information and therapeutic intervention, is important (Dyregrov, 2002; Provini et al., 2000).

Purpose of the Study

Because of the frequency of suicide in the United States, the increased number of suicides within the U.S. military, and the impact of suicide on the family, the bereavement process among female spousal survivors of military suicides deserves further exploration. The purpose of this study was to explore bereavement in female spousal survivors of military suicides. Using LCMS, the study explored the relationship of bereavement and stigma, social support, primary appraisal, secondary appraisal, and coping skills among women whose military spouse had completed suicide.

Summary of the Study and Methodology

This study investigated the linear relationship between the dependent variable of bereavement and each of five independent variables—primary appraisal, secondary appraisal, coping skills, perceived social support and stigma—among women whose military spouses had completed suicide. The following hypotheses guided the study. Hypothesis 1 stated that there would be a relationship between bereavement and stigma; this positive relationship was significant. Hypothesis 2 stated that there would be a relationship between bereavement and social support; the relationship was not statistically significant. Hypothesis 3 stated that there would be a relationship between bereavement and primary appraisal; this positive relationship was significant. Hypothesis 4 stated that there would be a relationship between bereavement and secondary appraisal; this negative relationship was significant. Hypothesis 5 stated that there would be a relationship between bereavement and coping skills; this negative relationship was significant.

Using hierarchical regression analysis, the researcher examined the relationship of five independent variables—primary appraisal, secondary appraisal, coping skills, social support and stigma—to bereavement. The relationship was statistically significant. The model was a good fit and controlled for time since death (i.e., number of years since the person completed suicide). Therefore, for this sample, the five independent variables are components of a statistically significant model.

Participants and Recruitment

The participants in this study were women aged 18 and older who had lost a military spouse to suicide. Criteria for inclusion were that (a) the service member who had completed suicide had been either on active duty or of veteran status, (b) the survivor was female and 18 years of age or older, and (c) the survivor was considered a spouse. A spouse was defined as legally married to another person

or living and cohabiting with another person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender. Participants were chosen from seven national organizations serving veterans. The researcher recruited participants from these organizations by explaining the study and asking for volunteers. The director or assistant director of each organization distributed study information and materials through listservs and posted them on their Web sites. Once prospective participants received an e-mail, they decided whether they wanted to participate and whether they met the eligibility requirements. If the spouses decided to participate in the study, they would complete the survey through Survey Monkey.

Variables

Demographic variables included age, race/ethnicity, length of relationship with the deceased partner, the decedent's military status (active or retired), the decedent's length of service, and time elapsed since death. The survey also asked about the deceased's rank, education level, surviving children and prior suicide attempts.

A self-report online survey was constructed using the following five instruments: the Core Bereavement Items (CBI; Holland, Futterman, Thompson, Moran, & Gallagher-Thompson, 2013), the Stigma of Suicide and Suicide Survivor Scale (STOSASS; Scocco, Castriotta, Toffol, & Preti, 2012), the Coping Self-Efficacy Scale (CSES; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006), the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, 1988), and the Stress Appraisal Measure (SAM; Peacock & Wong, 1990). The SAM is one measure. However, the variables of primary stress appraisal and secondary stress appraisal within it were separated, and the questions within the SAM regarding primary stress appraisal were referred to as the primary stress appraisal measure (PSAM), and the remaining questions of the SAM were referred to as the secondary stress appraisal measure (SSAM). In addition to these assessments, participants would also answer 11 demographic questions and three open-ended questions. The survey was split into seven sections.

The first section had 11 demographic questions. The second section, comprised of the MSPSS, had 12 questions regarding social support of the participant and used a 7-point Likert scale. The third section, comprised of the CBI, had 26 questions regarding the participant's ability to cope and used a 10-point Likert scale. The fourth section, comprised of the SAM, had 19 questions regarding participant's stress appraisal measures and used a 4-point Likert scale. The fifth section, comprised of the STOSASS, had 17 questions regarding the participant's perceived stigma and used a 4-point Likert scale. The sixth section, comprised of the CBI, had 17 questions regarding the participant's bereavement process and used a 4-point Likert scale. The survey included the three following open-ended questions that were derived from the Grief Evaluation Measure (GEM) and reviewed by three licensed professional counselors working in the field of suicide bereavement: (1) What do you recall about how you responded to the death of your spouse at the time?; (2) What was the most painful part of the experience to you?; and (3) How has this experience affected your view of yourself or your view of your world? To analyze the qualitative responses, the researcher identified the most commonly recurring words or phrases used by participants for each question. Three experts in the field of grief and loss were consulted and confirmed the content and face validity of the survey.

Data Analysis

The Statistical Package for the Social Sciences (SPSS), a statistical software package, generated all of the statistics for this research investigation. A Pearson correlation analysis was conducted to determine whether there was a linear relationship between primary appraisal, secondary appraisal, social support, coping skills, stigma and bereavement for women whose military spouse

had completed suicide. Following this analysis, a multiple regression was used to describe the relationships of the independent or predictor variables to the dependent or criterion variable (Lussier & Sonfield, 2004). Because LCMS states that it is possible to discern the order in which a person experiences each variable with regard to a particular event, the variables were entered into the regression using the following equation: Bereavement = {time since death} + {primary appraisal} + {secondary appraisal} + {coping skills} + {perceived social support} + {perceived stigma}.

Results

Descriptive Statistics

Descriptive statistics provided simple summaries of the demographic characteristics of the sample, as well as descriptors such as means and standard deviations for these characteristics. The sample was a well-educated, racially diverse group of women who had lost their military spouses to suicide. The majority of participants were non-Hispanic White females who had attended at least some college. Most were affiliated with the Army and had been married to the military member who had completed suicide. The majority of the partners had committed suicide while on active duty. The mean age of respondents was 33.48 years (*SD* = 5.20; *SE* = .373); their ages ranged from 23–50 years. The mean number of children aged 17 or under that were a product of the relationship with the service member was 1.12 (*SD* = .79; *SE* = .064); the range was 0–4 children. The mean number of prior suicide attempts by the service member (known/confirmed by the surviving female spouse) was 1.31 (*SD* = 1.06; *SE* = .096); the range was 0–4 prior suicide attempts.

Correlation Results

Using SPSS Student Version 22.0 software, a Pearson correlation coefficient was used to measure the relationship of bereavement, primary appraisals, secondary appraisals, coping skills, social support, and stigma among women whose military spouses had completed suicide. The correlation coefficient measures the strength and direction of the relationship among variables. When conducting a correlational analysis of two co-occurring variables, the researcher can indicate whether change in one is accompanied by systematic change in the other. Examination of intercorrelations among study variables indicated statistically significant correlations between bereavement and each of four independent variables: primary appraisal, secondary appraisal, coping skill, and stigma. The results for each correlation are presented separately and summarized below as well as in Table 1.

Table 1

Correlations for Independent, Dependent and Control Variables

	CBI	TSD	PSAM	SSAM	MSPSS	CSES
1. TSD	.277*					
2. PSAM	-.309*	-.167				
3. SSAM	-.309*	-.151	.602*			
4. MSPSS	-.039	.032	.379*	.172*		
5. CSES	-.174*	-.167*	.494*	.473*	.585*	
6. STOSASS	.252*	.095	-.196*	-.221*	.022	-.253

Note: *N* = 194; CBI = Core Bereavement Items; TSD = Time Since Death (in months); PSAM = Primary Stress Appraisal Measure; SSAM = Secondary Stress Appraisal Measure; CSES = Coping Self-Efficacy Scale; MSPSS = Multidimensional Scale of Perceived Social Support; STOSASS = Stigma of Suicide and Suicide Survivor Scale.
**p* < .05.

Control variable. There was a statistically significant relationship between time since death and bereavement for women whose military spouse had completed suicide, $r(194) = .277$, $p < .01$. The shorter the amount of time elapsed, the higher the bereavement scores.

Independent variables. Primary stress appraisal, $r(193) = -.309$, $p < .01$: There is a weak negative linear relationship between bereavement and primary stress appraisal. Secondary stress appraisal, $r(193) = -.309$, $p < .01$: There is a weak negative linear relationship between secondary stress appraisal and bereavement. Coping skills, $r(193) = -.174$, $p = .015$: There is a weak negative linear relationship between coping skills and bereavement. Social support, $r(193) = -.039$, $p = .594$: There is no linear relationship between perceived social support and bereavement. Stigma, $r(193) = .252$, $p < .01$: There is a weak positive linear relationship between perceived stigma and bereavement.

Multiple Regression

Following the correlational analysis, a multiple regression was utilized. This analysis was appropriate to describe the relationships between the independent or predictor and dependent or criterion variables in an objective manner (Lussier & Sonfield, 2004). The design was appropriate because the purpose of the study was to explain the relationships between variables.

Model 1 (TSD onto bereavement) yielded $R = .277$, $R^2 = .077$, $F(1, 125)$, $p < .001$. The portion of the variance explained was 7%. Model 2 (TSD and primary appraisal) yielded $R = .431$, $R^2 = .186$, $F(2, 124)$, $p < .001$. The portion of variance explained was 18.6%. Model 3 (TSD, primary appraisal and secondary appraisal) yielded $R = .454$, $R^2 = .206$, $F(3, 123)$, $p < .001$. The portion of variance explained was 20.6%. Model 4 (time since death, primary appraisal, secondary appraisal and coping skills) yielded $R = .455$, $R^2 = .207$, $F(4, 122)$, $p < .001$. The portion of variance explained was 20.7%. Model 5 (time since death, primary appraisal, secondary appraisal, coping skills and social support) yielded $R = .471$, $R^2 = .221$, $F(5, 121)$, $p < .001$. The portion of variance explained was 22.1%. Model 6 (time since death, primary appraisal, secondary appraisal, coping skills, social support, and stigma) yielded $R = .482$, $R^2 = .232$, $F(6, 120)$, $p < .001$. The portion of variance explained was 23.2% (see Table 2).

Qualitative Component

There is a growing interest in integrating qualitative data across quantitative studies to discover patterns and common threads within a specific topic or issue (Erwin, Brotherson, & Summers, 2011). The main aim of the qualitative questions within the survey is to gain insight into the participants' world and capture their unique experiences (e.g., naturally occurring events and/or social or human problems) and their interpretations of these experiences (Jones, 1995; Sarantakos, 1993).

A total of 55 (28.4%) participants responded to the question, "What do you recall about how you responded to the death of your spouse at the time?" Of these, 24 stated recalling "sadness" as most frequent. Fifteen participants indicated disbelief, shock, feelings of helplessness or feelings of fear. Other participants' responses included "trying not to think about what had happened," crying, sobbing, physical symptoms, physical pain, collapsing, fainting, being unable to forget what happened, and being unable to recall or process the event. A total of 68 (35.1%) participants responded to the question, "What was the most painful part of the experience to you?" Of these, 50 reported physical and emotional numbness and only partial recollection of learning about the death (e.g., who told them, where they were when notified, immediate responses). These participants indicated that they could recall parts of the experience but struggled with identifying feelings or emotions directly following the event. Other responses included being hospitalized, contemplating suicide, refraining from eating, and feeling that their future had been lost. Although four reported

contemplating suicide following the death of their spouse, no participants reported attempting suicide at any point. A total of 36 (18.6%)participants responded to the question, “How has this experience affected your view of yourself or your view of your world?” Of these, 15 participants indicated that they no longer feared death, while seven reported having a negative reaction to relationships. Eleven participants reported that they perceived stress as more threatening than before the suicide of their spouse and were unaware of the triggers that brought on stress during the bereavement process. Ten participants indicated that their view of love had changed since the loss of their spouse. Nine participants wrote about making an effort to enjoy life after the suicide of their spouse.

Table 2

Hierarchical Multiple Regression

Model	*R*	R^2	*t*	*p*	*B*	β	R^2 Change
Model 1	.277	.077	61.600	.000	.049	.277	0
TSD			3.228	.002			
Model 2	.431	.186	19.482	.000			.109
TSD			2.696	.008	.039	.222	
PSAM			-4.074	.000	-.406	-.335	
Model 3	.454	.206	19.646	.000			.02
TSD			2.618	.010	.038	.214	
PSAM			-1.947	.054	-.254	-.209	
SSAM			-1.782	.077	-.192	-.191	
Model 4	.455	.207	16.971	.000			.001
TSD			2.622	.010	.038	.216	
PSAM			-1.952	.053	-.262	-.216	
SSAM			-1.788	.076	-.199	-.198	
CSES			.266	.791	.004	.025	
Model 5	.471	.221	12.989	.000			.015
TSD			2.307	.023	.034	.192	
PSAM			-2.359	.020	-.335	-.276	
SSAM			-1.111	.269	-.132	-.132	
CSES			-0.710	.479	-.012	-.083	
MSPSS			1.505	.135	.091	.167	
Model 6	.482	.232	9.026	.000			.010
TSD			2.329	.022	.034	.194	
PSAM			-2.187	.031	-.312	-.257	
SSAM			-1.105	.271	-.131	-.131	
CSES			-0.320	.750	-.006	-.039	
MSPSS			1.107	.271	.069	.128	
STOSASS			1.280	.203	.086	.112	

Note: TSD = Time Since Death (in months); PSAM = Primary Stress Appraisal Measure; SSAM = Secondary Stress Appraisal Measure; CSES = Coping Self-Efficacy Scale; MSPSS = Multidimensional Scale of Perceived Social Support; STOSASS = Stigma of Suicide and Suicide Survivor Scale.

Discussion

This study investigated the relationships between bereavement and primary appraisal, secondary appraisal, coping skills, perceived social support and stigma among women whose military spouses had completed suicide. There are several study findings that deserve further exploration.

First, there was a statistically significant positive relationship between stigma and bereavement, suggesting that as female survivors perceive increased stigma regarding the suicide of their spouse, they present more symptoms of bereavement. Knieper (1999) suggested that bereavement following suicide is not the same as that following natural death. He reported that stigma and avoidance continue to be central issues for suicide survivors. Psychological projection of feelings of rejection and the actual social response to the survivor interact in a complicated manner. Worden (2009) also noted a difference between suicide bereavement and other forms of bereavement, suggesting that suicide is often associated with stigma and a sense of shame. Such shame can result in the complete isolation of the bereaved during the period immediately following the suicide event. Eaton and associates (2008) examined survivors' barriers to seeking mental health treatment after the suicide of their partners and found that spouses were 70% less likely to seek treatment following a suicide, as compared to a natural death, and that stigma was a recurrent theme in the qualitative analysis. However, Eaton et al.'s study did not directly examine the impact of stigma on bereavement. It did show that stigma is an important variable that needs to be investigated further. The present study showed similar results to Eaton et al.'s (2008) research.

The qualitative comments recorded in the open-ended question section of the survey supported the study findings. For example, one participant responded, "I blamed myself for not doing more, not being there enough, or not being there when the death happened." Another participant noted, "Suicide is one of the most difficult and painful ways to lose someone we love, because we are left with so many unanswerable questions." One participant expressed the following:

> [I felt] anger at family members for not assisting me with my husband and anger at physicians that treated my husband and were not able to see the warning signs or provide assistance in caring for them properly. I was then left with the scars after the death and had to explain to people what happened. I felt I got blamed and it was not my fault.

Several participants expressed "numbness and isolation." Responding to stigma, people with mental health problems often internalize public attitudes and become embarrassed or ashamed. These feelings can lead them to conceal symptoms and fail to seek treatment (President's New Freedom Commission on Mental Health, 2003). These survey responses assist in understanding the impact of stigma upon the military spouse survivors and imply that unanswered questions, as well as guilt, are important factors to explore in the grief process following a suicide.

Second, a statistically significant relationship between primary appraisal and bereavement was reported, suggesting that survivors who perceive the death of a spouse to be stressful are more likely to experience bereavement. This result is supported by the bereavement literature (Cvinar, 2005; Jordan, 2001; McIntosh, 1993). Lazarus (2005) argued that primary appraisal shows that it is not the situation, but the way a person interprets the situation, that affects the person's experience. The

way a person appraises a situation can impact the way the person reacts to it. Primary appraisal is an important step in processing the stress of bereavement, since grieving is such an individualized experience.

The qualitative comments recorded in the open-ended question portion of the survey supported the statistical relationship between primary appraisal and bereavement. For example, one participant indicated that her worldview had changed when she responded, "My world has become gray; I have made myself closed. I live in a rain cloud and now know that good people do bad things that change lives." The participant had changed her worldview such that her world became a smaller, more restricted place. Another stated, "This death, this loss, makes small things seem insignificant. Material things are insignificant. Relationships with people are more important. I don't have a fear of dying and in fact, feel like I will die at a young age." This concept of primary appraisal is based on the idea that emotional processes are dependent on a person's expectancies about the significance and outcome of a specific event. The same event within the same community (in this case, suicide within the military) can elicit responses of different quality, intensity and duration due to individuality in experiences and personality (Krohne, Pieper, Knoll, & Breimer, 2002). The different kinds of stress identified by the primary appraisal may be embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotion (Lazarus & Folkman, 1984).

Third, a statistically significant negative relationship was reported between secondary appraisal and bereavement, suggesting that survivors who make a negative appraisal of their ability to control the outcomes of their spouse's death are more likely to experience bereavement. In the future, when examining outcomes of interventions that impact coping, beliefs about a person's ability to perform specific behaviors related to coping would need to be highlighted. This concept is known as specific coping behaviors and is also pertinent to stress, coping theory and secondary appraisal (Chesney et al., 2006). Part of secondary appraisal is the judgment that an outcome is controllable through coping; another part addresses the question of whether or not the individual believes he or she can carry out the requisite coping strategy (Chesney et al., 2006; DiClemente, 1986; Hofstetter, Sallis, & Hovell, 1990).

The qualitative comments recorded in the open-ended section of the survey supported this finding. For example, one participant indicated her appraisal of the situation by stating, "Everyone must learn to face the misfortune, because life on the road will not be smooth." Another stated that "time can dilute all and I must face life and accept my reality;" yet another wrote, "I want to work on longer range goals to give myself some structure and direction to my life and not focus on my loss. I am only interested in rebuilding my life." However, other participants stated that it was harder to assess the loss and to move forward after the suicide. One participant stated the following:

> I often find myself complaining to God about what seems senseless or unjust and unfair. I find myself bogged down in fear and even anger at myself or the person who died and "left" me. I do not accept what happen[ed] to me and my children.

Some participants reported not knowing what to do. An example of this feeling is the statement, "I perceive stress as threatening. I feel totally helpless." Perceived self-efficacy, defined as a belief about one's ability to perform a specific behavior, is a salient component of this theory. It highlights the importance of personal efficacy in determining the acquisition of knowledge on which skills are founded (Bandura, 1997; Chesney et al., 2006).

Fourth, a statistically significant negative relationship between coping skills and bereavement was reported, suggesting that survivors who believe they have a low ability to cope with their spouses' death are more likely to experience bereavement. Although it is important for survivors to become familiar with the stress appraisal process, the way they assign meaning to their spouse's death and their past experience with death also are important in their primary appraisal to the overall coping effort. One model of this process is the transactional model of coping (Lazarus & Folkman, 1984). This model of coping implies that a person's appraisal of his or her interaction with a difficult event naturally evokes a coping response for dealing with the situation. Experiencing a suicide or living in a social environment that hinders, stigmatizes or isolates a person who has experienced a suicidal death may cause demands to exceed his or her resources for dealing with certain situations. Few studies have examined the natural coping efforts used by suicide survivors, or have identified specific problems and needs that survivors experience following the suicide of a significant other (McMenamy et al., 2008). Interventions with suicide survivors have limited effectiveness (Jordan & McMenamy, 2004). Provini et al. (2000) presented four categories of concerns for suicide survivors: concerns related to (a) family relationships, (b) psychiatric symptoms, (c) bereavement and (d) stress. Family-related problems were the most frequently mentioned type of concerns (Provini et al., 2000). Examples of family relationship concerns included inability to maintain parenting roles, inability to maintain family routines, existence of different coping styles within the family, and inability to provide appropriate emotional support to family members.

Qualitative comments recorded in the open-ended section of the survey supported this study finding. For example, one participant stated, "I often feel distracted, forgetful, irritable, disoriented, or confused. I try to remember how I got over a death in the past, sometimes it helps and sometimes it does not." Another participant stated, "I know I need to start to form new relationships or attachments in my life but my mind [is] telling me 'there must be some mistake,' or 'this can't be true.' " Regarding bereavement, one participant wrote, "Grief is perhaps the most painful companion to death." Addressing coping, one participant stated, "I must also adjust to working or returning to work after the death. I know things can't go back to the way they were before, very difficult and painful to deal with and I better adjust to life." These statements support the need to further explore the relationship between one's ability to cope with the suicide of a spouse and one's ability to experience and acknowledge feelings and move forward with everyday life activities (e.g., employment, childcare, financial obligations). Ability to cope impacts a person's bereavement process; the ways and ability to cope vary with the individual. Stigma and amount of perceived social support have been correlated with ability to cope (Bandura, 1997). It is important to understand the individual impacts that stigma, social support, primary appraisal, secondary appraisal and coping have on bereavement. However, it is equally important to examine the relationships of these variables within the context of a model in order to establish future interventions for bereavement within the context of a suicide.

Fifth, results indicated that the model is statistically significant in predicting bereavement outcomes and provides considerable support for using the Lazarus model as a means of understanding the relationship between stress and bereavement when placed into the equation in a particular order: CBI = TSD + PSAM + SSAM + CSES + MSPSS + STOSASS.

This study suggests that the proposed model, using LCMS and assessment of stress, identifies the constructs associated with bereavement among women whose military spouses completed suicide. Future research could further explore the assessment of primary and secondary appraisal processes,

coping, stigma, and social support enhancement programs and interventions to improve the bereavement process for military spouses. When survivors can identify and address their needs, the bereavement process following a suicide can begin (Christensen & Yaffe, 2012).

Limitations

First, the majority of the sample (54.1%) were non-Hispanic White, or Euro-American. Second, there is limited representation across military branches. Third, the study collected data from a self-administered electronic survey. Fourth, although the social support measure (i.e., MSPSS) has good reliability and measures social support as a general feeling of belonging to a social network that one can turn to for advice and assistance in times of need (Uchino, 2006), it does not delineate various types of social support. Finally, most of the sample consisted of women whose spouses had completed suicide while on active duty. Active duty members typically live on base and are well connected to the military community. When the military spouse dies, these supports are often no longer available, and the stigma of a suicide could strongly affect these women.

Recommendations for Future Studies

There are several practice implications from this study. The statistically significant correlations between bereavement and four other variables (primary appraisal, secondary appraisal, coping skills and stigma), as well as the significance of the LCMS construct of primary appraisal within Model 6, indicate that LCMS holds promise for understanding symptoms of bereavement in females following the suicide of a military spouse. Primary appraisal, the most significant variable within this study, could be highlighted within bereavement research on women whose military spouses have completed suicide. When conceptualizing the responses of these women, counselors and clinicians could use LCMS, examining the three components of primary appraisal (goal relevance, goal congruence and ego involvement) and exploring the ways these components present during the client's bereavement process. The approach would focus on the role of maladaptive cognitions during times of stress (Sudak, 2009).

The reluctance of the military community to seek mental health support contributes to an inability to move through the bereavement process in a healthy way. Within the military community, it can be quite difficult to deal with the ambiguity of bereavement that is typically associated with emotional vulnerability (Lamorie, 2011). However, the current study suggests that four constructs—primary appraisal, secondary appraisal, coping and stigma—are significant when addressing the issues of bereavement in females who have lost a military spouse to suicide. Using LCMS to address cognitions, counselors might be able to assist a population whose members have been reluctant to seek mental health services in the past. Because the components of LCMS are correlated with bereavement, clinicians could use LCMS and cognitive stress research, which together seem to be a promising direction, when assisting women who have lost a military spouse to suicide.

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Interdisciplinary Training: Preparing Counselors for Collaborative Practice

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This article utilizes one counselor education program's experience as a framework for exploring how to prepare counselors to work in interdisciplinary teams. Based on an interdisciplinary training program that involves faculty and graduate students from counseling, social work, nursing, internal medicine and family medicine, the article explores the role discipline-specific orientations play in the outcome of interdisciplinary training programs. Using practical examples grounded by the program's experiences and literature on interdisciplinary training, understanding of the dynamics of interdisciplinary training programs is explored. Implications for preparing counselors for interdisciplinary work and future research are provided.

Keywords: **counselor education, interdisciplinary training, interdisciplinary teams, collaborative practice, medicine**

Counselors typically work in interdisciplinary settings, requiring them to navigate the complex dynamics of collaboration while maintaining a clear focus on the best interests of their clients. Interdisciplinary settings can be described as contexts that require collaboration and consultation between professionals and non-professionals from multiple disciplines in the process of providing service (Nancarrow et al., 2013). Collin (2009) clarified that interdisciplinary collaboration differs from multidisciplinary and transdisciplinary collaboration as it refers to the work of professionals grounded in their own separate disciplines coming together to work on a project that represents a "coordinated and coherent whole" (p. 103). Collin pointed out that this is different from professionals working independently on separate aspects of a project (multidisciplinary) or the coming together of multiple and varied professionals to conceptualize a problem or work on a project that transcends any of the various disciplines (transdisciplinary).

Counselor educators have argued that interdisciplinary collaboration is "a best practice strategy for addressing some of the nation's critical social problems" (Mellin, Hunt, & Nichols, 2011, p. 140). In fact, collaboration between disciplines has been described as being key to the effective delivery of services (McNair, 2005; Morphet et al., 2014) across a broad-spectrum of community mental health services, hospitals, institutions of higher learning and school contexts. In the field of counseling, the *ACA Code of Ethics* (American Counseling Association [ACA], 2014) and the standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) reflect this emphasis on the importance of counselors being able to work with interdisciplinary teams. The *ACA Code of Ethics* (ACA, 2014), for example, encourages counselors to recognize the value of interdisciplinary teamwork in meeting clients' best interests, even when certain professional values are not shared:

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> Counselors who are members of interdisciplinary teams delivering multifaceted services to clients remain focused on how to best serve clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines (ACA, 2014, D. 1. C., p. 10).

The *ACA Code of Ethics* also compels counselors to respect client rights, including those regarding confidentiality, in interdisciplinary treatment contexts (ACA, 2014, A. 2. b., p. 4; B. 3. b., p. 7). The CACREP (2009) training standards emphasize the importance of teaching counselors to understand the functions of other human service agencies and to learn strategies for inter-agency collaboration. In these standards, addictions, marriage, couples, family and career counselors are required to be familiar with the roles of other mental health professionals, and in the clinical mental health counselor standards, the importance of learning how to develop relationships across helping professions and interdisciplinary treatment teams is highlighted. Additionally, school counselors-in-training under CACREP standards also must learn models of consultation and collaboration as a part of their training programs.

Despite these standards, counselors appear to navigate the challenges of interdisciplinary collaboration with limited understanding and experience. Little has been written about interdisciplinary training or the development of interdisciplinary competencies by counseling professionals (Bemak, 1998). Counseling literature and training standards appear to operate from the premise that the process of professional development is automatically accompanied with the acquisition of skills to work in interdisciplinary teams. In contrast, the medical field and associated disciplines have actively documented interdisciplinary training initiatives as a means for facilitating interdisciplinary competencies among their professionals (Pollard & Miers, 2008). For example, in the United Kingdom, the integration of Interprofessional Education (IPE) is now mandatory in the fields of health and social care, with students being required to complete specific modules that have practical interdisciplinary components (Pollard & Miers, 2008). Medicine in the United States also is actively pursuing interdisciplinary training models with the support of the Institute of Medicine, which recognizes interdisciplinary teamwork as key to effective service delivery (Institute of Medicine, 2003; McNair, 2005). Therefore, while counselors continue to make a case for the value of interdisciplinary work, what remains unclear in the literature is how counselors can attain competence in facilitating and participating in interdisciplinary collaborative practices. It is particularly critical to examine how these competencies can be developed while neophyte counselors are also in the foundational stages of their professional development.

The purpose of this article is to use the experiences of one counselor education program currently engaged in an interdisciplinary training project as a framework for exploring some critical benefits and challenges of interdisciplinary training processes. This article provides a detailed description of the counselor education program's training module and also describes steps the program has taken to prepare students for interdisciplinary training contextual dynamics, measures the program has taken to advocate for the counseling profession, and efforts to enhance students' understandings of their professional roles in an interdisciplinary context. Using practical examples grounded by interdisciplinary literature, we expand understanding of shared interdisciplinary values and provide recommendations for more effective practices and future research.

Interdisciplinary Training Program Development

This training collaborative began with an interdisciplinary response to a grant call by the Substance Abuse and Mental Health Services Administration (SAMHSA) to submit a proposal on providing training in Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for adolescents and adults dealing with substance misuse issues (Agerwala & McCance-Katz, 2012; Davoudi & Rawson, 2010; Mitchell et al., 2012). This particular university's SBIRT Training Collaborative brings together master's students from the counseling program, the Department of Social Work, the College of Nursing, and family medicine and internal medicine residents in an interdisciplinary training program using a team-based care model of evidence-supported SBIRT interventions. These programs were chosen because they all are disciplines that deal with issues related to substance misuse. Additionally, these were the only disciplines at our university that responded to the call to participate in this particular project. The objective of the project is to offer brief intervention and referral training to medical residents and master's level graduate students in the area of substance use disorders over a 3-year period. An average of 20 students from each of the participating disciplines were expected to participate in the project annually. This training program began its third year of implementation this year. The SAMHSA grant enabled the interdisciplinary training collaborative to hire SBIRT consultants, a project manager, a project training director and qualified support staff to help administer the project. The funding is a critical part of the success of this project, allowing for faculty course buyouts across the participating disciplines.

The interdisciplinary collaborative aspect of this project began during the initial meeting of educators from the various disciplines, which was organized to discuss submitting a grant proposal in support of an interdisciplinary training program. Each program's director was required to submit a statement indicating how their program would benefit from an interdisciplinary training project. Two initial meetings and multiple e-mail exchanges later led to the formation of an interdisciplinary collaborative team and an agreement by the team on (a) the core foci of the grant, (b) the level of participation by each program and the roles of faculty representatives on the grant writing, (c) budget allocation parameters, and (d) the establishment of a project advisory council made up of the directors of each of the disciplines represented in the project. The purpose of the project's advisory council was to develop the curriculum for the program, which included assessing and ultimately agreeing on the online modules to use on the project, and to establish clear guidelines for the clinical training protocol. Secondly, the advisory council also was charged with ensuring that each discipline provided input on the curriculum development and project evaluation processes. This aspect of the dialogue was critical as one of the objectives of the grant was for programs to incorporate interdisciplinary training foci in their individual discipline's curriculum. Third, the council was charged with the responsibility of implementing and assessing the clinical training aspect of the interdisciplinary training project. Advisory council members committed to serve on interdisciplinary presentation panels and also to provide supervision during the interdisciplinary clinical training sessions. Finally, the council members were expected to be available to address student conduct issues as well as to meet with external grant reviewers during their visits to campus.

The SBIRT Interdisciplinary Training Model

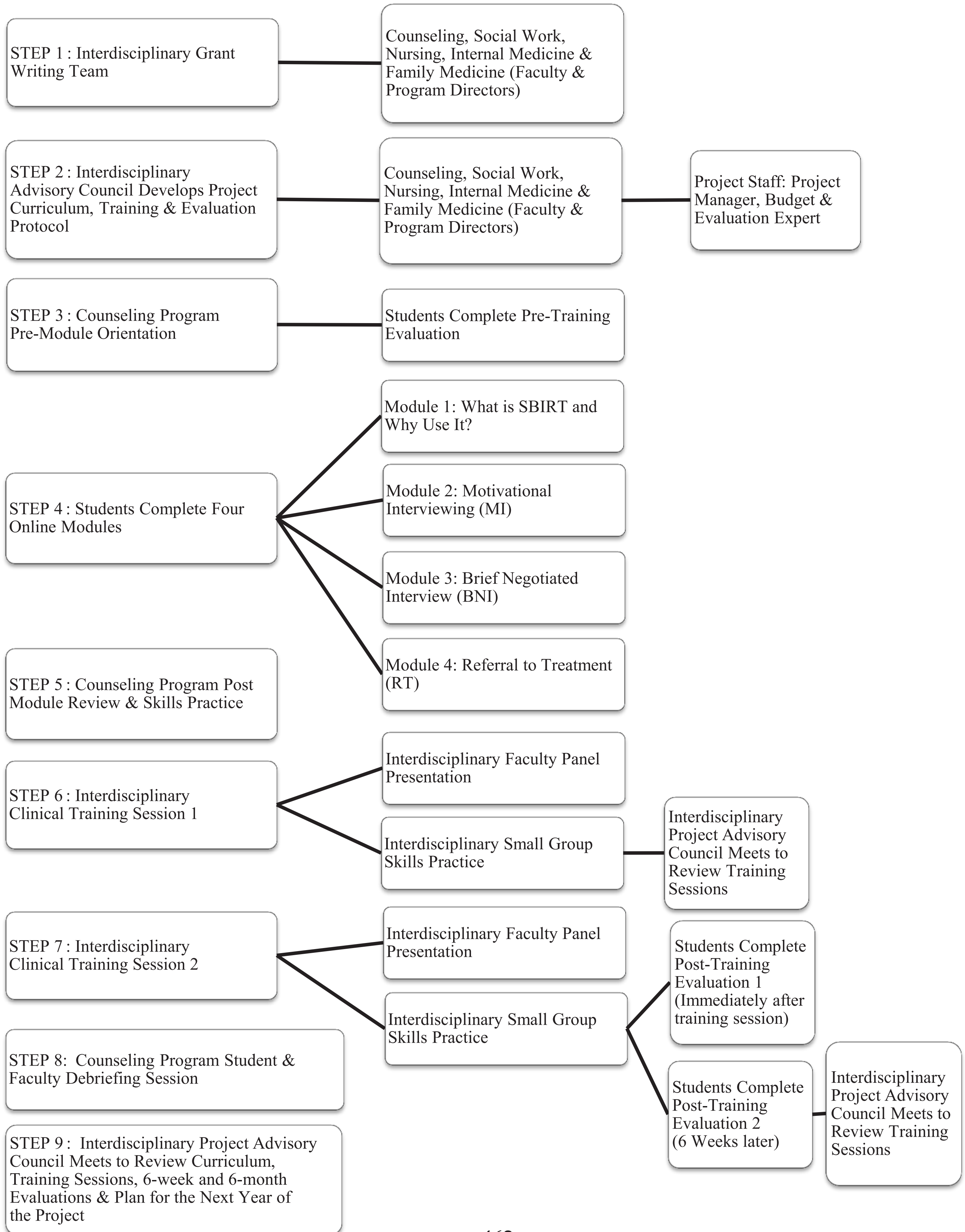
This university's SBIRT interdisciplinary training format is multifaceted, including online and real-time instruction and practice experiences. All family practice and internal medicine residents and master's-level graduate students in the participating disciplines are expected to sign a contract that they will participate in all required aspects of the training experience. SBIRT training is offered in four main areas: (1) screening for substance use disorders, (2) motivational interviewing skills, (3) brief intervention, and (4) referral to treatment. Training includes providing conceptual information (e.g., substance use and motivational interviewing), teaching the use of assessment tools to establish risk or levels of substance misuse, and promoting skill development. Modeling and skill practice with feedback from faculty are important components of this training.

The first SBIRT training cohort started with first-year master's-level graduate students and medical residents. The counseling students involved in the project were in their second semester in the program and concurrently enrolled in a practicum course. For counseling students, the training began with an orientation (counseling program pre-module orientation) to the SBIRT training experience. In the orientation, counseling faculty offered students an overview of the various components of the training project, outlining specific expectations and completion dates. Beginning in the project's second year, the orientation included the film, *The Hungry Heart* (O'Brien, 2013), which explores the depth of prescription drug and opiate addiction in our home state. This film was followed by a discussion regarding the need for SBIRT screening and referral skills. While counseling students are required to participate in this orientation, the option to attend the session also is open to participants from other disciplines.

The next component of the training, conducted online, is required for all participants (faculty and students), regardless of discipline. The online training includes four instructional modules (see Figure 1) and requires a commitment of approximately four to six hours. The first of these online training modules offers an introduction to the SBIRT process and includes data regarding alcohol and substance use. This information builds a case for the need for SBIRT screening and referral practices. The other modules provide instruction in the areas of conducting a brief screening intervention, motivational interviewing, and making appropriate referrals. Each module begins with instruction in a particular area and requires completion of a test before the participant is issued a completion certificate. The certification process was included as a means of ensuring that all participating students complete the required didactic training and tests prior to participating in the interdisciplinary clinical training portions of the program.

At the end of the online training period, counseling students are required to attend a 2-hour practice review (counseling program post-module review and skills practice) session (see Figure 1). A similar post-module review and practice session is offered by other SBIRT project faculty for medical residents and to promote interdisciplinary training; each discipline-specific post-module review is open to participants from other disciplines. In this training, counseling faculty offer a brief review of the information provided in the modules, focusing primarily on the steps of the brief negotiated interview (alcohol and substance use screening) and the motivational interview. Participants engage in role-plays to practice these skills and are provided with instruction and feedback by the counseling faculty.

Figure 1 – Interdisciplinary Training Protocol



The intent of this training session is to reinforce counseling students' sense of competence prior to engaging in interdisciplinary training sessions. This session helps students frame the online training information into counseling-specific terms, steps and experiences while providing them the opportunity to ask questions and clarify their understandings. Importantly, this session requires students to practice the SBIRT skills and to receive feedback and instruction on their use of the skills from familiar faculty in the comfortable environment of counseling peers. Ultimately, this preparation is designed to fortify the confidence that the counseling students bring into the larger, unfamiliar, interdisciplinary practice setting.

Next, all participants in the SBIRT training, regardless of specific discipline, are expected to attend two clinical interdisciplinary training sessions. The first of these focuses on screening and motivational interviewing; the second is on referrals. These sessions begin with an introduction to the concepts that will be covered in that training followed by a panel discussion about the particular application of skills in the various disciplines and the modeling of skills (a role play by two of the program directors). The participants are then required to practice the skills with "live" practice clients (i.e., professional actors from the local community that were already employed by the medical school for medical student training) playing patients/clients with substance use or misuse issues. In this part of the training, participants are randomly assigned to small practice groups, providing an interdisciplinary practice milieu, with a faculty instructor. Each interdisciplinary practice group meets with four professional clients over the course of 2 hours. The participants in each group take turns using screening, motivational interviewing and referral skills. In each group, participants receive feedback and instruction from the faculty instructor who has observed their practice. At the end of the session, the training directors engage participants in a large group discussion about their experiences and observations of being part of an interdisciplinary training group. The intent of this approach is to provide participants with the opportunity to practice with students who have different professional orientations and to receive supervision from faculty who may also have diverse experiences and perspectives; thus, the interdisciplinary focus of this project.

The final component of the training is follow-up. For counseling students, this begins with a follow-up discussion about the training experience with the counseling faculty at the end of the first year of training (after the second interdisciplinary training session). In this meeting, students are asked to reflect on their experiences in SBIRT training and also to discuss their ideas regarding the implementation of this training into their upcoming internship experiences. The purpose of this discipline-specific follow-up is to assess and solidify the integration of the interdisciplinary experiences into their development as professional counselors.

A comprehensive formal evaluation protocol also is in place for the interdisciplinary training program. Students from each of the participating disciplines complete pre- and post-training evaluation forms. During the first year of the project, formal follow-up evaluations were completed in four stages: (1) immediately after students completed the counseling program's pre-module orientation session; (2) immediately after students completed each of the two interdisciplinary clinical training sessions; (3) six weeks after students completed the final interdisciplinary training session, and (4) six months following completion of the final interdisciplinary clinical training session. These evaluations solicit student self-perceptions of their own competence during the various training experiences and also ask for general feedback about the training process. The six-month follow-up evaluation process is meant to coincide with the students' internship and residency experiences. The core objective of the final evaluation will be to assess the impact of interdisciplinary training on the students' current interdisciplinary teamwork experiences.

Interdisciplinary Training Challenges

Interdisciplinary training and practice is complicated; sound logic and good intentions can easily be derailed by any number of intra- and interprofessional challenges. Here we will discuss challenges related to training in silos, and professional orientation, values and attitudes.

Training in Silos

The literature suggests that understanding the skills, knowledge and values of the various disciplines involved in an interdisciplinary collaboration is key to success (Wellmon, Gilin, Knauss, & Linn, 2012). Yet, this may be a challenge when professionals require specialized training that sometimes has the effect of narrowing their views and approaches to service delivery (Forrest, 2004). That is, it can be difficult for professionals to acquire the skills needed for communicating and collaborating across disciplines (Miller & Katz, 2014) when training in silos orients professionals to become strongly acculturated in their own language and practice styles.

We found in the interdisciplinary SBIRT project that these silo effects of discipline-specific training were apparent. It became clear immediately that most of the participants had strong discipline-specific skills and orientation allegiance, and many had little information about conditions and situations beyond their specific training area. This dynamic was evident at both faculty and trainee levels. Faculty had to navigate this dynamic during the process of planning and writing the grant proposal and negotiating the development of the training curriculum in the project's advisory council (made up of program directors of participating disciplines). For example, the counseling director had to educate her medical practice peers on counselor education curriculum, counseling professional practice, and contexts of counseling practice. Further, the directors of counseling and social work had to educate peers on the similarities and differences between the two professions. At the same time, the directors of the family medicine and internal medicine disciplines had to educate their counseling and social work peers on the difference between the two specializations in medicine. Nursing faculty also addressed the distinct role of nurse practitioners in the field of medicine and the intersections between their roles and that of medical doctors.

At the trainee level, the discipline-specific skills and orientation allegiance was evident, particularly in both the brief intervention and the referral to treatment components of the interdisciplinary training sessions. For example, while many of the medical residents were articulate when explaining the physical effects of potential substance use to their professional clients, they were slow to pick up on sociocultural variables that may have been key to the etiology of the substance misuse (and for later referral) in these same cases. An example of this was a professional client who hinted at challenges with a transgender social location that appeared relevant to his substance misuse. This was not addressed by many of the medical residents and faculty, even when those variables were noted in the training module to be risk factors for substance misuse. This variable appeared to be more readily explored by the counseling and social work participants. Conversely, many of the counseling and social work participants struggled to articulate the medical symptoms, risk factors and ramifications of substance misuse that were so easily identified and explored by their peers in nursing and medicine.

A second example of the silo effects of discipline-specific training arose when participants were engaged in the *referral to treatment* training. After a few practice sessions, it became clear that many of the counseling and social work participants did not understand the difference between family and internal medicine practices, or when to refer to a nurse as opposed to a doctor. Conversely, many of the medical practitioners did not have a clear understanding of the role of social workers and

counselors. Once noted, the program directors were able to address this gap in knowledge about participating professionals. For example, counseling and social work directors were able to educate the medical professionals about counseling and social work professional practice. This facilitated productive conversation about referral sources at the start of the subsequent training session; counseling and social work trainers were able to offer a more clear articulation of the professional training and role of their students. Anecdotes from a few of the medical residents and other trainers afterwards indicated that such information was useful for them in discussing referral to treatment in their practice groups. Clearly, knowing the practice parameters of colleagues is central to effective interdisciplinary practice (Wellmon et al., 2012). This knowledge should include some awareness of discipline-specific orientations, terminology and information regarding conceptual framework (McLean, 2012).

Professional Orientation, Attitudes and Values

Issues related to practicing in silos are further complicated by professional indoctrination, or professional identity orientation and development. Within each of the various helping professions, new practitioners are oriented to acquire their profession's unique and specialized identity. For example, in the profession of counseling, the establishment of a unique professional identity is considered a foundational training practice, as demonstrated in the *20/20: A Vision for the Future of Counseling* initiative (Kaplan & Gladding, 2011) and CACREP standards (CACREP, 2009). This intentional emphasis on professional identity in the counseling profession was promoted in order to emphasize the important philosophical beliefs that are the foundation of the profession (Mellin et al., 2011), to distinguish counselors from other helping professionals, to strengthen the profession, to assure licensure portability, and to establish a sense of pride (Mascari & Webber, 2013). According to Gibson, Dollarhide, and Moss (2010), new professionals are socialized into the language of their profession so as to learn what is expected of them, as well as what they can expect in practice—to behave as "native speakers" (p. 22) in their particular discipline. The challenge for counselor educators, as well as profession-specific educators in other related disciplines, is to teach students to navigate the complex dynamics of collaboration while maintaining a clear understanding of their own professional identity.

When professional identities are established in the context of practicing in silos, as well as competing for resources and job opportunities, interdisciplinary tensions may flourish. The results often are distance, barriers, mistrust and a lack of collegiality between disciplines (Arredondo, Shealy, Neale, & Winfrey, 2004; Miller & Katz, 2014). All of this is further complicated by "hierarchical schemas" (Delunas & Rouse, 2014, p. 101) in health care practice that award some individuals and professions more social capital than others (Bemak, 1998; Meyers, Hales, Young, Nesbitt, & Pomeroy, 2013). Clearly, interdisciplinary practice is hampered when some practitioners undervalue the perspectives of others (McLean, 2012).

In our training sessions, it was difficult to determine the extent to which differences in approach and conceptualization reflected different professional training orientations and professional identities or participants' (and their professional mentors') value orientations. That is, while it was clear that the different professions approached the practice components of SBIRT from a different lens, it also seemed that some of the participants valued their own training and knowledge over others. For example, in some of the discussion groups regarding the professional actor who played the role of a client who identified as transgender, some of the medical participants assertively questioned the utility of exploring gender orientation during the screening process. Most of the counseling and social work participants who actively explored the client's gender orientation in their practice sessions sat in

silence as their medical peers challenged faculty trainers on this point. Later, some of the counseling and social work participants described a sense of incompetence regarding knowledge about the medical aspects of substance misuse, as well as difficulties in countering the arguments raised by the medical residents, particularly those against exploring the client's gender orientation during the screening process, an area in which they had competence.

The confident expression of dissenting opinions by some participants juxtaposed with the relative silence of others during disagreements regarding practice orientation may have been an artifact of how practitioners-in-training are exposed to and experience supervision, particularly when delivered by a professional outside of their own discipline. It also may have mirrored the dynamics of many interdisciplinary treatment teams, which tend to be shaped by professional social hierarchy discourses. Given the strong component of professional identity in the training of the counselors and social workers who participated in our SBIRT training, we wonder if the assertiveness and self-silencing that we witnessed reflects social factors at work that go beyond professional identity orientation. As mentioned by Delunas and Rouse (2014), professional hierarchies in the field and in the lay public put physicians "at the top" (p. 101) and until hierarchical profession-centered structures (Meyers et al., 2013) and power sharing (Bemak, 1998) are realized, interdisciplinary collaboration will be stymied.

Interdisciplinary Training Recommendations

Understanding the challenges that arise from practicing in silos brings up complex issues and political nuances that sit between providing specialized, discipline-specific training, and preparing practitioners to work across disciplines. Wellmon et al. (2012) reminded us that "the skills necessary to work effectively as a member of a healthcare team are not intuitive and cannot be learned exclusively 'on the job'" (p. 26). Meyers et al. (2013) echoed this sentiment, pointing out that health care professionals simply are not taught teamwork skills. Bemak (1998) called for the deconstruction and redefinition of the counseling profession's central paradigms so that interdisciplinary collaboration can be a core component of counseling. He also asserted that professional counselors must be provided important skills for engaging in interdisciplinary collaboration. A similar request is made of professionals from other disciplines. Ultimately, if we expect health care practitioners to engage in interdisciplinary practice, they must be trained to engage in such practice.

The literature on interdisciplinary work consistently articulates the difficulty in identifying specific factors that can contribute to effective interdisciplinary work, and it calls for more writing and research by participants in interdisciplinary training programs (Arredondo et al., 2004; Bemak, 1998; Forrest, 2004; Nancarrow et al., 2013; Reubling et al., 2014). Based on our experience in the SBIRT interdisciplinary training and extant research in the field, we offer recommendations for how to promote effective engagement in interdisciplinary work among counselors-in-training. Our recommendations are summarized below in the categories of promoting professional identity and boundaries and teaching skills for collaboration.

Professional Identity and Boundaries

Professional identity. Due to the silo effects of discipline-specific training, negotiating curriculum and training processes can be challenging in interdisciplinary collaborations. The needs of constituent groups within the training can easily be lost to the louder voices or privileged perspectives. Yet, Mascari and Webber (2006, 2013) and Mellin et al. (2011) pointed out that having a clear sense of one's own professional identity and one's scope of practice and also recognizing differences between

counseling and other mental health disciplines enhances cross-discipline practice. These authors highlighted the importance of enlisting faculty representatives who are grounded in counselor and counselor educator identities, who also understand the value of interdisciplinary training and who have the interpersonal skills and expertise necessary for negotiating challenging interdisciplinary conversations. An understanding and appreciation of the interdisciplinary training protocol as a tool for enhancing professional interdisciplinary teamwork should be a core-guiding objective for counseling and all participating faculty members (Bemak, 1998), of course, but a solid grounding in one's own professional identity also is critical.

We learned that counseling faculty must invest in preparing students for participation in interdisciplinary training. The preparation process should be progressive in nature with scheduled periodic check-in sessions, particularly during interdisciplinary clinical training. In our experience, the challenge of navigating professional roles and functions during the interdisciplinary clinical training sessions was most difficult for our students. Counseling students appeared to need multiple opportunities to process their interdisciplinary practice experiences. It was most beneficial to students when the participating faculty had a clear understanding of all the training protocols and processes.

Secondly, positive outcomes came from pre-coaching for skills and knowledge with students during the counseling program post-module review and skills practice review session, and encouraging them to have the confidence to speak up about their concerns, professional differences, identities, and even to volunteer to demonstrate their skills when in the interdisciplinary training sessions. This is consistent with the Reubling et al. (2014) findings in a study comparing students' attitudes and perceptions in pre- and post-training experiences. Our experience highlighted the value of openly discussing the differences in professional and social capital in society and the impact that those differences have on students' approaches to the interdisciplinary training experience. Such discussions helped boost students' confidence to acknowledge issues that they avoided addressing in the initial phases of the training. Having a clear feedback loop from students to faculty, so that faculty can provide feedback to fellow collaborators at subsequent interdisciplinary training sessions, was particularly beneficial.

Finally, having a clear protocol for interventions with non-cooperative and challenging students was beneficial. For example, counseling students were required to sign a behavior and participation contract that was submitted prior to engagement in the interdisciplinary clinical training portions of the program. The foresight by the counseling program to request this contract may have been why no counseling student was cited for behavioral concerns during the interdisciplinary clinical training sessions. There were a handful of participants in other disciplines who required intervention from their own program directors regarding behavioral concerns emerging during interactions with training faculty who were not in their discipline area.

Professional boundaries. For this counselor education program's faculty, it was necessary to have a good sense of the boundaries of engagement during the project's initiation phases. Interdisciplinary training collaborations require much compromise in the curriculum development and training implementation phase; we wanted to be sure that the interdisciplinary training program would enhance rather than compromise the training experience of counseling students. We were consistently willing to compromise and accommodate other disciplines' perspectives, so long as training processes that are essential to the training of counselors were incorporated in the interdisciplinary training protocol. This is consistent with the recommendations of Nancarrow et al. (2013) regarding interdisciplinary training participants needing to understand and respect the professional roles, functions and boundaries of collaborators.

An example of this negotiated process happened after the first year of collaboration, when counseling faculty suggested changes in the scenarios presented to professional actors playing the roles of clients in the clinical component of the training. During the first year, the preparation of the professional actors was handled solely by a staff member employed by the medical school. As a result, the bulk of their presenting concerns were medical in nature. The majority of the professional actors appeared unprepared to discuss their psychological and sociocultural concerns. This was a major factor that affected collaboration because it made the initial practice session challenging for counseling and social work students who understandably felt that discussing medical presenting concerns was out of the scope of their competence and practice. During the second year of the training cycle, counseling faculty submitted case scenarios for the professional actors that started with an initial contact at a school or clinical mental health setting and that represented varied sociocultural and emotional concerns that coexist with physical medical concerns. This approach was intended to ensure that counseling students would be able to experience clinical training with case scenarios that were within their scope of study and practice and also allow them to practice making referrals to social workers and medical professionals.

Additionally, counseling and social work faculty, the two disciplines outside the medical field, actively advocated for all case scenarios used in the training to be truly interdisciplinary in nature. This meant that all the presenting concerns presented by the professional actors needed to provide an opportunity for an interdisciplinary intervention during the referral process. Negotiating these changes in the second year was easier given the professional relationships, trust and mutual respect that had evolved over the year among faculty from the different participating disciplines. Our challenges in negotiating the professional weighting of the training processes are not unusual and are consistent with what Mascari and Webber (2006, 2013) and Mellin et al. (2011) discussed regarding the challenges inherent to cross-discipline practice among professionals who have received specialized training and who have unique professional identities. We should have never assumed that the coordinator of the professional actors, who is based in the medical school, would understand how to prepare the actors to engage with students in a manner that would allow for an interdisciplinary intervention.

During the second year, faculty from the counseling program were more actively involved in the development of scenarios and instructions that would be shared with the professional actors playing the role of clients/patients in the project. In hindsight, the university SBIRT advisory council should have spent more time in deliberations about the potential obstacles that would emerge from interdisciplinary collaboration. We were excited about this new initiative and spent more time discussing the benefits and potential challenges for students rather than for the faculty and staff involved in the project. Thus, some identified challenges persisted in the second year.

Interdisciplinary focus as a goal. We realized the importance of all key participants (faculty and program directors) having a clear understanding of the interdisciplinary training goal of this project. For example and as mentioned, counseling faculty had to advocate multiple times for an interdisciplinary outlook as the curriculum and training protocol was planned and developed. In hindsight, we realize that while the core focus of the project was interdisciplinary training, participants and trainers seemed to return to familiar patterns of silo training as the project was carried out. We are reminded that an interdisciplinary focus requires constant reminders and intentionality to keep the focus interdisciplinary.

Another artifact of the challenges inherent to interdisciplinary initiatives that emerged was that it appeared participants (students) were not fully prepared to receive feedback during the training from

faculty who were not in their own discipline. After the first year of implementation, the program directors placed more emphasis and deliberated at length on how to assist trainees with navigating the dynamics of interdisciplinary training, and a protocol was discussed for addressing student-related training challenges. However, as mentioned above, a similar process was not identified for participating faculty and program directors. That is, at the director level, a process was not articulated for how to assure a truly interdisciplinary focus would be honored during the planning and implementation stages of the project, nor was a protocol developed to articulate how professional disagreements would be managed. While a process for navigating professional differences emerged organically, the absence of such a conversation in the early stages caused tense deliberations as participating faculty and program directors tried to communicate their professional boundaries, roles and functions. Therefore, we recommend that interdisciplinary teams develop protocols for addressing differences in perspectives for both students and training faculty. There is value in investing in leadership that understands the practice of the various disciplines involved in a project and has a commitment to infusing interdisciplinary and collaborative practices in every aspect of a training program (Nancarrow et al., 2013).

Skills for Collaboration

As previously mentioned, some authors have suggested that interdisciplinary collaboration requires particular skills or competencies (e.g., Arredondo et al., 2004; Bemak, 1998; Delunas & Rouse, 2014; Meyers et al., 2013) that are not regularly taught to health care professionals. These authors suggested that working in interdisciplinary teams also requires particular attitudes and special knowledge that are communicated through interpersonal skills.

Collaboration attitudes. Working with others across disciplines requires a certain spirit or willingness to share, collaborate and respect others (Nancarrow et al., 2013). This includes avoiding judgment, working in the spirit of "joining" (Miller & Katz, 2014, p. 7), and overcoming professional hostilities, prejudices or phobias (Bemak, 1998). It also requires openness to collective decision making, an ability to redefine one's role in an interpersonal context (Bemak, 1998) and demonstrating a sentiment of appreciation and accommodation to multiple perspectives (Arredondo et al., 2004). Included here is an ability to be flexible—to "share your street corner" as Miller and Katz (2014, p. 10) put it, or "playing well" with others (Arredondo et al., 2004, p. 791).

Being flexible also means remembering that one professional orientation/approach is not the only valid approach (Bemak, 1998); it requires an ability to be uncomfortable—"leaning into discomfort" (Miller & Katz, 2014, p. 8). An attitude of collaboration also requires being open to feedback (Nancarrow et al., 2013) and a willingness to negotiate power (Bemak, 1998; McLean, 2012). In our SBIRT training project, it appeared that a true spirit of collaboration developed over time among trainers. Its development appeared to emerge, as the examples from earlier discussions in this article illustrate, from the assertiveness and confidence as much as from the flexibility of faculty who may have otherwise been marginalized from decision making. Thus, it is possible that collaborative attitudes are more likely to develop when everyone in the group has had an opportunity to contribute, whether by invitation or self-assertiveness. It is essential to highlight the fact that even counseling and social work faculty, who have been trained to be open to multiple perspectives, engaged from time to time in their familiar silo foundation to professional orientation.

Collaboration knowledge. Interdisciplinary practice requires that individuals have professional competence in their own areas of expertise (Nancarrow et al., 2013) as well as an ability to effectively communicate this discipline-specific information effectively to others (Wellmon et al., 2012). It also requires an ability to learn about the language and roles that define other disciplines (Miller & Katz,

2014; Nancarrow et al., 2013). Knowledge about organizations or systems theory, as well as models of consultation, also is extremely helpful to professionals working across disciplines (Arredondo et al., 2004). Arredondo et al. (2004) and McLean (2012) point to a need to have an intuitive understanding of interpersonal and group dynamics. Finally, Arredondo et al. suggested that awareness of one's own beliefs, values and personal history—all of which are at play when interacting with others—and having "emotional intelligence" (p. 794) are necessary for effective interdisciplinary participation. It appears that as the various members of the interdisciplinary training team in our project asserted their voices at the decision-making table in our project, other trainers were able to learn more about discipline-specific practices and training needs. In order for this process to happen in a way that did not alienate others, we found it necessary to make careful decisions about what to say where and when. Knowledge of how to work in groups and teams was critical, especially for the professionals who were at risk of marginalization in the "collaborative" process.

Collaboration skills. The display of collaboration skills is predicated upon a firm grounding in collaborative attitudes and requisite knowledge, including those mentioned above. Putting these ideas into practice requires strong interpersonal skills such as listening, empathy, humor, facilitation, assessment (Arredondo et al., 2004), ability to participate in power sharing (McLean, 2012), and being able to use feedback to make subsequent changes (Nancarrow et al., 2013). Collaboration also requires problem-solving and decision-making skills (Nancarrow et al., 2013; Wellmon et al., 2012) as well as assertiveness, confidence and ability to communicate one's ideas appropriately (Miller & Katz, 2014; Nancarrow et al., 2013). Finally, most agree that skills for collaboration include being flexible (Arredondo et al., 2004; Miller & Katz, 2014). Power sharing is possible when participants demonstrate competence in their area of expertise as well as interest in learning about collaborators' fields of specialization. As already noted in our training project, the demonstration of professional competence, confidence and the ability to engage interpersonally in the spirit of collaboration and collegiality created an opportunity for power sharing. We also noticed in the SBIRT project that when we were flexible and willing to accommodate other's beliefs and values, they in turn made efforts to accommodate ours.

Conclusion

Counselor educators need to examine pedagogical means of providing counseling students with the knowledge, values and skills to work effectively in interdisciplinary teams. For one counselor education program, the experience of interdisciplinary training provoked passionate dialogue among students and faculty regarding their professional roles, functions, professional advocacy and positioning among other behavioral health professionals. Multiple opportunities for exploring interdisciplinary training and professional identity development processes were evident in the training project described in this article.

Of course, learning about interdisciplinary collaboration does not need to happen solely within a project such as this. Counseling internships typically offer an abundance of opportunities for interdisciplinary collaboration, and the points raised in this article are relevant to all training venues available for counseling students. As mentioned, providing counselors-in-training with a firm foundation in professional orientation both in terms of philosophical underpinnings as well as a clear understanding of their future scope of practice are critical. Additionally, instruction on the scope of practice and roles of other professionals with whom they may be working in practice settings is important. Assuring that counselors enter into internship settings with adequate competence is, of course, critical. But additionally, providing students with positive appropriate feedback so they develop a clear sense of confidence is equally as important for work in collaborative settings.

Finally, offering counseling students "pre-training" in collaborative practice, including the requisite skills and attitudes mentioned in this article, is an important component of preparing counselors for interdisciplinary practice. In training sessions such as these, counseling students should be coached to talk about the work they are trained to do, required to assert their perspective in treatment team decision making and offered feedback on the ways in which their voices are heard by others.

In terms of future directions, an exploration of counseling students' perceptions of the impact of interdisciplinary training on their professional identity development and their ability to work with interdisciplinary teams would be valuable for the field. The outcome of such a study might increase the understanding of the pedagogical experiences that enhance interdisciplinary work competencies for counselors.

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Advising Master's Students Pursuing Doctoral Study: A Survey of Counselor Educators and Supervisors

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This study explored what faculty members are recommending to counselor education master's students regarding post-master's experience when considering doctoral studies and what the current faculty hiring preferences are in reference to the amount of post-master's experience needed. Advisors in counselor education master's programs encounter these questions, and the authors believe the findings are beneficial in helping provide answers. Findings indicate faculty members believe post-master's experience informs supervision, teaching, research and professional identity during the doctoral program and in faculty roles. Findings also indicate faculty members consider the characteristics and circumstances of each individual in determining how important post-master's experience is prior to entering a doctoral program.

Keywords: **counselor education, faculty, supervision, post-master's experience, doctoral study**

An important duty of faculty counselor educators is advising master's-level students interested in obtaining doctoral education. A doctoral degree is designed to provide the student with advanced competencies in clinical practice, classroom instruction, supervision, research and leadership so that the student may serve as a future leader for the profession of counselor education in academic positions (Bernard, 2006; Goodrich, Shin, & Smith, 2011). While the primary focus of the counselor education doctoral degree is to prepare future leaders in the profession (Goodrich et al., 2011), counselor education has historically lacked clear professional standards regarding the amount or type of necessary counseling experience for admission into doctoral programs (Boes, Ullery, Millner, & Cobia, 1999; Schweiger, Henderson, McCaskill, Clawson, & Collins, 2012; Warnke, Bethany, & Hedstrom, 1999).

When applying for and entering a doctoral-level counselor education and supervision (CES) program, it is assumed that the student has achieved the competencies of an entry-level clinician and has met the requirements of a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited master's program (Goodrich et al., 2011). However, few guidelines have been provided to doctoral applicants about the types or amount of post-master's experience (PME) necessary or preferred for optimal hiring into a faculty position, for which CES graduates are uniquely qualified. Lack of guidelines can create confusion about how graduate students can best position themselves for successful academic employment (Schweiger et al., 2012; Warnke et al., 1999).

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Though conventional wisdom may tell us that the more experience one has, the better, we do not have empirical data in the CES field of how counselor educators are advising master's students on this issue, or of what faculty search committees prefer in terms of the clinical experience level of candidates. Thus, this study broadly examines the questions: What are faculty members recommending to counselor education master's students regarding PME when considering doctoral studies? What are current faculty hiring preferences in reference to levels of experience needed? Faculty members, supervisors and advisors frequently encounter these questions from master's students, and the researchers believe students, faculty and ultimately the counseling field will benefit from information clarifying the current industry standard for counselor education.

Research on CES Preferred Clinical Experience

The field of counselor education lacks clear professional standards regarding the amount or type of necessary counseling experience for admission into doctoral programs (Schweiger et al., 2012; Warnke et al., 1999). One study's findings concluded that work experience was a necessary component to doctoral admissions (Nelson, Canada, & Lancaster, 2003). Of the 25 CACREP programs that participated in this study, 20 programs rated successful work experience as a criterion for admission to their doctoral programs. In addition, 16 of those reported that work experience is often helpful or always helpful in selecting good doctoral students. One of their respondents reported difficulty in requiring successful work experience because so few applicants had post-master's counseling experience.

A recent study reviewed the requirements and preferences listed in counselor education faculty position postings on the Counselor Education and Supervision Network (CESNET) between 2005 and 2009 (Bodenhorn et al., 2014). The researchers found 83% of assistant and associate professor position announcements listed counseling experience or licensure as a required or preferred qualification. This remains consistent with a previous finding from Rogers, Gill-Wigal, Harrison, and Abbey-Hines (1998) that counselor education programs ranked clinical experience as the second most important criteria for faculty positions, second only to a PhD in counselor education. Researchers of the 1998 study asserted that although it is clear in their findings that clinical experience is important, whether that clinical experience occurs during internships or outside of coursework is unclear.

These studies showed that experience is prioritized in doctoral admissions (Nelson et al., 2003), as well as in hiring CES faculty members (Bodenhorn et al., 2014; Rogers et al., 1998), yet the counselor education field still lacks important information around this topic. Specifically, the field is lacking data indicating what advice counselor educators give master's-level students about the amount of experience to obtain prior to entering a doctoral program, and data indicating the amount of post-master's clinical experience CES faculty search committees prefer in candidates. The current study addresses these gaps in the literature in the exploration of preferences for PME.

Research on Other Helping Professions' Preferred Clinical Experience

A review of American Psychological Association (APA) accredited clinical psychology programs found academic criteria to be the most important in selecting doctoral students, with achievement of clinical competence also being important (O'Leary-Sargeant, 1996, as cited in Nelson et al., 2003). Another study's findings included that success in a marriage and family therapy doctoral program correlated positively with age, and students with clinical experience were rated as better clinicians than those who did not have clinical experience (Piercy et al., 1995). It should be noted that researchers did not distinguish between participants who became faculty or expert clinicians in their study.

In the related field of social work, Proctor (1996) and Munson (1996) had opposing viewpoints of whether doctoral programs should admit graduate students with fewer than 2 years of post-master's in social work (MSW) experience. Proctor argued that doctoral programs in social work should not require PME because it is a detriment to the field. He justified this viewpoint with the idea that by requiring experience, programs are missing out on students who are research-minded and eager to continue with their education; therefore, programs may lose them to other disciplines. Proctor also argued this requirement delays the onset of careers in social work education and research, with educators and researchers starting often in their late thirties and early forties, behind their counterparts in other disciplines. Munson argued that it is not possible for graduates of social work doctoral programs to fulfill the needs of the field, which include building knowledge, conducting practice research and effectively teaching social work practice, without post-MSW experience.

The research in CES and related fields in the area of experience preferred for doctoral programs and faculty positions is dated. Further, the CES field is lacking data on how counselor educators are advising master's students in terms of amount, if any, of PME that would be beneficial to obtain prior to entering a doctoral program. The field also is lacking clear data on preferences of CES search committees on clinical experience gained outside of program practicum and internships. An exploration of these two questions will equip counselor educators in more effectively advising master's students who are interested in doctoral programs and faculty careers in CES.

Method

The authors used a survey with both closed and open-ended questions to gain both quantitative and qualitative data about the research questions: What are faculty members recommending to counselor education master's students regarding PME when considering doctoral studies? What are current faculty hiring preferences regarding levels of experience needed? Surveys were developed by the research team and piloted among CES colleagues with questions about serving on search committees and what priority considerations are given during a search for CES clinical and tenure-track faculty. Hypothetical situations involving a master's student asking for advice about pursuing a doctoral degree and a search committee situation also were posed in the survey, with space to provide a rationale for the responses, which garnered qualitative data.

Procedure

Access to participants was developed in two different formats, using the same survey. Using a purchased list of 500 randomly selected members of the Association for Counselor Education and Supervision (ACES), half of the names on the list were contacted by postal mail, and half were contacted by e-mail with a request to complete the survey. Response rates have been shown to be higher for surveys sent through postal mail than for surveys sent electronically (Shannon & Bradshaw, 2002) and the researchers aimed to maximize the response rate; however, financial constraints mandated that only half of the surveys be sent through postal mail. Three weeks after the surveys were distributed, a reminder was sent electronically to request completion of the survey, providing the alternative of electronic completion for those who had received the initial request in postal mail. The survey was housed on SurveyMonkey, using the secure feature. The authors input the results in SurveyMonkey for the postal responses.

Simultaneously, the authors sent a survey electronically to the liaison for each of the programs listed on the CACREP Web site as accredited for a doctoral CES program. A question from that survey was used to provide insight about positive and negative impact of post-master's counseling experience on students' performance in doctoral classes.

Participants

One hundred and sixty-six respondents completed the ACES survey (33% response rate). In terms of rank, 35 respondents (21%) indicated they were a professor, 53 (32%) associate professor, 49 (30%) assistant professor, 23 (14%) non-tenure track (clinical or adjunct), and 6 (3%) indicated they fell into an other category. About 51% of the respondents had taught a doctoral-level counselor education course before (84), and the other half had not (81), having only taught master's-level classes. Twenty-seven percent (44) of respondents reported they had never served on a CES faculty search committee. Among the respondents who indicated they had served on CES faculty search committees, 44% (72) master's-level served on 1–4 committees, 19% (31) served on 5–8 committees, 4% (7) served on 9–12 committees, and 6% (10) served on more than 12 committees. Eighteen out of 57 CACREP liaisons responded to the survey (32% response rate). Demographic data was not collected from this group.

Survey Design

To respond to the stated research questions, the authors deemed it was important to request demographic information on rank, programs offered, doctoral teaching experience and the number of search committees on which the participants had served. Two questions were developed asking for level of importance of qualifications when considering candidates for a tenure-track position and a non-tenure track (i.e., adjunct or clinical) position. The qualifications the authors identified were: post-master's counseling, publications, grants, supervision, college teaching, professional organization involvement and professional organization leadership. Participants rated the level of importance as 1 (not at all), 2 (somewhat), 3 (quite a bit) and 4 (extremely). The participants also were asked to provide a minimum quantity for each qualification, if the participant deemed the qualification to be quite a bit or extremely important. The qualifications included were selected based on surveying position announcements for CES positions. Four hypothetical scenarios were presented to the participants that included situations involving serving on a search committee and serving as an advisor to a master's student with particular questions about pursuing a doctoral degree. Each of the hypothetical scenario questions asked for a response and a rationale for that response. Researchers piloted the survey with three faculty members who all reported that the survey was clear. The pilot participants' responses were reviewed to ensure survey questions measured what was intended.

Data Analysis

Authors analyzed the demographic and scaling questions by count and percentages using the SurveyMonkey results produced by the software. The results include numerical count of the participant responses.

The authors analyzed responses to the open-ended comment requests using a constant comparative method described by Anfara, Brown, and Mangione (2002), along with a form of check coding described by Miles and Huberman (1994). The first three authors were the analysis team for this process. Two team members independently conducted a first iteration of assigning open codes for each of the five open-ended questions by reading the data from each question broadly and noticing regularities (Anfara et al., 2002). The two authors then conducted a second iteration of comparison within and between codes in order to create categories and identify themes. The constant comparative method of analysis allows a way to make sense of large amounts of data by organizing into manageable parts first and subsequently identifying themes and patterns.

The third team member served in a peer review capacity (Miles & Huberman, 1994) during the categorizing and theme identification for that question. For each question, different team members were assigned as coders and the peer reviewer. Once the team members assigned individually

derived themes, the team came together and the peer reviewer for each question led the discussion to arrive at consensus for the categories. Each coder presented individually derived themes, listened to the other and, in areas of difference, the team discussed analysis and wording. During this discussion, the peer reviewer clarified and probed using the original comment wording, and the team came to consensus for the themes through this process. These team members sent the themes and the original data for each of the questions to each of the other authors, who served in another layer of peer review to examine the analysis.

Results

Hiring Preferences and Practices for CES Positions

When evaluating applicants for tenure-track CES positions at the assistant professor level, the largest group of respondents (46%) reported that post-master's counseling experience was *quite a bit important*. Forty-four percent of those respondents deemed 2 years to be the minimum number of experience. Also rated *quite a bit important* by most respondents was supervision experience (40%), with a minimum of 2 years of experience (45%), and professional organization involvement (43%), with a minimum of 2 years of experience (33%). As for publications, grants, college teaching and professional organization leadership experience, most respondents (48%, 55%, 35%, and 57% respectively) reported those qualifications were *somewhat important* when evaluating applicants for tenure-track positions. Respondents who deemed these areas as important reported a minimum of 2 publications submitted (41%), 1 year of college teaching experience (49%), and 1 year of professional organization leadership experience (71%).

When asking the same question, but when hiring for a non-tenure-track (clinical or adjunct) CES faculty position, respondents reported a different emphasis on priorities. Most respondents (43%) indicated that PME was *extremely important*, with a minimum number of 2 years (28%), and supervision experience was *quite a bit important* (43%), with a minimum of 2 years (31%). Most respondents indicated grants and professional organization leadership as *not at all important* (74% and 50% respectively), and respondents were split between *not at all important* (48%) and *somewhat important* (48%) for publications. The majority of respondents indicated college teaching (41%) and professional organization involvement (42%) as *somewhat important*.

Seventy-two participants responded to a question to indicate the top three priorities of counseling experience preferred for the most recent tenure-track CES assistant or assistant/associate professor faculty search committee they served on. The majority of respondents (64%) indicated school counseling experience was preferred, while 61% preferred experience with populations diverse in culture or ethnic identity, and 59% preferred experience in community-based agencies. Other areas of experience preference included the following: families (25%), addictions (17%), other (13%), private practice (13%), populations diverse in age (11%), play therapy (9%), populations diverse in religious/spiritual identity (9%), populations diverse in sexual identity (7%), inpatient or day treatment (5%), bilingual (2%) and in-home treatment (1%).

Hypothetical Situation Hiring for Tenure Track

Participants were asked which candidate they would prefer to hire for a tenure-track assistant professor position, given two candidates with all things being equal with one exception. Candidate 1 earned a master's degree, directly entered and completed a doctoral program and then went into the field and gained 3 years of professional experience. Candidate 2 earned a master's degree, directly went into the field and gained 3 years of professional experience, then entered and completed a

doctoral program. One hundred and thirty-eight participants responded to this question. Sixty percent of respondents would prefer candidate 2, 34% would have no preference and 6% would prefer candidate 1. Four themes emerged in the qualitative responses to this question: (1) PME is more relevant and important in training master's students, (2) PME makes the doctoral program more valuable, (3) research staleness and (4) fit.

PME is more relevant and important in training master's students relates to what the candidate would be doing in their role as a counselor educator, and participants reported having the clinical experience following their master's program and prior to their doctoral program was more beneficial in training master's students. One participant indicated:

> This candidate understands what it's like to work in the field with a master's degree—a very different experience than working with a PhD. They will be able to better prepare students for the common pressures and issues of working with a master's (degree) in an agency. This was critical for me as I began teaching.

Another participant spoke to this, specifically in training school counselors:

> (The) candidate needs to understand the professional role of a school counselor. This is best accomplished when employed as a school counselor—then a doctoral program afterwards—allows more thorough research on a profession. They understand at a ground level through personal experience.

The second theme, *PME makes the doctoral program more valuable*, represents participants' beliefs that having the clinical experience prior to their doctoral studies would make that learning more valuable, as they would have practical experience to help make sense of the abstract learning. One participant illustrated this theme: "I believe the post-master's degree experience provides candidates with context that helps make doctoral study richer and more relevant to practice." Another participant pointed to the benefit of PME evident in this theme: "Having experience prior to the PhD allows the (doctoral) student to anchor knowledge and the clinical experiences at the doctoral level, especially courses like supervision."

The third theme, *research staleness*, speaks to participants' concerns that candidates who had been practicing for several years after graduating from a doctoral program would be out of touch with research and writing required in academia. A participant clearly stated this concern: ". . . the candidate that worked after a doctoral program may lose scholarly writing and research skills." Another participant relayed a similar concern:

> I think coming right from the doc-level program would provide some of the most current literature/research knowledge for the new faculty, as well as increase the likelihood that the person is poised to submit manuscripts, have a research agenda and probably would have some grant writing experience. I know how busy the counselors in the field are with client productivity, and I think it's harder to commit to writing and research as a full-time clinician.

Finally, the fourth theme, *fit*, encompasses participants' feelings that either candidate would be fine if they were a good fit for the position and program. One participant shared his or her concern for the individual, rather than when they accrued experience:

They have the same amount of professional experience, just at different times in their career. I think there would probably be some pros and cons to each path. I would be more interested in HOW they each spoke about their experiences and the decision-making process they used.

Another participant stated that either candidate would work: "Regardless of order, the applicant received some of the same experience. Either the doctoral work informed their clinical work or their clinical work informed their doctoral work."

Hypothetical Advising Situations

Researchers asked participants how they would respond to a hypothetical advising situation with a master's student:

> Hypothetically, in October, a master's-level student who will graduate in May comes to you for advice. The student's ultimate goal is to be a faculty member and is planning to apply to doctoral programs for entrance in August. Please indicate what your response would be and explain your response in the space below.

One hundred and forty-two participants responded to this question. Twenty-nine percent responded that their recommendation would depend on the quality of the work accomplished by the student. Twenty-seven percent responded that it would depend on the age and maturity of the student. Eighteen percent responded that it would depend on some other factor. Fifteen percent responded they would encourage the student, and 12% responded that they would discourage the student. Three themes emerged from the explanations related to this question: (1) depends on the quality of the student (quality of work, etc. and things related to readiness), (2) need PME and license and (3) encourage student regardless.

The first theme, *depends on the quality of the student*, includes responses about the quality of the master's student's work, maturity level, life experience and readiness. This participant's response highlights this theme:

> It really depends on the quality of work AND the life experiences and maturity level of the student (not the age, but the maturity level). Thus, if (the student) had high levels of quality work, and had experience in a variety of settings (e.g., volunteering, clinical work, GA, etc.) outside of "just" coursework, and seemed to have a breadth of understanding and perspective (i.e., maturity), then I would encourage the doctoral program. However, if any of these areas were lacking I might discuss the possibility of gaining some experience first before applying. It also depends on how active (the student) was in terms of service at the master's level (e.g., CSI, or community activities).

Although this respondent clearly differentiated maturity from age, other respondents indicated age was a factor, such as this participant: "If the student is younger or has very limited mental health experience, I would probably suggest getting some counseling experience before beginning a doctorate."

The second theme, *needs PME and license*, includes the respondents who felt that regardless of the student qualities, PME and licensure are important. The following quote illustrates this theme: "I would encourage the student to work in the field and gain licensure or certification first. I believe that working provides valuable insight into the profession and prepares professors to be more effective when teaching students."

Finally, on the other end of the spectrum from the previous theme, some respondents said they would encourage any of their students who wished to pursue a doctorate, making up the third theme, *encourage student regardless*. A respondent expressed the opinion, "One can never know the success level of prospective doctoral student[s]. If they have the desire, they should be encouraged to pursue their goal."

In another hypothetical situation, researchers asked respondents the following:

> Hypothetically, a master's student who has the GOAL OF becoming a FACULTY MEMBER asks you for advice. The question asked is how many years of post-master's clinical experience the student should obtain prior to applying to a doctoral program. What would your advice be?

There were 136 respondents to this question. Forty-nine percent would advise at least 2 years of post-master's clinical experience, 21% would advise the student to enter the doctoral program right away without any experience, 13% would advise obtaining at least 3 years of experience, 14% would advise at least 1 year, 3% would advise at least 5 years, and none would advise more than 5 years. Two themes emerged related to the associated rationale for respondents' choices to this question: (1) depends on personal factors of the student and (2) enough time to gain experience.

The first theme, *depends on personal factors of the student,* included factors such as quality of the student, their readiness and maturity level, as well as doctoral program of interest. One respondent spoke to the importance of the student's readiness:

> If the student feels ready to enter the doctoral program, then I would encourage them. I would tell them to trust their own sense of timing. I would not recommend it if they were just trying to get through without being fully interested, eager and invested in the program.

Another respondent stressed the importance of considering each student and the quality of master's performance and desires for the future:

> I did not respond here because it does not include an "it depends" answer, as it depends what experience they have, what they have gained in their master's program, have they gone above and beyond the call of doing the basic requirements of clinical internship in the master's program and what type of faculty member are they hoping to be (e.g., teaching only, research heavy, etc.). Thus, it really depends on the uniqueness of each student as to what I would recommend.

Finally in this theme, some respondents referred to the importance of considering which doctoral programs the student is interested in applying to. One respondent spoke to this consideration here:

> Doctoral programs are designed differently. Some are designed to have clinical hours built in and are good for individuals going straight through while other programs require 2–5 years of work experience in the field and have less supervision and clinical hours.

Other respondents reported that having experience before entering a doctoral program was critical, regardless of the student, making up the second theme, *enough time to gain experience*. These respondents spoke to needing enough experience to earn licensure and supervision licensure and to develop a sense of professional identity first. Many also felt students should get a sense of the field before entering a doctoral program to see if they would prefer to practice at the master's level. The

following respondent spoke to the need for experience primarily to aid in his or her future doctoral student role of supervising and teaching master's students:

> In 2 years, a student would have completed or (be) near completion of licensure requirements and thus have some applied knowledge from which to draw upon. In so doing, the prospective doctoral student would bring experience and be better positioned, hierarchically speaking, to work with master's degree-seeking students. With no experience, the doctoral student may find themselves in a position where they would be supervising or teaching a master's degree-seeking student with greater clinical/life experience creating . . . an interesting power differential.

Similarly, another respondent expressed, "How can one teach or supervise what he or she has not yet experienced?"

Many respondents indicated that gaining licensure before entering a doctoral program was critical: "Licensure in most states requires a minimum of 2 years post-master's supervised work. I think licensure should be required before proceeding." Speaking to the need to develop professional identity and to confirm career goals, a respondent said, "(Two years)—this provides enough time to establish a professional identity, create a track record of excellence in the field and clarify their desire to enter the academy."

Not all respondents believed PME was vital for future faculty members however, as is evident with the following quote: "I entered right away and it worked out fine for me. I don't think it makes a big difference either way." Another respondent expressed concern that students who take time away from school often do not return: "I believe that people who go into post-master's work almost never go back to get their doctorate, no matter how strong the intentions of the person are at graduation."

In a final hypothetical situation, we asked participants the following:

> Hypothetically, a master's student who has the GOAL of becoming an ADVANCED PRACTITIONER asks you for advice. The question asked is how many years of post-master's clinical experience the student should obtain prior to applying to a doctoral program. What would your advice be?

There were 134 respondents to this question. Thirty-eight percent would advise at least 2 years of experience, 16% responded there is no need for a doctoral degree in this situation, 10% would advise that no experience is needed and to enter right away, another 13% would advise at least 5 years of experience before applying to a doctoral program, 13% would advise at least 3 years, 9% at least 1 year, and 1% would advise more than 5 years. Four themes emerged related to this question: (1) uncertainty about the purpose of the question, (2) no need for a doctorate to practice, (3) depends on the student and their attributes and (4) desire to specialize.

The first theme, *uncertainty about the purpose of the question*, encompasses many responses that communicated confusion about the meaning of "advanced practitioner." This is evident in the following quote: "Not sure what you mean by advanced practitioner." The intention of the question was to capture potential guidance given to advisees who may seek to obtain a doctoral degree with a goal to enter or return to the clinical field, or to advance into supervision or administrative positions. However, this theme clearly shows there was confusion among respondents over the question and its intent.

The second theme, *no need for a doctorate to practice*, consists of responses expressing the lack of need for someone to pursue a doctoral degree in order to practice because counselors can become fully licensed at the master's level. As one respondent stated, "A master's degree is a terminal degree. Our 60-hour requirement makes our master's degree an advanced clinical degree. No further coursework is needed for full licensure." This theme also includes responses indicating that a degree in CES does not prepare you for further clinical practice, as this respondent communicated: "Degrees in counselor education are really about preparing someone for a faculty or supervisor position, in my opinion, and often require little in the way of advanced counseling skill development."

For this question, as in many of the others, a theme emerged related to the individual student, *depends on the student and their attributes*. One respondent said that young and bright people can make it happen: "Still believing that bright young people can master most things easily, I don't believe that waiting to get experience is necessary."

The final theme, *desire to specialize*, includes responses indicating the following recommendations: use PME to find a specialization before pursuing a doctorate, PME would make the doctoral program more meaningful, and some students may decide they do not need the doctorate in order to do what they want. A respondent illustrated this theme: "Get some counseling experience and have your counseling license in hand before embarking on doctoral study. Gain some perspective about the areas you want to study in depth, based on what challenges you encounter in actual practice."

Impact of PME on Doctoral Student Performance

Finally, researchers asked CACREP liaisons about the positive or negative impact of post-master's counseling experience on their doctoral students' performance in class. Two themes emerged in the participants' answers: (1) the more experience the better and (2) experience is valuable, but not essential.

In the first theme, *the more experience the better*, respondents described the ways that PME helps doctoral students in the classroom. This includes observations from CACREP liaisons that doctoral students who have worked in the field know what mental health issues look like and how to respond. They also are better able to apply content learned in the doctoral program to practice. PME helps doctoral students feel more confident and increases their credibility with master's students they are teaching and supervising. When doctoral students have PME, they are better equipped to help master's students in their developmental journey. One respondent illustrated some of these thoughts:

> The more experience the better, particularly in terms of supervision and teaching. Without a fairly substantial fund of knowledge about applied practice, doctoral students have difficulty helping master's counselors-in-training understand abstract concepts in practical terms. What does PTSD look like? How do I respond to a client who becomes suicidal in session? . . . Because our doc students begin providing supervision in the first year of their program, I would be particularly concerned if the ONLY experience they had was in their own master's internships. They would be essentially just one year (maybe semester) ahead of those they are supervising.

In the second theme, *experience is valuable, but not essential*, respondents wrote about the experience gained in the master's and doctoral programs being enough. An example of this rationale is shown here: ". . . although we will admit students without post-master's experience, we offer deep clinical experience while in our doc program. Many doc students complete two full years of internship while in the program."

Discussion

The findings of this study help fill a gap in the literature identified by Boes et al. (1999) and Warnke et al. (1999) about the amount of counseling experience needed prior to entering doctoral programs. Goodrich et al. (2011) and Bernard (2006) asserted that doctoral degrees in CES are intended to provide the student with advanced competencies in clinical practice, classroom instruction, supervision, research and leadership so that the student may serve as a future leader for the profession of counselor education in academic positions. Specifically, these findings shed light on what faculty members are recommending to master's students regarding PME prior to entering a doctoral program and faculty members' preferences in hiring colleagues with regard to PME.

PME is important both for doctoral students and faculty members, as is indicated by our findings. According to respondents, experience informs supervision, teaching, research and professional identity during the doctoral program and in faculty roles. These findings are compatible with previous research (Bodenhorn et al., 2014; Munson, 1996; Nelson et al., 2003; Rogers et al., 1998). Nelson et al.'s (2003) findings point to the importance of PME in doctoral admissions. They found this was a helpful factor in selecting quality doctoral students, though their participants reported not all applicants have this experience. As for future faculty members, experience has been found to be important as well by Rogers et al. (1998) and Bodenhorn et al. (2014). Bodenhorn established that the majority of assistant and associate professor announcements on CESNET listed counseling experience or licensure as a required or preferred qualification, and Rogers et al. found that counselor education programs ranked clinical experience as their second most important criteria for faculty positions. Similarly, in the social work discipline, Munson (1996) asserted social work PhDs need to have post-MSW experience in order to fulfill the needs of the field, which include teaching master's-level students and researching to enhance knowledge.

CES faculty spoke to the importance of clinical practice in areas of teaching, supervision and research. Munson (1996) connected clinical experience to research performance in reporting that doctoral students who lack clinical experience tend to avoid practice-related dissertation studies. Similarly, respondents in our study wrote about doctoral students' clinical experience providing fodder for research ideas. Further, clinical experience may validate teaching credibility (Rogers et al., 1998). This was evident in this study's findings as well, along with validating supervision credibility. There was concern among respondents about doctoral students providing supervision to master's students who would possibly be only one semester behind them in experience. In addition, respondents expressed concern that doctoral students and future faculty members with no PME would exhibit rote, by-the-book teaching, rather than drawing on clinical experience to illustrate abstract concepts in counseling.

Though there was much support for PME in our findings, many respondents emphasized evaluating the circumstances of each student individually. Among the circumstances that stood out were age and maturity. Some respondents expressed concern that it can be difficult to return to school once individuals have careers and families. The academic and skill level of the master's student was another factor emphasized by respondents. Proctor (1996) asserted that the social work field might miss out on academically skilled and eager students by requiring PME. This may be a fear for some in the counselor education field as well. Indeed, within this study's findings, there was a tension between academically and clinically gifted students entering doctoral programs right away and the importance of getting experience.

For many respondents, the amount of experience obtained during the master's and doctoral programs is enough, especially in cases where students work in clinical positions while completing their doctoral degrees. Some respondents pointed out that doctoral programs in CES are designed differently, with some emphasizing clinical work as part of the doctoral training and others operating on the assumption that the doctoral student is already an experienced clinician. For example, faculty members might support a master's student going straight to a doctoral program if the student is applying to a doctoral program with robust opportunities to gain clinical experience.

Implications

These findings will help counselor educators better advise master's students who have aspirations for doctoral work. Specifically, this study informs the CES field about the value placed on PME. It may be beneficial for advisors to share the findings of this study with advisees who are considering doctoral programs. In addition, advisors may consider the academic and skill level strength of the master's student and may emphasize more years of clinical experience before applying to doctoral programs to those students who could benefit from the additional experience. Further, students who exhibit more maturity through age and life experience may be perceived as ready to handle doctoral work sooner than those who have entered the master's program immediately from their undergraduate program.

Responses in this study are in line with Goodrich et al.'s (2011) findings that CACREP-accredited doctoral programs train students in somewhat different ways. Advisors may have familiarity with a variety of doctoral programs and can help their advisees consider the cultures of each to find the best fit in terms of experience, as well as other characteristics.

Finally, it appears clear that experience is valuable; thus, advisors would be wise to encourage students to get PME. The findings of this study show that counselor educators believe experience enriches individuals' teaching, supervision and research. As such, master's students will make more effective future doctoral students and faculty members if they gain PME first.

There are limitations to this study that are important to note. While a 33% response rate is considered acceptable, we would prefer to have more than 166 responses. There is likely a portion of professional counselor educators who are not members of ACES and therefore were not included in our sample, and there is no way to determine the numbers or the characteristics of those who choose membership and those who do not. A significant number of the participants had not served on search committees or taught a doctoral class, so those responses might be considered more theoretical than historical. Finally, our hypothetical question related to how participants would advise master's students with the goal of becoming an advanced practitioner was not clear or well received given the confusion evident in the responses. Regardless of these limitations, the results of this study are compelling. Because of the length of the survey, the demographic questions did not include personal demographics such as gender, age, or ethnicity. Similarly, we did not ask for the type of university at which the participant works (e.g., Carnegie research or teaching designation). There may be intricacies of type of university and relevance of experience or advice that were not identified in this study.

Future research is needed on the role PME plays in the development of the counselor educator as a scholar, teacher and academic leader. Additional research exploring the impact of PME on a CES faculty member's success in a faculty role, particularly teaching and supervision, would be helpful to

the field. Furthermore, research delineating the different types of institutions and possibly different qualifications would assist CES advisors. Lastly, research exploring current practices and potential in the CES field for producing doctoral-trained counselors to represent the counseling discipline at the administrative and supervisory levels of mental health facilities may provide beneficial information for advancing the field.

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A Bystander Bullying Psychoeducation Program With Middle School Students: A Preliminary Report

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This study evaluated the effectiveness of a brief, stand-alone bystander bullying psychoeducation program for middle school students. The purpose of the program was to train students to take action as peer advocates. Pre- and post-tests indicated that after completing the 90-minute psychoeducation program, students reported an increase in their ability to identify what different types of bullying look like, knowledge of bystander intervention strategies, and general confidence intervening as peer advocates. Implications for school counselors are discussed, including (1) taking a leadership role in program implementation, (2) having access to a brief, cost-effective bystander training intervention, and (3) applying the ASCA model to a bullying intervention. Directions for further research are discussed.

Keywords: **bullying, bystander, middle school, peer advocates, school counselors, psychoeducation**

Bullying is a prevalent problem associated with emotional and academic consequences in schools nationwide. Because bullying escalates during middle school, middle school counselors need to be equipped with strategies to prevent bullying behaviors. Comprehensive, school-wide interventions are considered the standard for practice; however, they can be difficult to implement. Additionally, there is evidence that programs that do not place a high demand on school time and resources may be effective. Stand-alone bystander programs that train students to be peer advocates provide a promising approach to bullying intervention. The purpose of this study was to evaluate the effectiveness of a stand-alone bystander psychoeducation program on training students to identify bullying behavior, understand appropriate peer-advocate strategies and feel confident in intervening when they observe bullying behavior.

Prevalence and Negative Effects Associated With Bullying

Bullying is recognized as one of the major current problems that youth face (American Educational Research Association, 2013). According to national survey data, approximately one in three students between the ages of 12 and 18 report being bullied at school (Robers, Zhang, Truman, & Snyder, 2012; U.S. Department of Education, 2013). School personnel indicate that bullying is a problem, with 78% reporting that incidents of bullying have either increased or remained the same over time (School Safety Advocacy Council, 2012). In addition, bullying is associated with both short- and long-term psychosocial and academic difficulties. Students who are bullied report anxiety, low self-esteem and depression, a negative attitude toward school, decreased school attendance and lower grades (Rueger & Jenkins, 2014), lower academic achievement (Juvonen, Wang, & Espinoza, 2011; Nakamoto & Schwartz, 2010), and suicidal ideation and attempts (Klomek, Marrocco, Kleinman, Schonfeld, &

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Gould, 2007). Furthermore, students who are bullied are at higher risk of experiencing post-traumatic stress disorder (Nielsen, Tangen, Idsoe, Matthiesen, & Magerøy, 2015) and depression later in life (Ttofi, Farrington, Lösel, & Loeber, 2011). In contrast, students who bully are more likely to use addictive substances in adolescence (Kaltiala-Heino, Rimpelä, Rantanen, & Rimpelä, 2000) and to experience a variety of problems later in life such as higher incidences of antisocial behavior, criminal violence and contact with the police (Renda, Vassallo, & Edwards, 2011).

In addition to students involved in bullying as a target or as a bully, 70% of students report observing bullying at school (Rivers, Poteat, Noret, & Ashurst, 2009). These students, often referred to as bystanders, report a myriad of negative symptomology including somatic complaints, depression, anxiety, hostility and substance use (Rivers et al., 2009). In fact, compared to students who are bullied, bystanders are at greater risk of substance abuse; and compared to students who bully, bystanders are at higher risk of negative nonclinical outcomes (Rivers et al., 2009). Thus, given that bullying can have negative consequences for students, even when they are not directly involved as a target or a bully, it is important for school counselors to consider involving bystanders in interventions or psychoeducation programs.

Bullying in Middle School and the Role of the School Counselor

Currently, all 50 states in the United States have laws governing bullying that require school personnel (administrators, teachers and staff) to take action to intervene and protect students (Stopbullying.gov, 2015). Therefore, it is important for school counselors to be aware of bullying and its impact, as well as to have access to effective interventions. This is particularly important for middle school counselors as the prevalence of bullying increases during the transition to middle school, with 32.7% of middle school students reporting being bullied compared to 28.7% of students in primary school (U.S. Department of Education, 2013). During middle school, students perceive aggression less negatively than in elementary school (Bukowski, Sippola, & Newcomb, 2000) and aggressive behavior toward peers increases (Pellegrini & Van Ryzin, 2011). Additionally, during this time, peer relationships are highly valued and there are disruptions in previously established group affiliations (Pellegrini & Long, 2002). As a result, students may use bullying as a vehicle to gain control and status in an effort to re-establish their social hierarchy in a manner that is beneficial to them (Pellegrini & Van Ryzin, 2011). Given the importance of peer relationships in middle school and the need for students to establish themselves among their peers, it is helpful for school counselors to take on a leadership role in helping students navigate through these developmental issues.

According to the American School Counselor Association National Model (ASCA; 2012), the role of the school counselor has changed significantly, evolving into a leadership position as a systemic change agent based on a comprehensive school counseling program. Thus, counselors are in a heightened position to address bullying. School counselors are seen as leaders promoting student achievement through the delivery of school-wide initiatives that support the academic, career and personal/social development of all students (ASCA, 2012), which includes providing a safe learning environment, exclusive of bullying. Furthermore, accountability measures require school counselors to ensure their programs are in line with the school's mission and the academic, career and personal/social developmental needs of students (Education Trust, 2005). Therefore, implementing a bullying program that empowers students through the development of knowledge, skills and confidence is essential for comprehensive middle school counseling programs. Given that peer relationships are highly valued in middle school, it makes sense to incorporate a relational component in psychoeducational programs.

The Role of the Bystander

Researchers have identified four types of bystander roles: (a) "assistants" who actively and directly help the bully victimize a target, (b) "reinforcers" who laugh at or simply witness the situation, (c) "outsiders" who do not take sides and often disengage or walk away from the group in order to dismiss the situation, and (d) "defenders" who intervene and console the target of bullying (Salmivalli, Lagerspetz, Björkqvist, Österman, & Kaukiainen, 1996, p. 15). Researchers have found that when bystanders reinforce the bully, bullying behavior increases (Salmivalli, Voeten, & Poskiparta, 2011). In contrast, when bystanders intervene, they are able to stop bullying behavior within 10–12 seconds 57% of the time (Hawkins, Pepler, & Craig, 2001). Similarly, within a classroom setting, when bystanders defend the target, bullying behavior decreases (Salmivalli et al., 2011). Because research findings indicate that when bystanders intervene they are effective at stopping bullying behaviors, focusing on bystander behavior is an important aspect of school-based interventions and educational programs.

Comprehensive, School-Wide Bystander Intervention Programs

Because bullying occurs within the context of peer-based interactions (Hawkins et al., 2001) and most students are bystanders at some point in time (Rivers et al., 2009), bystander interventions are an important component of school-wide intervention programs (Polanin, Espelage, & Pigott, 2012). The purpose of bystander interventions is to work with students to teach them to intervene when they observe a bullying situation (Polanin et al., 2012). Recent meta-analyses and reviews of the intervention literature support the effectiveness of comprehensive, school-wide bullying intervention programs that include bystander interventions (Bradshaw, 2015; Polanin et al., 2012).

For example, KiVa, a Finnish acronym for Kiusaamista Vastaan, "against bullying" (Kärnä et al., 2011), is a comprehensive, school-wide program focused on bystander intervention (Salmivalli & Poskiparta, 2012). There are two key components to KiVa: universal actions and indicated actions. Universal actions include training all students within the classroom context about bullying and how to positively impact it through a variety of activities such as discussions, group discussions, role-plays, short films about bullying, and online games and instruction. Indicated actions involve engaging school personnel and students in intervening when an incident of bullying occurs. The intervention consists of several initial staff and teacher meetings, followed by a staff meeting with the bully, a staff meeting with the target, and selecting key students to meet with the target to provide support. Program implementation requires ten 90-minute classroom lessons for students, a two-day training for school personnel, the formation of an implementation team that works with classroom teachers to address indication actions, educating parents and completing annual evaluations. Consequently, KiVa was associated with significant reductions in bullying and victimization among students (Garandeau, Poskiparta, & Salmivalli, 2014).

In a recent study evaluating mechanisms of change, improving bystander behavior in bullying situations was a significant mediator in counteracting bullying (Saarento, Boulton, & Salmivalli, 2015). Reducing students' tendency to reinforce the bully appears to be an effective strategy. The program, however, can be difficult for many schools to implement. First, implementation requires a licensed partner who is an educational expert and can make a long-term commitment to program implementation (KiVa Anti-Bullying Program, 2014). Additionally, the program requires 900 minutes of teacher-delivered instruction in the classroom.

Bully-Proofing (Garrity, Jens, Porter, Sager & Short-Camilli, 2004a, 2004b, 2004c) is another example of a comprehensive, school-wide program that involves training administrators, staff, teachers, bystanders and parents. Bully-Proofing includes (1) increasing awareness of bullying, (2) working with targets to increase protective behaviors and skills, (3) working with students

who bully to change their behavior, and (4) changing the school climate to increase peer bystander interventions (Garrity et al., 2004b, 2004c; Menard & Grotpeter, 2014). As part of the Bully-Proofing classroom curriculum, teachers train students to intervene when they observe bullying (Garrity et al., 2004b). Students learn the CARES strategies which include, "creative problem solving," "adult help," "relate and join," "empathy," and "stand up and speak out" (Garrity et al., 2004b, p. 117). Students are trained to use these strategies when they observe bullying behavior. Implementation of Bully-Proofing includes administration of classroom management and rules, parent information and training, a minimum of 15 hours of teacher preparation, and 270 days of program implementation for students and teachers (Menard & Grotpeter, 2014).

In a recent study examining the effectiveness of Bully-Proofing (Menard & Grotpeter, 2014), researchers found the program was associated with decreased rates of victimization and perpetration relative to a control group. Additionally, students participating in the Bully-Proofing program reported higher perceptions of school safety during program implementation. Similarly to KiVa, however, the program requires a significant commitment of school resources as it is time intensive and relies on teacher instruction for program delivery.

Realistic Stand-Alone Bystander Interventions

Although comprehensive, school-wide programs including bystander components are effective in reducing bullying (Bradshaw, 2015; Polanin et al., 2012), many schools do not have the resources to implement time-intensive, multi-component programs. Thus, it may not be practical for schools to adopt comprehensive school-wide programs as they can be difficult to implement due to required resources, including time allocation and potential cost of materials, which is often dependent upon the size of the school and the school's specific needs. Therefore, it is important to realistically identify brief, cost-effective programs to promote school adoption and implementation.

Although limited, research on brief, school-based interventions provides preliminary evidence that stand-alone bystander programs are a promising alternative to comprehensive, school-wide programs. In one study examining the effectiveness of a brief, school-based program with a bystander component, researchers investigated the effects of training students from available classrooms during three 30-minute online sessions (Evers, Prochaska, Van Marter, Johnson, & Prochaska, 2007). A 10-page family guide and staff guide were also provided to participants' families and teachers. Results showed that students who received the intervention reported a decrease in bullying participation and identifying with the role of bully, target and passive bystander (Evers et al., 2007). In another study, researchers adapted KiVa, focusing only on the teacher-delivered curriculum segment of the intervention and shortening that piece from 20 hours to 8 hours (Andreou, Didaskalou, & Vlachou, 2008). The researchers found positive short-term outcomes regarding students' attitudes toward bullies and victims, perceived efficacy in intervening in bully-victim incidents, and actual rates of intervening behaviors.

Although brief, school-based interventions with bystander training are a promising strategy for bullying prevention and intervention, there is a need for further research into programs that provide education to increase student ability to identify what bullying behavior looks like, strategies they can use to intervene when they observe bullying and the confidence to intervene. It also is imperative to develop school-based interventions that can be implemented with limited time and resources. In contrast to school-wide interventions, brief, school-based interventions with bystander training can be implemented on a smaller scale and have the potential to be cost effective. Following ASCA's promotion of a leadership role for school counselors as systemic change agents, there also is a need for further research shifting implementation from teachers to school counselors in interventions

specific to bullying. Given the demands already placed on teachers, a leadership role in program implementation can be better suited for school counselors. This research would form a foundation for establishing school counselors as bullying prevention and intervention leaders or liaisons, promoting program implementation at their school.

This study serves as a first step in extending the literature by evaluating a brief, stand-alone bystander psychoeducation program in a middle school setting. In contrast to other brief, school-based programs, we chose to focus exclusively on bystander psychoeducation. We also were interested in developing a counselor-based psychoeducation program developed to teach students to identify bullying behaviors and intervene as "defenders." To meet this aim, we created a new program, STAC ("stealing the show," "turning it over," "accompanying others," and "coaching compassion"). STAC is a modification of the CARES bystander component of Bully-Proofing described above. STAC was adapted for school counselors to coordinate program implementation without relying on teacher instruction. The aim of the training is to teach students to identify bullying at school and intervene as peer advocates and to develop confidence with the STAC strategies. STAC is comprised of a didactic and experiential component described in detail in the psychoeducation program section. The purpose of the study was to evaluate whether or not the STAC psychoeducation program (a) increases student ability to identify what different types of bullying look like, (b) increases student knowledge of specific strategies that can be used to intervene appropriately, and (c) increases student confidence in their ability to intervene.

Method

Participants

Students from two Northwestern schools were recruited over two academic semesters. Students were recruited from a student body of 992 sixth through ninth grade students. One school counselor from each school coordinated program implementation. The school counselor at each school determined how many students per grade level to train as peer advocates. They made their determination based on the assumption that the training would be conducted annually, and that the number of peer advocates would increase over time. The school counselors at each school decided that if approximately 10% of the student body were trained annually, this would be sufficient to help shift the school bullying culture over time. Additionally, they made their determination based on the number of students they felt they could adequately support as peer advocates. After determining the number of students to train, a school counselor in collaboration with key teachers and staff at each school selected between 8–14 students per grade level to participate in the training. The counselors selected a total of 78 students who belonged to different peer groups and were perceived as possessing positive personal qualities such as maturity, leadership and responsibility.

After students were selected, the school counselor at each school briefly met with each student to discuss potential interest in the training. The school counselor emphasized that they were chosen because adults in the school believed they had positive qualities and would make a difference. Of these, 75 students expressed interest in being part of the training. Interested students were sent home with an informed consent to be signed by a parent or caregiver and returned to the school counselor. A school counselor at each school followed up with a phone call to a parent or caregiver when necessary. Of these 75 parents or caregivers, 74 provided consent. After the school counselor collected the signed parental informed consent, she met with each student briefly to explain the research in more detail and collect student assent. All students with parental or caregiver consent assented to participate in the research.

The final sample consisted of 74 students (51.4% female and 48.6% male), 49 from one school and 25 from the other school. Participants ranged in age from 12–15 (M = 13.42 and SD = .90), and were primarily Caucasian (89.2%), with 4.1% African American, 4.1% Asian American or Pacific Islander, and 2.6% Hispanic. The sample was similar to the total student population, with the exception that Hispanic students were underrepresented in the study sample with 2.6% of students reporting their ethnicity as Hispanic compared to 8.6% in the student population. Power calculations indicated the current sample size should yield power of ≥ 0.80 to detect a small effect size.

Procedures

A separate psychoeducation training was conducted at each school. Students at each school completed a 90-minute training during classroom time. The program, which is described in the Psychoeducation Program section below, was held in the school's library or an available classroom and was conducted by graduate students in a master's in counseling program. Two graduate students conducted the audiovisual presentation, and an additional two students were available to help facilitate activities and role-plays discussed below in the Psychoeducation Program section. Participants completed a pre- and post-test to measure the effectiveness of the training. The pre-test was conducted immediately prior to the training and the post-test was conducted immediately after the 90-minute training. All study procedures were approved by the university Institutional Review Board as well as the school district's review board.

Instruments

The Student-Advocates Pre- and Post-Scale was developed by the researchers to measure the effectiveness of the STAC training. The questionnaire is comprised of 11 items rated on a 4-point Likert-type scale ranging from "I totally disagree" to "I totally agree." Items were developed to measure the effectiveness of the training in increasing ability to identify what different types of bullying look like, knowledge of STAC strategies and confidence in intervening to stop bullying. The following items measured ability to identify different types of bullying: "I know what verbal bullying looks like," "I know what social/emotional bullying looks like," "I know what cyberbullying looks like," and "I know what physical bullying looks like." Knowledge of STAC strategies was measured by the following items: "I know how to use humor to get attention away from the student being bullied," "I know how to reach out to the student being bullied," "I know how to ask for help from an adult and report bullying at my school," and "I know how to offer suggestions for empathy when someone is bullying a student." Finally, confidence in intervening items included: "I feel confident in my ability to do something helpful to decrease bullying at my school," "I feel comfortable being an advocate to stop bullying at my school," and "I feel like I can make a positive difference against bullying at my school." Finally, a Total Scale was created by summing all 11 items. Cronbach's alphas for the Total Scale was a = .77.

Content validity of the questionnaire was established through professional review of the items. The three professional reviewers selected were a school counselor, a school teacher and a university faculty member with experience in instrument design. The items were generated by the first author to reflect the content of the training. The first author then elicited feedback from the three professionals. The feedback included revising language and formatting to be developmentally appropriate for this age group. The three reviewers agreed that the items appeared to measure the three areas described above. The pre-test was administered immediately prior to the training, and the post-test was administered immediately after the training. The pre- and post-tests were administered 90 minutes apart.

Psychoeducation Program

The first author, a school counselor, and two graduate students enrolled in a master's in counseling program collaborated to develop the STAC intervention. The primary purpose of the intervention is to train peer advocates to recognize bullying and possess the knowledge and confidence to intervene appropriately. The leadership role of the school counselor and the collaborative implementation of the STAC intervention are integral components of school-wide changes and are supported by the themes of the ASCA National Model, which includes leadership, advocacy, collaboration and teaming, as well as systemic changes (ASCA, 2012). The intervention is intended to increase student knowledge, provide skill-building opportunities, and increase confidence, all of which support the ASCA developmental domains of personal/social, academic and career growth (ASCA, 2012) for all students overtime.

The STAC intervention is an adaption of the Bully-Proofing CARES strategies (Garrity et al., 2004b). The CARES strategies were modified and the acronym was renamed STAC to accommodate the modifications and provide a simple mnemonic device for students. The first modification provided a strategy that focuses directly on utilizing humor as an intervention. This is important because humor is associated with popularity and social likeability in adolescence (Closson, 2009; Quatman, Sokolik, & Smith, 2000), thus providing students with a positive strategy for establishing themselves within their social hierarchy. Therefore, the CARES strategy "creative problem solving" was modified to "stealing the show" to focus directly on using humor to intervene. The CARES strategies "adult help" and "stand up and speak out" were kept, but renamed "turning it over" and "coaching compassion," respectively. These strategies were renamed so that a new acronym that included "stealing the show" could be created that would be easy for students to recall. Finally, the CARES strategies "relate and join" and "empathy" were kept, but combined because the researchers did not want to separate empathy from the action of befriending or consoling the target, renaming them "accompany others."

The CARES training also was adapted for school counselors to become leaders in implementation, without relying on teachers instructing the curriculum. Instead, counseling graduate students provided the training, which included a didactic and experiential component. Two counselor education students conducted the didactic component of the training, and six graduate student trainers were available to facilitate the experiential component. The same two students conducted the audiovisual presentation at each school, while a different group of graduate students facilitated the experiential role-play component. However, the number of graduate students present to conduct the program was the same at both schools. There were a total of eight graduate students per training; two to conduct the audiovisual presentation and six to facilitate the role-plays. The two students who conducted the didactic component of the training are the third and fourth authors and helped develop the STAC strategies. The researchers trained the graduate student trainers. More specifically, the two graduate students who conducted the didactic component practiced the audiovisual presentation on their own. Then they presented to the first author and received feedback. The two presenters practiced for a total of 4 hours, one of which was with the first author. The first, third and fourth authors also trained two additional graduate students per grade level who volunteered to facilitate the experiential component. The focus of their preparation was to become proficient with the STAC strategies. Furthermore, the researchers also discussed behavioral management strategies to utilize during the training with the middle school students if necessary. The researchers provided the graduate student volunteers with the STAC strategies and role-plays ahead of time. Then, the researchers met with the additional trainers for 3 hours during two separate meetings. During those meetings, the researchers presented an overview of the STAC training, discussed the STAC strategies and role-plays, and discussed behavioral management strategies for engaging

middle school students. Behavioral strategies included discussing behaviors graduate students could expect to observe and how they could respond positively through strategies such as waiting patiently for students to quiet down, counting backwards to gain students' attention, and engaging students by saying "if you can hear me, high-five your neighbor." Additionally, the researchers encouraged graduate students to move closer to middle school students when addressing them, engage respectfully with students, and utilize developmentally appropriate language and tone of voice.

STAC Strategies. Trainers taught students four strategies they could utilize when they observed bullying at school. The intent of the strategies was to provide peer advocates with a vehicle for expressing qualities and skills they possessed to engage with peers in a positive manner to intervene when they observed bullying situations. Trainers indicated that peer advocates did not have to utilize all four strategies. Instead, trainers encouraged peer advocates to focus on developing the strategies that seemed best suited for their personality and felt natural to them.

Stealing the Show. This involves using humor to turn students' attention away from the bullying situation. Peer advocates can implement this strategy in a manner that seems natural to them and in line with their personality. This way the intervention feels authentic and the advocate does not stand out in the peer group. Trainers indicated that peer advocates could utilize their sense of humor when they observed bullying to displace the attention away from the target. Trainers provided examples such as telling a funny joke or pretending to trip by acting silly.

Turning it Over. "Turning it over" involves informing an adult about the situation and asking for help. During the training, students identify safe adults at school who can help. Students are taught to always "turn it over" if there is physical bullying taking place or if they are unsure as to how to intervene.

Accompany Others. This involves the peer-advocate reaching out to the student who was targeted to communicate that what happened is not acceptable, that the student who was targeted is not alone at school, and that the peer-advocate cares about them. This can be accomplished subtly by spending time with the student who was bullied and inviting them to participate in a shared activity such as playing basketball or going for a walk. The strategy also can be implemented more directly by helping the student process his or her feelings about being bullied while offering support. Trainers taught this to students by providing examples of how they could utilize this strategy such as approaching a peer after they were targeted and inviting them to go for a walk during recess.

Coaching Compassion. "Coaching compassion" involves gently confronting the bully either during or after the bullying incident and communicating that his or her behavior is unacceptable. Additionally, the peer-advocate encourages the student who bullied to consider what it would feel like to be the target in the situation, aimed at fostering empathy toward the target. Peer advocates are encouraged to consider implementing "coaching compassion" when they have a relationship already established with the student who bullied, or if the student who bullied is in a younger grade and the peer-advocate believes the bully will respect them.

Didactic Component. The didactic component of the training was 50 minutes and included an ice-breaker exercise, an audiovisual presentation and hands-on activities to engage the students in the learning process. As the students entered the room where the training was conducted, a trainer handed them a card with a symbol on it. Then, students were asked to sit at the table where the symbol was displayed. This was done so that students had an opportunity to sit next to others whom they may not regularly interact with at school. After the trainers introduced themselves and welcomed students to

the training, they facilitated an ice-breaker exercise. Trainers asked students to look into a brown bag for a few seconds that contained random items such as crayons, pencils, and paperclips without any specific directions. After all students had an opportunity to look in the bag, the trainers asked students to recall what they observed. Generally, students were somewhat confused and could not recall all the items. At that point, the trainers explained that it is helpful to know what to look for in specific situations in order to be effective; therefore, the goal of the training was to help students become aware of what to look for to identify and intervene when they observe bullying at school.

After the ice-breaker, trainers conducted an audiovisual presentation teaching students about (a) the definition and different types of bullying (i.e., physical, verbal, relational, and cyberbullying), (b) the different roles associated with bullying (i.e., target, bully, and passive and active bystander), (c) the negative consequences associated with bullying, and (d) the STAC strategies for intervening. To maintain students' attention and engage them in the learning process, graduate students incorporated small group activities throughout the audiovisual presentation. After the trainers introduced the different types of bullying, they provided students at each table with one posterboard, markers, pencils, and crayons, and asked them to write or draw examples of bullying they have observed at school. Each table was asked to address a different type of bullying (i.e., physical, verbal, relational, or cyberbullying) within four different contexts including (a) their classroom; (b) areas of the school or periods of time when adults often are not monitoring (e.g., hallways, staircases, bathrooms, and before and after school); (c) physical education class; and (d) recess. After the small groups completed their work, trainers asked a representative from each group to share their poster with the larger group.

Next, after presenting the negative consequences associated with bullying, trainers provided students with a blank piece of paper and asked them to write down a bullying situation they have observed at school without including any names. Then, trainers invited students to crumple the paper up, and "throw" it at the trainers. The aim of this activity was to provide levity after presenting information that could potentially cause some level of emotional distress for students and for the researchers to learn more about the different types of bullying students observe at school. The presenters informed the students prior to the activity that they would randomly select a few examples to be shared with the group. Finally, the audiovisual component of the training concluded with a discussion of the STAC strategies.

Experiential Role-Play Component. The experiential component of the training lasted 25 minutes. After discussing the STAC strategies, trainers divided students into small groups by grade level and practiced utilizing the STAC strategies through set role-plays. Role-plays included hypothetical bullying situations that students can encounter at school. For example, "at lunch break, some of the boys you are friends with love to 'table top' people. While they are running, the boys will dive in front of them with the intention of tripping them. Often times the people they are targeting end up falling flat on their face and really get hurt, even though they pretend it was funny. How can you use your STAC strategies here?" The role-plays were developed in conjunction with the school counselors at the two schools where the trainings were conducted.

Trainers asked for student volunteers within each small group to act out the different characters embedded within the role-play. While one of the trainers briefly practiced the role-play with the students who volunteered, another trainer engaged the remaining students in preparing for a different role-play. Once the student volunteers were ready, they acted out the role-play. After they completed the enactment, the other students in the group were asked (a) what type of bullying was portrayed and (b) what STAC strategies could they utilize? After discussing the answers to the questions above, the trainers asked for another student volunteer to join the role-play and act as a peer-advocate utilizing

the STAC strategies to intervene. After the group conducted the role-play a second time with the peer-advocate intervening, trainers facilitated a discussion processing the STAC strategy utilized and suggesting other strategies and the possibility of linking more than one strategy together. Students practiced all strategies through four different role-plays covering the different types of bullying discussed during the didactic component of the training. Each role-play lasted approximately 5 minutes. All peer advocates who participated in the training were part of a small group and invited to be an actor in a role-play or practice utilizing a strategy.

Training Conclusion. The training concluded with the small groups coming together and each student sharing his or her favorite STAC strategy, signing a petition indicating "bullying stops with me," and receiving a certificate of participation. The training conclusion lasted 15 minutes. After the STAC training, the school counselors at each school provided ongoing informal support to students, including checking in with them individually or in small groups.

Results

Data were examined for extreme cases that might impact the results of the analyses including skew and kurtosis. We did not identify any outliers and all variables were within the normal range. Paired sample t-tests were conducted to examine the change in each item and the total scale score from pre-training to post-training (we selected the paired sample t-test as it is the appropriate statistical test to use when comparing means in correlated, matched pairs samples). All analyses were conducted at $p < .01$ to control for Type I error.

Means, standard deviations, t values, p values, and Cohen's d values are presented in Table 1. Results indicated participants reported significant increases on all items with the exception of identification of what physical bullying looks like. Examination of the means suggests a ceiling effect; that is, students' baseline ability to identify physical bullying was already quite high ($M = 3.7$, $SD = .49$). There also was a significant change for the total scale score from pre-test to post-test. As seen in Table 1, with the exception of the physical bullying item, all effect sizes were in the medium to large range. Examination of the effect sizes revealed that the STAC strategy "asking for help" and two confidence items "I feel comfortable being an advocate to stop bullying at my school" and "I feel like I can make a positive difference against bullying at my school" had the lowest effect sizes among the items.

Discussion

The purpose of this study was to serve as a first step in extending the literature evaluating the immediate impact of a brief, stand-alone bystander psychoeducation program in a middle school setting on increasing student ability to identify what different types of bullying look like, student knowledge of specific strategies that can be used to intervene appropriately, and student confidence in their ability to intervene. Overall, results supported the STAC program as a promising method for equipping bystanders to be advocates in addressing bullying at school. More specifically, after completing the training, students reported a significant increase in their ability to identify what different types of bullying look like, knowledge of the STAC strategies and general confidence intervening in bullying situations. This was true for identification of different types of bullying (i.e., verbal, social/emotional, and cyberbullying), knowledge of the STAC strategies (i.e., stealing the show, turning it over, accompanying others, and coaching compassion), and confidence in intervening

(i.e., confidence in doing something helpful, comfort in being an advocate, and belief in ability to reduce bullying). There was, however, no significant increase for identification of physical bullying, which 98% of students indicated they could identify at baseline.

Table 1

Means, Standard Deviations, and Contrast Between Pre- and Post-Training

	Pre-Training		Post-Training				
Item	*M*	*SD*	*M*	*SD*	*t*(73)	*p*	Cohen's *d*
Identification of Bullying							
Verbal Bullying	3.44	.55	3.85	.36	6.23	< .001	.75
Social/Emotional Bullying	3.28	.70	3.78	.43	5.42	< .001	.68
Cyberbullying	3.43	.66	3.78	.49	4.77	< .001	.65
Physical Bullying	3.70	.49	3.84	.34	1.92	.06	.23
Knowledge of STAC Strategies							
Stealing the Show	2.97	.67	3.73	.50	8.50	< .001	.96
Accompanying Others	3.33	.58	3.80	.41	6.70	< .001	.84
Turning It Over	3.35	.63	3.66	.52	3.79	< .001	.44
Coaching Compassion	3.01	.69	3.74	.44	8.02	< .001	.96
Confidence Intervening							
Do Something	3.41	.59	3.76	.44	5.58	< .001	.74
Advocate	3.54	.57	3.74	.46	2.75	.008	.38
Make a Positive Difference	3.43	.51	3.64	.49	2.89	.005	.38
Total Scale (11 items)	3.35	.34	3.76	.31	9.77	< .001	.89

Results of this study suggest that a brief 90-minute training is effective in increasing peer advocates' ability to identify different types of bullying behavior, knowledge of strategies that can be used to intervene when they observe bullying, and confidence to intervene. According to Polanin et al. (2012), these are the necessary components needed to equip bystanders to intervene when they observe bullying behavior. Thus, although we did not measure whether or not the peer advocates used the STAC strategies, the current findings suggest that the STAC intervention provided the students with the knowledge and confidence needed to intervene in bullying situations.

We also were interested in examining specific areas of growth in knowledge and confidence. Examination of the item effect sizes revealed that of the significant items, three were in the medium range. These items were the STAC strategy "asking for help" and two confidence in intervening items (i.e., advocating to stop bullying and making a positive difference at school). One possible explanation for why students' scores were lower on turning a bullying situation over to an adult may be related to the importance students place on peer relationships during middle school (Pellegrini & Long, 2002).

Students might be hesitant to turn away from their peer group and ask an adult for help instead. Regarding the smaller effect sizes for two of the confidence items, it is possible that confidence in one's skills as an advocate may be more difficult to change than knowledge. Because skill acquisition for children is largely related to practice (Diamond & Lee, 2011), greater changes in confidence are likely to be reported after students have an opportunity to use the STAC strategies over time.

Results of this study provide preliminary support for the use of STAC as a brief, stand-alone bystander psychoeducational program. This is consistent with prior research on brief, stand-alone programs designed to change bystander behavior and reduce participation in bullying (Evers et al., 2007) and change attitudes and increase efficacy and rate of intervening (Andreou et al., 2008). Taken together, these finding are important because although comprehensive, school-wide programs are considered the standard for practice (Bradshaw, 2015), they place high demands on schools in terms of time allocation and resources. In contrast, brief, stand-alone bystander interventions can provide easy to implement, cost-effective alternatives to school-wide programs.

Limitations and Directions for Future Research

While this study contributes to our understanding of how to equip student bystanders to be advocates to stop bullying at school, certain limitations should be considered. First, students were from predominantly Caucasian Northwest schools, thus limiting the generalizability of the results. Additionally, the sample size was relatively small, further limiting the generalizability of our findings. Thus, it is important for future research to be conducted with a larger and more diverse sample. Further, information was obtained through self-report. Self-report can potentially lead to biased or distorted reporting, including social desirability, resulting in students rating items higher after the training, particularly due to the recent exposure of the training. Self-report, however, is a common practice in counseling research and provides useful information in learning more about programs designed to address bullying in schools.

Additionally, participants were not randomly selected; instead, school counselors invited students to participate based on student attributes that were deemed appropriate for becoming peer advocates. Further, Hispanic students were underrepresented. Thus, selection procedures and the resulting sample also limit the generalizability of the study results. Another limitation is that the study design did not include a control group. Thus, it is not clear if study outcomes were related to selection variable, the STAC training or unmeasured variables. Future research using random assignment and a randomized controlled design in which students are randomly assigned to a STAC training group or a wait-list control group would improve the validity of the study.

Finally, the questionnaire used in this study was designed to measure outcomes specifically for STAC training. We used procedures to establish content validity for the questionnaire. Content validity, however, is not as strong as establishing criterion-related or construct validity, which was beyond the scope of this study. Future studies using questionnaires with established psychometric properties would strengthen the research examining the effectiveness of the STAC training.

Although the current study represents an important first step in evaluating the effectiveness of a brief, stand-alone training, this study was limited to examining changes in ability to identify what bullying looks like, knowledge of the STAC strategies and confidence intervening when bullying is observed. We did not examine (1) student retention of the STAC training information by administering a second post-test to students later in the semester (2) whether students used the STAC strategies learned during the training, (3) social and emotional outcomes for students trained

in the STAC strategies, or (4) if providing the STAC training impacts the prevalence of bullying. Thus, directions for future research include examining outcomes such as implementation of STAC strategies post-training, the social/emotional impact of using STAC strategies on the peer advocates, and the efficacy of the STAC training in reducing bullying behaviors at school.

Implications for School Counselors

This study has practical implications for school counselors. The findings provide preliminary evidence for a brief, stand-alone bystander psychoeducation program in increasing bystanders' knowledge of bullying and confidence intervening when they observe bullying at school. In addition to equipping bystanders to intervene, unlike comprehensive, school-wide programs, the STAC training can be brief and cost effective, allowing schools to have access to program implementation on a broader scale. The implementation of a stand-alone bystander program also can establish school counselors as leaders in addressing bullying in their schools since school counselors do not have to rely on teachers to instruct students through the context of their classroom setting.

School counselors can work collaboratively with a counselor education program at a local university to implement the STAC training and strategies as a brief, stand-alone bystander intervention program. This can be helpful to school counselors because they can be leaders and liaisons in implementation, without having the task of developing another program to be implemented at school. Furthermore, after implementing the STAC training and strategies, school counselors can follow up with small group activities for the middle school students who were trained as peer advocates. The small groups can serve several purposes: (a) to check in with peer advocates assessing whether they utilized the strategies and found them helpful, (b) to support peer advocates in implementing the strategies by practicing role-plays based on situations encountered, teaching advocates to link two or more strategies together, and discussing how peer advocates can work as a team in relevant situations, and (c) to learn more about bullying at school through a student perspective to guide future interventions. This is consistent with the ASCA National Model that emphasizes group activities specific to student needs and interests and supports a comprehensive school counseling program that impacts all students (ASCA, 2012).

Conclusion

This study evaluated the effectiveness of a brief, stand-alone bystander bullying psychoeducation program for middle school students. Results indicated the STAC training was effective in increasing students' ability to identify what different types of bullying look like, knowledge of the STAC strategies, and general confidence intervening as a peer-advocate. Findings provide preliminary support for the use of STAC as a brief, stand-alone bystander program, thereby providing school counselors with a low-demand approach that equips students to intervene as bystanders. This study is a first step in assessing the effectiveness of the STAC program, providing a foundation for future research examining the impact of STAC training on reducing bullying behaviors in the school setting.

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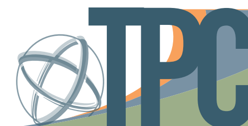
Considering the Cycle of Coming Out: Sexual Minority Identity Development



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Coming out is a decision-making process regarding disclosure of identity for sexual minorities. Existing literature on the coming-out process highlights a singular, linear emphasis, failing to highlight the recurring task of disclosure that sexual minorities endure. The purpose of this manuscript is to highlight the cyclical nature of the coming-out process and the importance of recognizing this cycle when counseling sexual minority clients. A case application is provided to illustrate the proposed cycle of coming out. Implications for counselors and suggestions for future research are discussed.

Keywords: **sexual minority, coming-out process, identity development, decision-making, disclosure**

Coming out is a pivotal process in the lives of sexual minority (e.g., lesbian, gay and bisexual) individuals. The term *sexual minority* is utilized in this paper to be both succinct and inclusive. Beyond the internal process of development, coming out is an interpersonal, diverse process of disclosure. During the lifetime, individuals may face various opportunities to disclose identity; each scenario may have unique implications that are essential to consider in regard to client safety. When counseling clients through the coming-out process (COP), it is essential to recognize the social context encompassing each unique occurrence in the lifelong cycle of coming out. The purpose of this manuscript is to highlight the recurring process of disclosure as we (a) address the stressors and benefits of coming out, (b) outline the social layers of coming out, (c) examine strengths and limitations of current models pertaining to coming out, (d) emphasize the importance of addressing coming out in counseling, and (e) introduce the application of a cyclical framework of the coming-out process through a case illustration.

Stressors and Benefits of Coming Out

Sexual minorities face considerable personal dilemmas regarding coming out. Coming out may be a threatening process as stigmatization and marginalization are by-products of sexual prejudice (Dermer, Smith, & Barto, 2010). Stressors include, but are not limited to, fears pertaining to acceptance, bullying, harassment, safety and oppression (Coker, Austin, & Schuster, 2010; Gay, Lesbian, and Straight Education Network [GLSEN], 2010). It is widely acknowledged that during the coming-out process, individuals may experience negative emotions (Bernal & Coolhart, 2005; Chutter, 2007; McDermott, Roen, & Scourfield, 2008). Internal discord may prompt feelings of loneliness, disconnection, confusion, grief, shame, anger, fear, vulnerability and depression that lead to potential suicidal ideations (Human Rights Campaign [HRC], 2013; Lewis, Derlega, Berndt, Morris, & Rose, 2001). Individuals facing this internal conflict may suffer from low self-esteem as low confidence and incongruence in identity prompts individuals to expend energy on suppressing identity. This stifling often prompts impulsive, negative coping mechanisms such as substance use,

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self-harm and engaging in risky sexual behaviors (Degges-White, Rice, & Myers, 2000; McDermott et al., 2008; Parks & Hughes, 2007).

Sexual minorities are faced with the risk that not everyone will understand or accept their identity. Individuals may react in a multitude of ways that include shock, hostility, confusion and disappointment. Reactions may reach levels of harassment and abuse. In choosing to disclose, sexual minorities must accept the risk that relationships, regardless of closeness, may permanently change. Regardless of a sexual minority's internal awareness, acceptance and congruence, it is important to acknowledge the risk involved every time one chooses to disclose their identity, thus highlighting the cyclical, recurring decision-making process every time one reveals their identity. Therefore, it is essential for counselors to be aware of the stressors involved in the coming-out process in order to effectively aid clients.

Although stressors exist, the decision to disclose one's sexual minority identity may be enticing and empowering. From enduring the process, individuals may experience coming-out growth (Vaughan & Waehler, 2010). Researchers often have discussed that coming out may improve the quality of one's life (Floyd & Stein, 2002; Mohr & Fassinger, 2003; Morris, Waldo, & Rothblum, 2001; Oswald, 2000; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). Moreover, studies have shown relationships between disclosing identity and reduced levels of distress. Rosario and colleagues (2001) learned that positive attitudes towards identity were related to lower anxiety and depression among sexual minority youth. Similarly, in a study of 2,401 lesbian and bisexual women, Morris and colleagues (2001) found that coming out reduces psychological distress. Furthermore, identity disclosure also has been associated with positive and strengthened identity, which often improves resilience and overall mental health (Floyd & Stein, 2002; Mohr & Fassinger, 2003; Oswald, 2000)

The interpersonal process of sharing a piece of one's self may prompt an individual to feel more honest, open and authentic with others; thus, coming out may enhance social skills and functioning (Savin-Williams, 2001; Stevens, 2004). Disclosing identity may help to form new relationships or to deepen existing relationships (Oswald, 2000; Savin-Williams, 2001). Coming out may be related to closeness for individuals who disclose in a relationship (Berger, 1990). The presence or absence of support following identity disclosure may help individuals to determine how to create healthier boundaries (LaSala, 2000; Oswald, 2000). Beyond personal relationships, outness may be linked to interest and involvement in advocacy. Individuals who have disclosed report an increased interest in changing judgmental, biased attitudes of individuals who may display prejudice (Oswald, 2000). Coming out has the potential to provide an array of benefits from individual to societal levels. Counselors who are informed and prepared have the potential to support clients who are coming out and assist in facilitating such benefits.

Layers of the Coming-Out Process

Sexual minorities may experience multiple layers when coming out, which may include factors of disclosing to family members, friends, various communities and professional colleagues throughout the lifespan (Datti, 2009; Espelage, Aragon, Birkett, & Koenig, 2008; Joos & Broad, 2007; Rickards & Wuest, 2006; Treyger, Ehlers, Zajicek, & Trepper, 2007; Waitt & Gorman-Murray, 2011). Therefore, the COP is better conceptualized as a cycle of coming out that includes several processes throughout an individual's lifetime. Familial disclosure is typically a salient layer, as reactions from family to identity disclosure exist on a spectrum of happiness and acceptance to anger and abandonment (Lewis, 2011; Pearson, 2003). The stressors of coming out have the potential to divide a family as some

members may ascribe to heterosexist beliefs and not be accepting of the individual (Gorman-Murray, 2008). Sexual minority youth must consider the potential ramifications of disclosing their sexual identity, particularly in conservative households. Due to differences in beliefs and consequential conflicts, sexual minority youth are often beaten, disowned and kicked out of their homes (Bernal & Coolhart, 2005). According to Hilton and Szymanski (2011), the entire familial unit is affected by the disclosure. Siblings may feel concerned for the sexual minority sibling, angry or disappointed with parental reactions, consider the changes that would need to occur for themselves, and prepare to deal with the challenge of heterosexism. Children of sexual minorities also are affected by disclosure. According to Joos and Broad (2007), adult children reported experiencing feelings of fear, terror and secrecy. It is suggested that the family as a whole endures a process of coming out that includes elements of embracing identity, integrating as a family, building social networks and experiencing social awakening (Baptist & Allen, 2008).

Another layer of the cycle of coming out (CCO) that is important to consider is peer disclosure. When sexual minorities choose to acknowledge their identity publicly and reveal to their peers, they often are met with threats, assaults, harassment and hostility (Alderson, 2003; Chutter, 2007; Degges-White & Myers, 2005). A 2010 report by the GLSEN revealed that almost 90% of sexual minority students heard the term "gay" used negatively, 61% felt unsafe at school due to identity, almost 85% experienced verbal harassment, and 40% experienced physical harassment. Given that peer groups are constantly evolving, sexual minorities must face disclosure to multiple peer groups over the course of their lifetime and hence the coinciding reactions, effects and consequence are important to consider and validate.

In addition to family and peer groups, societal messages highlight the marginalized status given to individuals who identify outside of the heterosexist binary established in Western society. This marginalization provides the foundation for the unique, complex process of identity development and disclosure for sexual minorities (Cooper, 2008; Dermer et al., 2010; Israel & Selvidge, 2003). For example, sexual minorities must consider disclosure toward those within their inner social circles (e.g., family, friends) as well as to individuals who are outside of this intimate realm (e.g., colleagues, employers, neighbors, strangers). With each decision, sexual minorities may experience persistent emotions, thoughts and behaviors associated with previous instances of coming out, highlighting the importance of acknowledging the recurring experience of sexual minority status that reaches beyond the scope of a pivotal one-time occurrence.

Need for Counselor Preparation

Counselors' competence in working with sexual minority clients requires counselors to be affirmative, open, supportive and utilize holistic approaches in assisting clients through the COP (Bidell, 2005; Cooper, 2008; Israel, Ketz, Detrie, Burke, & Shulman, 2003; Rutter, Estrada, Ferguson, & Diggs, 2008). Within this spectrum, a variety of topics have been considered as aspects to contribute to counselor preparedness such as ethical issues, terminology, awareness of current issues and willingness to advocate. Israel and colleagues (2003) conducted a modified Delphi study in an effort to better understand sexual minority counseling competencies. They surveyed professional experts who had published at least one book, book chapter, or article on lesbian, gay, and/or bisexual (LGB) clients as well as sexual minority clients who had experiences in counseling. Results indicated that out of 31 highlighted skills, the ability to assist clients through coming out was ranked as the third most important skill for working with sexual minority clients by professional experts and fourth most important skill by sexual minority experts. Although coming out is ranked highly as an important skill in assisting LGB individuals, clients are consistently dissatisfied with counselors' abilities to

assist in counseling. Nadal and colleagues (2011) conducted a qualitative study of 26 LGB clients. Participants noted several concerns with their counselors such as discomfort or disapproval, use of heterosexist language, assumption of pathology or abnormality, assumption of a universal LGB experience, exoticization and threatening. Similarly, Shelton and Delgado-Romero's (2013) study noted similar issues such as avoidance or minimization of identity, making stereotypical assumptions about identity, assumption that sexual orientation is the cause of presenting issues, and expressions of heterosexist bias.

In addition to client dissatisfaction, counselors have noted their own lack of confidence in helping sexual minority clients (Bidell, 2005; Israel & Selvidge, 2003). Oftentimes counselors have high awareness pertaining to sexual minority concerns; however, there is a lack of knowledge and subsequent skill (Bidell 2005; Farmer, Welfare, & Burge, 2013 Grove, 2009; Rutter et al., 2008). Experts have suggested methods to increase counselor competence such as assessing for social desirability in students, increasing positive attitudes and utilizing roleplay (Dillon & Worthington, 2003; Israel & Selvidge, 2003; Kocarek & Pelling, 2003). It is essential for counselors to be competent in order to be ethical and effective with sexual and gender minority clients (American Counseling Association [ACA], 2014; American Mental Health Counselors Association [AMHCA], 2010; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013). In an effort to increase counselor awareness, knowledge, skills and overall effectiveness in assisting sexual minority clients, we propose that particular attention should be given to understanding the factors of coming out. The proposed cycle of coming out may assist in better preparing counselors to assist sexual minority clients and may thus contribute to an increase in sexual minority competence overall.

Conceptualization: Past and Present

Since the 1970s, several researchers have acknowledged the importance of the COP and have created models to describe it (Alderson, 2003; Cass, 1979, 1984; Cooper, 2008; Degges-White & Myers, 2005; McCarn & Fassinger, 1996; Troiden, 1989). Although considerable research has been targeted toward understanding the COP, models vary considerably and encompass factors such as awareness, disclosure, community membership and intimate experiences. Researchers often place coming out within the overarching process of sexual minority identity development (e.g., Cass, 1979; Coleman, 1982). Additionally, coming out is commonly noted as a singular event that occurs as a stage within sexual minority identity development (Cass, 1979; Chapman & Brannock, 1987; Coleman, 1982; Minton & McDonald, 1983; Troiden, 1989). Common stage approaches assert a stepwise method to coming out (Cass, 1979; Fassinger & Miller, 1996; Minton & McDonald, 1983; Troiden, 1989), failing to demonstrate the complexity of coming out.

Eli Coleman's (1982) "Developmental Stages of the Coming Out Process" denotes potential age ranges in which coming out should occur; however, recent findings contradict this limited scope and critique the rigidity of such models (Degges-White & Myers, 2005; Dunlap, 2014; Floyd & Stein, 2002; Guittar, 2013). In a study examining milestone events of sexual minority individuals ages 16 to 27, Floyd and Stein (2002) found that some experienced coming out "early" ($n = 29$) while others experienced coming out beyond age 18 ($n = 43$). Contrary to the age implications suggested in early developmental models, coming out occurs well into adulthood as studies have explored the coming-out process for adults disclosing throughout the lifespan (Fruhauf, Orel, & Jenkins, 2009; Treyger et al., 2008).

Another concern with linear models is that research does not support the sequential transition from stage to stage. In 2000, Degges-White, Rice, and Myers conducted a qualitative study of 12 lesbian women. Results indicated that not all participants aligned with Vivienne Cass' *Homosexual*

Identity Formation Model (1979). Cass' six stages include (1) identity confusion, (2) identity comparison, (3) identity tolerance, (4) identity acceptance, (5) identity pride and (6) identity synthesis. Although all 12 participants experienced the initial stage of confusion and fourth stage of acceptance, the remaining four stages were not experienced by all participants. Further, the stage of identity pride, which is associated with visible demonstration of identity in the community, was only experienced by five women. The lack of alignment between participants' experiences and Cass' (1979) original model may be partially explained by the model being based on the experiences of adult white males. Some researchers acknowledge the rigidity of stages and propose phases instead; however, the stepwise approach is predominant in existing models on coming out (Fassinger & Miller, 1996; McCarn & Fassinger, 1996).

Models of coming out emphasize the internal process of identity awareness (e.g., Cass, 1979; Chapman & Brannock, 1987; Coleman, 1982). Although the internal process does require attention, the emphasis on this aspect causes the external process of disclosure to lose attention. Researchers utilize constructivist perspective to acknowledge the social factors at play in the coming-out process (Cox & Gallois, 1996; Fassinger & Miller, 1996); however, the process in which an individual evaluates disclosure for multiple interpersonal encounters and relationships is not thoroughly addressed in a manner that may assist counselors in helping sexual minority clients. In an effort to expand the conceptualization of the coming-out process, Fassinger and Miller (1996) proposed a phase model of coming out that acknowledged both a personal and social process; however, the social aspect addresses the individual joining the sexual minority community rather than the interpersonal task of disclosure to individuals at large. In 1983, Minton and McDonald noted the need to highlight the cyclical nature of disclosure that includes a cost-benefit analysis and changing life situations; however, no current model emphasizes the cyclical process of disclosure in which an individual, regardless of personal awareness, acceptance, and comfort, is continually confronted with the decision to disclose identity throughout the lifespan. Thus far, research has focused on confirming conceptual models rather than clarifying the pure reality of coming out for sexual minority individuals.

Therefore, we conceptualize the COP as a task that is related to the internal process of identity development; however, we highlight the interpersonal process of disclosure. Regardless of identity security, sexual minority individuals are faced with the task of disclosure throughout the lifespan (Chutter, 2007; McCarn & Fassinger, 1996; McDermott et al., 2008). Coming out is a decision-making process in which social situations activate an individual's awareness of the opportunity to disclose identity and the subsequent process of assessment and potential disclosure that ensues. Identity disclosure is an anxiety-provoking and potentially dangerous process in which counselors must acknowledge and be prepared to assist clients within counseling. We attempt to contribute to filling the gap in counselor preparedness by proposing a cyclical framework to assist clients through the COP.

The Cycle of Coming Out

The process of coming out is recurring and is influenced by a variety of factors (e.g., society, family, peers) that may overlap or interchange. Moreover, the cycle of coming out is a lifelong journey that influences the daily lives of sexual minorities (ALGBTIC, 2013; Chutter, 2007; Cooper, 2008; Cox, Dewaele, Van Houtte, & Vincke, 2011; Floyd & Stein, 2002; HRC, 2013; Hunter & Hickerson, 2003; Klein, Holtby, Cook, & Travers, 2015; McCarn & Fassinger, 1996). The cycle of coming out is a framework developed to assist counselors in understanding, recognizing, conceptualizing and

helping clients through the process of coming out. This framework supports the idea that individuals may experience instances of awareness, assessment and disclosure in phases rather than stages during the COP. Unlike stages that imply a sequential, linear trajectory of the process of coming out, phases embody the fluidity in which an individual may navigate through the process (i.e., variance in order, skipping a phase, simultaneous occurrence of phases, return to previously endured phases).

The coming-out cycle recognizes that a main factor contributing to the variability among sexual minorities is the external process of disclosure. Disclosure is the core concept in this cyclical process; therefore, this framework emphasizes the necessity of counselor awareness in order to validate and aid sexual minority clients through their COP. The following sections outline the three phases in the cycle of coming out: (a) awareness phase, (b) assessment phase, and (c) decision phase.

Awareness Phase

In the overarching process of sexual identity development, awareness entails an individual's recognition of sexual identity and external process in which an individual recognizes an opportunity for identity disclosure. Although triggers vary, common examples may include meeting a new person for the first time, being questioned about identity, or the desire to be open and honest in relationships with others. Awareness may be associated with confusion and contemplation (Alderson, 2003; Cass, 1984; McCarn & Fassinger, 1996; Riley, 2010).

An individual may be aware, congruent and grounded in sexual minority identity; however, societal contexts pose triggers that spark the social disclosure process. For example, an individual may identify as homosexual and his or her family and close friends may be aware of identity; however, being asked about family by a coworker may prompt him or her to consider whether or not he or she would or should disclose identity (Datti, 2009). Therefore, stressors may prompt individuals to re-experience their COP regardless of sexual minority identity development. New, unfamiliar situations raise the question of whether or not an individual should choose to disclose identity. When this prompt is posed, individuals may relive stressful risks related to coming out such as feelings of anxiety, depression, isolation, frustration and anger (Cass, 1984; McCarn & Fassinger, 1996; Pearson, 2003). In this process, individuals are at risk for negative coping mechanisms associated with coming out such as promiscuity, substance use and destructive behaviors at large (Chutter, 2007; Degges-White et al., 2000; McDermott et al., 2008; Parks & Hughes, 2007).

Assessment Phase

The assessment phase is characterized by the analysis of whether or not it is appropriate, necessary or warranted to disclose. Exploration of alternatives regarding action or inaction is often displayed. In the assessment phase, energy is expended on planning and considering potential outcomes. Regardless of how long an individual has openly identified as a sexual minority, assessment may be influenced by past experiences in the coming-out cycle. Worries prompted with the awareness phase increase as actions are planned; hence, risks during the awareness phase, such as anxiety and depression, have the potential to be exacerbated. If an individual has had a positive experience with disclosure, the assessment phase may not be a difficult process. However, if an individual has endured negative reactions to disclosure, the assessment phase may include more hesitance, anxiety and overall analysis (Joos & Broad, 2007). An individual needs to re-address the pros and cons related to coming out within the given context. Therefore, although an individual may have previously chosen disclosure, that does not necessitate the automatic disclosure in future circumstances.

In this phase, it is important to ensure that the client is internally prepared to handle the decision-making process. A counselor should aid the client in recognizing outside influences that may affect

the decision-making process such as health concerns or situations of grief. The assessment phase may elicit negative emotions related to stress, anxiety and depression that prompt the need to cope. Establishing a positive support system is an essential component in preparing the client during the assessment phase. Support systems may include individuals who have positively experienced the client's disclosure process, support groups, peer mentors or community agencies.

During the assessment phase the counselor needs to have the safety of the client in mind at all times (Cooper, 2008). Counselors should assist clients in determining a safety plan within the cost-benefit analysis related to disclosure (Floyd & Stein, 2002). Main aspects of safety planning in the assessment phase include fostering positive self-esteem, exploring appropriate methods for coping and establishing social supports (Bernal & Coolhart, 2005; Chutter, 2007; Degges-White et al., 2000; Grove, 2009). Safety planning should consider dangers at intrapersonal and interpersonal levels. Through assessment, the counselor may be able to recognize that a client may be in a situation in which disclosure may be unsafe, although that client may be unaware. For example, a sexual minority youth who is deciding to disclose identity to a conservative parent or legal guardian should consider the danger ahead in the event that the disclosed identity is not accepted positively. The counselor should assist in thoroughly processing the client's action plan and potential consequences (Lewis, 2011). For example, possible repercussions of disclosure may include physical abuse, homelessness, neglect and excommunication from family members. Contrastingly, a client is not free from consequences if the decision to not disclose is chosen; instead, the client may be at risk for internal discord such as feelings of sadness, isolation, confusion, anger, shame and depression. Subsequently, such sentiments could cause the client to turn to self-harm or suicide (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; McDermott et al., 2008). Counselors should collaborate with the client to create a safety plan that considers the potential consequences of the client's choice. This safety plan is essential in assuring safety as the client transitions into the decision phase.

Decision Phase

The decision phase encompasses an individual's commitment to disclosing or withholding identity (McCarn & Fassinger, 1996; McDermott et al., 2008; Troiden, 1989). Commitment to a decision may provide the client with feelings of self-acceptance, fulfillment, synthesis, pride, resilience, happiness, strength, courage and overall improved quality of life (Floyd & Stein, 2002; McCarn & Fassinger, 1996; McDermott et al., 2008; Troiden, 1989; Vaughan & Waehler, 2010). However, the decision phase may be influenced by feelings of fear, confusion, vulnerability and uncertainty (HRC, 2013). Due to these risks, it is beneficial for the client to follow the previously established safety plan. The previously developed plan from the assessment phase is followed through in the decision phase. Clients may battle with conflicting emotions and concerns with congruence; however, it is important to recognize risks and the various layers involved in the decision to disclose.

The power of choice is understood to be within the client; however, in assuring the client's safety, it is helpful for the counselor to be realistic, open, honest and genuine in aiding the client to address concerns prior to disclosure (Chutter, 2007; Degges-White et al., 2000). The essential responsibility of the counselor in the decision phase is to continue to support clients in executing their process. In addition, it is important to follow up on personal reactions, adjustments in relationships, and safety plans that may be components in the decision phase (HRC, 2013; Riggle, Gonzalez, Rostosky, & Black, 2014). Reflecting on the recurring process may assist in integrating the current process into the narrative of the client's overall coming-out experiences. The CCO is intended to be a flexible approach that allows counselors to utilize their theoretical orientation within the awareness, assessment and decision phases. Counselors may be creative in utilizing interventions of their choice

that align to phase goals. The following case provides an example of how to incorporate the cycle of coming out with a client.

Case Application

Jane is a 28-year-old middle school teacher who initiated counseling due to concerns with her increasing anxiety. Jane's anxiety has been increasing within recent months; she also is concerned about the necessity of medication management. In the intake interview, Jane identifies as lesbian and states she has been "out" for a decade. When asked about her experience with coming out, she shares that she first disclosed her identity to her parents and has been warmly accepted since that very day. She also states that she is embraced by her friends; however, acceptance was not always the case. In high school, Jane developed feelings for her best friend of five years, Sarah. Unfortunately, Sarah did not share Jane's feelings and took it upon herself to "out" Jane to the entire school.

In exploring the root of anxiety, social factors are considered in counseling. Jane informed the counselor that she experiences anxiety in uncertain situations, but it often subsides. She noticed her anxiety level when applying for her current job a few months ago. This is not her first job or her first time enduring anxiety with the interview process. Jane happily reports that she obtained the job and is now working as an eighth grade teacher in a new school. Although she enjoys her job, she is upset that her anxiety has not diminished since her employment.

When a cyclical perspective of coming out is shared with Jane, she is able to reflect on her experiences. Jane notes that throughout her life, regardless of her own comfort level, she has experienced at least some level of anxiety when disclosing to others. Jane clarifies that the anxiety with disclosing has been severe in some cases, such as when she disclosed to her college roommate and grandparents. Jane shares a recent incident in which a colleague made inappropriate remarks pertaining to a student who identifies as gay. Since then, Jane has noted the teacher's homophobic jokes and believes that the instructor treats the student unfairly. Recognizing the injustice, Jane has been concerned about the student as she noticed an increase in bullying and lack of the support from the teacher. As Jane is disclosing these recent events, the counselor notices she becomes tearful, is speaking rapidly, and is having difficulty breathing. In the moment, the counselor's first priority is to de-escalate Jane's increased anxiety. It is important to note that her natural demonstration displays a link between the predicaments at work and her anxiety, and also shows that the situation is influential and meaningful to Jane.

Case Discussion

The case of Jane illustrates how a cyclical model of coming out can be helpful in counseling. Applying the cyclical model may begin prior to counseling itself, as with any intake process, it is essential to gather thorough, pertinent information for case conceptualization. One common mistake at this pivotal point would be to minimize Jane's coming-out process. From the intake paperwork, we know that Jane has been open with her sexual identity for 10 years; however, we do not know what this means for Jane's overall identity. Individuals define "out" differently; out can mean that identity is shared with individuals who are deemed important or can mean that the individual specifically discloses to individuals beyond the personal realm. Due to fear, in some cases individuals are more comfortable sharing identity with acquaintances rather than close individuals. Probing about coming out should be handled delicately, with care and respect, as the therapeutic alliance may be threatened if the client presumes that the inquiry is trivial, insensitive or thoughtless.

Awareness Phase. When Jane clarifies her experiences with coming out, it is essential to understand the importance of what Jane discloses pertaining to her previous experiences as they may have influenced her development. For one, Jane was fortunate to have a positive experience with her nuclear family; it is possible that this experience caused her to have an optimistic perspective regarding identity disclosure. The genuine respect and care from her parents is helpful for Jane overall; however, it may have caused her to presume she would certainly receive similar approval when disclosing to others. Secondly, the societal perspective of coming out as a one-time process may have caused Jane to only assess the positives and negatives of disclosure in reference to her parents and may have prompted her to undermine future disclosure. Finally, it is important to consider that disapproval from her friends and subsequent marginalization may have contributed to her previously disclosed experiences with anxiety.

Jane shares helpful information to better understand her reported anxiety. As recognized by Jane, stress in new situations, such as interviews or jobs, may prompt anxiety; however, it is important to note that this steady maintenance of anxiety is uncharacteristic. Although Jane explicitly states that she enjoys her job, it is possible that she may be reminded of her previous experience being "outed" in high school. Additionally, her new environment may have triggered her to consider identity disclosure, and, unbeknownst to Jane, she may be in the cycle of coming out. Specifically, the recent occurrence at work may have triggered Jane to re-experience the turmoil associated with her past experiences. Therefore, it may be helpful to discuss this view with Jane in order to collaborate in understanding her anxiety and planning for counseling.

Assessment Phase. It is possible that the scenario at work may have prompted Jane to the phase of assessment in which a cost-benefit analysis of disclosure is warranted. The assessment process should be gentle and collaborative; Jane should explore potential avenues as the counselor serves as the helpful facilitator. Pros and cons to the assessment phase vary per individual; however, useful variables to consider include (a) motivation, (b) importance and (c) safety. The bullied student may be at the epicenter of Jane's motivation. On one hand, Jane has the ability to model appropriate disclosure and provide support, respect and acceptance for the student in a time of need. On the other hand, intrinsic motivation is needed in addition to advocacy as the decision should be congruent with personal values and beliefs regarding identity. For example, disclosure to colleagues may not be an important value; however, advocacy may be a strongly held value and thus eliciting such meaning may influence the decision-making process. It is important to consider perceptions of importance held by the counselor and client. For example, the counselor may believe that coming out displays congruency and assists individuals in leading fulfilling lives. However, simplifying the coming-out process to a personal decision uninfluenced by societal factors is unrealistic. A counselor may regard disclosure as a necessary decision, causing the client to ignore the assessment phase and be in a place of danger. Regardless of motivation and meaning, assessment of safety is paramount. Certain environments may be toxic for sexual minorities and disclosure may cause danger. It is important to caution minimizing lack of disclosure as "passing." An individual can be secure in identity; however, disclosure could prompt harassment or violence. A person has the right to choose when to disclose or to withhold personal information, and this choice does not bear influence on identity synthesis. When navigating the assessment phase with Jane, it is important to assist in covering the subtopics of motivation, importance and safety while validating and supporting the process.

Decision Phase. Following a thorough evaluation of the risks and benefits of coming out and the importance of coming out for Jane's values, Jane proceeds into the decision phase. Similar to the assessment phase, safety is a primary concern in this phase. If Jane chooses to not disclose,

it is important to clarify that her identity is not influenced by her choice. When clients choose to not disclose, there are often ramifications for self-worth; however, it is helpful to delineate that disclosure is a difficult task that is not always the answer. Since coming out is cyclical, a decision to disclose does not deem future decisions, as each scenario is comprised of unique variables. Therefore, if an individual chooses to disclose in one context, that does not immediately prompt all future disclosures. Due to context, an individual can select to waiver and choose between instances of disclosing and withholding personal identity information. If Jane chooses to disclose, it would be helpful to develop a disclosure plan in which she considers her method of disclosure, potential outcomes and plans for safety. The role of the counselor in this process is to assist in developing a disclosure plan that is consistent with Jane's wishes and values, addresses the range of outcomes, and consistently supports Jane throughout the process. Beyond counseling, Jane should be provided resources for support that may include supportive family and friends, books, Web sites, movies and LGB-affirmative centers. Counseling should provide Jane with a safe space to process her plan and overall process. Processing should validate the experience, discuss the process in relation to values, and consider plans for future COP. Since the cyclical nature of coming out is undermined in our society, counseling provides an important space to recognize the strength and resilience warranted in the process.

Implications for Counseling

It is essential for counselors to collaborate in order to utilize the client's definition of coming out, educate their clients on the cycle of coming out, and recognize their own biases. Coming out is often conceptualized as linear not only in the field of counseling, but in the lives of clients as well. Clients may or may not recognize the implications of coming out and the cyclical nature at large; therefore, it is important for counselors to assist in exploring beyond a one-time culminating event. However, it is equally as important to not force a cyclical perspective on a client. The counselor facilitates exploration, but it is unethical to attempt to change clients' opinions and values or impose decisions (ACA, 2014; AMHCA, 2010).

Counselors should utilize their knowledge of the recurring cycle by educating their clients of this occurrence and affirming the overall experience. Conjointly, counselors and clients can process the potential to be in the awareness phase. Table 1 displays areas to consider when counseling a client who is coming out. A counselor should be knowledgeable of the recurring process of coming out and the potential risks and associations that may surface. A client who is triggered into the awareness phase may have anxiety, confusion and stress regarding the question of disclosure. These stressors may be misdiagnosed or underrepresented clinically if there is a lack of focus on the actuality of the potential cause (Pearson, 2003). Counselors should consider the client's current status of identity in separate forms; the counselor may collaborate with the client to understand the client's individual definition of sexual minority identity and how the client chooses to define being "out." Counselors should assist in acknowledging risks, recognizing experiences and validating emotions when a sexual minority client has been triggered and is in the awareness phase (Bernal & Coolhart, 2005; Chutter, 2007). This overall analysis and subsequent clinical action may aid in alleviating risks and stressors as it prompts counselors and clients to address the concern directly.

We aimed to specify the coming-out process for sexual minority clients; however, we do not wish to undermine this experience for gender minorities as well. When considering gender identity and the potential interaction with relationship orientation, the coming-out process may become more complex. Further, the primary internal process may have different implications in considering

instances of disclosure. We do not wish to exclude the potential utilization of this model for gender minorities; however, we also do not wish to disrespect unique identities by suggesting a one-size-fits-all approach. It is possible that this model may be applied to gender and other minorities as well; nevertheless, we do not wish to minimize the unique experience of other minority identities. Furthermore, research is needed on the coming-out process as a cyclical occurrence for various minorities.

Table 1.

Phases of Coming Out and Areas to Explore

Phase	Areas to Explore
Awareness Phase	Does the client identify as a sexual minority? Is the client questioning sexual minority identity? Does the client identify as "out"? Has the client disclosed sexual minority identity previously? Is there a present trigger prompting the client to consider disclosure? Is the client experiencing mental health concerns as an effect of this phase?
Assessment Phase	Is the client actively considering disclosure? Is disclosure important to the client? What are the client's motivations for disclosure? What are the client's perceived benefits for disclosing? What are the client's perceived consequences for disclosure? Is the client experiencing mental health concerns as an effect of this phase? Is the client's safety at risk?
Decision Phase	Has the client assessed the benefits and consequences of disclosure? Is the client adhering to the safety plan? Who does the client have as a support system? Is the client experiencing mental health concerns as an effect of this phase?

Conclusion

The American Counseling Association (2014) encourages counselors to support the "worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (p. 3). It is essential for counselors to be aware of and acknowledge experiences of sexual minorities' coming-out processes throughout their lives. In addition to supporting the safe, nurturing environment required for counseling during these times, a counselor has the responsibly to identify heterosexism, homophobia and prejudice that underlie the need for the multiple processes endured. A client may be clouded by his or her experience and may be unable to accurately assess the situation at hand; hence, it is the counselor's duty to assist in understanding and shedding light on the surrounding scenario. Further, counselors need to understand the varying contextual layers applied to each unique process within the cycle in order to best assist sexual minority clients. Practitioners should be cognizant of the potential for variables to serve as catalysts or obstacles in the unique, complex cycle of coming out and to address these matters in counseling (ALGBTIC, 2013). Although the continual nature of

coming out is implied in existing frameworks, it is not emphasized. Counselors should acknowledge the recurring cycle in an effort to better assist sexual minority clients (ALGBTIC, 2013; HRC, 2013). Future research is needed in order to emphasize the cycle of coming out rather than a linear, simplistic and unrealistic process. Additionally, effective clinical methods that consider the cycle of coming out as influential should be included in mental health counselor training in order to better assist minority clients in counseling.

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Development and Factor Analysis of the Protective Factors Index: A Report Card Section Related to the Work of School Counselors

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The scale development and exploratory and confirmatory factor analyses of the Protective Factor Index (PFI) is described. The PFI is a 13-item component of elementary students' report cards that replaces typical items associated with student behavior. The PFI is based on the Construct-Based Approach (CBA) to school counseling, which proposes that primary and secondary prevention activities of school counseling programs should focus on socio-emotional, development-related psychological constructs that are associated with students' academic achievement and well-being, that have been demonstrated to be malleable, and that are within the range of expertise of school counselors. Teachers use the PFI to rate students' skills in four construct-based domains that are predictive of school success. School counselors use teachers' ratings to monitor student development and plan data-driven interventions.

Keywords: **protective factors, factor analysis, school counselors, construct-based approach, student development**

Contemporary models for school counseling practice (ASCA, 2012) emphasize the importance of school counselors using quantitative data related to students' academic achievement to support professional decisions (Poynton & Carey, 2006), to demonstrate accountability (Sink, 2009), to evaluate activities and programs (Dimmitt, Carey, & Hatch, 2007), to advocate for school improvement (House & Martin, 1998) and to advocate for increased program support (Martin & Carey, 2014). While schools are data-rich environments and great emphasis is now placed on the use of data by educators, the readily available quantitative data elements (e.g., achievement test scores) are much better aligned with the work of classroom teachers than with the work of school counselors (Dimmitt et al., 2007). While teachers are responsible for students' acquisition of knowledge, counselors are responsible for the improvement of students' socio-emotional development in ways that promote achievement. Counselors need data related to students' socio-emotional states (e.g., self-efficacy) and abilities (e.g., self-direction) that predispose them toward achievement so that they are better able to help students profit from classroom instruction and make sound educational and career decisions (Squier, Nailor, & Carey, 2014). Measures directly associated with constructs related to socio-emotional development are not routinely collected or used in schools. The development of sound and useful measures of salient socio-emotional factors that are aligned with the work of school counselors and

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that are strongly related to students' academic success and well-being would greatly contribute to the ability of counselors to identify students who need help, use data-based decision making in planning interventions, evaluate the effectiveness of interventions, demonstrate accountability for results, and advocate for students and for program improvements (Squier et al., 2014).

Toward this end, we developed the Protective Factors Index (PFI) and describe herein the development and initial exploratory and confirmatory factors analyses of the PFI. The PFI is a 13-item component of elementary students' report cards that replaces typical items associated with student deportment. The PFI is based on the Construct-Based Approach (CBA) to school counseling (Squier et al., 2014), which is based on the premise that primary and secondary prevention activities of school counseling programs should be focused on socio-emotional development-related psychological constructs that have been identified by research to be associated strongly with students' academic achievement and well-being, that have been demonstrated to be malleable, and that are within the range of expertise of school counselors. The CBA clusters these constructs into four areas reflecting motivation, self-direction, self-knowledge and relationship competence.

The present study was conducted as collaboration between the Ronald H. Fredrickson Center for School Counseling Outcome Research and Evaluation and an urban district in the Northeastern United States. As described below, the development of the PFI was guided by the CBA-identified clusters of psychological states and processes (Squier et al., 2014). With input from elementary counselors and teachers, a 13-item report card and a scoring rubric were developed, such that teachers could rate each student on school counseling-related dimensions that have been demonstrated to underlie achievement and well-being. This brief measure was created with considerable input from the school personnel who would be implementing it, with the goal of targeting developmentally appropriate skills in a way that is efficient for teachers and useful for counselors. By incorporating the PFI into the student report card, we ensured that important and useful student-level achievement-related data could be easily collected multiple times per year for use by counselors. The purpose of this study was to explore relationships between the variables that are measured by the scale and to assess the factor structure of the instrument as the first step in establishing its validity. The PFI has the potential to become an efficient and accurate way for school counselors to collect data from teachers about student performance.

Method

Initial Scale Development

The PFI was developed as a tool to gather data on students' socio-emotional development from classroom teachers. The PFI includes 13 items on which teachers rate students' abilities related to four construct-based standards: *motivation*, *self-direction*, *self-knowledge* and *relationships* (Squier et al., 2014). These four construct clusters are believed to be foundational for school success (Squier et al., 2014). Specific items within a cluster reflect constructs that have been identified by research to be strongly associated with achievement and success.

The PFI assessment was developed through a collaborative effort between the research team and a group of district-level elementary school administrators and teachers. The process of creating the instrument involved an extensive review of existing standards-based report cards, socio-emotional indicators related to different student developmental level, and rating scales measuring identified socio-emotional constructs. In addition, representatives from the district and members of the research team participated in a two-day summer workshop in August of 2013. These sessions included school

counselors and teachers from each grade level, as well as a teacher of English language learners, a special education representative, and principals. All participants, except the principals, were paid for their time. Once the draft PFI instrument was completed, a panel of elementary teachers reviewed the items for developmental appropriateness and utility. The scale was then adopted across the district and piloted at all four (K–5) elementary schools during the 2013–2014 school year as a component of students' report cards.

The PFI component of the report card consists of 13 questions, which are organized into four segments, based on the construct-based standards: *motivation* (4 items), *self-direction* (2 items), *self-knowledge* (3 items) and *relationships* (4 items). The items address developmentally appropriate skills in each of these domains (e.g., *demonstrates perseverance in completing tasks*, *seeks assistance when needed*, *works collaboratively in groups of various sizes*). The format for teachers to evaluate their students includes dichotomous response options: "on target" and "struggling." All classroom teachers receive the assessment and the scoring rubric that corresponds to their grade level. The rubric outlines the observable behaviors and criteria that teachers should use to determine whether or not a student demonstrates expected, age-appropriate skills in each domain. Because the PFI instrument is tailored to address developmentally meaningful competencies, three rubrics were developed to guide teacher ratings at kindergarten and first grade, second and third grade, and fourth and fifth grade.

At the same time that the PFI scale was developed, the district began using a computer-based system to enter report card data. Classroom teachers complete the social-emotional section of the standards-based report card electronically at the close of each marking period, when they also evaluate students' academic performance. The data collected can be accessed and analyzed electronically by school administrators and counselors. Additionally, data from two marking periods during the 2013–2014 school year were exported to the research team for analysis (with appropriate steps taken to protect students' confidentiality). These data were used in the exploratory and confirmatory factor analyses described in this paper.

Sample

The PFI was adopted across all of the school district's four elementary schools, housing grades kindergarten through fifth. All elementary-level classroom teachers completed the PFI for each of the students in their classes. The assessment was filled out three times during the 2013–2014 school year, namely in December, March and June. The data collected in the fall and winter terms were divided into two sections for analysis. Data from the December collection (N = 1,158) was used for the *exploratory factor analysis* (EFA) and data from the March collection was randomly divided into two subsamples (subsample A = 599 students and subsample B = 591 students) in order to perform the *confirmatory factor analysis* (CFA).

The sample for this study was highly diverse: 52% were African American, 17% were Asian, 11% were Hispanic, 16% were Caucasian, and the remaining students identified as multi-racial, Pacific Islander, Native Hawaiian, or Native American. In the EFA, 53.2% (n = 633) of the sample were male and 46.8% (n = 557) of the sample were female. Forty-seven kindergarten students (3.9%), 242 first-grade students (20.3%), 216 second-grade students (18.2%), 222 third-grade students (18.7%), 220 fourth-grade students (18.5%), and 243 fifth-grade students (20.4%) contributed data to the EFA.

The first CFA included data from 599 students, 328 males (54.8%) and 271 females (45.2%). The data included 23 kindergarten students (3.8%), 136 first-grade students (22.7%), 100 second-grade students (16.7%), 107 third-grade students (17.9%), 102 fourth-grade students (17.0%), and 131 fifth-grade students (21.9%). The data analyzed for the second CFA included assessments of 591

students, 305 males (51.6%) and 286 females (48.4%). The data consisted of PFI assessments from 24 kindergarten students (4.1%), 106 first-grade students (17.9%), 116 second-grade students (19.6%), 115 third-grade students (19.5%), 118 fourth-grade students (20.0%), and 112 fifth-grade students (19.0%).

Procedures

Classroom teachers completed PFI assessments for all students in their class at the close of each marking period using the rubrics described above. Extracting the data from the district's electronic student data management system was orchestrated by the district's information technology specialist in collaboration with members of the research team. This process included establishing mechanisms to ensure confidentiality, and identifying information was extracted from student records.

Data Analyses

The PFI report card data was analyzed in three phases. The first phase involved conducting an EFA at the conclusion of the first marking period. The second phase was to randomly select half of the data compiled during the second marking period and perform a confirmatory factor analysis. Finally, the remaining half of the data from the second marking period was analyzed through another CFA.

Phase 1. Exploratory factor analysis. An initial EFA of the 13 items on the survey instrument was conducted using the weighted least squares mean adjusted (WLSM) estimation with the oblique rotation of Geomin. The WLSM estimator appropriately uses tetrachoric correlation matrices if items are categorical (Muthén, du Toit, & Spisic, 1997). The EFA was conducted using Mplus version 5 (Muthén & Muthén, 1998–2007).

Model fit was assessed using several goodness-of-fit indices: comparative fit index (CFI), Tucker-Lewis Index (TLI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR). We assessed model fit based on the following recommended cutoff values from Hu and Bentler (1999): CFI and TLI values greater than 0.95, RMSEA value less than 0.06, and SRMR value less than 0.08.

Phase 2. First confirmatory factor analysis. An initial CFA was conducted on the 13 items from the instrument survey to assess a three-factor measurement model that was based on theory and on the results yielded through the exploratory analysis. Figure 1 provides the conceptual path diagram for the measurement model. Six items (3, 4, 6, 7, 11 and 13) loaded on factor one (C1), which is named "*academic temperament*." Three items (8, 9 and 12) loaded on factor two (C2), which is referred to as "*self-knowledge*." Four items (1, 2, 5 and 10) loaded on factor three (C3), which is titled "*motivation*." All three latent variables were expected to be correlated in the measurement model.

This CFA was used to assess the measurement model with respect to fit as well as convergent and discriminant validity. Large standardized factor loadings, which indicate strong inter-correlations among items associated with the same latent variable, support convergent validity. Discriminant validity is evidenced by correlations among the latent variables that are less than the standardized factor loadings; that is, the latent variables are distinct, albeit correlated (see Brown, 2006; Kline, 2011; Schumacker & Lomax, 2010).

The computer program Mplus 5 (Muthén & Muthén, 1998-2007) was used to conduct the CFA with weighted least square mean and variance adjusted (WLSMV) estimation. This is a robust estimator for categorical data in a CFA (Brown, 2006). For the CFA, Mplus software provides fit indices of a given dimensional structure that can be interpreted in the same way as they are interpreted when conducting an EFA.

Phase 3. Second confirmatory factor analysis. A second CFA was conducted for cross-validation. This second CFA was conducted on the 13 items from the instrument survey to assess a three-factor measurement model that was based on the results yielded through the first confirmatory factor analysis. The same computer program and estimation tactics were used to conduct the second CFA.

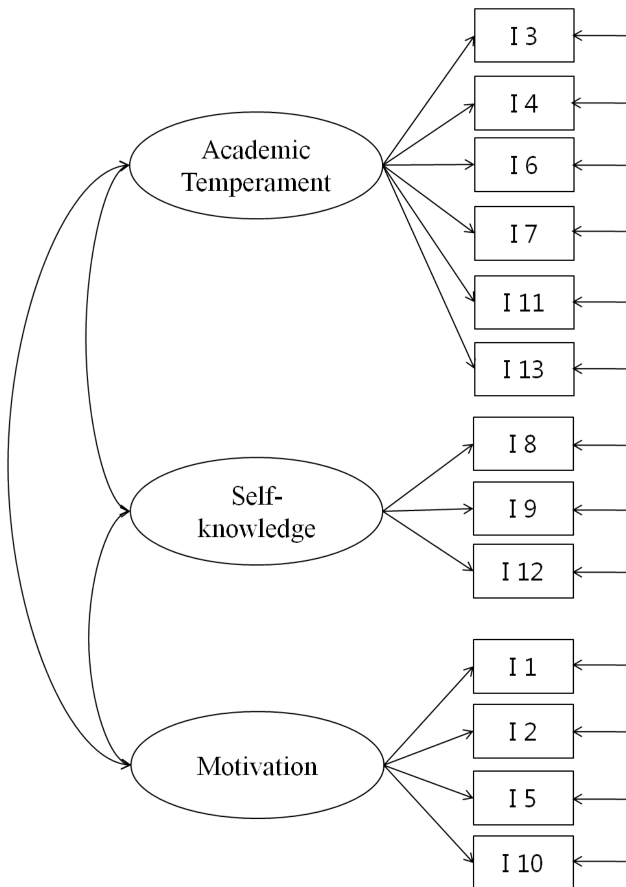

Figure 1. Conceptual diagram of three-factor measurement model

Results

Phase 1. Exploratory Factor Analysis

Complete descriptive statistics for the responses to each of the 13 items are presented in Table 1. The response categories for all questions are dichotomous and also identified in Table 1 as "On Target" or "Struggling," while incomplete data are labeled "Missing." A total of 1,158 surveys were analyzed through the EFA. The decision to retain factors was initially guided by visually inspecting the scree plot and eigenvalues. The EFA resulted in two factors with eigenvalues greater than one (one-factor = 8.055, two-factor = 1.666, and three-factor = 0.869). In addition, the scree test also supported the idea that two factors were retained because two factors were left of the point where the scree plot approached asymptote. However, considering goodness-of-fit indices, the models specifying a three-factor structure and four-factor structure fit the data well. Methodologists have suggested that "underfactoring" is more problematic than "overfactoring" (Wood, Tataryn, & Gorsuch, 1996). Thus, there was a need to arrive at a factor solution that balanced plausibility and parsimony (Fabrigar, Wegener, MacCallum, & Strahan, 1999).

Table 1

Summary of Item Descriptive Statistics for EFA

Item	Struggling *n* (%)	On Target *n* (%)	Missing *n* (%)
1	176 (14.8%)	982 (82.5%)	32 (2.7%)
2	294 (24.7%)	864 (72.6%)	32 (2.7%)
3	214 (18.0%)	943 (79.2%)	33 (2.8%)
4	362 (30.4%)	795 (66.8%)	33 (2.8%)
5	202 (17.0%)	955 (80.3%)	33 (2.8%)
6	177 (14.9%)	981 (82.4%)	32 (2.7%)
7	138 (11.6%)	1017 (85.5%)	35 (2.9%)
8	225 (18.9%)	932 (78.3%)	33 (2.8%)
9	159 (13.4%)	999 (83.9%)	32 (2.7%)
10	387 (32.5%)	769 (64.6%)	34 (2.9%)
11	125 (10.5%)	1032 (86.7%)	33 (2.8%)
12	194 (16.3%)	962 (80.8%)	34 (2.9%)
13	260 (21.8%)	896 (75.3%)	34 (2.9%)

Methodologists (e.g., Costello & Osborne, 2005; Fabrigar et al., 1999) have indicated that when the number of factors to retain is unclear, conducting a series of analyses is appropriate. Therefore, two-, three-, and four-factor models were evaluated and compared to determine which model might best explain the data in the most parsimonious and interpretable fashion. In this case, the two-factor model was eliminated because it did not lend itself to meaningful interpretability. The four-factor model was excluded because one of the factors was related to only one item, which is not recommended (Fabrigar et al., 1999). Researchers evaluated models based on model fit indices, item loadings above 0.40 (Kahn, 2006), and interpretability (Fabrigar et al., 1999).

The three-factor measurement model fit the data well (RMSEA = 0.052, SRMR = 0.036, CFA = 0.994, TLI = 0.988, $\chi^2 = 173.802$, $df = 42$, $p < 0.001$). As shown in Table 2, the standardized factor loadings were large, ranging from 0.58 to 0.97. The first factor included six items. Items reflected students' abilities at emotional self-control and students' abilities to maintain good social relationships in school (e.g., demonstrates resilience after setbacks and works collaboratively in groups of various sizes). This first factor was named "academic temperament."

The second factor included three items. All of the items reflected the understanding that students have about their own abilities, values, preferences and skills (e.g., identifies academic strengths and abilities and identifies things the student is interested in learning). This second factor was named "self-knowledge." The third factor included four items. All of the items reflected personal characteristics that

help students succeed academically by focusing and maintaining energies on goal-directed activities (e.g., demonstrates an eagerness to learn and engages in class activities). This third factor was named "motivation." The three-factor measurement model proved to have parsimony and interpretability.

The two-factor model did not fit the data as well as the three-factor model (RMSEA = 0.072, SRMR = 0.058, CFA = 0.985, TLI = 0.978, χ^2 = 371.126, *df* = 53, $p < 0.001$). As shown in Table 2, the standardized factor loadings were large, ranging from 0.59 to 0.94. The first factor included seven items. This first factor reflected self-knowledge and motivation. It was more appropriate to differentiate self-knowledge and motivation considering interpretability. The two-factor model provided relatively poor goodness-of-fit indices and interpretability.

The four-factor model fit the data slightly better than the three-factor model (RMSEA = 0.035, SRMR = 0.023, CFA = 0.998, TLI = 0.995, χ^2 = 76.955, *df* = 32, $p < 0.001$). As shown in Table 2, the standardized factor loadings were large, ranging from 0.54 to 1.01. The first factor included one item, however, and retained factors should include at least three items that load 0.05 or greater (Fabrigar et al., 1999), so the first factor was removed. The second factor was comprised of six items that all relate to the construct of academic temperament. The third factor includes four items that reflect motivation. The fourth factor is composed of three items that relate to self-knowledge. The four-factor model was strong in terms of goodness-of-fit indices, though it was not possible to retain the first factor methodologically, due to the fact that it only involved one item. Therefore, given a series of analyses, the three-factor model was selected as the most appropriate.

Table 2

Two-, Three-, and Four-Factor Models for Standardized Factor Loadings

Item	Two-Factor Model		Three-Factor Model			Four-Factor Model			
	C1	C2	C1	C2	C3	C1	C2	C3	C4
1	.787	*	*	*	.636	.572	*	.755	*
2	.641	*	*	*	.627	*	*	.672	*
3	*	.779	.736	*	*	*	.877	*	*
4	*	.886	.823	*	*	*	.832	*	*
5	.778	*	*	*	.603	*	*	.636	*
6	*	.722	.659	*	*	*	.770	*	*
7	*	.869	.832	*	*	*	.881	*	*
8	.938	*	*	.974	*	*	*	*	1.014
9	.794	*	*	.924	*	*	*	*	.629
10	.592	*	*	*	.801	*	*	.972	*
11	*	.944	.882	*	*	*	.913	*	*
12	.689	*	*	.670	*	*	*	*	.557
13	*	.664	.577	*	*	*	.535	*	*

Phase 2. First Confirmatory Factor Analysis

Complete descriptive statistics for the items are presented in Table 3. The responses for all items were dichotomous. A total of 569 (95.0%) of 599 surveys were completed and were used in the first CFA.

Table 3

Summary of Item Descriptive Statistics for CFA

Item	CFA 1			CFA 2		
	Struggling *n* (%)	On Target *n* (%)	Missing *n* (%)	Struggling *n* (%)	On Target *n* (%)	Missing *n* (%)
1	71 (11.9%)	498 (83.1%)	30 (5.0%)	83 (14.0%)	481 (81.4%)	27 (4.6%)
2	126 (21.0%)	443 (74.0%)	30 (5.0%)	137 (23.2%)	427 (72.3%)	27 (4.6%)
3	95 (15.9%)	474 (79.1%)	30 (5.0%)	78 (13.2%)	486 (82.2%)	27 (4.6%)
4	157 (26.2%)	412 (68.8%)	30 (5.0%)	163 (27.6%)	401 (67.9%)	27 (4.6%)
5	81 (13.5%)	488 (81.5%)	30 (5.0%)	85 (14.4%)	479 (81.0%)	27 (4.6%)
6	93 (15.5%)	476 (79.5%)	30 (5.0%)	87 (14.7%)	477 (80.7%)	27 (4.6%)
7	68 (11.4%)	501 (83.6%)	30 (5.0%)	64 (10.8%)	500 (84.6%)	27 (4.6%)
8	83 (13.9%)	486 (81.1%)	30 (5.0%)	93 (15.7%)	471 (79.7%)	27 (4.6%)
9	56 (9.3%)	513 (85.6%)	30 (5.0%)	49 (8.3%)	515 (87.1%)	27 (4.6%)
10	178 (29.7%)	391 (65.3%)	30 (5.0%)	175 (29.6%)	389 (65.8%)	27 (4.6%)
11	58 (9.7%)	511 (85.3%)	30 (5.0%)	48 (8.1%)	516 (87.3%)	27 (4.6%)
12	82 (13.7%)	487 (81.3%)	30 (5.0%)	79 (13.4%)	485 (82.1%)	27 (4.6%)
13	118 (19.7%)	451 (75.3%)	30 (5.0%)	107 (18.1%)	457 (77.3%)	27 (4.6%)

The three-factor measurement model provided good fit to the data (RMSEA = 0.059, CFI = 0.974, TLI = 0.984, χ^2 = 104.849, *df* = 35, $p < 0.001$). Table 4 reports the standardized factor loadings, which can be interpreted as correlation coefficients, for the three-factor model. The standardized factor loadings were statistically significant ($p < 0.001$) and sizeable, ranging from 0.72 to 0.94. The large standardized factor loadings support convergent validity in that each indicator was primarily related to the respective underlying latent variable. Table 5 reports the correlation coefficients among the three latent variables. The correlation coefficients were less than the standardized factor loadings, thus supporting discriminant validity.

Table 4

Standardized Factor Loadings for Three-Factor Model

Item	CFA 1			CFA 2		
	C1	C2	C3	C1	C2	C3
1	*	*	.84	*	*	.86
2	*	*	.92	*	*	.93
3	.72	*	*	.70	*	*
4	.88	*	*	.84	*	*
5	*	*	.86	*	*	.85
6	.92	*	*	.90	*	*
7	.84	*	*	.83	*	*
8	*	.94	*	*	.91	*
9	*	.82	*	*	.82	*
10	*	*	.87	*	*	.85
11	.87	*	*	.83	*	*
12	*	.81	*	*	.73	*
13	.88	*	*	.85	*	*

Phase 3. Second Confirmatory Factor Analysis

Complete descriptive statistics for the items are presented in Table 3. The type of responses for all items was dichotomous. A total of 564 (95.4%) of 591 surveys had all the items complete and were used in the first CFA.

The second CFA was conducted on the three-factor measurement model to cross-validate the results from the first CFA. The three-factor model provided acceptable fit to the data in this second CFA (RMSEA = 0.055, CFI = 0.976, TLI = 0.983, χ^2 = 100.032, *df* = 37, $p < 0.001$). Table 4 reports the standardized factor loadings, which can be interpreted as correlation coefficients, for the three-factor model. The standardized factor loadings were significantly large, ranging from 0.70 to 0.93. These large standardized factor loadings support convergent validity in that each indicator was largely related to the respective underlying latent variable. Table 5 reports the correlation coefficients among the three latent variables. The correlation coefficients were less than the standardized factor loadings so that discriminant validity was supported. Given these results, it appears that the three-factor model is the most reasonable solution.

Table 5

Latent Variable Correlation Coefficients for Three-Factor Model

	CFA 1				CFA 2		
	C1	C2	C3		C1	C2	C3
C1	1.00	*	*	C1	1.00	*	*
C2	0.63	1.00	*	C2	0.64	1.00	*
C3	0.81	0.82	1.00	C3	0.77	0.83	1.00

Discussion

The ASCA National Model (2012) for school counseling programs underscores the value of using student achievement data to guide intervention planning and evaluation. This requires schools to find ways to collect valid and reliable information that provides a clear illustration of students' skills in areas that are known to influence academic achievement. The purpose of developing the PFI was to identify and evaluate socio-emotional factors that relate to students' academic success and emotional health, and to use the findings to inform the efforts of school counselors. The factor analyses in this study were used to explore how teachers' ratings of students' behavior on the 13-item PFI scale clustered around specific constructs that research has shown are connected to achievement and underlie many school counseling interventions. Because the scoring rubrics are organized into three grade levels (kindergarten and first grade, second and third grade, and fourth and fifth grade), the behaviors associated with each skill are focused at an appropriate developmental level. This level of detail allows teachers to respond to questions about socio-emotional factors in ways that are consistent with behaviors that students are expected to exhibit at different ages and grade levels.

Considering parsimony and interpretability, the EFA and two CFAs both resulted in the selection of a three-factor model as the best fit for the data. Through the EFA, we compared two-, three- and four-factor models. The three-factor model showed appropriate goodness-of-fit indices, item loadings and interpretability. Additionally, the two CFAs demonstrated cross-validation of the three-factor model. In this model, the fundamental constructs associated with students' academic behavior identified are "academic temperament," "self-knowledge," and "motivation." "Self-knowledge" and "motivation" correspond to two of the four construct clusters identified by Squier et al. (2014) as critical socio-emotional dimensions related to achievement. The "academic temperament" items reflected either self-regulation skills or the ability to engage in productive relationships in school. Squier et al. (2014) differentiated between self-direction (including emotional self-regulation constructs) and relationship skills clusters.

Although not perfectly aligned, this factor structure of the PFI is consistent with the CBA model for clustering student competencies and corresponds to previous research on the links between construct-based skills and academic achievement. Teacher ratings on the PFI seemed to reflect their perceptions that self-regulation abilities and good relationship skills are closely related constructs. These results indicate that the PFI may be a useful instrument for identifying elementary students' strengths and needs in terms of exhibiting developmentally appropriate skills that are known to influence academic achievement and personal well-being.

Utility of Results

The factor analysis conducted in this study suggests that the PFI results in meaningful data that can allow for data-based decision making and evaluation. This tool has possible implications for school counselors in their efforts to provide targeted support, addressing the academic and socio-emotional needs of elementary school students. The PFI can be completed in conjunction with the academic report card and it is minimally time-intensive for teachers. In addition to school-based applications, the socio-emotional information yielded is provided to parents along with their child's academic report card. This has the potential to support school–home connections that could prove useful in engaging families in interventions, which is known to be beneficial. Finally, the instrument can help school counselors identify struggling students, create small, developmentally appropriate groups based on specific needs, work with teachers to address student challenges that are prevalent in their classrooms, evaluate the success of interventions, advocate for program support, and share their work with district-level administrators. The PFI could come to be used like an early warning indicator to identify students who are showing socio-emotional development issues that predispose toward disengagement and underachievement.

The PFI also may prove useful as a school counseling evaluation measure. Changes on PFI items (and perhaps on subscales related to the three underlying dimensions identified in the present study) could be used as data in the evaluation of school counseling interventions and programs. Such evaluations would be tremendously facilitated by the availability of data that is both within the domain of school counselors' work and that is known to be strongly related to achievement.

The findings offer great promise in terms of practical implications for school personnel and parents. This analysis quite clearly illustrates "academic temperament," "self-knowledge" and "motivation" as factors that are demonstrated to be foundational to school success. The results indicate that the teachers' ratings of students' behavior align with findings of existing research and, thus, that the instrument is evaluating appropriate skills and constructs.

Implications for School Counselors

The PFI was developed as a data collection tool that could be easily integrated into schools for the purpose of assessing students' development of skills that correspond to achievement-related constructs. Obtaining information about competencies that underlie achievement is critical for school counselors, who typically lead interventions that target such skills in an effort to improve academic outcomes. Many developmental school counseling curricula address skills that fall within the domains of "academic temperament," "self-knowledge," and "motivation" (see: http://www.casel.org/guide/programs for a complete list of socio-emotional learning programs). Teachers can complete the PFI electronically, at the same intervals as report cards and in a similarly user-friendly format. Therefore, the PFI facilitates communication between teachers and school counselors regularly throughout the school year. Counselors can use the data to identify appropriate interventions and to monitor students' responsiveness to school counseling curricula over time and across settings. Although not included in this analysis, school counselors could also measure correlations between PFI competencies and achievement to demonstrate how academic outcomes are impacted by school counseling interventions and curricula.

Limitations and Further Study

Despite the promising findings on these factor analyses, further research is needed to confirm these results and to address the limitations of the present study. Clearly, additional studies are needed to confirm the reliability of PFI teacher ratings and future research should explore inter-rater

reliability. Further research also is needed to determine if reliable and valid PFI subscales can be created based on the three dimensions found in the present study. Test-retest reliability, construct validity and subscale inter-correlations should be conducted to determine if PFI subscales with adequate psychometric characteristics can be created. Subsequent studies should consider whether students identified by the PFI as being in need of intervention also are found by other measures to be in need of support. Another important direction for future research is to examine the relationships between teachers' ratings of students' socio-emotional skills on the PFI and the students' academic performance. Establishing a strong link between the PFI and actual academic achievement is an essential step to documenting the potential utility of the index as a screening tool. As this measure was developed to enhance data collection for data-based decision making, future research should explore school counselors' experiences with implementation as well as qualitative reporting on the utility of PFI results for informing programming.

Although the present study suggests that the PFI in its current iteration is quite useful, practically speaking, researchers may consider altering the tool in subsequent iterations. One possible revision involves changing the format from dichotomous ratings to a Likert scale, which could allow for teachers to evaluate student behavior with greater specificity and which would benefit subscale construction. Another change that could be considered is evaluating the rubrics to improve the examples of student behavior that correspond to each rating on the scale and to ensure that each relates accurately to expectations at each developmental level. Furthermore, most of the items on the current PFI examine externalizing behaviors, which poses the possibility that students who achieve at an academically average level, but who experience more internalizing behaviors (such as anxiety), might not be identified for intervention. Subsequent iterations of the PFI could include additional areas of assessment, such as rating school behavior that is indicative of internalized challenges. Finally, it will be important to evaluate school counselors' use of the PFI to determine if it actually provides necessary information for program planning and evaluation in an efficient, cost-effective fashion as is intended.

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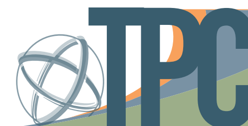
Shelter From the Storm: Addressing Vicarious Traumatization Through Wellness-Based Clinical Supervision



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Counselors continually encounter clients who have experienced emotional and psychological trauma. Repeated vicarious exposure to clients' trauma can affect counselors' personal and professional wellness. Vicarious traumatization can impair counselors' current and future clinical work and lead to significant distress. Clinical supervisors can play an important role in assessing and supporting counselors' wellness related to vicarious traumatization. The purpose of this article is to introduce a framework and related strategies for counseling supervisors based on wellness theory to address vicarious traumatization in counselors. A case study is provided to illustrate an integrated wellness approach to supervision.

Keywords: **vicarious traumatization, counselor wellness, clinical supervision, emotional trauma, psychological trauma**

Mental health counselors who provide services to traumatized clients (e.g., military personnel, clients who have been victimized, witnesses to traumatic events) help to process traumatic experiences. Consequently, providing therapy to traumatized clients often involves the counselor listening to repeated graphic descriptions of traumatic recollections while remaining empathically engaged during discussions (Moulden & Firestone, 2007). For example, counselors working with military personnel and veterans may be provided information that involves the gruesome details of service members' recollections, including death (e.g., via combat, witnessed aftermath of execution) and violence to children. In addition, these clients are often struggling to manage their own anxiety dealing with the overall threat to personal survival in combat situations. There also may be instances in which counselors are exposed to clinical concerns such as addictions that may not involve diagnosable traumatic stress but have the potential to be significantly impactful on the therapist. The effect of this vicarious exposure to clients' experiences can place counselors at risk to be traumatized themselves. This exposure can negatively impact their psychological well-being and contribute to the development of vicarious trauma.

Although there is some discussion within the professional literature regarding vicarious exposure to clients' traumatizing recollections, limited information is available regarding how to address this issue in supervision. Supervisors may benefit from operating within a theoretical framework to support counselor supervisees' exposure to vicarious trauma. Given the potential for significant detrimental effects on counselors, it seems imperative to focus attention on vicarious exposure to trauma within the context of clinical supervision.

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Trauma and Vicarious Exposure

Traumatic events have been described as negative, sudden and uncontrollable (Creamer, McFarlane, & Burgess, 2005; Olff, Langeland, Draijer, & Gersons, 2007; Sarri, 2005), often involving serious injury, threats of death or actual death, or challenges to the physical integrity of oneself or another (American Psychiatric Association, 2013). Traumatic experiences often result in a crisis during which an individual is unable to effectively use typical problem-solving methods and can experience frustration and distress with the disruption of daily activities and life goals (Brammer, 1985; Caplan, 1961; James & Gilliland, 2013). Traumatization also can occur when individuals have neither the internal nor external resources to adequately cope with the results of these crisis events (van der Kolk, 1989). It has been stated that traumatic events are not the cause of harm to individuals' psychological or physical self; it is their reaction to the trauma that leads to harm (Williams, 2006).

In general practice, counselors are often exposed to and affected by trauma-related issues shared by clients (Michalopoulos & Aparicio, 2012). Approximately 70% of 221 mental health workers reported being exposed to moderate or profound amounts of trauma material in a study examining vicarious or secondary exposure to trauma (Kadambi & Truscott, 2004). In an earlier study, 37% of mental health workers reported emotional, physical and mental problems related to secondary trauma associated with their clinical work (Cornille & Myers, 1999). Additional research has confirmed the potential deleterious effects on counselors of continual exposure to clients' traumatic issues (e.g., Arvay, 2001; Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Figley, 2002; Pearlman & Mac Ian, 1995).

While providing general psychotherapy can affect a counselor both personally and professionally, trauma therapy often has a unique effect on therapists distinctive from general counseling (Pearlman & Mac Ian, 1995). Counselors who work primarily with clients with trauma issues are at a higher risk for developing vicarious trauma than those with a general caseload (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassan-Adams, 1995; Pearlman & Mac Ian, 1995 Schauben & Frazier, 1995).

Vicarious Traumatization

Figley (1983) suggested "secondary victimization" and "secondary traumatic stress" as terms to characterize the effect of exposing traumatic material to other people. Furthermore, secondary traumatic stress has been defined by Figley (1993) as the natural consequent behaviors and emotions resulting from awareness of a traumatizing event experienced by a significant other and the associated stress resulting from helping or wanting to help. Though similar in its connection to the impact on counselors exposed to the traumatic experiences of clients, vicarious traumatization (VT) possesses unique characteristics in relation to the degree of impact.

VT was later coined as a term to describe the situations in which a counselor experiences intrusive imagery that appear as disruptions to a therapist's imagery system of memory and yield painful experiences of images and emotions associated with clients' traumatic memories (Pearlman & Saakvitne, 1995). As described in Moulden and Firestone (2007), the three primary characteristics of VT are: (a) pervasive impact that affects several aspects of therapists' lives; (b) cumulative effect in that each exposure to the trauma reported by victims increases the risk and impact of the trauma response in the helper; and (c) potentially permanent detrimental emotional and psychological effects such as a change in perspective and imagery. The primary symptoms of VT include disturbances in

affect tolerance, cognitive frame of reference, interpersonal relationships, psychological needs and identity (Moulden & Firestone, 2007), with effects that can be profound and long-lasting (McCann & Pearlman, 1990). In contrast, counselors experiencing VT have been found to experience decreased personal and professional sense of well-being, depending on their personal trauma history and length of time working with traumatized clients (Pearlman & Mac Ian 1995). In addition, there is a disrupted sense of safety and altered perceptions of self that are significantly correlated with experiencing negative psychological effects (Culver, McKinney, & Paradise, 2011). There have been indications of positive effects of VT as exposure to vicarious trauma may even result in psychological growth of the counselor (Brockhouse, Msetfi, Cohen, & Joseph, 2011). Regardless of the nature of the impact, there appears to be unique aspects of providing services to clients experiencing issues of trauma.

Several internal and external factors contribute to the manifestation of VT. Counselors' personal trauma history, the meaning of traumatic life events to counselors, psychological style, interpersonal style, professional development, and current stressors and supports may all influence the development of VT (McCann & Pearlman, 1990). Elements faced in the work environment, such as the nature of the clientele and the material they present in therapy, stressful client behaviors, and social and cultural context, also may contribute to VT (McCann & Pearlman, 1990. Though one experience with a client's traumatic issue can negatively affect the counselor, the manifestation of VT often occurs after repeated exposure to clients' traumatic narratives (Moulden & Firestone, 2007; Pearlman & Mac Ian, 1995). Due to the potential for counselors to experience VT, organizational support systems to manage the impact of trauma work are needed (Cohen & Collens, 2013). Clinical supervision, when held at regular intervals, provides an opportunity for the identification and remediation of VT to promote the wellness of counselors.

Supervision for Vicarious Traumatization

Lack of training and supervision have been cited as points of concern for counselors at risk for developing VT. For example, Pearlman and Mac Ian (1995) found that trauma therapists who did this work for a shorter period of time and did not receive supervision reported higher levels of disrupted beliefs associated with their clinical work. More recently, Dunkley and Whelan (2006) found that only about a third (27.9%) of the counselors providing trauma therapy via the telephone received supervision.

The literature supports the purported need for supervision among trauma counselors. In a structured interview of mental health agency directors ($n = 5$) working in New Orleans post-Hurricane Katrina, all five directors believed that coping strategies and support were necessary for mental health practitioners to continue working with trauma victims (Culver et al., 2011). Similarly, in a recent study with six peer-nominated master therapists, all six stressed the importance of counselors receiving supervision to lower the risk of VT when working with trauma victims (Harrison & Westwood, 2009). Further supporting these findings, Michalopoulos and Aparicio (2012) found that a decrease in VT symptoms can be predicted by high levels of social support. Neumann and Gamble (1995) recommended that supervision be provided by experienced trauma therapists. Given the indications of a need for support of counselors working with trauma victims by clinicians and supervisors, ensuring appropriate supervision of trauma-focused counseling is a necessary component in addressing the impact of the work.

During the process of supervision, it is important for supervisors to be mindful of the potential for VT manifesting in their supervisees. The signs of distress that may become evident in supervision

include changes in counselors' behavior with and reaction to clients, intrusions of client stories in counselors' lives, signs of burnout, feelings of being overwhelmed, signs of withdrawal in either the counseling or the supervisory relationship, and indications of general stress and decreased self-care (Etherington, 2000). If VT appears present, it is imperative that supervisors address this issue.

A positive relationship between supervisor and supervisee may reduce disruptions in cognitive beliefs (Dunkley & Whelan, 2006). For counselors experiencing symptoms of VT, the supportive supervision environment can promote the counselor's ability to acknowledge, express and work through these painful experiences (McCann & Pearlman, 1990). When the affective response to the clinical work is not acknowledged and addressed, there is a risk that counselors may be unable to maintain a warm, empathetic and responsive stance in their clinical interactions, thereby increasing risk of harm to clients (McCann & Pearlman, 1990).

Counselor Competence

In relation to the impact of VT on counselors, the American Counseling Association's *Code of Ethics* (2014) emphasizes the importance for counselors to address potential impairment (Section C.2.g., F.5.b.) and client welfare (Section F.1.a.). Supervisors play a critical role in this process by providing a context in which impairment of the counselor and by extension the welfare of clients can be addressed. Supervisors are thus ethically obligated to address VT among supervisees as the presence of this condition may limit the capabilities of counselors (F.6.b.). If it becomes apparent that their needs will not be fully met within the context of supervision, a referral for additional mental health counseling for the supervisee may be necessary (F.6.c.).

It is important to note that not every counselor who works with traumatic material develops VT (Moulden & Firestone, 2007). Nonetheless, supervisors of counselors at risk for VT should address the inherent challenges in working with trauma. Failure to provide appropriate supervision, in which counselors are able to address their work with clients, can be considered unethical given the potential harm to the clinician (Sommer & Cox, 2005). Utilizing a theoretically sound, holistic approach in supervision can provide a framework to address the myriad of issues associated with counselor VT.

In addition to accessing mental health assistance if needed, supervision is an important resource for counselors who work with issues of trauma. The manner in which supervision is structured appears critical in the appropriate assessing and remediating of VT. Using a holistic and integrated approach can offer a comprehensive strategy to ensure the well-being of counselors at risk for VT.

Effective Components of Supervision in Relation to VT

Counselors have noted that engaging in supervision itself is a positive coping strategy to address the impact of working with victims of trauma (Hunter & Schofield, 2006). Researchers have typified effective supervision of trauma counselors into several core elements. Four components of effective supervision of trauma counselors suggested by Pearlman and Saakvitne (1995) are (1) a strong theoretical grounding in trauma therapy; (2) attention to both conscious and unconscious aspects of treatment; (3) a mutually respectful interpersonal climate for supervision; and (4) educational content that directly addresses VT. Similarly, Sommer and Cox (2005) offered four themes of effective supervision and training of counselors at risk for VT: (1) freely discussing personal feelings and reactions to trauma counseling; (2) the need for focused attention on VT, both in supervision and at the agency level; (3) utilizing a gentle, collaborative approach to supervision rather than an expert-based model; and (4) addressing the potential for dual relationships between supervisor and supervisee. In addition, counselors defined good supervision as having two main components:

practical case management through advice, direction and reassurance, and a space in which counselors can voice any traumatic incidences or personal reactions arising from their encounter (Hunter & Schofield, 2006). A wellness approach has been offered as a unique framework to address VT within the context of supervision that can be utilized to support counselors working with victims of trauma (Lenz & Smith, 2010). The wellness approach is highlighted henceforth while keeping in mind the majority of the tenets proposed by Pearlman and Saakvitne (1995) and Sommer and Cox (2005).

A Wellness Framework for Supervision

Lenz and Smith (2010) noted that when wellness is an essential part of the supervision process, the effects of trauma can be prevented or mitigated. Models of wellness address physical, mental, social, emotional, and spiritual as well as other aspects of individuals' lives (e.g., Ardell, 1988; Hettler, 1984; Myers & Sweeney, 2004; Myers, Sweeney, & Witmer, 2000). Wellness has been defined as a way of life focused toward optimal health and well-being. Within this perspective, the body, mind and spirit are integrated, resulting in a life lived more fully within the human and natural community. Fully realized, it is considered a state of optimal health and well-being that each individual is capable of achieving. This is a condition that exists on a continuum as opposed to an end state (Myers et al., 2000; Roscoe, 2009).

Lenz and Smith (2010) introduced the Wellness Model of Supervision (WELMS). Supervisors engaging in this approach are able to address issues that arise in supervision in a fluid and adaptable manner. The authors emphasized a process for educating supervisees about wellness, assessing supervisees' level of wellness, evaluating wellness throughout the supervisory relationship, and developing strategies to address supervisees' personal wellness. In a study by Lenz, Sangganjanavanich, Balkin, Oliver, & Smith (2012), when comparing WELMS to alternate approaches to supervision, individuals assigned to the WELMS group developed more comprehensive persona definitions of wellness in addition to increasing their total wellness over the span of 10 weeks.

Alternately, the Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2004) is an evidence-based model of wellness (Hattie, Myers, & Sweeney, 2004; Myers & Sweeney, 2004) that can be applied to help supervisees address the conscious and unconscious effects of VT as it relates to: (1) Coping Self (e.g., stress and burnout); (2) Essential Self (e.g., identity and self-care); (3) Creative Self (e.g., professional/work well-being and emotions); (4) Physical Self (e.g., physical health and eating habits); and (5) Social Self (e.g., interpersonal relationships and expressions of love). The IS-Wel model (Myers & Sweeney, 2004) may have particular utility in addressing VT, given the holistic and interconnected nature of the model. Additionally, this model incorporates the opportunity for formal assessment of the five factors described above using the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005)

In regard to the relationship between supervisor and counselor, Sommer and Cox (2005) recommended that trauma-sensitive supervision should utilize a collaborative strengths-based approach and should include time for talking about the effects of the work and concomitant personal feelings. A collaborative relationship that focuses on the strengths of supervisees also is a cornerstone to the wellness approach (Myers & Sweeney, 2008). An IS-Wel approach to supervision is structured to provide opportunities for supervisees to reflect on their emotional and cognitive resources to deal with the effects of VT. The purpose of this paper is to integrate the aforementioned wellness and supervision models into an overall wellness approach to the process of supervision for VT.

Process of Supervision Using an Integrated Wellness Model

Wellness Approach With VT

In the initial work of utilizing a wellness approach, supervisors assist supervisees with evaluating their own wellness. An informal assessment of the counselor is performed noting not only the content of the supervisee's discussion, but also his/her disposition, affect, and associated thinking as the supervisee articulates case material. Supervisors also attend specifically to, and assess for, features of VT (e.g., change in perspective, cognitive frame of reference). In cases where there is concern for the potential for VT, the supervisor would intentionally inquire about the recurrence and intrusiveness of case material in the supervisee's personal life as well as other symptoms of VT.

Formal assessment of wellness can be accomplished via the IS-Wel model (Myers & Sweeney, 2004) using the previously mentioned 5F-Wel inventory (Myers & Sweeney, 2005). As a standardized measure, this instrument provides not only normative references, but also an opportunity for discussion of one's definition of wellness. The respondents indicate their agreement on a scale ranging from *strongly disagree* to *strongly agree* to an array of questions such as "I am satisfied with how I cope with stress," "I eat a healthy amount of vitamins, minerals, and fiber each day," and "I often see humor even when doing a serious task" (Myers & Sweeney, 2005). There are additional demographic questions used to provide a description of the various characteristics of the supervisee. The supervisor uses the wellness assessment data to determine the impact of the exposure to traumatic material on the counselor's physical and psychological well-being.

Supervisors use the results of the wellness assessment as an opportunity to discuss wellness with the counselor. Specifically, supervisors discuss the results, educate the supervisee about wellness and collaborate with the supervisee to develop a plan for strategies to address VT using a strengths-based approach (Sommer & Cox, 2005). At this juncture, it is suggested that supervisors take the facilitator role rather than that of an expert (Lenz & Smith, 2010).

Working within the supervisory relationship, supervisors may suggest coping strategies for supervisees to mitigate the stress associated in working with victims of trauma. Personal coping mechanisms include counselors maintaining a balance of work, play and rest (Pearlman & Mac Ian, 1995; Trippany, White Kress, & Wilcoxon, 2004), and cultivating skills to decrease one's negative reaction to stress such as a mindfulness practice (Rybak, 2013). Supervisors and supervisees can co-create intervention strategies to attend to potential reactions related to the supervisees' clinical work. Self-care on the part of counselors is an important component of lessening the potential effects of VT (Sommer & Cox, 2005) and can be considered an aggregated result of the various elements of the IS-Wel (Myers & Sweeney, 2004). Supervisors also can support counselors at risk for VT by continually evaluating the wellness of their supervisees throughout the supervision process.

A key element of an integrated wellness approach is to be adaptable to the needs of a diverse population of supervisees. Learning the multicultural identity of supervisees early in the supervisory alliance can assist in creating a supportive supervisory climate, identifying key beliefs and potential resources that may come to bear in maintaining counselor wellness. Considering the diverse needs of supervisees at all junctures, but especially when a heightened likelihood of impairment exists, can be a critical element of effectively preventing and remediating VT.

Connectivity and Caseload Management

In the application of the integrated wellness approach within counseling supervision, supervisors

can be strategic in helping supervisees mitigate the VT response. In order to empower supervisees to be active agents in assessing and enhancing their wellness, supervisors can provide specific information regarding the integrated model of wellness. This can be beneficial to both parties offering a common reference point to be used throughout supervisees' clinical work. Embedding elements of the integrated model into different modalities of supervision (i.e., individual, triadic, and group) can also reinforce critical elements of this approach. Equipped with this information, supervisees can be the primary manager of their own wellness with the supervisor serving in a facilitative and supportive role.

To ensure meaningful engagements on the part of supervisees allowing for examination of the five elements of the IS-Wel (i.e., Coping Self, Essential Self, Creative Self, Physical Self, Social Self), supervisors can encourage their supervisees to increase collegial interaction and avoid professional isolation. Formal or informal support groups may be an adjunctive venue in which these components are assessed and remediated when appropriate. Evidence suggests that support groups for professionals who deal with trauma issues in their clinical work are a useful tool (McCann & Pearlman, 1990). Discussion regarding these resources can occur both at the beginning of the supervisory relationship and at appropriate times when a supervisee appears at risk for VT.

Apart from support groups, supervisors can take an active role to support the Coping Self by monitoring the amount of traumatized clients assigned to a counselor. As noted earlier, the amount of exposure to client trauma is related to VT in counselors (Pearlman & Mac Ian, 1995). Managing counselors' caseloads through monitoring and limiting the number of trauma clients can minimize the potential vicarious effects of working with traumatized clients (Trippany et al., 2004). According to Pearlman and Mac Ian (1995), this can minimize the cumulative effect of counselors' work with clients with traumatic experiences. For example, the caseload of traumatized clients could be equally distributed among qualified providers so as to avoid overwhelming or overloading a counselor at risk for VT, even if trauma therapy is the expertise of only one or a few in the agency. Training for those not specializing in this topic can broaden the number of counselors equipped to address this issue. Additional professional development opportunities, such as workshops focused on trauma therapy, may also help other agency personnel become more comfortable in providing services to traumatized clients.

In the following section, a composite case is provided to illustrate the integrated wellness approach to supervision with counselors treating traumatized clients. In this example, the clinical supervisor is working with a counselor who has several clients struggling with issues of trauma related to military experiences. This case incorporates the previously discussed strategies but is not the only potential response clinical supervisors may utilize to address the counselor's issues. It is suggested that the reader consider the adaptability of the case to their own supervisory interactions.

Case Study of Richard

Richard was a licensed professional counselor working in a community mental health agency near a U.S. Marine Corps military installation. This installation had several military personnel who returned from deployment in which they were involved in active combat. Although a civilian agency, the counselors on staff provided services to many military personnel and veterans. Thus, this agency was often identified as a resource to military service members and their families.

Richard did not have a personal history of military service, but had extended family members who were military veterans. He had a passion for assisting soldiers who were struggling with issues

of trauma related to their combat service. As a result, Richard attended several trainings on combat-related psychological trauma and was also familiar with military culture based on his experiences growing up in a family connected to the military.

Sarah, Richard's clinical supervisor, was tasked with assigning the military referrals to various counselors. An unintended trend developed in which clients who endorsed trauma symptoms were assigned to Richard due to his interest in this area. Richard's caseload began with two or three new referrals a month related to the return of a military division from deployment. As time passed, the frequency of referrals increased significantly to eight to nine new referrals per month. Thus, an informal protocol was established in which Richard was designated as the primary counselor for those reporting trauma issues, mostly combat-related PTSD, sleep disturbance and interpersonal difficulties. Richard initially indicated his appreciation for the opportunity to work with this population as he was honored to serve them in this capacity.

Initially excited to assist these clients, Richard started exhibiting changes in his personal and professional perspectives. In his conversations with his colleagues, Richard expressed he had been ruminating about some of the gruesome details that his clients described in trauma counseling sessions. He also expressed feeling generally overwhelmed in relation to his work in the agency. Richard stated that a majority of his clients seemed to have significant traumatic experiences and that he felt emotionally drained at the end of his time with them due to the intensive nature of his clinical work. In a group supervision meeting, Richard shared that he found himself thinking more about his clients' issues while away from work, often contributing to difficulty being psychologically present with his family and friends.

Structure of Supervision

As his supervisor, Sarah followed an integrated wellness approach to address the counseling and professional issues discussed with supervisees. Her approach to supervision involved working collaboratively with supervisees and educating them about wellness throughout the supervision process. Using informal and formal assessments, Sarah assisted supervisees in evaluating their personal wellness. She then worked with her supervisees to co-construct a holistic wellness plan. She used the IS-Wel model of wellness (Myers & Sweeney, 2004, 2005) to address specific aspects of wellness including Coping Self (e.g., stress and burnout), Essential Self (e.g., identity and self-care), Creative Self (e.g., professional/work well-being and emotions), Physical Self (e.g., physical health and eating habits), and Social Self (e.g., interpersonal relationships and expressions of love). Sarah often administered the 5F-Wel (Myers & Sweeney, 2005). She would discuss elements of the wellness approach both in individual and group supervision meetings, ensuring congruence and consistency of her approach across the different methods of supervision. The information gathered from this assessment would be used to determine areas of focus in Sarah's work with her supervisees.

Assessment

In Sarah's subjective assessment of Richard, she noticed changes in his disposition from his previous affable state to a more pessimistic outlook on his personal and professional life. In a subsequent supervision meeting, Richard discussed the trauma experiences of his clients in depth and became tearful when discussing a client who had witnessed the death of his unit members due to an improvised explosive device. Sarah further assessed how Richard's counseling experiences were affecting his perceptions of his clients in relation to the context of their clinical work. Additionally, she inquired about how clients' trauma recollections were affecting Richard's professional life, personal relationships and level of self-care.

Through this informal assessment, Sarah discovered that Richard lacked hope in his clients' ability to overcome their symptoms related to trauma experiences. He reported withdrawing from family and friends in addition to constantly thinking about his clients' trauma experiences. It appeared that Richard was being negatively impacted both personally and professionally by his engagement with his clients' trauma-related concerns.

Concerned for Richard's well-being, Sarah aimed to provide a supportive environment to help him work through his painful experiences. Sarah determined she would use the context of supervision to assess his well-being and acknowledged the potential for a referral for counseling for Richard if deemed necessary. In her interactions with Richard, Sarah continually affirmed her interest in Richard's personal and professional development and inquired into his activity apart from work. She emphasized the collaborative aspect of supervision and created a supportive environment via the use of empathy, non-judgmental interaction and willingness to allow him to direct their discussion.

Sarah formally evaluated Richard's wellness using the 5F-Wel inventory (Myers & Sweeney, 2005). She believed that the comprehensive nature of this evaluation tool would provide Richard with an understanding of various aspects of his well-being, while also providing him with an understanding of the interconnectedness of his overall functioning. Richard was initially unsure of the shift of focus within supervision from his clients to him, but was willing to engage given his self-disclosed struggles. Sarah provided a detailed rationale for the shift, indicating her sense that Richard appeared to be significantly impacted by his work with his clients. Sarah made sure to ground the discussion in the importance of Richard's clients receiving quality assistance, differentiating her role as his supervisor despite the personal nature of their focus on Richard. She requested that Richard be willing to share if he felt the conversation seemed too much like a counseling interaction.

Evaluation and Results

Richard was provided with the results of the 5F-Wel assessment (Myers & Sweeney, 2014), including a visual profile of his overall wellness. Given the results of the 5F-Wel, Richard noted that his Physical Wellness (i.e., exercise and nutrition) score was low, yet he was satisfied with the physical aspects of his life. He also noted that his Social Self (i.e., friendship and love), Coping Self (i.e., leisure, stress management, self-worth, and realistic beliefs), and aspects of his Creative Self (i.e., thinking, emotions, positive humor, work, and control) were low. He expressed satisfaction with the high score on the Essential Self domain (i.e., spirituality and gender identity).

Education

In their next session, Sarah and Richard discussed his wellness. Using the profile of his 5F-Wel results, she explained to Richard that all aspects of his wellness are interconnected, and a change in one domain can impact other aspects of his well-being. Despite the empirical support for the assessment, Sara explained that the results of his evaluation should be interpreted with caution as various aspects can influence the results such as his mood during the administration process, interpretation of specific items on the inventory and his understanding of the words in each item.

To help Richard connect the assessment results with the self-assessment of his wellness, Sarah asked Richard to informally rate his current wellness on a scale of 1 to 10. This number was then compared to the results on the formal inventory. Richard rated his wellness as a 4. This was repeated within each area of the wellness perspective.

Sarah spent the remainder of this supervision session educating Richard on aspects of his wellness using the accompanying definitions presented in the wellness profile (see Myers & Sweeney, 2011).

The two of them discussed Richard's positive and negative reactions to the results. They then processed the possible reasons why scores on certain aspects of wellness were low or high. Sarah explained that positive, high levels of wellness can be used to address lower levels of wellness.

Stress Reduction Plan

Richard chose to develop a plan, with Sarah's help, for addressing the stress related to VT. Sarah helped Richard explore various strategies that would support his efforts for improving his wellness in the Coping Self (i.e., stress management) area. Richard and Sarah outlined activities that addressed Richard's Physical Self, an area in which Richard scored slightly lower than his self-perception in this area. Given the interconnectedness of the domains, Sarah suggested increased physical activity to positively affect his stress management and improve problematic sleeping patterns as a result of VT. Specifically, Richard decided to add resistance training to his normal four-day-per-week cardiovascular exercise.

Almost immediately, Richard sensed an improvement in Physical Self and in his sleep patterns. Richard also noticed the indirect effects of these activities on some other aspects of his wellness. For example, he was able to meet more people while at the gym (an improvement in Social Self), and became more grounded spiritually (the time he spent in cardiovascular exercise allowed him time to reflect on the spiritual aspects of his life). However, Richard's overall stress level had not improved.

Despite this change in activity, Sarah noticed that Richard's stress management skills had seemingly regressed in that he reported an increase in his level of anxiety as he would prepare for his sessions. The two believed that now that Richard spent more time addressing and mobilizing the physical aspects of his life, he had less time to complete work-related tasks, increasing his stress level. Though Richard enjoyed the noted improvements, his concern for his time management and decreased coping suggested to him that these activities were not addressing the negative effects of VT and his overall wellness.

Thus, Sarah helped Richard choose alternate activities to address the stress management and self-worth issues related to VT. Richard chose to review the positive aspects of his Creative Self (e.g., work) in determining this plan. They decided that Richard might benefit by examining his work schedule to optimize time devoted to developing other aspects of his life to assist in coping with the traumatic material he was exposed to via his clients. It was hoped that strategically adjusting his work schedule also would provide him an opportunity to reach work-related goals.

Sarah became conscious of the number of traumatized clients she assigned to Richard. She also focused the next couple of group supervision meetings on the concept of VT to assist Richard as well as other counselors on staff to process their reaction to their clinical work. Sarah used the time in group supervision to educate the staff of symptoms indicative of the potential harmful consequences of working with traumatized clients. She also added a formal case presentation component to the group supervision meetings to allow further processing and debriefing for the counselors. She specifically encouraged Richard to attend available professional development activities. Richard's ongoing supervision continually involved discussion of his well-being, focusing on his work with clients as well as his sleep patterns and stress levels.

Over a period of a few weeks, Richard's stress management and self-worth improved. Though initially hesitant to engage in the shift in focus, he expressed appreciation for Sarah's ability to educate him regarding the interconnectedness of his wellness, her ability to continually evaluate all

aspects of his wellness, her sense of helping him create plans to live a full life, and her support in addressing the symptoms related to VT for the improvements he had experienced. In her approach, she balanced offering a supportive environment while still serving the role of supervisor, as is consistent with previous literature on addressing VT in counseling supervision (Berger & Quiros, 2014). In the future, Sarah endeavored to more equitably distribute clients with trauma concerns to other staff members and provide training to those new to this type of work.

Case Study Summary

This case was provided to illustrate the potential manifestation and remediation of VT within a supervisory relationship utilizing an integrated wellness approach. Readers may find details of this example not applicable to their specific experience, as there exists significant variance in the characteristics of clients, counselors and supervisors. This discussion does, however, provide a framework in which an integrated wellness approach can be implemented within clinical supervision to prevent and remediate VT.

Future Considerations

Given the potential impact of clinical work on counselors, supervisors would benefit from considering comprehensive and integrated approaches to supervision. There is a need to establish best practices in intervening when counselors demonstrate signs of VT. While prevention of this concern is ideal, VT may still occur, requiring interventions to alleviate this condition. Further examination both in research and practice regarding ways in which a supervisor can effectively intervene by utilizing specific approaches with a counselor with VT is still needed.

Additional empirical examination of theoretical approaches in supervision, such as wellness models to address VT, would be a useful contribution in assisting supervisors to effectively support their supervisees. While the wellness approach appears applicable to identifying and remediating VT, more research studies investigating the effectiveness of this approach would further the body of knowledge pertaining to strategies for addressing VT. Although wellness is one approach, other approaches may complement this framework, including existential-based conversations on meaning attributed to clinical interactions, as well as discussions regarding the impact of this type of work on the counselor. Given the severity of impact on counselors at risk, future research on identifying empirically validated approaches for addressing VT within the clinical supervision context is warranted.

Conclusion

Repeated exposure to clients with trauma-based issues can lead to cognitive, behavioral and emotional disturbance in the counselor, potentially leading to VT. The lack of training and quality supervision for counselors providing trauma therapy is a systemic issue contributing to the development of VT. Clinical supervisors are in a unique position to identify and remediate this issue. Quality supervision can be an effective deterrent and intervention for this potentially harmful condition. Supervisors can emphasize the positive aspects of counselors' work and encourage engagement in self-care. Ensuring that supervisees who address traumatic concerns are supported in their work can significantly benefit both counselors and their clients.

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