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Lifetime Achievement in Counseling Series

An Interview With Theodore P. Remley, Jr.

Neal D. Gray, Lindsay Kozak

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This interview begins the Lifetime Achievement in Counseling Series at TPC that will present an annual interview with a seminal figure who has attained outstanding achievement in counseling over a career. Although there are many people in counseling who deserve to be designated as the first interviewee, I am honored to present the inaugural interview of Dr. Theodore P. Remley, Jr. I have known Ted for 25 years and consider him to be a mentor, a colleague and foremost, a friend. His contributions to the counseling profession, from teaching, research and scholarship to mentoring and introducing students to the globalization of counseling, is laudable. Dr. Neal Gray and Lindsay Kozak are no less worthy in accepting my editorial assignment of interviewing Dr. Remley. What follows are thought-provoking reflections from an outstanding counseling leader and visionary. —J. Scott Hinkle, Editor

Theodore P. Remley, Jr. is an author or editor of three counseling textbooks, a monograph series, numerous book chapters, and over 40 refereed journal articles, most of which are related to law and ethics in counseling. His co-authored textbook with Dr. Barbara Herlihy, *Ethical, Legal, and Professional Issues in Counseling*, is the most widely used ethics text in the counseling profession. He also has published books on ethical and legal issues in school counseling and marriage and family therapy. Dr. Remley has been a professor of counseling for over 35 years and currently holds the position of Professor of Counseling and Booth-Bricker Endowed Professor at the University of Holy Cross in New Orleans. In addition, he has held full-time faculty positions at Old Dominion University, where he was also the Batten Endowed Chair, the University of New Orleans, Mississippi State University and George Mason University. He is a former Executive Director of the American Counseling Association. Dr. Remley held the rank of Captain in the United States Army and has practiced as a school counselor, college counselor and private practitioner in both counseling and law.

Dr. Remley received a PhD in counselor education and supervision from the University of Florida and holds a JD degree from Catholic University in Washington, DC. He is a National Certified Counselor and a Licensed Professional Counselor in Louisiana, Mississippi and Virginia, as well as a Marriage and Family Therapist in Louisiana. He also is licensed to practice law in Florida and Virginia. Dr. Remley is a Fellow in the American Counseling Association and is the recipient of a Lifetime Achievement Award from the Association for Counselor Education and Supervision. He was selected as a counseling leader and featured in the book *Leaders and Legacies: Contributions to the Profession of Counseling*, edited by West, Osborn and Bubenzer (2003).

Dr. Remley has directed international counseling institutes in Ireland, Bhutan, Argentina, Africa and Italy. He was President of the Virginia Counselors Association and Chair of the Southern Region of the American Counseling Association. He was one of the leaders involved in getting the first licensure bill for counselors passed in Virginia in 1976. He has served on four state counseling licensure boards and chaired the boards in Virginia and Louisiana. He helped draft regulations for the District of Columbia board when it was first established and chaired the ethics committee for

the boards in Virginia, Mississippi and Louisiana. He is the Founding President of the American Association of State Counseling Boards, the organization that provides a forum for counseling licensure boards in all states and jurisdictions to communicate with each other and work toward appropriate and fair regulation of the counseling profession. He served as a trustee on the board of Divine Word College in Epworth, Iowa, and was a member of the TRICARE study panel for the National Academy of Sciences Institute of Medicine. Dr. Remley offers readers a valuable perspective on the counseling profession based on his extensive experiences.

In this interview, Dr. Remley responded to seven questions formulated to explore his career, his impact on the counseling profession, and his thoughts about the current state and future of the counseling profession:

1. **The counseling profession has made substantial progress during the time you have been a member of the profession. In your opinion, what are the three major accomplishments of the profession?**

I earned my master's degree in counseling from the University of Florida in 1971. More than 45 years ago the counseling profession was in a much different place than it is today. At that time, counselors in schools were called *guidance counselors* and most had minimal preparation in the field of counseling; there was little conversation about the professional identity of counselors; cultural differences were not acknowledged in the counselor preparation curriculum; almost all counselor educators were counseling or clinical psychologists; and employment possibilities for master's-level counselors were limited primarily to schools, higher education, and rehabilitation agencies. Counselors who earned doctoral degrees in counselor education and supervision at the time would obtain licenses as psychologists because there were no licenses for counselors. The profession has indeed come a very long way in the past 45 years.

The most significant accomplishment the counseling profession has made during my career has been achieving licensure for counselors in all 50 states plus the District of Columbia and Puerto Rico (American Counseling Association [ACA], 2010). I was involved in lobbying the Virginia Legislature, which resulted in the first counselor licensure bill being passed in 1976. At that time in Virginia, counselors had been accused of practicing psychology without a license, and we thought the best response to that injustice was to create a separate license for counselors. We were fortunate to have Dr. Carl Swanson, who at the time was a counseling faculty member at James Madison University in Harrisonburg, Virginia, lead the effort that resulted in the first counselor license in the United States being established. In addition to being a counselor, Dr. Swanson also was an attorney and an Episcopal priest. I'm not sure whether it was his legal preparation or his spiritual connections that helped us get the bill passed, but we were successful in Virginia and the rest of the United States followed our lead. California was the last state to pass a bill to license counselors in 2009 (ACA, 2010). So, the effort to establish counselor licensure in all states took from 1976 to 2009 . . . a total of 33 years.

The second most significant accomplishment of the counseling profession has been the successful accreditation of counseling graduate programs through the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015). My international work in counseling has taught me that to be a recognized profession in any country, counselors have to be educated at universities. In most of Europe and in some other places in the world, counselors are prepared in private schools outside university settings, as indicated in *Counseling Around the World: An International Handbook* (Hohenshil, Amundson, & Niles, 2013). But requiring university degrees in the United States to become counselors was not enough. We had counseling master's degree programs long before

CACREP was established, but most programs were weak in that many required only 30 to 36 credits; there was no standardized curriculum, and clinical practica and internships were rare. CACREP has led the profession in establishing minimum standards for counselor preparation. Today in the United States, when a counselor graduates from a CACREP-accredited program, employers and the general public know the counselor is well-prepared to provide counseling services to clients. I am proud that my graduate advisor and mentor, Dr. Robert Stripling at the University of Florida, was a major leader in establishing CACREP for the benefit of the counseling profession.

The third major accomplishment of the counseling profession is the success of the National Board for Certified Counselors (NBCC, 2015). NBCC was created in 1982 when counselor education programs varied in quality and only a few states had licensure laws that provided a credential that demonstrated a counselor was well-educated and knowledgeable. Now that state licensure for counselors has been accomplished in all states, NBCC has developed into a major force in the continued development of the counseling profession. When the American Counseling Association is mired down by an impossible division-based governance structure and is pondering whether ACA can take a stand on important issues, NBCC, with its small board that has a strong commitment to advancing the counseling profession, has provided lobbying in Washington, DC, and throughout the United States to ensure counselors have the right to practice their profession and have access to jobs for which they are qualified. NBCC also has led the profession in supporting the development of the counseling profession throughout the world. By administering federal scholarships and creating their own scholarships, NBCC has supported the continued growth of the profession and encourages entry into needed areas in counseling (e.g., rural, minority services, military).

2. **Which of the major accomplishments that you listed above was the most difficult to achieve for the counseling profession, and why?**

Achieving counselor licensure in the 50 states, the District of Columbia, and Puerto Rico was the most difficult accomplishment. Counselors had to organize separately in 52 political jurisdictions, work together cooperatively and settle differences among themselves, overcome external resistance, particularly from psychologists and social workers, and often go year after year to state legislatures in order to get a state counselor licensure bill passed. Accomplishing such a monumental and difficult task in only 33 years still amazes me.

There was tremendous resistance to counselor licensure from many organizations, including state legislatures, psychologists, social workers and special interest groups. Ironically, the psychology profession actually started the counselor licensure movement by default because counselors were forced to seek licensure (or state regulation) when they started being accused by psychologists of practicing psychology without a license.

Generally, states do not favor regulating professions. In order to convince legislators that the counseling profession needed to be regulated, counselors argued that the general public cannot distinguish a qualified counselor from one who is not qualified and that unregulated counselors have the potential of doing significant harm to the public. State regulation of a profession defies the concept of free enterprise and has the potential of keeping qualified individuals from practicing a profession for which they have been prepared. Once a state starts regulating a profession, the process is quite expensive and must be monitored by legislatures to ensure that applicants and licensees are being treated fairly. Paradoxically, counselors who consider themselves helpers had to present arguments to legislators that some counselors had the potential of inflicting substantial harm upon members of the public who did not have the capacity to determine whether a particular counselor was competent.

Providing examples of counselor incompetence to legislators was a painful but necessary task that was required to convince state lawmakers that regulation of the counseling profession was needed to protect the public.

In order to get counselor licensure bills passed, we also argued that counseling was a unique profession that was distinct and different from psychology and other helping professions. In Virginia, after the counselor licensure law was passed and implemented, we went back to the state legislature to argue that counseling was quite similar to the profession of psychology in that counselors had the proper training to diagnose and treat mental disorders, in order to be qualified to receive third party insurance company payments for services. Interestingly, legislative processes and politics often require compromise and even making seemingly contradictory arguments from time to time.

When state counselor licensure bills were being considered, psychologists, supported financially by the American Psychological Association (APA) and state psychological associations, argued before state legislators that counselors did not have adequate education to provide counseling services. Social workers essentially agreed with psychologists. Of course it was to the advantage of psychologists and social workers to keep counselors out of the job market so that counselors could not compete for professional positions and clients in private practices.

But psychologists and social workers were not the only groups who opposed counselor licensure—some counselors opposed it as well. Counselors who did not meet the minimum requirements state licensure bills established to become licensed argued that counselor licensure would take away their ability to practice in their respective states. As a result, almost all states grandfathered in the counselors who were already practicing, whether or not they met the minimum licensure requirements. While many counselors at the time were distressed that unqualified counselors were allowed to be licensed, this was one of the many compromises that had to be reached in order for counselor licensure bills to be passed.

Other compromises included the number of credits required for a counseling master's degree (which ranged from 30 to more than 60), the required post-degree supervised experience (which ranged from none to 3 years), and the type of exam required (which varied from state to state). The result of such compromises was counselor licensure laws varying widely from one state to another. The differences in state counselor licensure laws is currently having an adverse effect on counselors who move from one state to another and also confuses the public because of the lack of standardization regarding the requirements for practicing the profession of counseling. It would be possible to rewrite state statutes to align with one another, but that would need to be accomplished state by state over time.

3. **What do you consider to be your major contribution to the development of the counseling profession and why?**

While I was Executive Director of the American Counseling Association (between the years 1990 and 1994), I wrote a column in the ACA newsletter called *Guidepost*, in which I listed the elements of professional counselor identity. That column has been quoted often and the statements of professional counselor identity being published today look very similar to what I wrote about more than 20 years ago. In my opinion, these are the four critical elements of professional counselor identity: (a) counselors approach mental health from a wellness (rather than an illness) perspective, (b) counselors believe that most mental health problems are related to a person's developmental stage in life and therefore are transitory in nature, (c) counselors value prevention of mental health

problems and early intervention when possible, and (d) counselors strive to empower clients to live independently and help them avoid becoming reliant on counseling services. After consultation with my colleagues in rehabilitation counseling, I added the fourth empowerment component of my counselor identity statement.

Counselors-in-training and counselors who interact with the public at large have to be able to articulate in a positive manner who counselors are and what we believe. We should never say that counseling is similar to psychology or social work, but instead should focus on statements that define our philosophy of helping others. When we fully explain our beliefs about helping, we are able to assist the members of the public to choose practitioners who are best suited to address their mental health needs. By providing counselors the four areas listed above that define our beliefs about counseling, I believe I have helped to advance the counseling profession and I am pleased I was able to publish that statement.

4. **What three challenges to the counseling profession as it exists today concern you most?**

The American Counseling Association's (ACA) Ineffectiveness. ACA officers and staff members are dedicated and capable professionals who are not able to be effective in advancing the counseling profession because of the flawed structure of the organization. Our national counseling professional association has an organizational structure ineffective in moving the counseling profession forward; this is arguably the most significant challenge to the profession today. The major divisions of ACA have created very successful independent specialization organizations at the expense of the success of ACA. Unfortunately, we have the impossible situation in which specialty associations are actually in control of ACA, and whose interests likely include maintaining a weak national counseling association. Currently, divisions are allowed to include members who are not members of ACA, which increases their membership at the expense of ACA membership numbers. Divisions can operate independently of ACA, holding their own revenue-generating conferences and being involved with other activities that directly compete with similar ACA revenue-generating activities. This independence of divisions allows them to reap the benefits of being under the ACA umbrella without having any responsibilities and enables them to compete directly with ACA for members and revenue. Our professional association should have the ability to stand firm on professional issues that affect the livelihood of all professional counselors and should not be limited and held back by those who appear to want ACA to be a weak organization so that specialization organizations can prosper.

Unfortunately, the governing body of ACA is made up primarily of division representatives whose first allegiance is to promote their specialization organizations, not to promote the counseling profession as a whole. The unfortunate governance structure of ACA that allows divisions the power to make decisions for ACA as a whole is the result of the history of ACA, an umbrella association that was created as a federation of independent counseling associations. Although the profession of counseling has moved beyond the specialties controlling the overall counseling profession, ACA is stuck in the past with a governance structure that allows specialty divisions to make decisions for ACA. The profession of counseling currently lacks one singular, strong professional association presence. ACA should provide the united voice for all counselors and not allow special interest viewpoints to keep the profession from moving forward. We have worked hard to create the recognized and viable profession of counseling. CACREP and NBCC have done an excellent job of strengthening the counseling profession as a whole. However, the fact that the specialization divisions of ACA have separate administrators, offices, conferences and programs that compete directly with ACA threatens the future of the counseling profession. For each professional issue affecting counselors, for ACA to take a position, all specializations have to agree, which is almost

impossible to accomplish. ACA as an organization is paralyzed and must be restructured or replaced with an effective association for all counselors if the counseling profession is to continue to prosper.

Failure to Standardize. A second concern is the inability of the counseling profession to standardize. CACREP has provided a model for preparing capable counselors and now the CACREP standards need to become the standard for state licensure. CACREP has already been adopted by NBCC as the standard for future national certification (NBCC, 2014). A lack of standardization has led to current issues and problems, including portability of counseling licenses from state to state, that in turn keep the profession from agreeing upon a strong professional identity, which in turn confuses the general public. If we want the public to embrace the counseling profession, we must standardize the profession and agree upon what is required to be a professional counselor.

The current attention given to complaints from psychologists about excluding them from holding faculty positions in counselor education programs and the response of some leaders trying to accommodate these complaints is a symptom of the counseling profession not having the ability or courage to take the steps necessary to standardize. Of course, as the counseling profession becomes stronger, there will be individuals who are dissatisfied. But those who are not supportive of strengthening the counseling profession should not be given the power to limit the counseling profession from moving forward. All counselors should be supportive of CACREP and NBCC, and those who are not supportive should refrain from negatively affecting the future of the counseling profession.

Job Categories. A third concern is that there continue to be many governmental agencies at all levels (federal, state and local) that lack job categories for counselors. As a result, counselors are sometimes not eligible for jobs they are qualified to perform where such positions are filled only by psychologists, social workers, or other non-counselors. In some agencies, counselors take jobs that include titles such as *psychological technician*, *psychological assistant*, *social assistant*, or even *psychologist* or *social worker*. With such inappropriate job titles, counselors often have no opportunity for advancement and their professional identity as counselors is compromised. We have made some progress in getting job categories for counselors established in some agencies, but there is much more work to be done in this arena.

5. **What needs to change in the counseling profession for these three concerns to be successfully resolved?**

ACA's Ineffectiveness. Unfortunately, ACA is a dysfunctional association that has been paralyzed by its governance structure. The specialization divisions have control over the association that should be representing *all* counselors. The only solution, in my opinion, would be to restructure ACA so that the association would be governed by a small board of directors that is elected from the general membership and is responsive to the counseling profession, instead of being controlled by specializations within the profession. Interestingly, the *TPC* editor discussed this point at the Association for Counselor Education and Supervision conference 20 years ago (Hinkle & Kline, 1996), yet ACA continues to have an ineffective governance structure. Those in control of ACA should have a commitment to the best interests of the counseling profession as a whole. Currently, individuals whose main allegiance is to counseling specializations are in control of ACA. In order for the ACA governance to be restructured, the current ACA Governing Council members, who represent counseling specializations, would have to vote to give up their power over ACA, which I doubt they would consider. In my opinion, the division representatives who hold ACA Governing Council seats do not represent the view of the vast majority of ACA members who want ACA to be a strong

association that promotes the overall counseling profession. If ACA cannot restructure so that it represents the counseling profession as a whole, then perhaps a new association that is not controlled by specializations should be formed that would replace ACA.

Failure to Standardize. State counseling licensure boards need to work together to achieve standardization in licensure laws and rules. The current movement to require that those licensed hold master's degrees from CACREP-accredited programs is the best way to achieve standardization. NBCC has already announced that in the future only graduates of CACREP-accredited programs will be eligible for national counselor certification. The American Association of State Counseling Boards (AASCB; 2015) is encouraging state licensure boards to standardize counselor licensure requirements and to recognize counselor licenses from state to state. When AASCB was formed in 1986, a major goal of the new association was to standardize state counseling statutes, but obviously it is a difficult task since 30 years later that goal has not been accomplished.

Job Categories. In order to create job categories for counselors, each federal, state, and local agency and all private companies that hire mental health professionals must be lobbied individually. A massive effort to create job categories should be supported by NBCC and all counseling professional associations, and that effort should become a top priority.

6. **Assuming some challenges will get resolved and others will not, what do you think the counseling profession will look like 20 years from now?**

In 20 years, if the current challenges I have identified can be met and resolved successfully, I believe the public will have a better understanding of who counselors are, what their training is, and what services they are capable of delivering. Counselors will be the preferred mental health providers of the public because counselors are better prepared than other mental health professionals to deliver high quality counseling services. If the current challenges for the counseling profession are not resolved, in 20 years we will be where we are today, stalled on the road to establishing counseling as a strong profession in American society and being left behind in the arena of public recognition compared to other mental health professions.

7. **If you were advising current counseling leaders, what advice would you give them about moving the counseling profession forward?**

I see several contemporary leaders in the counseling profession already providing strong positive leadership. So I would say to other counselors that they should follow the lead of counselors who are arguing that ACA should be restructured so that it represents the counseling profession as a whole, who are advocating that state licensure boards adopt CACREP-accredited master's degrees as the standard for licensure, and who are strongly and continually urging ACA to recognize that CACREP is the only legitimate organization that accredits counseling graduate programs. At the state level, counselor leaders should work toward getting counselor licensure board members appointed by governors who support adopting CACREP-accredited master's degrees as the minimum standard for state counselor licensure. I appreciate the courageous leaders in counseling today who are willing to take the steps necessary to advance the counseling profession even when they lack the support they deserve.

This concludes the initial interview for the annual Lifetime Achievement in Counseling Series. TPC is grateful to Dr. Neal Gray and Lindsay Kozak for providing this interview. Neal D. Gray is an Associate Professor at Lenoir-Rhyne University. Lindsay Kozak is a counselor at Crossroads Counseling Center. Correspondence can

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School Counseling Faculty Perceptions and Experiences Preparing Elementary School Counselors

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Emily Goodman-Scott, Jennifer Scaturo Watkinson, Ian Martin, Kathy Biles

School counselors' job roles and preferences reportedly vary by educational level (i.e., elementary, middle and high school); however, several organizations, such as the American School Counselor Association, conceptualize and recommend school counseling practice and preparation through a K–12 lens. Little is known about how or if school counseling faculty members vary their preparation for specific educational levels. In this article, we discuss a national, mixed methods study of school counseling faculty (*N* = 132) experiences and perceptions regarding school counselor preparation for the elementary level. We focused on elementary school counselors due to their unique roles. Findings included faculty's varied experiences and perceptions of differentiation, prioritizing a K–12 preparation focus, and several external factors driving their preparation such as state licensure and mandates, school counseling job opportunities, and student enrollment, motivation and interest in elementary school counseling.

Keywords: **school counseling, elementary school, elementary school counseling, school counselor preparation, school counseling faculty**

School counselors meet students' academic, career, social and emotional needs through comprehensive school counseling programs (CSCPs) such as the American School Counselor Association (ASCA) National Model (2012, 2014a; Gysbers & Henderson, 2012). CSCPs have existed for the last 40 years and are frameworks for facilitating data-driven, student-focused, preventative, systemic and developmental school counseling services implemented in schools from preschool through 12th grade (ASCA, 2012; Gysbers & Henderson, 2012). According to student reports, CSCP implementation has been associated with higher student achievement scores (Sink, Akos, Turnbull, & Mvududu, 2008; Sink & Stroh, 2003); higher student grades and a more positive school climate (Lapan, Gysbers, & Sun, 1997); and students feeling safer, having better relationships with teachers, and earning higher grades (Lapan, Gysbers, & Petroski, 2001). Additionally, researchers found CSCP implementation was associated with higher student math and reading achievement scores; increased college and career readiness; lower suspension, discipline and truancy rates; and higher attendance, graduation and retention rates (Burkard, Gillen, Martinez, & Skytte, 2012; Carey, Harrington, Martin, & Hoffman, 2012; Carey, Harrington, Martin, & Stevenson, 2012). In summary, "when highly trained, professional school counselors deliver ASCA National Model comprehensive school counseling program services, students receive measurable benefits" (Lapan, 2012, p. 88).

Typically, school counselors are first equipped to implement CSCPs through their pre-service preparation programs. School counselor preparation, licensure and practice are often recommended as uniform across educational levels (i.e., elementary, middle, and high school). The Council for Accreditation of Counseling and Related Educational Programs (CACREP), the primary counseling accrediting organization, provides school counselor preparation standards P–12 (CACREP, 2015);

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most U.S. states and territories (*N* = 43/55) certify and license school counselors K–12 (American Counseling Association [ACA], 2012); and the ASCA National Model also describes their CSCP as K–12 (ASCA, 2012). However, many researchers have found differences in school counselors' reported perceptions and job activities by educational level and have highlighted the unique role of the elementary school counselor (Dahir, Burnham, & Stone, 2009; Hatch & Chen-Hayes, 2008; Perera-Diltz & Mason, 2008; Rayle & Adams, 2008; Scarborough, 2005; Scarborough & Culbreth, 2008; Studer, Diambra, Breckner, & Heidel, 2011).

Compared to school counselors at other educational levels, elementary school counselors reported performing and placing greater emphasis on delivering classroom lessons and curriculum (Dahir et al., 2009; Perera-Diltz & Mason, 2008; Rayle & Adams, 2008; Scarborough, 2005; Studer et al., 2011), counseling interventions (Dahir et al., 2009; Perera-Diltz & Mason, 2008; Rayle & Adams, 2008; Scarborough, 2005), and school counseling program coordination and management activities (Dahir et al., 2009; Rayle & Adams, 2008; Scarborough, 2005). Further, elementary school counselors reported a greater emphasis on personal and social development and focused less on academic and career development when compared to high school counselors (Dahir et al., 2009); spent more time on parent planning, teacher consultation and collaboration, non-CSCP activities, and CSCP implementation based on the ASCA National Model (Rayle & Adams, 2008); were the most likely level to conduct activities aligned with CSCPs (Scarborough & Culbreth, 2008); and performed the least individual student planning (i.e., individual and group advisement) of all the levels (Perera-Diltz & Mason, 2008). Thus, despite the K–12 focus in school counselor preparation, licensure, certification and practice, school counselors reported significant differences between job activities at the elementary and secondary levels.

While much is known about differences among the educational levels, there has been little research directed toward investigating school counselor preparation by level. In this article, our research team reports the perceptions and experiences of a national sample of school counseling program faculty (*N* = 132) regarding elementary level preparation and discusses potential implications and future research. The aim of this study was to gain preliminary data and provide a foundation for future in-depth research and potential advocacy. Next, we will review literature on school counselor preparation.

School Counselor Preparation

General trends in school counselor preparation are sparse within the literature. School counseling faculty are members of master's- and doctoral-level school counselor preparation programs who prepare pre-service school counselors through related academic, supervision and practical experiences (ASCA, 2014b; CACREP, 2015). Examining how school counseling students are prepared, Pérusse, Poynton, Parzych, and Goodnough (2015a) published the results of a national survey of school counselor preparation programs (*N* = 131) to identify trends in school counselor preparation credit hours, faculty professional experience, and course content required for school counseling students, comparing data collected in 2010 to similar data collected in 2000 (Pérusse, Goodnough, & Noël, 2001). When comparing trends in previous course offerings to those more recent, the researchers found substantial decreases in the percentage of school counseling preparation programs offering elementary (from 14.3% to 1.6%) and secondary (from 13.8% to 1.6%) school counseling specific courses (Pérusse et al., 2015a).

Next, Pérusse and Goodnough (2005) examined school counselors' perceived preparation by educational level. In this national study, school counselors (*N* = 568) ranked the importance of 24

course content areas that prepared them for school counseling jobs; results included both similarities and differences in elementary and secondary school counselors' responses. Both elementary and secondary school counselors ranked the same top five course content items as most important: individual and small group counseling, parent and teacher consultation, child growth and development, and legal and ethical issues in counseling. However, elementary school counselors ranked the following course content items as having a higher importance than secondary school counselors: understanding child growth and development; theories in counseling; psychopathology, *DSM-IV* and diagnosis; play therapy; curriculum and instruction, including classroom management; individual counseling, including crisis interventions; small group counseling; consultation with parents and teachers; coordination between teachers, parents and community; classroom guidance curriculum; program evaluation and developmental needs assessment; parent education; and writing research and grant proposals. Several participants recommended distinguishing elementary from secondary school counselor preparation. In analyzing participants' anecdotal comments, researchers reported: "preparation should reflect that elementary school counseling is different from secondary school counseling" (Pérusse & Goodnough, 2005, p. 115).

In contrast, Goodman-Scott (2015) conducted a national survey that examined school counselors' perceptions of their preparation and actual job activities ($N = 1052$), using a modified version of the School Counselor Activity Rating Scale (Scarborough, 2005). She found no significant difference by educational level in regards to participants' reported preparation or job activities. Findings from Goodman-Scott, as well as those of Pérusse et al. (2015a), denote school counseling preparation and job activities could be shifting toward uniformity across K–12 settings, rather than differentiation by educational level.

Rationale and Purpose of This Study

Scarborough and Culbreth (2008) proposed that school counselors "may receive more generic training that covers grades K through 12 and lack exposure to the differences that exist between school levels" (p. 457). However, there is very little published research on school counselor preparation by educational level. The present study was developed by members of the Elementary Advocacy Task Force for the Association for Counselor Education and Supervision School Counseling Interest Network. We sought to conduct a study to investigate the current status of elementary school counselor preparation and lay the groundwork for future research and advocacy. We collected data from a national sample of school counseling faculty regarding their perceptions and experiences preparing school counseling students for the elementary level. The following mixed methods research question guided our study: What are school counseling faculty members' perceptions and experiences preparing school counseling students for the elementary level?

Method

Mixed method designs employ both qualitative and quantitative methods, which can provide a rich and comprehensive understanding of a phenomenon (Creswell & Plano Clark, 2010; Frels & Onwuegbuzie, 2013). Researchers in the past have used descriptive studies to gather preliminary data and summarize trends on under-researched areas within counseling (Holcomb-McCoy, 2010; Lambert et al., 2007). Further, studies often employ qualitative methods to explore a phenomenon (Hunt, 2011). Due to the lack of research on school counselor preparation by educational level, we adopted similar approaches within a convergent mixed methods design. We analyzed demographic data and descriptive closed-ended survey responses (quantitative), and performed a qualitative thematic analysis on open-ended survey responses (Braun & Clarke, 2006). Then we used

triangulation to converge the results of all analyses, with the overall goal of expansion, increasing the depth and breadth of the study due to multiple methods (Creswell & Plano Clark, 2010; Greene, Caracelli, & Graham, 1989). We prescribed to a social constructivist paradigm and relied heavily upon relativistic theory. Within this perspective, reality is subjective, there exists no absolute truth, and gathering multiple perspectives across sources is a research priority (Hays & Singh, 2012; Schwandt, 2007).

The Survey

We used a Web-based survey as a low-cost, rapid-return data collection method (Fowler, 2014). Through this survey, we gathered quantitative and qualitative data: participant and program demographics, descriptive information regarding school counseling topic differentiation, and open-ended responses regarding school counselor preparation by level. All data for this study were collected via Qualtrics, a university-sponsored, Web-based survey tool. We pilot-tested the survey for content and procedures with two leaders in school counselor education (Dillman, Smyth, & Christian, 2008) and made several related changes based on their feedback.

We collected a range of participant and program demographic and background information. Specifically, we gathered participant personal and professional demographics, and background information on their preparation programs and state requirements. Further, participants reported their related opinions and preferences regarding elementary school counselor preparation.

We examined school counseling faculty members' perceptions of their differentiation of topics for elementary school counseling using 24 descriptive items. On the survey, we defined differentiation as school counselor preparation programs tailoring or modifying school counseling topics and program requirements, such as academic advisement and internship, respectively, by educational level (i.e., elementary, middle or high school). Based on the literature and national foci, we created these 24 items based on topics that elementary school counselors frequently conducted and current school counseling trends. These 24 descriptive items were two-part questions in which participants responded using two 5-point Likert scales: one to report their *current* level of differentiating each topic for elementary school counseling (0 = no current differentiation; 4 = highly differentiated; n/a = not applicable), and the second to communicate their *preferred* level of differentiating topics for elementary school counseling (0 = no differentiation; 4 = high differentiation; n/a = not applicable). Lastly, participants responded to open-ended questions regarding their perceptions and experiences pertaining to school counselor preparation by level.

Data Collection and Procedures

We solicited participants after obtaining approval from the primary researcher's university institutional review board and recruited participants through several e-mail lists and professional contacts. For instance, we e-mailed the following individuals and organizations approximately twice, requesting they complete and distribute the survey to their membership: (a) the Association for Counselor Education and Supervision national and regional leadership, as well as the corresponding School Counseling Interest Network; (b) the Counselor Education and Supervision Network Listserv; (c) professional school counseling faculty contacts; and (d) counselor educators listed in the American School Counselor Association online membership directory. Our e-mail solicitations included a description of the participation criteria and study, informed consent, participants' rights, researchers' contact information and a survey link.

After closing the survey, we cleaned the data, including participants who met the inclusion criteria: participants who (a) identified as full-time school counseling faculty in the United States whose job

description included teaching and supervising students in school counseling master's programs, (b) completed 90% or more of our survey, and (c) agreed to the informed consent. Regarding survey completion, 271 participants started the survey, 192 completed the survey, and 132 met the inclusion criteria. We were unable to calculate a response rate due to the unknown number of individuals who received the request and were eligible for participation.

Participants

Participants were 74% female and 26% male. Their races and ethnicities included: 85% Caucasian, 4% African American, 3% Latino and 2% Asian and Pacific Islander, and 2% self-identified as multi-ethnic. Participants worked in 37 different states within the United States, representing all regions (19% West, 24% Midwest, 32% South and 25% Northeast).

Ninety-eight percent of the participants had earned a doctorate; doctorates included counselor education (64%), counseling psychology (11%), and either doctorates in educational leadership, educational psychology or clinical psychology (22%). Fifty-three percent of participants earned their doctorates from CACREP-accredited programs. Many participants described previously working as a full-time school counselor (94%), while approximately 63% of participants reported that either they, or another full-time school counseling faculty member in their program, had paid work experience as an elementary school counselor. Lastly, most participants (94%) believed school counseling professional organizations should advocate for elementary school counselors to be mandated in every state. In Table 1 we list additional reported participant, program and state information.

Table 1

School Counseling Program Demographics

School Counseling Program Demographics	%
Require Clinical Experience at All Three Educational Levels	31
Clinical Requirements Are Based Upon State Certification/Licensure Standards	83
Group Supervision Is Separated by Educational Level	15
Internship Group Supervision with Other Counseling Specialties [e.g., mental health]	26
Program Has a Concentration for Students Who Desire to Be Elementary SC	15
State Mandates Elementary School Counselors	27
K–12 Certification/Licensure	86
Program Meets State's School Counseling State Certification/Licensure Requirements	100
Program Is Accredited by CACREP	66
ASCA National Model Is Taught	93

Data Analysis

As is common with convergent mixed methods studies (Creswell & Plano Clark, 2010), our data analyses involved independently analyzing each type of data (demographic and descriptive) and conducting the qualitative thematic analysis. We then merged the data in the interpretation. We concurrently organized demographic data and analyzed descriptive data using Microsoft Excel 2013

to examine participants' reported current and suggested differentiation of school counseling topics for elementary school counseling.

Simultaneously, we also analyzed the open-ended survey data through Braun and Clarke's (2006) thematic analysis (TA) methodology to analyze participants' perceptions and experiences related to elementary school counselor preparation. Scholars have described TA as an independent method and a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (Braun & Clarke, 2006, p. 5). Braun and Clarke outlined TA as a six-step process to identify, analyze and report qualitative data, including: (1) becoming familiar with the data, (2) creating initial codes through systematically coding the data, (3) developing initial themes, (4) reviewing the themes, (5) defining and naming the themes, and (6) creating a corresponding research report. We began TA by first becoming familiar with and immersing ourselves in the data—reading and re-reading the content, discussing our overarching reactions, and deciding on data analysis within the TA framework. Next we, the four members of the research team, each independently open coded the data (Creswell, 2013) and compared our results through consensus coding (Hays & Singh, 2012). During in-depth research meetings over the span of several months, we engaged in the iterative and consensual process of creating, defining and reviewing codes and themes until reaching consensus, or agreement between all team members. During this analysis, we used several TA strategies: theoretical theme development (i.e., analysis driven by the research question), a semantic approach (i.e., codes created from the data—we analyzed the concrete words/descriptions), and utilizing an essentialist-realist method to communicate participants' realities (Braun & Clarke, 2006). Concurrent with the last stage of TA, we discussed our results and created this manuscript.

Lastly, we used data triangulation to compare several survey data sources. For instance, we triangulated demographics and background information, descriptive data and qualitative TA results to gain information about varied aspects of elementary school counselor preparation and create a more multifaceted understanding of the specified phenomenon (Maxwell, 2013). Overall, triangulation "is both possible and necessary because research is a process of discovery in which the genuine meaning residing within an action or event can best be uncovered by viewing it from different vantage points" (Schwandt, 2007, p. 298).

Strategies for Trustworthiness

We used a myriad of trustworthiness strategies to strengthen rigor of the qualitative thematic analysis (Hays & Singh, 2012). First, we utilized investigator triangulation to analyze data through many in-depth collaborative research meetings over the span of several months (Creswell, 2013; Hays & Singh, 2012), and we engaged in consensus coding–intercoder agreement through verbally reaching shared agreement on codes and themes (Creswell, 2013; Hays & Singh, 2012). Next, we created an audit trail to document our data analysis and research processes (Hays & Singh, 2012; Schwandt, 2007), and enlisted an external auditor who reviewed our codes, themes and data analysis to provide feedback and confirm systematic data analysis (Creswell, 2013; Hays & Singh, 2012). We participated in research team discussions at the start of and during data analysis to identify and bracket our assumptions and researcher biases (Schwandt, 2007).

The research team. A crucial component of the methodology was the establishment of the research team (Creswell, 2013). The research team was comprised of four individuals who met regularly for 2 years as part of the Elementary Advocacy Task force for the Association for Counselor Education and Supervision School Counseling Interest Network. This research project was initiated as part of the named task force. All authors were counselor educators and had previous school counseling experience. Specifically, the first author completed 2 years as a counselor educator and 3 years as a

school counselor; the second author was a counselor educator for 8 years and a school counselor for 14 years; the third author was a counselor educator for 7 years and had 5 years of school counseling experience; and the fourth author had 12 years of experience as a counselor educator and 4 years of experience as a school counselor. The first three authors identified as Caucasian of European descent and had previous elementary school counseling experience; the fourth author identified as multi-ethnic (Caucasian of European descent and Native American) and had experience as a secondary school counselor. Additionally, the primary author was a female in her mid-30s; the second author was a female in her mid-40s; the third author was a male in his 40s; and the fourth author was a female in her mid-50s. We utilized the research team to challenge each other's assumptions and biases during data analysis, as well as engage in researcher triangulation.

Results

In this study, we examined school counseling faculty members' perceptions and experiences regarding school counselor preparation for the elementary level. To examine the research question, we triangulated three data sources: demographic and background information, descriptive data (Table 2), and qualitative thematic analysis results. Three themes resulted from the data analysis: *Varying Conceptualizations of Differentiation*, *K–12 Preparation Focus* and *Factors Driving Elementary School Counseling Preparation*. We will subsequently describe the themes and provide the results of the triangulation.

Table 2

School Counseling Faculty's Highest Five Means and Lowest Five Means for Perceived Current and Preferred Differentiation of Elementary School Counseling Topics

Current Elementary School Counseling Topic Differentiation	***M***	***SD***	**Preferred Elementary School Counseling Topic Differentiation**	***M***	***SD***
Highest Five Items			**Highest Five Items**		
Classroom Lessons	2.62	1.38	Classroom Lessons	3.26	1.03
Social/Emotional Issues	2.50	1.46	Career Exploration	3.20	1.20
Human Growth and Development	2.48	1.62	Human Growth and Development	3.05	1.37
Career Exploration	2.41	1.51	Classroom Management Techniques	3.04	1.89
Creative Counseling Techniques	2.37	1.41	College Readiness	3.02	1.22
Lowest Five Items			**Lowest Five Items**		
Educational Policies (Federal and State)	1.36	1.34	Educational Policies (Federal and State)	2.01	1.50
Professional Identity	1.24	1.40	School Counselor Leadership	1.90	1.58
School Counselor Leadership	1.19	1.38	Professional Identity	1.80	1.57
Cultural Competency	1.18	1.40	Social Justice/Advocacy	1.73	1.58
Social Justice/Advocacy	1.09	1.34	Cultural Competency	1.69	1.60

Note. M = mean; *SD* = standard deviation. Perceived Current Differentiation of Elementary School Counseling Topics items: 0 = no current differentiation; 4 = highly differentiated. Perceived Preferred Differentiation of Elementary School Counseling Topics: 0 = no differentiation; 4 = high differentiation.

Varying Conceptualizations of Differentiation

Participants described their perceptions and experiences regarding the differentiation of school counseling preparation through descriptive and open-ended qualitative data. In looking at the *current*

and *preferred* descriptive items, participants ranked the degree to which they were currently and preferably differentiating school counseling topics for elementary school counseling, using a 0–4 point scale (0 = no differentiation and 4 = high differentiation). Participants' *current* differentiation means were fairly moderate to low (means ranged from 1.09–2.62), meaning participants perceived providing little to average elementary school counseling topic differentiation. At the same time, participants communicated differences between their current level of differentiation and their preferred level of differentiation (*preferred* means ranged from 1.69–3.26). For example, participants' means for each *preferred* item were higher than the means for each *current* item. Thus, participants reported low to moderate differentiation for the elementary level, but desired to differentiate elementary school counseling content to a greater degree than they were actually doing. Further, participants reported conducting and desiring greater differentiation among practical or application-based topics (e.g., developing classroom lessons, addressing social and emotional issues) compared to theoretical or philosophically geared topics (e.g., professional identity, cultural competency).

Through the open-ended responses, participants described their perceptions of and experiences with differentiating school counselor preparation for educational levels. For example, one participant described a practicum experience specific to the elementary level:

> Our program adopted a K–5 charter school who has no school counseling services. We . . . provided supervised classroom lessons pre-practicum in this elementary school. . . . The experience has been phenomenal for my students to learn about developmentally appropriate classroom management, curriculum design, lesson planning and delivery, as well as the social-emotional needs of kids.

Another participant described differentiation as modifying class discussions according to level: "The discussion in a class will of course be different depending on the level being addressed." A different participant described differentiation occurring for assignments, based on students' interests, yet also provided an alternative strategy for viewing the concept of differentiation:

> Students can often tailor assignments so that they are most relevant to the [desired] level(s). . . . Readings that have to do with specific levels are generally required for everyone [because] . . . it's good to know what's happening at other levels. I wonder if differentiation is what's called for or if instead, inclusion and gauging the needed depth of exposure and skill?

A separate participant conceptualized differentiation as, "separate courses by level or that the instructor differentiates within the course by providing examples or options for various levels." Yet, another participant described differentiation within the context of school counseling compared to other counseling tracks such as mental health counseling: "I have seen programs with 'concentrations' by which students take only one standalone course in SC [school counseling], MH [mental health], CC [college counseling] and the rest of the program is generic counseling." Overall, participants' responses to open-ended questions revealed varying conceptualizations and the implementation of differentiation.

K–12 Preparation Focus

Through demographic data and open-ended responses, participants relayed exposure to and a preference for using a K–12 focus when preparing school counseling master's students. First, the majority of participants conveyed graduating from a CACREP-accredited doctoral program (53%) and current employment in a CACREP-accredited school counseling master's program (66%). Nearly all participants reported teaching the ASCA National Model in their preparation program (95%). Additionally, most participants (86%) reported working within states with K–12 school counseling

certification and licensure, and all (100%) participants' preparation programs met their states' certification and licensure requirements.

Through open-ended responses, several participants also described preferring and implementing a K–12 focus in preparing school counseling students. One participant said:

> I think we are doing a disservice to our SC graduate students if we specialize too much during their master's programs. It is important that they really understand the full range of developmental challenges and educational transitions so they can best collaborate across a comprehensive K–12 SC program.

Further, another participant stated: "Clearly there are level differences, but comprehensive programming needs to be K–12 and counselor education programs need to teach as such." A different participant described:

> I like that we prepare our students for elementary and secondary levels. This gives them the confidence to work at all levels once they graduate. I also think that training across levels is important to promote vertical articulation in school counseling programs and services.

Within the K–12 school counseling focus, participants valued some topic differentiation for elementary school counseling to reflect the unique components of that level. For example, two participants described the distinct differences between levels within a K–12, unified professional identity:

> In our state, our students earn a K–12 certification. . . . We try to do the best job we can in preparing students for working at ALL levels. . . . There are some areas where we need to provide specific differentiated knowledge or skills just for elementary-age, but there are many things that cut across all levels (e.g., strong collaboration, teaching, listening, meeting facilitation, student advocacy, partnering skills and clear sense of school counselor identity, professional advocacy, comprehensive planning).

Another participant suggested providing a unified professional identity overall, despite some differentiation for each level:

> The expectations . . . and the emphasis on specific roles, skills are different [for each level], and that needs to be addressed. . . . At the same time, too much differentiation can lead to more splintered identity and a less general skills set, which in the long run may not serve our graduates or their students well. [We are] striving for a balance of knowledge, skills and supervision that is level-specific with enough breadth of experience to solidify a professional identity.

Factors Driving Elementary School Counseling Preparation

Through open-ended responses and demographic data, participants described various drivers or influencing elements that impacted their decisions and beliefs regarding elementary school counselor preparation. Examples of drivers included state licensure and mandates; school counseling job opportunities; and student enrollment, motivation, and interest in elementary school counseling. According to participants, several external drivers impacted their school counseling preparation.

Several participants conveyed that various state licensing requirements and mandates influenced

their elementary level preparation. For example, the majority of participants (86%) reported their state certified or licensed school counseling K–12, and all participants (100%) identified that their preparation programs met the state certification or licensure requirements. Thus, most participants' school counselor preparation was driven by their state's K–12 certification and licensing requirements. Several participants echoed these sentiments in their open-ended responses, including: "The certificate [is] K–12 so students must be prepared for all levels," and "When I first started teaching about 13 years ago, there seemed to be a greater differentiation in levels. But within our state over the past year, the cert has moved to a PK–12, which better aligns with ASCA model roles and functions."

Next, most participants' states (70%) did not mandate elementary school counseling; thus, many participants did not feel they could prioritize elementary school counselor preparation. One participant stated: "Elementary school counselors are not required [in my state]." Another participant noted, "but for those of us in states with no mandate for ESC [elementary school counseling] positions, it's [focusing on elementary school counseling] not feasible."

Participants further described school counseling job availability as a driving force in their elementary school counselor preparation. A participant said, "we cannot offer courses specific to level based on the limited opportunities for elementary school counselors in our state," and "[it] would be hard to justify an elementary school counseling focus in my program . . . locally few school districts have them [elementary school counselors]." Similarly, another participant stated: "Our students get 90% of their jobs in high schools." Thus, participants may focus little on elementary school counseling due to the lack of available jobs.

Additionally, job availability and student interests were co-mingled driving forces. Some participants described implementing a K–12 focus in order to expose their students to a range of levels, in the event they cannot secure a job at their desired level. According to one participant:

> Frequently, students leave our program hoping to work at a particular level but due to job scarcity in the region where they chose to live, they need to obtain a job at a different level. Sometimes they end up loving the level where they end up even though it was not their first choice.

Another participant mentioned: "I find that some of our students don't necessarily go on to work at the level they interned at (or thought they would work at) and [the students] indicate they benefitted by being in courses that address all levels."

According to several participants, student interest in pursuing jobs at the elementary school level was low and offering courses specific to preparing the elementary school counselor was not feasible. According to one participant: "We cannot offer courses specific to level based on enrollment issues." Other participants stated the following: "We have a small program so we would not be able to offer classes for specific levels of school counseling practice," and "We also have very few students interested in elementary. For some reason, only about two students or less tend to be interested in elementary every year. Most prefer secondary." According to participants, students' preferences were driving forces in school counselor preparation programs' elementary school counseling focus. Generally speaking, participants' decisions and preferences regarding elementary school counseling differentiation and preparation were influenced by the driving factors, or contextual realities, associated with certification and licensure, state mandates, job availability, and student interests.

Discussion

The school counseling faculty in our study reported conducting and preferring a K–12 focus in preparing school counselors, which is similar to preparation standards, certification and licensure requirements, and suggested school counseling job activities (ACA, 2012; ASCA, 2012; CACREP, 2015). The K–12 school counseling preparation focus in this study also is consistent with findings from recent studies from Pérusse et al. (2015a) and Goodman-Scott (2015), in which participants reported little difference in preparation by educational level. Thus, despite school counselors in several studies reporting differences in job activities and perceptions by level, school counseling preparation programs may incorporate a K–12 focus.

However, within a K–12 preparation focus, participants did see the necessity for differentiating certain educational topics to the elementary school level more than others. The highest means for *current* and *preferred* differentiation items included classroom lessons, classroom management techniques, social and emotional issues, human growth and development, career exploration, and creative counseling techniques. In comparison with the literature, school counselors at the elementary level report performing classroom instruction and management more often than school counselors at the secondary level (Dahir et al., 2009; Perera-Diltz & Mason, 2008; Rayle & Adams, 2008; Scarborough, 2005; Studer et al., 2011). Additionally, Dahir and colleagues (2009) reported that elementary school counselors spend more time on personal and social development as compared to their secondary counterparts. Furthermore, Pérusse and Goodnough (2005) found that elementary school counselors placed more priority on human growth and development and creative counseling techniques, such as play therapy, than secondary school counselors. Differentiating topics specific to career exploration and college readiness suggest that the participants believed these topics to be developmental, or K–12 in nature. A developmental perspective related to college and career counseling is widely discussed within the school counseling literature (Gysbers, 2013; Pérusse, Poynton, Parzych, & Goodnough, 2015b; Trusty & Niles, 2004). For instance, the College Board National Office for School Counselor Advocacy (2010) differentiates college and career readiness objectives by educational level with a strong focus on career exploration at the elementary level, where high school counseling attends to college admission and post-secondary transition to college. In addition to a career exploration, Trusty, Mellin, and Herbert (2008) contended that elementary school counselors should focus on building caring school cultures and increasing opportunities for family engagement as part of the college and career focus.

Content topics that participants perceived as requiring little differentiation at the elementary school level were the professional skills and knowledge associated with leadership, cultural competency, social justice and advocacy, professional identity, and knowledge of federal and state policies. Hence, the school counseling faculty in our study conducted and suggested less differentiation for broad, philosophical topics often addressed in the literature as spanning K–12. For example, within the ASCA National Model (2012), leadership, social justice and advocacy are addressed within a K–12 framework for program implementation. The most recent version of the ASCA National Model (2012) does not distinguish the role responsibilities of elementary school counselors differently than the secondary level. Additionally, within school counseling literature, professional identity (Gibson, Dollarhide, & Moss, 2010; Konstam et al., 2015), leadership (Mason, 2010), social justice and advocacy (Ratts, Dekruyf, & Chen-Hayes, 2007) and cultural competency (Moore-Thomas & Day-Vines, 2010) are not discussed specific to the role responsibilities of counselors at different educational levels.

Not only did participants express differentiating some educational topics, but through their open-ended responses they conveyed varied perceptions of and experiences with the overall differentiation construct, including differentiating class discussions and assignments, specific courses, practical experiences, and differentiating school counseling courses from other counseling tracks, such as mental health counseling. The examination of the school counseling preparation differentiation construct has been nearly nonexistent in the literature. The results of this study demonstrate initial insight to school counseling faculty's perceptions and experiences regarding differentiation and the need for further related research.

Lastly, according to the school counseling faculty in our study, their preparation was driven by several external factors. Participants described their desire and actions to prepare school counseling students for all educational levels, K–12, which was often driven by K–12 state licensure and certification requirements. However, due to a lack of state-level elementary school counseling mandates, as well as limited job opportunities and student enrollment and interests, many school counseling faculty expressed concerns with and a lack of focus specifically on elementary school counselor preparation. In light of these external forces, it appears that the preparation of elementary school counselors may be less prioritized within a K–12 focus. Similarly, with the heightened national focus on college and career readiness, including the Reach Higher (The White House, n.d.) and Race to the Top (U. S. Department of Education, 2016) initiatives, and increased emphasis on college application rates, we wonder if elementary school counseling could be de-emphasized in national school counseling conversations.

Future Research and Implications

This study provided preliminary data on school counseling faculty members' perceptions of and experiences with preparing school counselors for the elementary level. The most substantial implication is our hope that this study will provide a springboard for future research, which may inform teaching and advocacy. First, we suggest future studies utilize qualitative interviews to gain in-depth information regarding school counseling faculty processes and conceptualizations of differentiation in pre-service school counseling preparation. Researchers also could develop an instrument to measure differentiation in school counselor preparation to better understand the construct and its application. Further, more research is needed to examine the impact of external drivers and how school counseling faculty and preparation programs address such external drivers, including state-level school counseling mandates, job opportunities and national initiatives. Specifically, how do these external drivers influence school counseling preparation, practice and policy? Finally, future research can examine school counselor preparation for all levels. For instance, are certain levels prioritized within a K–12 focus?

This study also contains interesting implications for teaching and advocacy. Our findings suggest that many school counselor preparation programs wrestle with preparing students for aspirational practice versus preparing students for the realities of the field. Research shows the benefits of implementing a school counselor-run CSCP from kindergarten through graduation; however, there are many barriers to doing so. School counseling faculty must teach students best practices and cultivate their professional identity, while also preparing students to navigate the current educational climate and advocate for systemic change, bridging the gap between ideal and real school counseling. Further, school counseling faculty also must advocate for systemic change, supporting state-level mandates requiring school counselors at all levels and ensuring that national school counseling conversations and initiatives are inclusive of a K–12 focus.

Limitations

We identified several study limitations. Web-based surveys reach a limited sample due to the need for e-mail addresses (Fowler, 2014), and e-mail solicitations may be undeliverable due to e-mail filters (Dillman et al., 2008). We attempted to mitigate these concerns by soliciting participants through various school counselor education outlets. Next, we enlisted a convenience sample, and participants may have been motivated to complete the survey due to their interests and experiences; thus, our sample is not necessarily representative of all school counseling faculty across states. At the same time, the goal of this study was not to generalize findings but to gather exploratory data to guide future inquiry. Lastly, despite providing a definition of differentiation in the survey, participants expressed differing views on this construct, which turned out to be one of our primary themes.

Conclusion

Scholars have shown that students benefit from fully implemented CSCPs, which are facilitated at the elementary, middle and high school levels. Elementary school counseling is a crucial foundation of K–12 school counseling, especially in regard to proactive prevention activities for all students. Thus, school counseling students should be prepared for school counseling across all three levels. While little research has been conducted on differentiating school counselor preparation for the three levels, this study provides findings regarding school counseling faculty's perceptions and experiences differentiating preparation for the elementary level, finding varying conceptualizations of differentiation, a K–12 preparation focus generally with some differentiation of school counseling topics, and factors driving elementary school counseling preparation. While more research is needed to further examine and expand on our study, there also exists a need to take stock of these preliminary findings. Participants reported several barriers to school counseling preparation at the elementary level. School counselors and school counseling leaders must investigate and advocate for the role and existence of the elementary school counselor to ensure that K–12 school counseling truly remains K–12, and that all students in K–12 can be served by a school counselor.

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The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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Meeting the Mental Health Needs of Syrian Refugees in Turkey

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Movements such as the Arab Spring (as described by popular media) and recent regional conflicts have forced people to leave their homes and flee to other countries or regions. Syrian refugees are currently the second largest refugee group worldwide, with half of them resettled in Turkey. Turkish government and non-governmental civil organizations have mobilized efforts to address the immediate survival needs of these refugees such as food, shelter and other provisions. Despite efforts to manage the complexity of mental health and social service needs of forcibly displaced people, counseling services are still lacking. This expository article addresses the mental health needs of Syrian refugees and provides implications for counseling professionals working with displaced people from a crisis intervention approach built on principles and perspectives of humanistic mental health. In addition, programs of support, such as the Mental Health Facilitator program, are discussed.

Keywords: **Syrian refugees, mental health, Turkey, displaced people, Arab Spring**

The Arab Spring has affected many Arabic countries in the region and resulted in regime changes and general disruption in people's lives (Khan, Ahmad, & Shah, 2014). The Arab Spring refers to a wave of revolutionary civil unrest, riots, demonstrations and protests in the Arab world that began in December 2010 in Tunisia, and spread throughout the countries of the Arab League and its surroundings ("Arab Spring", n.d.). The Syrian Republic is embroiled in a civil war in which separatists have been protesting for more democratic rights and the imposition of a civilian government. The region has been further destabilized by the conflict surrounding ethnic origin, and the political and religious activities of the Islamic State of Iraq and Syria (ISIS).

Approximately 6 million people have taken refuge in Turkey, Lebanon, Jordan, Iraq and Egypt since the Syrian conflict began in 2011 (United Nations High Commissioner for Refugees [UNHCR], 2016). According to the UNHCR (2016), the Republic of Turkey (Turkey) has accommodated the largest number of Syrian refugees in the region. The Turkish government quickly took the necessary steps, such as opening the border and providing food and shelter, after the first group of Syrian refugees entered Turkey on April 9, 2011. To date, there are roughly 2.8 million refugees living in camps and urban areas; half of these refugees are children (UNHCR, 2016). The majority of refugees (90%) live outside of camps and are surviving under challenging circumstances compared to the refugees who live in camps. Refugee camps offer health care, education, food, security and social services. However, refugees who live outside of camps have limited access to information and public services such as education and health care.

Syrian refugees are enduring daily challenges to physical and mental survival. In addition to the extreme needs for physical and nutritional interventions, mental health professionals recognize the urgent need for counseling services based on widespread documented reports of refugees' exile

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experiences and exposure to multiple sources of trauma (Sirin & Rogers-Sirin, 2015). This crisis has resulted in a population of displaced people suffering from a number of mental health issues (Alpak et al., 2014; Betancourt et al., 2015; Clarke & Borders, 2014; Özer, Şirin, & Oppedal, 2013). For example, Önen, Güneş, Türeme, and Ağaç (2014) conducted a quantitative study on Syrians who resettled in refugee camps. The results indicated that 19% of refugees reported high levels of anxiety and 9% experienced high levels of depression. In a recent study, Alpak et al. (2014) reported that approximately one third (33.5%) of Syrian refugees showed symptoms consistent with a diagnosis of post-traumatic stress disorder (PTSD).

The fact that many of the displaced Syrians are especially vulnerable children living far from their homes, cultures and countries further highlights the magnitude of the crisis (Özer et al., 2013). Recent reports indicate that up to 50% of the Syrian refugees are children suffering from exposure to severe traumatic events at rates higher than their adult counterparts (Sirin & Rogers-Sirin, 2015). Özer et al. (2013) reported that 74% of Syrian children in a refugee camp have experienced the loss of a family member or a loved one, and 60% of children felt their lives were in danger. These self-reports of distress and concern are consistent with another recent study of 8,000 displaced Syrian children who reported constant fears (15.1%) and suicidal thoughts (26%; James, Sovcik, Garoff, & Abbasi, 2014).

Several indicators suggest that the severity of the current Syrian refugee crisis is unprecedented. A recent meta-analysis compared the relative rates of mental health disorders between refugees from different world regions and ultimate country of relocation (Fazel, Wheeler, & Danesh, 2005). Fazel et al. (2005) found that while up to 10% of refugees who relocated in Western countries experienced symptoms of PTSD, major depression and generalized anxiety disorder, the frequency of these diagnoses is significantly greater among the current Syrian refugee population (Alpak et al., 2014; Önen et al., 2014). For example, Syrian refugees who resettled in Turkey had a higher incidence of mental health disorders when compared to refugees from Southeast Asia, former Yugoslavia, and Central America who settled in Western countries (i.e., United States, Australia or Canada) collectively referred to as the Organization for Economic Cooperation and Development.

Recognizing the severity of the crisis, Turkey has initiated legal reform, established programs and practices, and requested humanitarian assistance from the international community to help manage the influx of Syrian refugees (Özden, 2013). Turkish government and non-governmental civil organizations have mobilized efforts to address the immediate survival needs of refugees, such as providing food and shelter. Despite these efforts, the available resources, including the number of counselors and other qualified mental health professionals, are inadequate to deal with the constant flow of Syrian refugees (Sahlool, Sankri-Tarbichi, & Kherallah, 2012). The vestiges of war have resulted in an increase in the prevalence of a number of psychosocial stressors and disorders (e.g., PTSD) as well as total desolation of social networks of family, friends and loved ones (Akinsulure-Smith & O'Hara, 2012). These challenges underscore the complexity of mental health and social service needs of forcibly displaced people in the region (Alpak et al., 2014).

This article highlights the challenges faced by the Turkish government related to a humanitarian response to the Syrian refugee crisis. Suggestions are provided for designing appropriate responsive counseling services for refugees from a diversity of sociocultural and geopolitical contexts. Principles and best practices (grounded in humanistic counseling theory) for addressing the mental health needs of diverse displaced people are discussed. Opportunities for generalization and specific cultural applications and adaptations are presented as well.

The Syrian Culture

Syria is located in Southwestern Asia at the eastern end of the Mediterranean Sea. It has its longest border with Turkey on the north, and is bordered by Israel and Lebanon on the west, Iraq on the east, and Jordan on the south. The majority of Syria's population consists of Arabs (90.3%) and the remaining 9.7% consists of Kurds, Armenians and others (The World Factbook, n.d.). Religiously, Syria is a mosaic society. The vast majority of the population (87%) consists of Muslims (74% are Sunni and 13% are Alawi, Ismaili and Shia). Christians (Orthodox, Uniate, and Nestorian) are the largest single minority religious group (10%), and 3% of the population consists of Druzes (The World Factbook, n.d.). Before the beginning of the civil conflict (between the Syrian government and groups of citizens), positive intergroup relationships, for example between Christians and Muslims, were readily observed. However, the current situation of intergroup relationships is unknown since the political equilibrium has changed and continues to change rapidly.

Adherence to religious principles and cultural edicts are fundamental to a typical Syrian's daily life. Islamic creeds and beliefs, such as *Iman* (faith) and *Qadar* (destiny), are elemental and strictly proscriptive of Muslim lifestyle (Eltaiba, 2014). Accordingly, traditions and customs associated with family life (relationships, marriages and future plans) are rooted in cultural and religious traditional practices. Family life is the center of Syrian social structure and extended families are the most common family type (Mahdi, 2003). Intermarriages between ethnic groups, religions and social classes are rare. As an authority figure, the father or the eldest man (grandfather) in the household has the power and is the foundation of a patriarchal structure, giving an advantage to males (Mahdi, 2003).

Addressing the Needs of the Syrian Refugees

Turkish officials have utilized a physiological and psychological needs-based approach (Inter-Agency Standing Committee [IASC], 2007) in the planning for a response to the refugee crisis. The approach has largely been adapted from humanitarian organizations (e.g., Red Crescent, UNHCR) that provide relief, crisis interventions and emergency services. Counseling services are usually not the immediate priority of refugees; most refugees will not seek available counseling or even be able to take part in counseling activities if they do not have a roof over their heads or food in their stomachs and are struggling to survive (International Federation of Red Cross and Red Crescent Societies [IFRCRCS], 2009). Consistent with Maslow's (1943) original theory, crisis intervention efforts need to address the most immediate needs that threaten basic survival (e.g., hunger, safety) first. Once these basic needs have been met, individuals can address other difficulties associated with the experience of trauma (IFRCRCS, 2009). In this respect, the crisis level and needs of refugees determine the priority of counseling and psychosocial support services. National and international mental health crisis intervention organizations (IASC, 2007; IFRCRCS, 2009), such as the Turkish Red Crescent organization, have adopted IASC guidelines (2007) and the recommended four-level approach, which is described below, to assess the urgency of needs for refugees and victims of natural disasters.

Level 1: Basic Needs and Security

Syrian refugees are in need of basic services such as shelter, nutrition, education, medication and health care services. Approximately 1.4 million Syrian refugees are children (Orhan & Gündoğar, 2015; UNHCR, 2016), and the United Nations Children's Fund (UNICEF; 2014) has reported that these children are at risk of being a "lost generation." Moreover, security is a source of distress because of recurring aggression towards refugees who live out of the camps. These events continue along the border with Turkey. For example, a car bombing killed 57 refugees and wounded at least 80 Syrians near a border crossing between Turkey and Syria (UNICEF, 2014).

Level 2: Situation of the Community and Family Support

There is a sense of distrust within the Syrian refugee community that is rooted in the ongoing conflict in Syria (Chammay, Kheir, & Alaouie, 2013). Displaced persons from both sides of the conflict are often resettled together, despite differing political affiliations. Refugee families are struggling to survive in the midst of widespread fragmentation. For instance, Özer et al. (2013) reported that 74% of children in the Islahiye refugee camp had experienced the loss of a family member, affecting the well-being of the whole family.

Level 3: Focused, Non-Specialized Counseling Support

According to the Disaster and Emergency Management Presidency (DEMP; 2013), 51% of Syrian refugees report a need for some form of psychological support. In the same report, approximately 26% of refugees indicated dissatisfaction with the mental health care they received. In parallel with this finding, Chammay et al. (2013) stated that Syrian refugees felt disrespected by the mental health professionals.

Level 4: Specialized Counseling Services

In Turkey, counseling services are different than those in the United States and other developed countries. Turkish counseling services have focused exclusively on school settings and most counselors work as school counselors (Korkut, 2007; Stockton & Yerin Güneri, 2011). When compared to the United States, there are no specializations in the counseling education system in Turkey, such as clinical mental health, career counseling and addictions counseling. In Turkey, mental health services are provided within the medical field; thus, the majority of professionals who work in mental health have consisted of psychiatrists and nurses (Yilmaz, 2012). This situation has affected the availability of counseling and mental health services for Syrian refugees seeking assistance. The efforts of DEMP, Red Crescent, UNHCR, and other non-government and non-profit humanitarian organizations (e.g., Humanitarian Relief Foundation, Support to Life) are not enough to meet the counseling and mental health needs of Syrian refugees.

Mental Health Needs

Empirically validated research on the mental health needs of the Syrian refugees in Turkey and other countries (e.g., Lebanon) is limited due to a lack of focus on the assessment procedures and diagnostic reporting (Chammay et al., 2013). As documented by previous reports of forcible displaced peoples, Syrian refugees are at especially high risk for mental health problems as well as social and physical concerns and uncertainty about the future and current situation in Syria. Individual accounts of extensive violence, death and war illustrate the distress of refugee life at the personal level. For example, the following illustrates one refugee's account of witnessed chaos in Syria:

> The soldiers were gathering men in some areas. They interrogated a father, "Which one is your son?" the soldier demanded. The desperate man pointed out his son. The soldier then cut the man's son's throat first, then they shot the father. They were killing and burning so many people that the smell of burning bodies spread through the entire city, like a blanket of death smothering any hope of survival. (Korucu, 2013, p. 90)

This story highlights not only the experience of physical pain, but also fears, losses and spiritual wounds associated with protracted exposure to physical and emotional trauma. Although all refugees did not experience traumatic events or witness a massacre, they fled with other refugees who experienced loss, trauma and torture. The stories spread to others in camps and in the media, and as a result many fled to other countries to protect themselves and their loved ones.

Each refugee client has different needs, and "not every refugee who seeks counseling will require individual therapy for psycho-emotional issues. Counselors should not assume simply because of a traumatic background, intense loss, and other aspects of refugee experience that a refugee is necessarily psychologically impaired" (Baker, 2011, p. 122). In addition to basic physical needs, counselors need to be aware of and focus on the wellness and psychological needs of refugees. Research on well-being (Davidson, Murray, & Schweitzer, 2008) has highlighted the fact that health and wellness is indicated by more than a "lack of diagnosis" (Savolaine & Granello, 2002). There are common concerns that affect refugees in general. For instance, distress about the future, housing, employment, and separation from the family and the culture of the host country or community are predominant issues in refugees' lives. These factors affect their emotions and holistic wellness (Clarke & Borders, 2014; Tempany, 2009). There are specific situations that affect the mental health of Syrian refugees. First, 83% of Syrian refugees have experienced a traumatic event (Chammay et al., 2013). The intensity of the experience and duration of exposure may affect the level of mental health. Stories and experiences of refugees who were exposed to the traumatic events can frighten other refugees who did not experience a traumatic event, triggering anxiety and stress. Second, unmet physiological needs may exacerbate feelings of insecurity and affect healthy psychological responses. Moreover, refugees' lack of personal awareness of their own mental health needs can affect help-seeking behaviors. Third, there may be acculturative stress stemming from cultural differences and adaptation to the host culture, which can adversely affect mental health factors after immigration. Specifically, high risks exist for children who lost one or both of their parents in the war. Last, hearing about and seeing people continuing to die in the conflict through news and social media can increase or sustain depression and PTSD symptoms (Alpak et al., 2014).

These compounding mental health issues exacerbate the daily struggles faced by Syrian refugees and underscore the need for mental health intervention (Alpak et al., 2014; James et al., 2014; Özer et al., 2013). One of the most important counseling services would be multicultural transition and adaptation to a new (even if only temporary) living situation.

The Availability of Multiculturally Competent Mental Health Counselors

The impact of a counselor's awareness of personal cultural values and a client's worldview is foundational to multicultural counseling competence (Arredondo et al., 1996). We believe that mental health professionals in Turkey will be better able to provide culturally sensitive counseling support to refugees when they make efforts to understand and appreciate the customs and traditions of their Syrian clients (Arredondo et al., 1996). Despite the proximity and often shared religious ideology, considerable differences between Turkish and Syrian citizens (e.g., language, beliefs, cultural practices) may influence the quality of social services refugees receive in their host country. Although Turkey is the neighbor of Syria and shares many cultural and historical ties, a healthy process of cultural transition and adaptation is needed for refugees. More counselors, mental health facilitators (MHFs) and interpreters are needed to provide adequate mental health services, guide the refugee community in meeting their physiological needs, and inform the host culture to decrease prejudice.

Barriers, Challenges and Implications for Counseling

Counseling professionals need to be mindful of the diversity of displaced people. The majority of Syrian refugees fleeing to another country for survival bring different political experiences, levels of education, religions, ethnicities and levels of income to the resettled environment **(**DEMP, 2013**)**. Counselors may face some challenges and barriers to providing services when working with this unique population. These challenges may include, but are not limited to, language, culture and dependence on Western-based counseling interventions. For example, some refugees might not

attend group counseling if they are assigned to the same group with refugees who have different religious beliefs or ethnicity (Eltaiba, 2014). In such cases, counselors' sensitivity and skills for addressing issues of cultural heritage and historical background of culturally different clients can transform disadvantages into advantages (Sue, Arredondo, & McDavis, 1992). There are effective resources and handbooks that provide detailed guidelines for working with refugees and forced migrants (Hinkle, 2014; IFRCRCS, 2009; UNHCR, 2013). A counselor can create his or her own guidelines for specific or general challenges of working with a refugee population. Specifically, when counselors work with Syrian refugees to create treatment plans, they should consider clients' culture, religion, ethnicity, worldview and language in order to be more effective.

Language Barriers

The majority of Syrian refugees have resettled in Jordan, Lebanon, Iraq, Egypt and Turkey (UNHCR, 2016). While Syria, Jordan, Lebanon, Iraq and Egypt are Arabic countries and have a common culture and language, the majority of people in Turkey have a Turkish heritage and speak Turkish. Furthermore, the availability of Arabic-speaking counselors in Turkey is limited. Government organizations and social service agencies have experienced difficulty finding bilingual personnel as well (e.g., medical doctors, counselors; DEMP, 2013). Providers have responded by employing language interpreters to facilitate counseling contacts with refugees. Language barriers may create trust issues due to the existence of a third person in the session and it may be difficult for the counselor to establish rapport with the refugee client (Akinsulure-Smith & O'Hara, 2012; Baker, 2011). In this respect, several best practice approaches for maximizing the beneficial usefulness of interpreters are warranted. First, counselors may need to meet with the interpreter to explain confidentiality and the goals of the counseling interview; discuss the interpreter's cultural background and cultural expectations; explain the need for detailed translation in the assessment; and discuss seating positions in the session (Baker, 2011; Paone & Malott, 2008).

When counselors work with interpreters they also need to consider interpreters' citizenship status. Interpreters who are themselves refugees may be vicariously vulnerable to experiences reported by clients. Therefore, a program of careful screening, ongoing training, supervision and support for interpreters is vital (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Programs of support, such as the National Board for Certified Counselors' (NBCC) Mental Health Facilitator (MHF) program (Hinkle, 2014), would be helpful for Turkish counselors and interpreters. The MHF program covers the global aspects of community-based mental health training. The MHF initiatives are designed to empower local community members with skills for providing basic mental health services to people who are in crisis (Hinkle, 2014). By working with local volunteers, the MHF programs bridge the gap created by limited access to mental health services provided by mental health professionals, such as professional counselors, psychiatrists, social workers and clinical psychologists. The MHF curriculum includes implementation strategies for nonclinical, basic assessment, social support and referral services (Hinkle, 2014). While the current MHF curriculum and materials are available in the Arabic language, recent reports indicate that materials have not yet been translated to Turkish. Access to culturally sensitive training programs like MHF may be a crucial element to increasing the impact of mental health initiatives targeting refugee populations. Turkish governmental authorities and non-profit organizations would be wise to take immediate action with NBCC to adapt this program to Turkish.

Language immersion efforts are one promising approach to minimizing the impact of linguistic barriers. For example, approximately 87% of the Syrian refugees in Turkey reported that they wanted to learn Turkish (DEMP, 2013). The government and non-profit organizations have Turkish courses for refugees in the camps and cities. Counselors may use these classes as one of their referral sources.

The classes also give an opportunity for clients to attend an activity, engage in the society, meet with new people from their own cultures and communicate with local residents.

Challenges Due to Refugee-Host Community Relations

A rapid influx of migrants can place considerable stress on the fiscal and emotional resources of the host country (Orhan & Gündoğar, 2015). The current Syrian refugee crisis has shifted from a humanitarian to a political crisis for other countries (e.g., Germany, Sweden, France; Hebebrand et al., 2016). Many refugees who live in Turkey are trying to fly to other European countries. However, politicians of those countries are not willing to accept refugees because of security, resources and possible dissent of their citizens (Hebebrand et al., 2016).

Although Turkey and Syria have longstanding historical ties and similar cultural and religious orientations, refugees will almost certainly experience acculturative stress, oftentimes as a result of negative reception from the host country (Betancourt et al., 2015). For instance, residents of the Gaziantep province, which has the second highest number of Syrian refugees in Turkey, protested against refugees and initiated physical attacks on them. The conflict increased the tension in the city and forced authorities to resettle some refugees in other provinces.

Bektaş (2006) has indicated that attempts at a multicultural curriculum in Turkish counseling education programs are not enough, and there is not a current mechanism or system (e.g., CACREP) to promote multicultural counseling competencies among Turkish counselors. Governmental and non-profit organizations need to consider diversity and ethical considerations when recruiting counselors for counseling and mental health services. The Turkish government's policies toward the ongoing situation in Syria might polarize the government officials and mental health professionals who work with the Syrian refugees. At this point, counselors should be aware of their own personal views, biases and political ideas. They should be able to focus on their role as counselor rather than as resident or citizen.

With respect to provision of clinical mental health services, tensions between residents and refugee groups may interfere with effective receipt of counseling interventions by refugees. These events might cause mistrust towards counselors since they can be seen as part of the system, members of the host culture or representatives of the authorities (Vanguard, 2014). Holistic and advocacy-based services are more beneficial for refugees to cope with cultural difficulties (Baker, 2011; Clarke & Borders, 2014). These services include psychosocial support, counseling, referral sources, education and programs for the host community. Furthermore, counselors can provide additional services, which are not listed here, based on the needs of refugee clients.

Cultural and Spiritual Challenges

Syria represents an Eastern culture with dominant collectivist characteristics (Samovar, Porter, & McDaniel, 2010). The religion of Islam plays a role not only in individuals' personal lives, but also in social life and society. Religion and spirituality are a way of life for Muslims across different cultures (Eltaiba, 2014). Religion determines the relationship between men and women, social roles, laws of inheritance, what people can and cannot eat, childcare, marriage and more. In addition to the culture of religion, traditions guide people's lives as well. As mentioned before, the Syrian culture has a patriarchal structure. In this situation, men have more rights and freedom than women (Mahdi, 2003). For example, this patriarchy can create problems when counselors plan for group counseling. It can be difficult for women to talk about or share their problems in front of men. In this respect, dividing groups based on gender can be more effective.

In such cases, religion and spirituality can be explored in individual counseling sessions. Research has shown that religious coping can be used effectively by refugees (Clarke & Borders, 2014). For example, a Muslim refugee client might think that he or she deserves the current circumstances and whatever happens is Allah's will. This belief represents the basic idea of *Qadar* – destiny or fate – and should be addressed carefully by the counselor because *Qadar* includes the individual's will and belief that everything comes from Allah/God, and since refugees are under stress they can give up all the responsibility to Allah or God. A holistic approach that focuses on both the individual's and society's values and needs should be implemented since culture and religion provide significant means for coping.

Challenges With Counseling Interventions

Many migrants and forced refugees are not familiar with the concepts of counseling, which might seem strange to them (Akinsulure-Smith, 2009; Akinsulure-Smith & O'Hara, 2012). Refugees need to understand the services available in order to benefit maximally from them. The government and humanitarian agencies need to use terms that make sense for Syrians. When organizations prepare brochures, handbooks, reports and name plates, they should explain available mental health and counseling services, define *counselor*, and explain their services. Most Turkish counselors who work with Syrians were educated in Turkish counseling programs, which were modeled on U.S. programs and included Western-based counseling theories (Mocan-Aydin, 2000). This Western-based education and theories might decrease the effectiveness of counseling and challenge counselors because Syrians come from an Eastern culture. Since they have moved to a new culture, been separated from families, and experienced pressure and persecution, many refugees do not understand their new culture or know where to find help. In this respect, a group of Syrian mental health facilitators trained with the NBCC MHF program can be a valuable resource for working with this population (Hinkle, 2014). The inclusion of trained community volunteers will likely increase refugees' access to mental health services while simultaneously decreasing the work load of professional counselors.

Conclusion

Over 2.8 million Syrian refugees have resettled in Turkey in the period of 2011 to 2016 (UNHCR, 2016). As the refugee population continues to grow, host nations will need to prepare a systematic response to this continuing humanitarian crisis in ways that support the basic human needs of forcibly displaced people. The Turkish government has responded to the presence of Syrian refugees with interventions that support basic survival needs (i.e., food and shelter). The availability of mental health and social services for refugees is limited and remains a focus of humanitarian assistance. Counselors should be cognizant of the traumatic experiences refugees often endure in the context of displacement and ongoing conflict. Counselor training and facilitation of community-based mental health advocates such as those provided by MHF can increase the impact of available counseling interventions for refugees. In addition, the IASC four levels crisis intervention approach, which is used by the Turkish Red Crescent organization, can be beneficial to address traumatic experiences and the needs of refugees.

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Violence and Residual Associations Among Native Americans Living on Tribal Lands

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The article reviews the empirical literature regarding exposure to violence among Native Americans living on tribal lands. The prevalence of various types of violence experienced by this population is identified. Predictive characteristics correlated with higher rates of violence among Native Americans living in tribal communities have been reported by researchers to include socioeconomic status, unemployment, gender, cultural affiliation, substance abuse, relationship status, history of violence exposure, and adverse childhood experiences. Residual associations include PTSD, anxiety, depression, chronic pain, substance abuse, promiscuity, suicidal ideation, communal deterioration, and cardiovascular disease. Barriers for addressing mental health needs in this population, implications for mental health counselors and directions for research are provided.

Keywords: **Native Americans, tribal lands, violence, predictive characteristics, residual associations**

The treatment of Native American populations has not been a traditional area of focus among mental health researchers (Matamonasa-Bennett, 2013). However, a push for increased knowledge in the effective treatment of this population has led to an influx of empirical attention in the past few decades. The National Congress of American Indians declared violence against Native Americans, particularly those living on tribal lands, as the most critical issue faced by Native Americans (Matamonasa-Bennett, 2013). Complicating the interpretations of the subsequent studies, Evans-Campbell (2008) concluded significant differences between Native Americans living on tribal lands and Native Americans living in urban areas. It is critical that counselors be cognizant of such within-group differences (Brown-Rice, 2013). Research efforts related to Native American populations living in tribal communities have predominately focused on exposure to violence. In order to bridge the gap in understanding how violence impacts Native Americans, the current review addresses the prevalence, predictive characteristics and residual associations related to violence among Native American men and women living on tribal lands. Moreover, the barriers to addressing mental health treatment among this population are discussed. Implications for counselors and directions for research are provided.

Violence and Mental Health Issues for Native Americans

Violence can consist of physical, sexual and emotional assault (Watts & Zimmerman 2002). Many acts of violence can be characterized as a combination of these categories, such as a sexual assault that also produces physical harm to the survivor. Physical violence can include assault, neglect of basic needs (which is most common among children), exploitation of labor and false imprisonment. Sexual violence includes rape, fondling, genital mutilation and sex trafficking (Watts & Zimmerman, 2002). Emotional violence includes isolation, verbal abuse, economic abuse, coercion, threats and intimidation (Pence & Paymar, 1993). Because violence is often conceptualized as a means to gaining or maintaining power and control over others, a survivor of violence is often victimized by those closest to him or her, such as a family member or friend (Watts & Zimmerman, 2002).

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Post-traumatic stress disorder (PTSD) has been associated with exposure to physically, sexually and emotionally violent experiences (Ford, Grasso, Elhai, & Courtois, 2015). Traumatic stress symptoms are often more complicated to treat in circumstances when an individual has been exposed to prolonged or repeated violence. Furthermore, these symptoms are more likely to develop when survivors of violence feel a sense of betrayal from the perpetrator, which is often reported by those who experience sexual assault and domestic abuse (Ford et al., 2015). Researchers have concluded that these issues are more prevalent among Native Americans living on tribal lands (Malcoe, Duran, & Montgomery, 2004; Yuan, Koss, Polacca, & Goldman, 2006), which may suggest a higher likelihood for the development of PTSD when compared to other populations.

Although PTSD is the mental health disorder most often associated with individuals who experience violence, depression (Cascardi, O'Leary, & Schlee, 1999) and anxiety (Pico-Alfonso et al., 2006) symptoms have been highly correlated to violence exposure. Clearly, those who survive violence are at high risk of developing mental health symptoms and can benefit from professional intervention. However, the experiences of Native Americans related to violence are not likely to be completely congruent to other populations (Sue & Sue, 2012). For this reason, it is crucial for counselors to gain increased competency in the unique factors impacting the Native American community in order to provide effective care.

Violence Against Native American Women

United States legislators acknowledged in the 2005 Violence Against Women Act (VAWA) that Native American women living on tribal lands were a particularly marginalized population (Crossland, Palmer, & Brooks, 2013). VAWA mandated that several governmental organizations begin a series of research efforts in order to better understand the prevalence and residual consequences experienced by this population when violence was present (Crossland et al., 2013). Bryant-Davis, Heewoon, and Tillman (2009) concluded that the studies succeeding VAWA indicated that violence against women had significantly decreased in the 10 years preceding the studies for every population except Native American women. These researchers also concluded that Native American women living on tribal lands account for the highest rates of exposure to violence compared to any other population. Despite these conclusions, Matamonasa-Bennett (2013) reported that Native American women continue to be underrepresented in research regarding violence against women.

Prevalence of Violence Against Native American Women

Determining the precise prevalence of violence among Native American women living on tribal lands is a complicated endeavor. There can be substantial differences between communities, leading to frequent misinterpretation in the results of research (Yuan et al., 2006). It is common that researchers report the prevalence of violence among *Native Americans*, even though the results of their studies accounted for the prevalence among a specific *tribe*. For this reason, it is important not to make generalizations regarding reports that do not expand to various regions by examining the methodological decisions of the researchers in order to better interpret the results (Gone, 2010). In response to the need for clarity on the prevalence of violence in tribal communities, Oetzel and Duran (2004) concluded that many researchers asked vague questions and excluded common types of physical violence, prompting them to investigate exposure to violence among Native American women by asking a wider range of specified questions. They determined that women in tribal communities reported the prevalence of violence exposure at rates ranging from 46–91%. They compared these results to non-Native populations, which had previously reported prevalence rates ranging from 7–51%. Similarly, Wahab and Olson (2004) examined the prevalence of physical violence among Native American women living on tribal lands while accounting for vast differences

between tribes. These researchers concluded that this population experienced higher rates of physical violence than women of any other ethnicity.

While researching violence among Native American women, many researchers have focused on domestic violence. In a study spanning 12 distinct tribal communities, researchers reported that 58.7% of Native American women had been victims of domestic violence, resulting in severe physical trauma in 39.1% of these women (Malcoe et al., 2004). Hart and Lowther (2008) reported domestic violence incidents had increased each of the past 10 years prior to their study, indicating that this issue is escalating in tribal communities. Moreover, Native American women have reported higher levels of re-victimization than other female populations (Urquiza & Goodlin-Jones, 1994). L. Jones (2008) concluded that Native American women living on tribal lands found it difficult to leave violent relationships due to communal feedback which encourages victims to protect their abusers. Because Native American women are more likely than other women to be recurrently assaulted, there may be implications for the development of complex traumatic stress symptoms (Ford et al., 2015).

Sexual assault also appears to be a common form of violence experienced by Native American women. Prevalence rates of rape among this population have been reported as high as 34.1%, which is nearly twice the rates among other women in the United States (Tjaden & Thoennes, 2000). Behaviors of perpetrators of sexual assault on tribal lands also have been studied among researchers. When surveyed about sexual assault history, Native American women living in tribal communities have reported male relatives as the most often cited perpetrator of sexual assault, accounting for 55% of the incidents (Yuan et al., 2006). Significant percentages of perpetration of sexual assault also have been attributed to romantic partners (46%), acquaintances (29%) and strangers (28%). The likelihood of developing complicated traumatic stress symptoms may be increased due to the high frequency of sexual assault of Native American women by individuals who are familiar to them (Ford et al., 2015). Moreover, it appears that once a Native American woman living on tribal land is exposed to sexual violence, the likelihood of subsequent exposure is high. The recurrence of sexual assault among this population has been reported to be as high as 79% (Roodman & Clum, 2001).

Predictive Associations of Violence Against Native American Women

Malcoe, Duran, and Ficek (2002) concluded that socioeconomic status is a significant predictor of exposure to violence among Native American women living on tribal land. Specifically, women who have reported low socioeconomic characteristics are two and half times more likely to be exposed to physical violence (Malcoe et al., 2002; Oetzel & Duran, 2004). Specifically, it was reported that Native American women living on tribal lands who were receiving governmental financial assistance were nearly two and a half times more likely to report exposure to physical violence. According to the United States Census Bureau (2014), less than half of the residents of the Pine Ridge reservation in South Dakota were employed between 2010 and 2014. As a result, 52.2% of those living in this area were below poverty standards, which is well above the national average of 14.8%.

Native American women living on tribal lands with substance abuse issues are at a higher risk for exposure to both physical and sexual violence (Yuan et al., 2006). Substance abuse issues among individuals close to Native American women have been reported to predict exposure to violence. Native American women with alcohol abuse issues, for example, reported significant levels of exposure to domestic violence (Yuan et al., 2006). Furthermore, Native American women have reported heavy alcohol use by 62% of their perpetrators, compared to 42% from women of other ethnic backgrounds (Ferraro, 2008). There is evidence to suggest that Native American women living on tribal land who identify with traditional Native American culture are less likely to be associated with substance abuse and related physical violence (Whitbeck, Adams, Hoyt, & Chen,

2004). Conversely, Native American women living on tribal land who report higher associations with traditional Native American culture have reported increased frequency of exposure to sexual violence (Yuan et al., 2006). However, increased focus on traditional Native American culture could be a coping mechanism used by women following victimization, potentially making cultural affiliation a residual effect of violence.

When considering sexual violence, the factor most predictive of exposure in Native American populations has been concluded to be gender (Yuan et al., 2006). Both Native American men and women are sexually assaulted, but Native American women report sexual assault at rates 14 times higher than males (Yuan et al., 2006). The relationship status of women living on tribal lands also has been correlated to exposure to sexual violence. Women engaged in cohabitating relationships and women separated and divorced were concluded by researchers to be at a higher risk for sexual violence (Bryant-Davis et al., 2009). Moreover, Bryant-Davis and Ocampo (2006) postulated that Native American women are sexually assaulted at higher rates than women of other ethnicities due to systematic eroticization, devaluation and objectification by American culture.

Yuan et al. (2006) reported that Native American women living on or near tribal lands who experience emotional abuse as children report significantly higher rates of sexual violence exposure as adults. Similarly, women in this population who have survived sexual and physical abuse before the age of 18 are more likely to be raped in adulthood. Because a history of emotional, sexual or physical abuse appears to significantly contribute to the predictability of future exposure to violent traumatic stressors, increased attention on providing interventions to young Native American populations may prove beneficial for prevention efforts (Yuan et al., 2006).

Residual Associations of Violence Against Native American Women

Arbuckle et al. (1996) concluded that Native American women are three times more likely to be murdered than Latino and White women. Hence, death is a relatively common residual association to violence among this population. Witnessing homicide also can be a form of exposure to violence. When homicide occurs, there are often secondary victims seeking mental health services. Family and friends of a victim of homicide within the Native American population often report cognitive patterns of self-blame, which exacerbates mental health symptoms (Weinberg, 1994).

Native American women exposed to physical violence have reported high levels of traumatic stress symptoms (B. Duran et al., 2009). In a study that surveyed 3,084 Native Americans living on tribal lands across the United States, women reported PTSD symptoms with a frequency twice the rate of men (Buchwald, Goldberg, Noonan, Beals, & Manson, 2005). It was concluded that 16% of women living on tribal lands met the criteria for PTSD, which is 6% higher than the national average for women (Ford et al., 2015). Exposure to violence on tribal lands also has been associated with increased likelihood to develop mood disorders, anxiety disorders (B. Duran et al., 2009) and chronic pain (Buchwald et al., 2005).

The relationship between exposure to violence in tribal communities by Native American women and mental health disorders was examined by Oetzel and Duran (2004). These researchers concluded that physical injuries and medical assistance on tribal lands were highly correlated with symptoms of depression and that increased exposure to violence appeared to lead to negative sociological effects such as unemployment. Oetzel and Duran theorized that exposure to physical violence on tribal lands could be directly linked to chronic pain and psychological symptoms which limit the capacity for Native American women to change their environment when desired.

It is common that persons exposed to violence display high-risk behaviors, including substance abuse and sexual promiscuity (Hobfoll et al., 2002). It is believed that these behaviors can be conceptualized as a means of coping with traumatic stressors (Ford et al., 2015). Substance abuse, which has been identified as a predictive factor to physical violence exposure, also appears to be a residual association. Saylors and Daliparthy (2005) concluded that Native American women often use alcohol and illicit drugs in order to numb cognitive and emotional reactions to physical and sexual violence. Furthermore, among Native American women living in tribal communities, those with a history of exposure to violence are five times more likely to contract sexually transmitted infections when compared to women with no history of exposure to violence (Hobfoll et al., 2002). As a result, this population is more likely to contract HIV than women in other communities. When the spread of sexually transmitted infections is intentional or the risks are disregarded by carriers, it can be conceptualized as sexual abuse, even when sex is consensual. When considering the spread of HIV, this act can be criminal (Hobfoll et al., 2002).

Despite the high rates of sexual assault victimization that have been reported by Native American women living on tribal lands, residual effects of exposure to sexual violence have not been a major focus by researchers (Bryant-Davis et al., 2009). However, there have been several associations that have been linked to rape. Similar to what researchers have concluded from studying the effects of exposure to physical violence, researchers have concluded that Native American women living on tribal lands who reported a history of sexual violence victimization display high frequencies of symptoms that meet the criteria for PTSD and other anxiety disorders (Bryant-Davis et al., 2009). Perhaps related to this phenomenon is the research indicating that this population has reported high levels of suicidal ideation and more frequent suicidal attempts than women in other communities following sexual violence exposure (Bohn, 2003). Among Native American women who attempted suicide in one tribal community, 87% reported exposure to some level of sexual violence and 59% reported exposure to rape (Bohn, 2003).

Violence Against Native American Men

A review of the literature on violence experienced on tribal lands reveals that the majority of the focus has been on the prevalence, predictive factors and residual associations of exposure to violence among Native American women. Although men living in these areas have received less attention, it is important to be familiar with the available research related to the victimization of men. Gaining a broader understanding of how all individuals living on tribal lands experience violence will assist in the ability to be sensitive to issues faced by both men and women and aid counselors to choose culturally competent interventions.

Prevalence of Violence Against Native American Men

Robin, Chester, Rasmussen, Jaranson, and Goldman (1997) reported that among Native American men residing in Southwest tribal communities, 81% reported exposure to a violent act at some point in their lives. Among Native American men living on seven tribal communities in Montana, nearly one in ten reported exposure to physical violence in the year preceding the survey (Harwell, Moore, & Spence, 2003). This figure was nearly double the prevalence reported by women living in the same communities, although women reported higher frequencies of sexual violence and emotional abuse (Harwell et al., 2003). A study on the prevalence of aggravated assault among Native Americans living on tribal lands found that men were victims of severe physical violence at a rate of 36% since turning 18 years of age (Yuan et al., 2006). These reports suggested that although women may be exposed to various types of violence at higher rates in tribal communities, men may be subject to a higher likelihood of physical injury due to exposure to higher rates of physical violence.

Native American men are more likely than men of any other ethnicity to experience traumatic brain injury (TBI) as a result of violence (Nelson, Rhoades, Noonan, & Manson, 2007). Moreover, Native American men living in rural tribal communities are more likely to seek medical attention for a TBI than those living in urban areas (Nelson et al., 2007). Hence, a Native American man living on tribal lands appears to have a higher risk than any other population in the United States to experience severe enough violence to sustain an injury to the brain. The only comparable population was concluded to be African-American men living in urban inner-city communities (Nelson et al., 2007).

Although domestic violence is typically considered by many to be a women's issue, Robin, Chester, and Rasmussen (1998) surveyed both men and women living on tribal lands about their lifetime and recent prevalence of intimate partner violence experiences. These researchers concluded that men reported rates of lifetime prevalence of domestic violence at 91%, with 31% reporting recent exposure to violence perpetrated by intimate partners. However, despite these high rates, men were concluded to be less likely to need medical assistance as a result of domestic violence when compared to the women in their tribal communities.

Predictive Associations of Violence Against Native American Men

Homicide occurrence among Native American men living on tribal lands has been reported to be highly correlated to unemployment and impoverished standards of living (Lester, 1995). Criminal mentalities that often accompany a lack of occupational routine and structure may contribute to increases in the capacity to commit homicide (Lester, 1995). It is possible that factors that lead to unemployment, such as substance use, play a role in the propensity to experience or commit homicide in tribal communities (Koss et al., 2003).

Yuan et al. (2006) investigated the predictive characteristics of physical violence exposure among Native American men living in six distinct tribal communities, studying the effects of variations in demographics, alcohol dependence in adulthood, cultural variables, regional variables, and adverse childhood experiences on the prevalence for physical violence victimization. The researchers concluded that only adverse childhood experiences and alcohol dependence in adulthood mediated the likelihood of exposure to violence across similar communities.

Native American men under the age of 18 have been studied by researchers to determine predictive characteristics and protective factors related to the perpetration and exposure to physical violence. Pu et al. (2013) concluded that men under the age of 18 living on tribal lands have more desire to learn and practice traditional Native American culture than the women in their similar age ranges. The men who reported high levels of desire to practice their traditional culture also displayed higher levels of self-efficacy to avoid perpetration and victimization of physical violence. High levels of parental involvement were associated with lower levels of exposure to violence among this population.

Residual Associations for Violence Against Native American Men

While the prevalence and predictive characteristics of exposure to violence among Native American men living on tribal lands have been understudied, there have been higher rates of contributions from empirical literature regarding the residual associations related to victimization. When surveyed using qualitative methods, Native American men reported that one substantial observed consequence of violence on tribal lands is the expanding discrepancies between traditional Native American values and behaviors witnessed in tribal communities (Matamonasa-Bennett, 2013). These men reported beliefs that Native American men did not frequently commit violence against Native American men or women until the introduction of colonization and alcohol. These men

feared that continued trends in violence would serve to further the gap between the values held by traditional Native American culture and the values of those living on tribal lands.

Beals et al. (2013) studied PTSD among 1,446 Native Americans living in southwest tribal communities and 1,638 Native Americans living in Northern Plains tribal communities. Rates of traumatic stress symptomology that suggested PTSD were reported to vary between 5.9% and 28.3% for Native American men. On average, men reported rates of PTSD at 14.8%, which is approximately triple the national average for men (Ford et al., 2015). Therefore, although Native American women living on tribal lands have reported higher rates of PTSD than men, the discrepancy between the rates on tribal lands and the national average is far more pronounced for Native American men than it is for women. Beals et al. also concluded that Native American men were just as likely to develop traumatic stress symptoms (15.9%) as men in other populations following exposure to traumatic stressors. This indicates that the increased frequency of PTSD among Native American men living on tribal lands is a function of increased exposure to traumatic experiences. There also may be certain types of violence that lead to increased likelihood for the development of PTSD. Researchers have reported that sexual violence exposure has been associated with increased anxiety symptoms among Native American men (Gnanadesikan, Novins, & Beals, 2005). Furthermore, Native American men who have experienced six or more incidents of violence are significantly more likely to develop traumatic stress symptoms. Indeed, PTSD is a prevalent and serious residual effect of exposure to violence in tribal communities.

Cardiovascular disease (CVD) has been concluded to be higher among Native American men living on tribal lands when compared to men in other populations (Sawchuk et al., 2005). When researchers have examined factors that correlate to CVD, only exposure to violent traumatic stressors and subsequent traumatic stress symptoms have been significantly correlated to increased likelihood for CVD. General stress and the presence of depression do not account for the same variance on CVD as traumatic stress (Sawchuk et al., 2005). It is possible that exposure to violence among Native American men can lead to decreased life expectancy due to serious heart conditions.

Similar to the reports of residual associations for Native American women who experience violence, Native American men living on tribal lands with a history of victimization report increased prevalence of high-risk behaviors, including substance abuse (M. C. Jones, Dauphinais, Sack, & Somervell, 1997). Because high-risk behaviors can be considered both predictive characteristics and residual effects of exposure to violence, these behaviors can seemingly serve to initiate and exacerbate violence. For example, if a Native American man abuses alcohol, effectively lowering inhibitions, he may find himself at increased risk to be subjected to a physical altercation. As a result, the man may turn to alcohol as a means to cope with reactions to the exposure to violence, creating a cycle of substance abuse that heightens the likelihood of future exposure to violence, culminating in the need for mental health care.

Barriers to Mental Health Care

Native American victims of violence are more likely than other populations to require medical care due to the severity of the sustained injuries (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010). Because the development of PTSD is more frequent when physical trauma occurs as a result of violence (Ford et al. 2015), it is possible that Native Americans living on tribal lands are a population with an increased need for effective mental health interventions. The Indian Health Service (IHS) is the primary medical and mental health agency providing care to Native Americans on tribal lands (Katz, 2004). The IHS system has chronically reported issues with underfunding and understaffing

due, in part, to legislative policies that do not allow for funds to be provided to IHS through the United States government. As a result, the care that individuals receive through the agency is often lacking in comparison to the standards of non-tribal health care agencies. Furthermore, these services are not guaranteed to those with Native American heritage, and nearly half of the low-income Native American individuals on tribal lands cannot afford health insurance (Katz, 2004). Effectively, this renders the population within tribal lands as having the highest risk for exposure to violence, yet with limited resources to treat the effects of violence.

The largest barrier to receiving mental health care in the wake of a sexual violence crisis for Native Americans living on tribal lands may be the lack of available services within a reasonable distance. Juraska, Wood, Giroux, and Wood (2014) examined 873 Sexual Assault Response Teams (SARTs) within a designated proximity to Native American lands. SARTs are teams that provide emergency mental health care and advocacy to survivors of sexual assault and are widely used in the United States on both tribal and non-tribal lands. They reported that only 30.7% of these lands fell within a 60-minute driving range from a SART or sexual assault examiner. These researchers also reported that more than two-thirds of the tribal lands in the continental United States would not be accessible to SARTs and 381 of the 605 tribal communities were left with no coverage. Considering the high level of sexual violence that has been reported on tribal lands, it appears that SARTs are not being deployed in the areas that may need mental health care and advocacy the most.

In the area of domestic violence, researchers have concluded that significant stigmas have led to underreporting of violence by women to IHS staff (Clark, 2001). Specifically, Native American women have shared with researchers that they refused to report incidents of domestic violence to IHS staff because of the manner in which the topic was addressed and fear regarding how the staff may react. Moreover, although screening for domestic violence has become commonplace among medical facilities in the United States, only 62% of the surveyed IHS facilities had protocols to screen for domestic violence (Clark, 2001). If survivors of violence do not feel safe reporting violence to their medical and mental health professionals, appropriate aid cannot be deployed to prevent the development (or exacerbation) of traumatic stress symptoms. Furthermore, it has been theorized that Native American men and women underreport violence to IHS staff because of altered perceptions as to what constitutes violence (Tehee & Esqueda, 2008). In particular, incidents that may be reported as abuse by other populations may not be severe enough to be considered reportable violence by Native American individuals living on tribal lands.

Furthermore, a general lack of multicultural competency displayed by counselors toward Native Americans appears to be a significant barrier for this population receiving adequate mental health care. Although there has been a push for increased multicultural competency in the field of counseling in the last decade (Toporek & Vaughn, 2010), educational institutions have not traditionally focused on providing counselors-in-training the capacities for effectively working with diverse cultures (Garrett & Herring, 2001; Ponterotto, Casas, Suzuki, & Alexander, 2009; Sue, Arredondo, & McDavis, 1992). Even the theories that have enjoyed the most empirical support, such as cognitive behavioral therapy, have been scrutinized for a general lack of applicability to diverse cultures (Graham, Sorenson, & Hayes-Skelton, 2013). In fact, many common therapeutic approaches may serve to further marginalize minority populations by expecting clients to conceptualize issues and develop problem-solving strategies from the dominant culture perspective (Sue & Sue, 2012).

Even when research and educational entities commit to better competency in understanding and working with minority populations, the majority of the attention is allotted to Hispanic, Black, and Asian populations. It is theorized that these phenomena may contribute to low rates of mental health

seeking behaviors and high rates of dropout from Native American clients (Garrett & Herring, 2001). Moreover, it has been theorized that counselors, due to multicultural competency deficiencies, may even reinforce continued physical and sexual violence in Native American populations by focusing only on a client's behavioral flaws as a means of therapeutic intervention (E. Duran, Duran, Heart, & Horse-Davis, 1998). Clearly, increased efforts in training counselors to work with Native American clients are necessary to adequately provide mental health services to this high-need population.

Implications for Counselors

To summarize, Native Americans living on tribal lands are at a higher risk for exposure to violence than other populations (Wahab & Olson, 2004). Predictive characteristics associated with increased risk include low socioeconomic status (Malcoe et al., 2002), unemployment (Lester, 1995), gender (Oetzel & Duran, 2004), cultural affiliation (Yuan et al., 2006), substance abuse (Ferraro, 2008), relationship status (Roodman & Clum, 2001), history of previous exposure to violence (Bryant-Davis et al., 2009), and adverse childhood experiences (Yuan et al., 2006). Residual associations to experiencing violence on tribal lands include PTSD (Beals et al., 2013; B. Duran et al., 2009), symptoms of anxiety and depression (Bryant-Davis et al., 2009), chronic pain (Buchwald et al., 2005), substance abuse (Yuan et al., 2006), increased high-risk behaviors such as promiscuity (Hobfoll et al., 2002), suicidal ideation (Bohn, 2003), decreased communal cohesion (Matamonasa-Bennett, 2013), and cardiovascular disease (Sawchuk et al., 2005).

Barriers experienced by Native Americans living on tribal lands for obtaining mental health services have been identified as poor standards in IHS agencies (Katz, 2004), inability to access mental health crisis SARTs (Juraska et al., 2014), underreporting of violence by Native American clients (Clark, 2001), and a lack of multicultural competency displayed by counselors (Garrett & Herring, 2001). In understanding barriers faced by Native Americans living on tribal lands, counselors can make informed decisions about intervention strategies that best aid clients in overcoming these barriers. This may mean altering therapeutic intervention approaches, increasing focus on establishing positive working alliances with clients through increased cultural competency, meeting with clients in their local communities, and advocating for systemic change in governmental and mental health agencies. Working to help eliminate the barriers to obtaining mental health services among Native Americans living on tribal lands may be the difference between those who fall into the cycle of re-victimization and those who break this cycle through collaborative efforts with the counselor.

Despite the disheartening research revealing the prevalence of violence among Native Americans living on tribal lands, this phenomenon does not appear to be common knowledge or an area of passion among some mental health counselors. Without a shift in the ways counselors view and treat violence within this population, oppression which lends to violence exposure and consequent mental health issues is not likely to subside as a result of mental health intervention. In particular, mental health counselors must commit to gaining increased competency in working with Native Americans and advocate for effective and ethical therapeutic strategies.

Counseling Practice Implications

Although many clinical approaches have been reported to exhibit limited effectiveness when working with Native American populations, some researchers have attempted to expand on empirically validated approaches in order to increase the likelihood of effectiveness with this population. Bigfoot and Schmidt (2010) adapted cognitive behavioral therapy (CBT) approaches to incorporate teachings from the traditional Native American Medicine Wheel. These researchers concluded that their method of therapy was particularly beneficial for Native American children with

traumatic stress symptoms. When working with Native American survivors of trauma, counselors can expand this model by incorporating the Native American Medicine Wheel throughout the cognitive restructuring process.

The Native American Medicine Wheel is comprised of four sections with various concepts dedicated to each section. The wheel symbolizes how various elements in one's life are separate, yet interconnected. When utilizing the wheel as an intervention tool, counselors can focus on the sections dedicated to thoughts, emotions, behavior and spirituality. CBT aims to help clients identify, challenge and change dysfunctional thought patterns in order to alter emotions and behaviors. Therefore, the counselor can use the Native American Medicine Wheel as a guide to help the client conceptualize how change is created. It may be beneficial to begin by focusing on the section dedicated to spirituality in order to gain insight into the spiritual beliefs and values held by the client. The knowledge gained in this process will help the counselor to understand what spiritual practices may be incorporated into sessions. The counselor can proceed by focusing on the sections dedicated to cognition, emotion and behavior. The suggested goals for counseling sessions are provided in Figure 1.

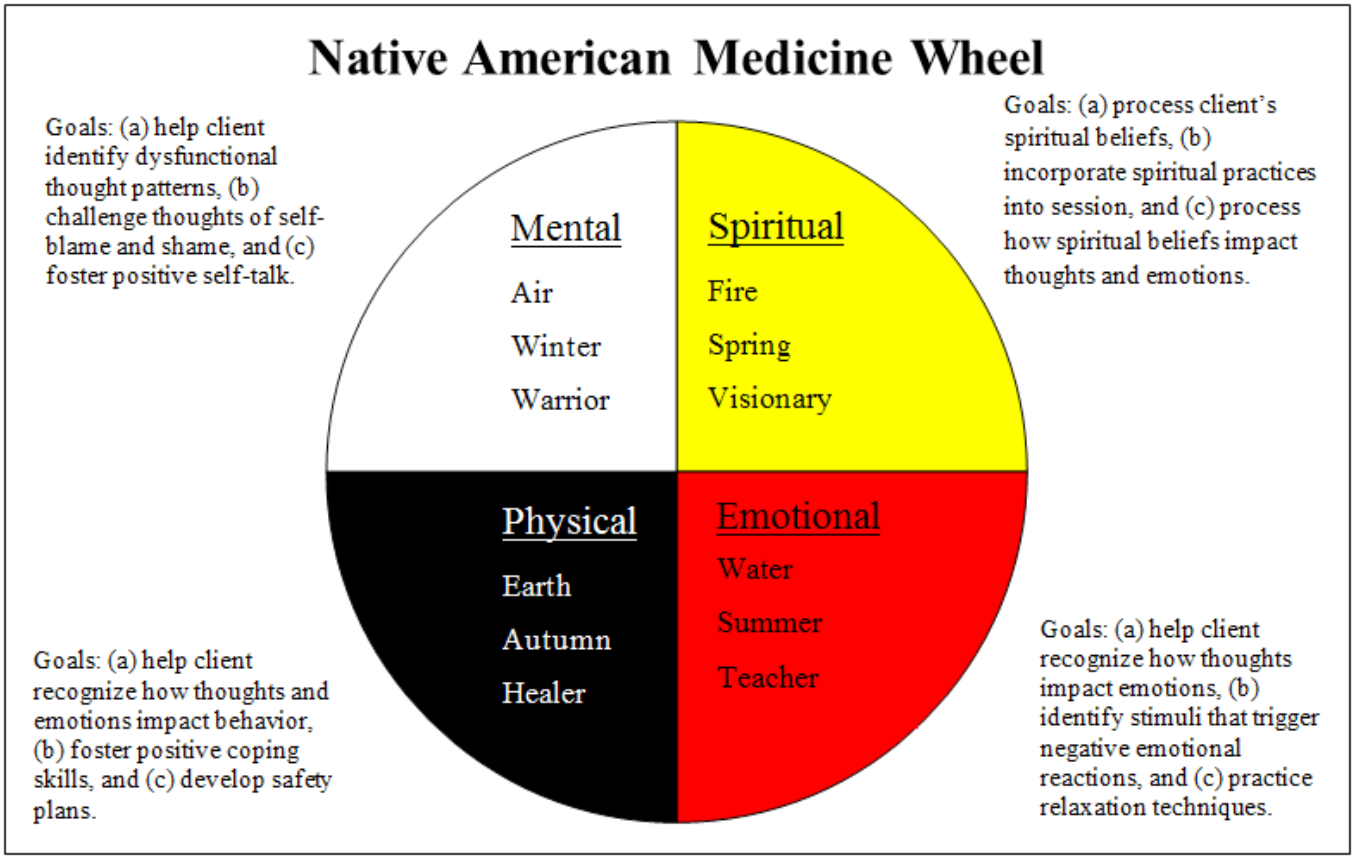

Figure 1. Incorporating the Native American Medicine Wheel into CBT.

As the counselor and client move through these sections, the counselor also can incorporate the other elements within each section. For example, while processing the section dedicated to emotion, the counselor can incorporate visual imagery of *summer* and *water* while practicing relaxation techniques. The counselor and client can process how the role of the *teacher* applies to training oneself to cope with environmental triggers. It is further suggested that the counselor find opportunities to use traditional Native American healing methods during counseling sessions

such as (a) smudging, (b) using Native American symbols to represent new topics, (c) incorporating Native American languages, (d) creating visual representations using Native American art forms, (e) forming talking circles, and (f) consulting with elders in the tribal communities (Bucharski, Reutter, & Ogilvie, 2006). Counselors also should be educated on the theory of historical trauma to assist clients in understanding how the traumas of the past impact the Native American community today. Native American clients should be educated regarding how previous traumas can impact current behavior across generations (Brown-Rice, 2013).

Although several researchers have called for increased focus on spiritual exercises while working with Native American clients (Bucharski et al., 2006; Matheson, 1996), counselors must be cautious when implementing these interventions. Matheson (1996) urged non-Native American counselors to consider the difference between cultural *competencies* and *understanding*. He reported that non-Native counselors often attempt to implement a Native American spiritual exercise as the counselor understands it, which can prove to be misguided, counterproductive and offensive. Instead, it is best to collaborate with Native American clients about how an activity should be executed and seek permission to engage in the exercise with the client. This will help to account for any violations of sacred practices and saturate the power between the counselor and client. Matheson theorized that Native Americans are often turned away from counseling due to perceived power differential and lack of interdependence between the counselor and client.

There also may be environmental changes that can be incorporated into counseling that help facilitate spiritual expression when working with Native American clients. For example, counselors may decide to hold counseling sessions outside of an office setting. A counselor may take the client to a garden or observe nature while conducting counseling sessions. Moreover, a counselor may use pet therapy techniques to help Native American clients feel a connection to nature. This technique also may help clients to express empathy (Hunter & Sawyer, 2006). Again, it is best if the counselor collaborates with the client to ensure that the setting changes are congruent with the personal beliefs and values of the client.

When a high level of exposure to traumatic stressors is present, as it often is with Native American populations, a client is likely to have biological and environmental needs that supersede mental health counseling. Targeting these needs early in the counseling relationship is likely to increase the ability of the client to meet counseling objectives. B. Jones, Tilden, and Gaines-Stoner (2008) suggested a multi-modal approach to working with Native Americans living on tribal lands due to the nature of complex trauma. First, Jones suggested that counselors build the therapeutic alliance with Native American clients by demonstrating a high level of value for sharing, autonomy and informal interpersonal interaction. Second, Jones suggested that counselors be active in consulting with agencies to provide aid with substance abuse services, housing, legal assistance, transportation, childcare and job development.

Of course, a multi-modal approach would be particularly difficult to implement for Native Americans who present with substantial barriers to mental health care. Although it is crucial that the counseling field advocate for bureaucratic changes, creating a trusting and therapeutic rapport with Native American clients is the barrier that counselors must address immediately. Native Americans living on tribal lands prefer counselors who are sensitive to Native American values and use a non-directive theoretical approach to counseling (Bichsel & Mallinckrodt, 2001). This suggests that counselors who employ more directive approaches, such as the cognitive behavioral techniques previously described, may incorporate increased person-centered approaches while building the initial working alliance with Native American clients. Native Americans have reported a preference

for frequent use of collaboration (Scholl, 2006) and little use of concrete advice-giving in counseling (Garrett, 2003).

Counselors can give special considerations to Native American clients when they have been exposed to sexual violence. In particular, counselors can aid these individuals in the process of identifying and challenging self-blame and shame; survivors of sexual assault report feelings of shame and self-blame at a rate of 75% (Vidal & Petrak, 2007). Perspectives of survivors have been linked to negative self-concept (Miller, Handley, Markman, & Miller, 2010) and PTSD (Ullman, Townsend, Filipas, & Starzynski, 2007). It is important to note that the relationship between self-blame and PTSD has been theorized to be mediated by negative social reactions (Ullman et al., 2007). This suggests that processing blame and taking a position of unconditional positive regard toward the client can function to decrease PTSD symptoms.

High levels of self-blame among survivors of physical and sexual violence can serve as a predictor for re-victimization. Miller, Markman, and Handley (2007) reported increased re-victimization rates among survivors of sexual assault who reported elevated levels of self-blame. These conclusions were echoed by Edwards, Kearns, Gidycz, and Calhoun (2012), who determined that women who reported high levels of self-blame were more likely to remain in an intimate relationship with perpetrators of domestic abuse. Although there is no research available regarding the role self-blame plays among Native Americans living on tribal lands, it is clear that counselors must assess for self-blame when working with this population. In order to accomplish this task, and to collect needed research data, counselors can administer the Sexual Assault Symptom Scale (SASS), which includes subscales for self-blame, disclosure shame, safety fears and depression (Ruch, Gartrell, Amedeo, & Coyne, 1991).

Directions for Future Research

In order to increase the effectiveness of counseling interventions with Native American clients, there are several areas that warrant investigation. First, researchers should gain a better understanding of the differences between Native American tribes. The rate of violence exposure between tribes varies greatly (Oetzel & Duran, 2004), with some tribal communities being less impacted. Thus, researchers should conduct a more thorough examination of the prevalence, predictive characteristics and residual associations related to exposure to violence in tribal communities to determine the practices of those with lower levels of violence. In better understanding these factors, researchers can focus their attention on specified preventative approaches utilized by these communities and guide future counseling practices.

Furthermore, researchers should devote increased efforts to collecting data on male Native American survivors of violence. Certainly, researchers have investigated assault and homicide among this population, but prevalence and residual factors related to domestic and sexual violence is lacking in the literature. Many male survivors of physical and sexual assault are hesitant to report their experiences due to social factors including (a) fear of judgment by peers, (b) fear they will not be believed, (c) fear of being labeled homosexual, and (d) concerns about counselors maintaining confidentiality (Sable, Danis, Mauzy, & Gallagher, 2006). However, it is not known what additional factors may contribute to the hesitation of Native American men to report violence. Increased knowledge in this area could have significant implications for the prevention of violence on tribal lands among men, as well as positively impact the counseling process.

The negative impact that self-blame has on survivors of trauma has been well established (Miller et al., 2010; Ullman et al., 2007). However, the impact of self-blame in the Native American community,

the population most affected by exposure to violence, has not been researched. It is important for counselors to know whether the existing research on self-blame is applicable to the Native American community in order to understand whether techniques must be altered. If self-blame was determined to be more or less prevalent among this population, researchers can help instruct counselors how to alter interventions to better account for cultural factors.

Researchers should aim to better understand the barriers to Native Americans living on tribal lands in obtaining mental health services. Specifically, the interpersonal factors in seeking services, the capacity of individuals to find services, and the role of bureaucracy in limiting resources should be further investigated. Gaining a greater understanding of efficient methods of deploying mental health services to Native American populations is only beneficial if administering services is a realistic possibility. Given that Native American people have a history of being diminished and marginalized in the interest of research (Walters & Simoni, 2009), research efforts need to be conducted in a culturally appropriate and ethical manner (Brown-Rice, 2013). If the mental health community were to commit to these research endeavors, it would provide a sufficient foundation for creating changes in the effectiveness of the treatment of this highly victimized population.

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Burnout, Stress and Direct Student Services Among School Counselors

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The burnout and stress experienced by school counselors is likely to have a negative influence on the services they provide to students, but there is little research exploring the relationship among these variables. Therefore, we report findings from our study that examined the relationship between practicing school counselors' (*N* = 926) reported levels of burnout, perceived stress and their facilitation of direct student services. The findings indicated that school counselor participants' burnout had a negative contribution to the direct student services they facilitated. In addition, school counselors' perceived stress demonstrated a statistically significant correlation with burnout but did not contribute to their facilitation of direct student services. We believe these findings bring attention to school counselors' need to assess and manage their stress and burnout that if left unchecked may lead to fewer services for students. We recommend that future research further explore the relationship between stress, burnout and programmatic service delivery to support and expand upon the findings in this investigation.

Keywords: **burnout, stress, school counselors, student services, service delivery**

The American School Counselor Association (ASCA; 2012) recommends that school counselors enhance the personal, social, academic and career development of all students through the organization and facilitation of comprehensive programmatic counseling services. Delivery of student services is part of a larger framework articulated by ASCA's National Model (2012) that also includes management, accountability and foundation components of school counseling programs. However, ASCA notes that school counselors should "spend 80 percent or more of their time in direct and indirect services to students" (ASCA, 2012, p. xii). ASCA defines *indirect student services* as services that are in support of students and involve interactions (e.g., referrals, consultations, collaborations and leadership) with stakeholders other than the student (e.g., parents, teachers and community members). On the other hand, *direct student services* are interactions that occur face-to-face and involve the facilitation of curriculum (e.g., classroom guidance lessons), individual student planning and responsive services (e.g., individual, group and crisis counseling). In either case, ASCA charges school counselors with prioritizing the delivery of student services.

As a part of their work, school counselors often incur high levels of stress that may result from multiple job responsibilities, role ambiguity, high caseloads, limited resources for coping and limited clinical supervision (DeMato & Curcio, 2004; Lambie, 2007; McCarthy, Kerne, Calfa, Lambert, & Guzmán, 2010). In addition, burnout can result from the ongoing experience of stress (Cordes & Dougherty, 1993; Maslach, 2003; Schaufeli & Enzmann, 1998) and can result in diminished or lower quality rendered services (Lawson & Venart, 2005; Maslach, 2003). While research on burnout is common in the school counseling literature (Butler & Constantine, 2005; Lambie, 2007; Wachter, Clemens, & Lewis, 2008; Wilkerson & Bellini, 2006), studies have not focused on the relationship between burnout and school counselors' service delivery. Yet, burnout has the potential to produce negative consequences for the work rendered by school counselors and could result in fewer services

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for students (Lambie, 2007; Lawson & Venart, 2005; Maslach, 2003). Therefore, the purpose of this research was to examine the contribution of school counselors' levels of burnout and stress to their delivery of direct student services.

School Counselors and the Delivery of Student Services

Research on school counselors' delivery of student services has produced positive findings. In a meta-analysis that included 117 experimental studies, Whiston, Tai, Rahardja, and Eder (2011) identified that, in general, school counseling services have a positive influence on students' problem-solving and school behavior. Furthermore, in schools where school counselors completed higher levels of student services focused on improving academic success, personal and social development, and career and college readiness, students experienced a variety of positive outcomes, such as increased sense of belongingness, increased attendance, fewer hassles with other students, and less bullying (Dimmitt & Wilkerson, 2012). Moreover, researchers have shown that the higher occurrence of school counselor-facilitated services is beneficial for students' educational experience and academic outcomes (Carey & Dimmitt, 2012; Lapan, Gysbers, & Petroski, 2001; Wilkerson, Pérusse, & Hughes, 2013). Overall, the services conducted by school counselors have a positive impact on student success. As such, research investigating the factors related to higher incidence of school counselors' direct student services could provide significant educational benefits to schools.

Researchers have examined a variety of topics that relate to increased student services. Clemens, Milsom, and Cashwell (2009) found that if school counselors had a good relationship with their principal and were engaged in higher levels of advocacy, they were likely to have increased implementation of programmatic counseling services. Another study concluded that school counselors' values were not associated with the occurrence of service delivery, but researchers did find counselors with higher levels of leadership practices also delivered more school counseling services (Shillingford & Lambie, 2010). Other factors related to increased levels of school counselors' service delivery are increased job satisfaction (Baggerly & Osborn, 2006; Pyne, 2011) and higher self-efficacy (Ernst, 2012; Mullen & Lambie, 2016). These studies provided notable contributions to the literature; however, at this time no known studies have examined the relationship among school counselors' burnout, perceived stress and direct student services.

Stress and Burnout Among School Counselors

Stress is a significant issue that relates to the impairment of work performance (Salas, Driskell, & Hughes, 1996) and is a likely problem for school counselors. The construct of stress has a rich history in scientific literature dating back to the 1930s (Cannon, 1935; Selye, 1936). Selye (1980) articulated one of the first broad definitions of stress by defining it as the "nonspecific results of any demand upon the body" (p. vii). Over time, various authors developed an assortment of definitions (Ivancevich & Matteson, 1980; Janis & Mann, 1977; McGrath, 1976), but Lazarus and Folkman's (1984) definition of stress is common among scholars (Driskell & Salas, 1996; Lazarus, 2006). In their Transactional Model of Stress and Coping, Lazarus and Folkman (1984) defined stress as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing" (p. 19). Lazarus and Folkman conceptualized that stress results from an imbalance between one's perception of demands or threats and their ability to cope with the perceived demands or threats. Consequently, one's appraisal of demands and their assessment of their coping ability becomes a critical issue in relationship to whether or not the demand will trigger a stress response.

McCarthy et al. (2010) applied Lazarus and Folkman's model of stress (1984) to school counselors using an instrument that measures the demands and resources experienced by school counselors called the Classroom Appraisal of Resources and Demands–School Counselor Version (McCarthy & Lambert, 2008). McCarthy et al. (2010) found that school counselors who reported challenging demands as a part of their job also had higher levels of stress. This finding is troubling considering that school counselors oftentimes encounter ambiguous job duties, inconsistent job roles and conflicts in their job expectations (Burnham & Jackson, 2000; Culbreth, Scarborough, Banks-Johnson, & Solomon, 2005; Lambie, 2007; Scarborough & Culbreth, 2008). An additional concern is that stress occurring over an extended period of time can lead to emotional and physical health problems (Sapolsky, 2004) along with increased likelihood of leaving the profession (DeMato & Curcio, 2004). Fortunately, prior research reveals that school counselors have reported low stress levels (McCarthy et al., 2010; Rayle, 2006). Still, research on school counselors' stress and its effects on the services they provide is important.

An additional factor that we believe may have an impact on direct student services is burnout. Burnout was first recognized in the 1970s (Freudenberger, 1974; Maslach, 1976) and is considered to have significant consequences for counseling professionals (Butler & Constantine, 2005; Lambie, 2007; Lawson, 2007; Lee et al., 2007). The topic of burnout is common in the literature across many disciplines (Schaufeli, Leiter, & Maslach, 2009) and has been given particular attention in school counseling research (Butler & Constantine, 2005; Lambie, 2007; Wachter et al., 2008; Wilkerson & Bellini, 2006). Freudenberger (1974, 1986) suggested that burnout results from depleted energy and the feelings of being overwhelmed that emerge from the exposure to diverse issues related to helping others, which over time affects one's attitude, perception and judgment. Pines and Maslach (1978) described burnout as an ailment "of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitude, and loss of concern and feelings for clients" (p. 234). In 1981, the Maslach Burnout Inventory (MBI) was developed as a method to measure one's experience of burnout in the helping and human service field (Maslach & Jackson, 1981).

More recently, Lee et al. (2007) expanded the measurement of burnout and presented the construct of *counselor burnout*, which they defined as "the failure to perform clinical tasks appropriately because of personal discouragement, apathy to symptom stress, and emotional/physical harm" (p. 143). Within their model, Lee and associates found that counselor burnout includes the constructs of exhaustion, negative work environment, devaluing clients, incompetence and deterioration in personal life. These constructs correlate with the factors measured by the MBI (Maslach & Jackson, 1981), but provide a definition consistent with the work of school counselors (Gnilka, Karpinski, & Smith, 2015).

Many researchers have explored factors related to school counselor burnout. Overall, scholars have found that school counselors report low levels of burnout (Butler & Constantine, 2005; Gnilka et al., 2015; Lambie, 2007; Wachter et al., 2008; Wilkerson & Bellini, 2006). Nonetheless, researchers also reported that higher collective self-esteem is associated with a higher sense of personal accomplishment and lower emotional exhaustion (Butler & Constantine, 2005), whereas higher levels of ego development are associated with higher personal accomplishment (Lambie, 2007). Moreover, Wilkerson and Bellini (2006) discovered that school counselors who handle stressors with emotion-focused coping are at a higher risk of experiencing burnout symptoms, and Wilkerson (2009) established that school counselors' emotion-focused coping increases their likelihood of experiencing symptoms of burnout. Yet, there is no research on the connection between school counselors' burnout and the direct student services they provide despite a high likelihood that burnout is the cause of fewer and deteriorated services for students (Maslach, 2003).

The purpose of this study was to build upon existing literature regarding school counselors' stress, burnout and their facilitation of direct student services. The guiding research questions were: (a) Do practicing school counselors' levels of burnout and perceived stress contribute to their levels of service delivery? and (b) Do practicing school counselors' levels of stress correlate with their burnout? Consequently, the following research hypotheses were examined: (a) School counselors' degree of burnout and perceived stress contributes to their facilitation of direct student services, and (b) School counselors' degree of perceived stress correlates positively with their level of burnout.

Method

Procedures

To answer the research questions associated with this study, we employed a cross-sectional research design (Gall, Gall, & Borg, 2007). Furthermore, this study utilized online survey data collection procedures. Prior to any data collection, we received approval from the Institutional Review Board at the first author's university. During the first step in the data collection process, we retrieved the name and e-mail address of every school counselor listed in the ASCA online directory of membership. Next, we generated a simple random sample of school counselors. Then, we sent the sample selected from the ASCA online directory a series of three e-mails that aligned with *tailored design method* (Dillman, Smyth, & Christian, 2009) recommendations for survey research. Each e-mail contained a brief description of the survey and a link to the online survey managed by Qualtrics (2013). If a participant wished to take the survey, he or she was directed to the Web site that posted the explanation of the study. If they agreed to participate, they would move forward and complete the survey. Participants were screened as to whether they were practicing school counselors or not (e.g., student, counselor educator or retired). Of the 6,500 participants sampled, 41 indicated they were not a practicing school counselor. In addition, 312 e-mails were not working at the time of the survey. Out of the 6,147 practicing school counselors surveyed, 1,304 (21.21% visit response rate) visited the survey Web site and 926 completed the survey in its entirety, which resulted in a 15.06% useable response rate. The response rate received for this study is high in comparison to studies using similar methods (e.g., 14%, Harris, 2013; 11.4%, Mullen, Lambie & Conley, 2014).

Participant Characteristics

Participants (N = 926) were practicing school counselors in private, public and charter K–12 educational settings from across the United States. The mean age was 43.27 (SD = 10.03) and included 816 (88.1%) female and 110 (11.9%) male respondents. The participants' ethnicity included 50 (5.4%) African Americans, 5 (.5%) Asian Americans, 29 (3.1%) Hispanic Americans, 11 (1.2%) Multiracial, 2 (.2%) Native Americans, 4 (.4%) Pacific Islanders, 811 (87.6%) European Americans, and 13 (1.5%) participants who identified their ethnicity as "Other." On average, participants had 10.97 (SD = 6.92) years of experience and 401.45 (SD = 262.05) students on their caseload. The geographical location of the participants' work setting favored suburban (n = 434, 46.9%) and rural communities (n = 321, 34.7%) with fewer school counselors working in urban settings (n = 171, 18.5%). Most participants reported that they worked in the high school grade levels (n = 317, 34.2%) closely followed by elementary (n = 270, 29.2%) and middle school or junior high school (n = 203, 21.9%) grade levels, with 136 (14.7%) respondents working in another grade level format (e.g., grades K–12, K–8, or 6–12).

Measures

This study used the (a) Counselor Burnout Inventory (CBI; Lee et al., 2007), (b) the School Counselor Activity Rating Scale (SCARS; Scarborough, 2005), and (c) the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983). Participants also completed a researcher-created demographics form regarding their personal characteristics (e.g., age, gender and ethnicity) and

work-related characteristics (e.g., location type, grade level, caseload, experience as a school counselor and percentage of time they directly work with students).

CBI. The CBI (Lee et al., 2007) is a 20-item self-report measure that examines counselor burnout across five domains. The domains that make up the CBI include: (a) exhaustion, (b) incompetence, (c) negative work environment, (d) devaluing client, and (e) deterioration in personal life. The CBI makes use of a 5-point Likert rating scale that ranges from 1 (*never true*) to 5 (*always true*) and examines emotional states and behaviors representative of burnout. Some sample items include "I feel exhausted due to my work as a counselor" (exhaustion), "I feel I am an incompetent counselor" (incompetence), "I feel negative energy from my supervisor" (negative work environment), "I have little empathy for my clients" (devaluing client), and "I feel I have poor boundaries between work and my personal life" (deterioration in personal life). Lee et al. (2007) demonstrated the construct validity of the CBI through an exploratory factor analysis that identified a five-factor solution in addition to a confirmatory factor analysis that supported the five-factor model with an adequate fit to the data.

Gnilka et al. (2015) found support for the five-factor structure of the CBI (Lee et al., 2007) with school counseling using confirmatory factor analysis, which supports the CBI as an appropriate measure for school counselor burnout. Lee et al. (2007) established convergent validity for the CBI based upon the correlations between the subscales on the Maslach Burnout Inventory-Human Services Survey (Maslach & Jackson, 198l) and the CBI. In prior research, the Cronbach's alphas of the CBI subscales indicated good internal consistency (Streiner, 2003) with score ranges of .80 to .86 for exhaustion, .73 to .81 for incompetence, .83 to .85 for negative work environment, .61 to .83 for devaluing client, and .67 to .84 for deterioration in personal life (Lee et al., 2007; Lee, Cho, Kissinger, & Ogle, 2010; Puig et al., 2012). The internal consistency coefficients of the CBI in this investigation also were good (Streiner, 2003) with Cronbach's alphas of .87 for exhaustion, .79 for incompetence, .84 for negative work environment, .79 for devaluing client, and .81 for deterioration in personal life.

SCARS. The SCARS (Scarborough, 2005) is a 48-item verbal frequency measure that examines the occurrence that school counselors actually perform and prefer to perform components of the ASCA National Model (2012). The SCARS measures school counselors' ratings of activities based on the four levels of interventions articulated by ASCA (1999) and the ASCA National Model (2003). Unfortunately, a more recent version of the SCARS that articulates the new ASCA National Model (2012) does not exist. Nevertheless, this study utilized two SCARS scales (counseling and curriculum) that measure the incidence of direct student services. To the benefit of this investigation, the direct services measured on the SCARS have not changed in the new edition of the ASCA National Model (2003, 2012). Similar to Shillingford and Lambie (2010) and Mullen and Lambie (2016), this investigation utilized the *actual* scale, but not the *prefer* scale, on the SCARS (Scarborough, 2005) because this study sought to examine the frequency that school counselors delivered direct student services, not their preferences and not the difference between their preference and actuality. The subscales that measure direct student services used in this study included the counseling (e.g., group and individual counseling interventions; 10 items) and curriculum (e.g., classroom guidance interventions; 8 items) subscales, whereas the coordination, consultation and other activities scales were not used because they measure indirect activities.

The SCARS (Scarborough, 2005) assesses the frequency of school counselor service delivery with a 5-point Likert rating scale that ranges from 1 (*I never do this*) to 5 (*I routinely do this*). Scores on the SCARS can be total scores or mean scores. Some sample items from the counseling subscale are "Counsel with students regarding school behavior" and "Provide small group counseling for

academic issues." Some sample items from the curriculum subscale are "Conduct classroom lessons addressing career development and the world of work" and "Conduct classroom lessons on conflict resolution." Scarborough (2005) examined the validity by investigating the variances in score on the actual scale based on participant grade level and found that participants' grade level had a statistically significant effect across the scales with small to large effect sizes (e.g., ranging from .11 to .68[ω^2]), which supported the convergent validity of the SCARS. Additionally, construct validity was supported using factor analysis. In prior research using the SCARS, the internal consistency of the counseling and curriculum scales was strong with Cronbach's alphas of .93 for the curriculum actual scale and .85 for the counseling actual scale (Scarborough, 2005). The internal consistency coefficients of the SCARS actual subscales in this investigation were good (Streiner, 2003) with Cronbach's alphas of .77 for the counseling scale and .93 for the curriculum scale.

PSS. The PSS (Cohen et al., 1983) is a 10-item self-report measure that examines the participants' appraisal of stress by asking about feelings and thoughts during the past month. The PSS uses a 5-point Likert scale that ranges from 0 (*never*) to 4 (*very often*) and includes four positively stated items that are reverse coded. Some sample items include, "In the last month, how often have you felt that you were on top of things?" (reverse coded), and "In the last month, how often have you been upset because of something that happened unexpectedly?" The PSS has been shown to have acceptable internal consistency with Cronbach's alphas ranging from .84 to .91 (Chao, 2011; Cohen et al., 1983; Daire, Dominguez, Carlson, & Case-Pease, 2014). The internal consistency coefficient of the PSS in this study also was acceptable (Streiner, 2003) with a Cronbach's alpha of .88.

Results

Preliminary Analysis

Initial screening of the data included the search for outliers (e.g., data points three or more standard deviations from the mean) using converted z-scores (Osborne, 2012), which resulted in identifying 21 cases that had at least one variable with an extreme outlier. To accommodate for these outliers, the researchers utilized a Windorized mean based on adjacent data points (Barnett & Lewis, 1994; Osborne & Overbay, 2004). Next, the assumptions associated with structural equation modeling (SEM) were tested (e.g., normality and multicollinearity; Hair, Black, Babin, Anderson, & Tatham, 2006; Tabachnick & Fidell, 2007). Multicollinearity was not present with these data; however, the data violated the assumption of normality of a single composite variable (e.g., devaluing clients scale on the CBI). Researchers conducted descriptive analyses of the data using the statistical software SPSS. Table 1 presents the means, standard deviations and correlations for the study variables.

Model Testing

This correlational investigation utilized a two-step SEM method (Kline, 2011) to examine the research hypothesis employing AMOS (version 20) software. The first step included a confirmatory factor analysis (CFA) to inspect the measurement model of burnout and its fit with the data. Then, a structural model was developed based on the measurement model. The measurement model and structural model were appraised using model fit indices, standardized residual covariances, standardized factorial loadings and standardized regression estimates (Byrne, 2010; Kline, 2011). Modifications to the models were made as needed (Kline, 2011). Both the measurement and the structural models employed the use of maximum likelihood estimation technique despite the presence of non-normality based on recommendations from the literature (Curran, West, & Finch, 1996; Hu, Bentler, & Kano, 1992; Lei & Lomax 2005; Olsson, Foss, Troye, & Howell, 2000).

Table 1

Correlations among measures of direct student services, perceived stress, and burnout

		M	*SD*	1	2	3	4	5	6	7	8	9
1.	Counseling	3.02	.60	-								
2.	Curriculum	2.77	1.16	.44	-							
3.	Percent of Time	59	78	.36	.27	-						
4.	Perceived Stress	1.56	.63	-.15	-.11	-.14	-					
5.	Exhaustion	3.04	.86	-.15	-.11	-.11	.61	-				
6.	Incompetence	2.29	.68	-.31	-.14	-.18	.49	.44	-			
7.	NEW	2.56	.87	-.23	-.19	-.22	.46	.53	.39	-		
8.	DC	1.39	.50	-.20	-.17	-.14	.32	.28	.45	.64	-	
9.	DPL	2.39	.80	-.19	-.12	-.16	.58	.66	.41	.47	.30	-

Note. $N = 926$. All correlations (r) were statistically significant ($p < .001$). Counseling = frequency of direct counseling services, curriculum = frequency of direct curriculum services, percent of time = percent of time in direct services to students, NEW = negative work environment, DC = devaluing client, DPL = deterioration in personal life.

Multiple fit indices were examined to determine the goodness of fit for the measurement model and structural model (Hu & Bentler, 1999; Kline, 2011; Weston & Gore, 2006). The fit indices that were used include: (a) chi-square, (b) comparative fit index (CFI), (c) goodness of fit (GFI), (d) standardized root mean square residual (SRMSR), and (e) root mean square error of approximation (RMSEA). Furthermore, we consulted the normed fit index (NFI) and Tucker-Lewis index (TLI) because they are more robust to non-normal data as compared to other indices (Lei & Lomax, 2005). For a detailed description of these fit indices, readers can review the works of Hu and Bentler (1999), Kline (2011), and Weston and Gore (2006). We used these fit indices to establish a diverse view of model fit.

Measurement model. First, we employed a CFA model to examine the latent variable representing burnout (Lee et al., 2007). The research team totaled each subscale on the CBIs to develop a composite score for each domain. The initial measurement model for burnout produced acceptable standardized factor loadings ranging from .41 (devaluing client) to .57 (incompetence), .62 (negative work environment), .77 (deterioration in personal life), and .82 (exhaustion). Furthermore, all fit indices for the measurement model indicated an adequate fitting model except chi-square, RMSEA, and TLI: $\chi 2$ ($df = 5$, $N = 926$) = 107.07, $p < .001$; GFI = .96; CFI = .92; RMSEA = .15; SRMR = .06; NFI = .92; TLI = .85. Therefore, we consulted the modification indices and standardized residual covariance matrix and tested a new CFA based upon these consultations.

The modifications indices indicated the need to correlate the error terms for incompetence and devaluing client. The resulting model produced a model in which all fit indices indicated an adequate fitting model: χ^2 ($df = 4$, $N = 926$) = 12.03, $p = .02$; GFI = .99; CFI = .99; RMSEA = .05; SRMR = .02; NFI = .99; TLI = .99. Further inspection of the standardized factor loadings for the model indicated they were all acceptable except for the factor loading for devaluing client, which dropped to .36 (below .40; Stevens, 1992). While these modifications improved the overall fit of the CFA, the correlation of incompetence and devaluing client has no theoretical justification (Byrne, 2010). In addition, the correlation of the error terms for incompetence and devaluing client produced a standardized factor loading below the noted standard of .40 (Kline, 2011; Stevens, 1992). Subsequently, we removed the

subscale of devaluating client given: (a) the low factor loading produced after modification of the initial model, and (b) the lack of normality in the composite score.

Next, we examined the new modified measurement model that included the removal of the subscale devaluing client. The resulting model (see Figure 1) produced a model in which all fit indices indicated a good fitting model: χ^2 (df = 2, N = 926) = 8.25, p = .02; GFI = .99; CFI = .99; RMSEA = .06; SRMR = .02; NFI = .99; TLI = .98. The modified measurement model for burnout produced acceptable standardized factor loadings ranging from .53 (incompetence) to .63 (negative work environment), .77 (deterioration in personal life), and .85 (exhaustion). In review of the model fit indices and standardized factor loadings, we deemed the measurement model acceptable for use in the structural model.

Structural model. We developed the structural model (see Figure 1) based on a review of the literature, and it was theorized in this model that school counselors' perceived stress correlates to school counselors' burnout and contributes to the frequency with which they provide direct student services. In addition, this model tested the hypothesized model that school counselors' burnout contributes to their frequency of direct student services. The structural model includes the measurement model previously tested that consisted of the latent variable of burnout. School counselors' perceived stress and burnout were defined as exogenous or independent variables. Perceived stress was a manifest variable consisting of participants' composite scores on the PSS (Cohen et al., 1983).

Additionally, we defined the manifest variables of percentage of time at work providing direct services to students, direct curriculum activities, and direct counseling activities as the endogenous or dependent variables that measure participants' facilitation of direct student services. The variable of percentage of time at work providing direct services to students was a single demographic item reported by participants, while direct curriculum activities and direct counseling activities were the participants' composite scores derived from subscales on the SCARS (Scarborough, 2005). In addition, the error terms of the direct student services variables—percentage of time at work providing direct services to students, direct curriculum activities and direct counseling activities—were correlated given that they measure similar constructs.

An examination of the structural model indicated a strong goodness of fit for all fit indices except for chi-square: χ^2 (df = 14, N = 926) = 108.37, p < .001; GFI = .97; CFI = .96; RMSEA = .07; SRMR = .04; NFI = .95; TLI = .91. The researchers deemed the structural model as suitable with these data despite the significant chi-square (Henson, 2006; Kline, 2011; Weston & Gore, 2006). A closer examination of the standardized regression weights identified that school counselors' burnout scores contributed to 12% (β = -.35, p < .001) of the variance in their direct counseling activities and 5% (β = -.22, p < .001) of the variance in their direct curriculum activities. Furthermore, school counselors' burnout scores contributed to 6% (β = -.24, p < .001) of the variance in percentage of time at work providing direct services to students. Perceived stress did not contribute to direct counseling activities (β = .11, p = .04), direct curriculum activities (β = .06, p = .31), and percentage of time at work providing direct services to students (β = .04, p = .51). In addition, perceived stress and burnout produced a statistically significant correlation (β = .75, p < .001; 56% of the variance explained).

The structural model (Figure 1) indicates that school counselors' level of counselor burnout had a negative contribution to the frequency of their direct counseling activities, direct curriculum activities and percentage of time at work providing direct services to students. However, it should be noted that the effect sizes of these findings were small to medium (Sink & Stroh, 2006). An additional

finding from this investigation was that the perceived stress correlated with burnout with a large effect size (Sink & Stroh, 2006); however, perceived stress did not have a statistically significant contribution to school counselors' direct counseling activities, direct curriculum activities, and percentage of time at work providing direct services to students.

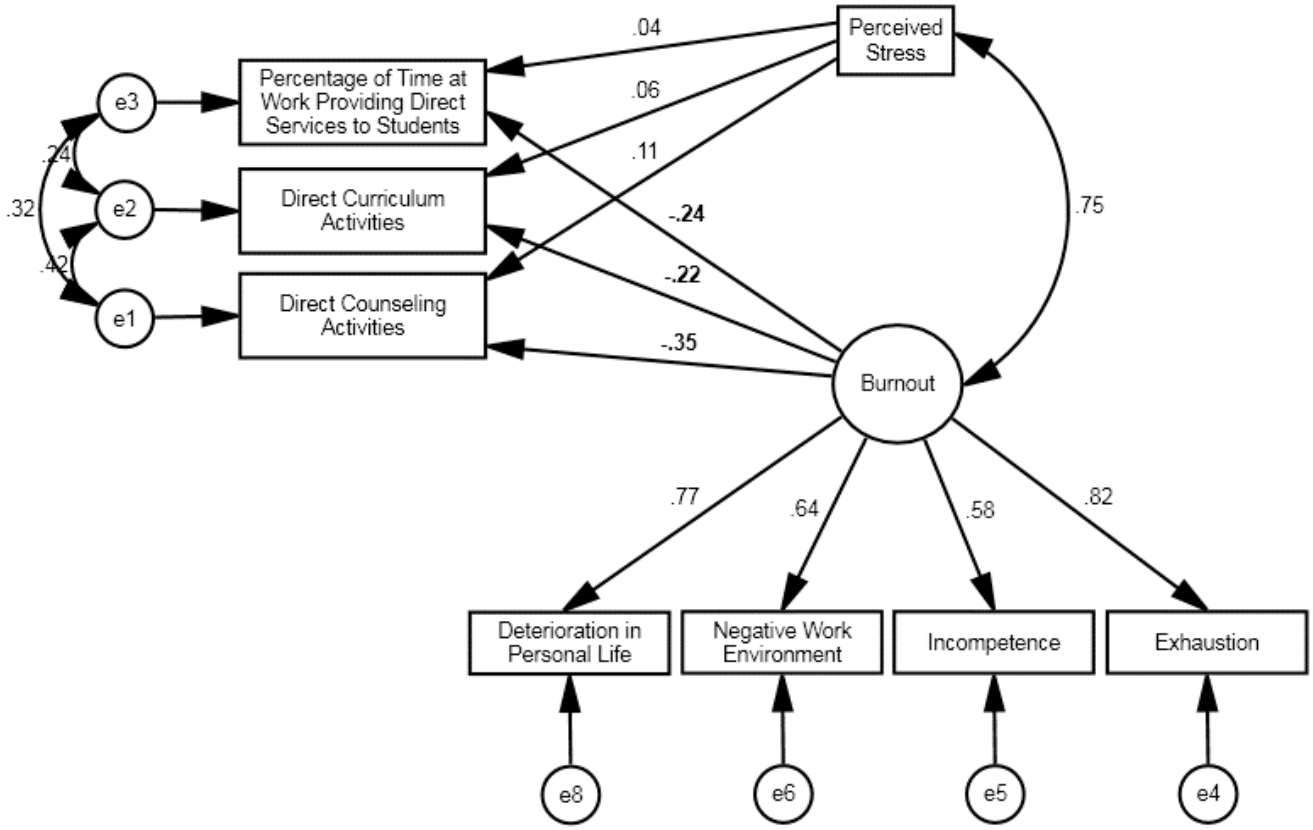

Figure 1. Final hypothesized structural model depicting the relationship between school counselors' (N = 926) perceived stress, burnout, and direct student services.

Discussion

This study examined the relationship between school counselors' reported burnout, perceived stress and frequency of direct student services. The findings indicated burnout was a statistically significant contributor to the frequency of direct counseling services (β = -.35; medium effect size) and direct curriculum services (β = -.22; small to medium effect size). Furthermore, the findings identified that burnout was a significant contributor to the participants' report of the percentage of time they spend on their job working directly with students (β = -.24; small to medium effect size). Although the results should be interpreted with some level of caution, we found that burnout also had a statistically significant relationship to frequency of direct student services with increased levels of burnout relating to lower levels of direct student services. Nonetheless, these findings are not surprising considering the literature on burnout emphasizes the important role burnout plays on the effort one places on their job, with individuals presenting with higher burnout typically having lower investment interest in their job (Garman, Corrigan, & Morris, 2002; Landrum, Knight, & Flynn, 2012; Maslach, 2003). While the findings support the literature on the role of burnout, they also bring attention to the possibility that burnout does not have a strong relationship to school counselors' facilitation of direct counseling services as noted by the small effect size.

An interesting finding was that school counselors' degree of perceived stress did not contribute to the direct student services variables and yet did correlate with burnout. In fact, the relationship between perceived stress and counselor burnout had a large effect size, with 56% of the variance among these variables explained by their relationship. This finding accentuates the difference between the constructs of burnout and stress because burnout had a statistically significant relationship with the direct student services variables and stress did not, despite the strength of the relationship between burnout and stress. One interpretation of this finding is that school counselors' ability to manage and cope with stress permits them to complete their job functions, whereas burnout may be more challenging to overcome. Furthermore, scholars state that prolonged exposure to stress worsens or cultivates burnout (Cordes & Dougherty, 1993; Schaufeli & Enzmann, 1998). This finding is logical given the theory behind burnout (Lee et al., 2007; Maslach, 2003); yet, this is one of only a few studies (McCarthy et al., 2010; Wilkerson & Bellini, 2006) in the school counseling literature to examine this relationship. However, these results need further exploration. As McCarthy et al. (2010) noted, the construct of stress is multidimensional (includes appraisal of resources and demands) and the PSS (Cohen et al., 1983) is a single-dimension scale. Therefore, a scale that examines stress in a multifaceted manner may produce different results.

An additional finding worth discussion involves the measurement model of the CBI (Lee et al., 2007). Specifically, this study found that the construct of devaluing client did not fit with the data. Furthermore, participants reported low scores regarding the devaluing client scale, as indicated by the descriptive statistics. The devaluing client subscale also was the only subscale on the CBI that was not normally distributed. These results were similar to Gnilka et al.'s (2015) findings that indicated school counselors are likely to maintain high levels of empathy and positive regard for their students. These findings may indicate that the devaluing clients subscale may not reflect symptoms of burnout for school counselors. This is a promising finding as it suggests that school counselors do not develop a negative perspective of students because of the negative consequences of their job.

The descriptive statistics from this investigation also provide some noteworthy information. First, participants reported moderate to low levels of burnout across the five factors of the CBI (Lee et al., 2007), with exhaustion having the highest mean score. These results are consistent with prior research (Butler & Constantine, 2005; Lambie, 2007; Wachter et al., 2008; Wilkerson & Bellini, 2006) on burnout and indicate that, overall, school counselors report low levels of burnout. An additional finding was that school counselors reported a low level of perceived stress, which is surprising given the challenge of role ambiguity, confusion and conflict (Burnham & Jackson, 2000; Culbreth et al., 2005; Lambie, 2007; Scarborough & Culbreth, 2008). However, school counselors have reported low levels of stress in other research (e.g., McCarthy et al., 2010; Rayle, 2006). The last noteworthy finding from the descriptive statistics was the measures of direct student services. This investigation was one of the first to focus specifically on the topic of direct student services versus other aspects of school counselors' roles. This study found that school counselors reported that, on average, they spend over half their time working directly with students. In addition, they reported high frequencies for facilitating both curriculum and counseling activities. These findings are promising and consistent with other research examining these constructs (Mullen & Lambie, 2016; Scarborough & Culbreth, 2005; Shillingford & Lambie, 2010). Overall, the results from this study provide new and novel information for the school counseling discipline.

Limitations and Implications for Future Research

Readers should interpret these findings within the context of their limitations. Some limitations from this study include: (a) associational research using correlation statistics does not establish cause and effect relationships; (b) the response rate, although high as compared to other studies

with similar methods, is low; and (c) the generalizability of these findings is limited by the sampling procedures (e.g., only sampled ASCA members; Gall et al., 2007). In addition, participants who respond to surveys may have different characteristics as compared to those school counselors who chose not to participate (Gall et al., 2007).

The findings from this study have implications for future research. A prominent direction for future research is the examination of the relationship between stress and programmatic service delivery, including direct student services. This study identified that perceived stress has no relationship with direct service delivery, but a multidimensional measure of stress (McCarthy & Lambert, 2008) may produce different results. Similarly, this study found that perceived stress relates to higher levels of burnout and supports the theory that chronic stress relates to increased burnout. Future research might further confirm these findings.

Another relevant future research implication is exploring factors that prevent or mediate the contribution of burnout to school counselor service delivery, considering this investigation found a significant relationship between these constructs. A variety of mechanisms may serve as buffers between burnout and programmatic service delivery, such as coping skills, career-sustaining behaviors, emotional intelligence, grit, or self-efficacy. Nonetheless, the identification of preventative skills or personal traits that inhibit the effects of burnout may lead to interventions to support school counselors' work. Future research also can examine training interventions that target school counselors' susceptibility to burnout or stress. A final research implication is the need to replicate and confirm our findings. Researchers might consider replicating this study with similar or different measures and data collection methods.

Implications for School Counseling Practitioners and Supervisors

The degree of perceived stress for participants in this study had a positive correlation with their degree of burnout. Furthermore, participants' burnout negatively contributed to their level of direct student services. While this study included several limitations, these findings provide more evidence for the positive relationship between stress and burnout, in addition to the negative contribution burnout can have on the job functions of school counselors. In an effort to support direct student services, it would behoove school counselors to take steps to increase their awareness about their well-being, including symptoms of burnout, and seek support to address concerns as they arise. Additionally, school counselors' failure to address burnout is an ethical concern (American Counseling Association, 2014). School counselors could utilize a self-assessment (i.e., Counselor Burnout Inventory [Lee et al., 2007] or Professional Quality of Life Scale [Stamm, 2010]) to examine their level of burnout and subsequently address their work functions and lifestyle to alleviate symptoms.

As Moyer (2011) pointed out, supervision plays a vital role in school counselor development and can be a way to alleviate burnout. Thus, supervisors can provide opportunities for school counselors to learn ways to assess their well-being with the aim of developing career-sustaining behaviors to prevent burnout. For example, supervisors can inform school counselors of available screening measures and provide resources to aid in the development of career-sustaining behaviors. Similarly, supervisors can create activities (Lambie, 2006) that assess school counselors' well-being, which allows counselors to address negative feelings. Efforts made to prevent burnout may increase the chances of school counselors performing direct student services. Higher rates of direct student services, such as individual and group counseling, also may lead to better educational outcomes for students (Lapan, 2012).

In an effort to reduce school counselors' burnout and potentially increase their delivery of direct student services, practitioners and supervisors can initiate wellness-related activities. Butler and Constantine (2005) noted that peer supervision or consultation along with social support from colleagues and administrators might be helpful for reducing the effects of burnout. Furthermore, Lawson and Myers (2011) reported on the highest rated career-sustaining behavior, which provides potential to support the wellness of school counseling practitioners. As Meyer and Ponton (2006) noted, counselors as a whole tend to put their own wellness to the side in order to provide services to their clients. Therefore, another consideration for school districts and school counseling organizations is to offer wellness-focused training that could raise attention to counselors' level of stress and burnout and provide strategies to enhance their wellness. Additionally, school counselors should remember to advocate for the profession and for themselves (Young & Lambie, 2007). It is important that administrators understand the critical wellness needs of school counselors, and school counselors should be among the first to advocate for this cause. As these findings indicate, there is a relationship between burnout and the quality of services offered by school counselors. Therefore, it is important that counselors "learn to be their own advocates and help dysfunctional workplaces become well" (Young & Lambie, 2007, p. 99).

In summary, this study examined the association of practicing school counselors' degree of burnout, perceived stress and frequency of direct student services. The findings indicated that higher levels of burnout contribute to a decreased frequency of direct student services. Furthermore, school counselors' perceived stress does not contribute to their facilitation of direct student services, but was positively associated with burnout. Overall, these findings are encouraging because the descriptive statistics indicate that school counselors operate at a low level of burnout and perceived stress and provide a moderate to high frequency of direct student services.

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The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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Clinical Supervisors' Perceptions of Wellness: A Phenomenological View on Supervisee Wellness

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Wellness is an integral component of the counseling profession and is included in ethical codes, suggestions for practice and codes of conduct throughout the helping professions. Limited researchers have examined wellness in counseling supervision and, more specifically, clinical mental health supervisors' experiences with their supervisees' levels of wellness. Therefore, the purpose of this phenomenological qualitative research was to investigate experienced clinical supervisors' ($N = 6$) perceptions of their supervisees' wellness. Five emergent themes from the data included: (a) intentionality, (b) self-care, (c) humanness, (d) support, and (e) wellness identity. As counselors are at risk of burnout and unwellness because of the nature of their job (e.g., frequent encounters with difficult and challenging client life occurrences), research and education about wellness practices in the supervisory population are warranted.

Keywords: **supervision, wellness, unwellness, phenomenological qualitative research, helping professions**

Wellness is an integral component of the counseling profession (Myers & Sweeney, 2004; Witmer, 1985) and is included in ethical codes, suggestions for practice and codes of conduct throughout the helping professions of counseling, psychology and social work (American Counseling Association [ACA], 2014; American Psychological Association [APA], 2010; National Association of Social Workers [NASW], 2008). Yet, individuals in the helping professions do not necessarily practice wellness or operate from a wellness paradigm, even though counselors are susceptible to becoming unwell because of the nature of their job (Lawson, 2007; Skovholt, 2001). As a helping professional, proximity to human suffering and trauma, difficult life experiences and additional occupational hazards (e.g., high caseloads) make careers like counseling costly for helpers (Sadler-Gerhardt & Stevenson, 2011). Further, helpers may be vulnerable to experiencing burnout because of their ability (and necessity because of their career) to care for others (Sadler-Gerhardt & Stevenson, 2011). Compassion fatigue, vicarious traumatization and other illness-enhancing issues often coincide with burnout, increasing the propensity for therapists to become unwell (Lambie, 2007; Puig et al., 2012). Extended periods of stress also can lead to helping professionals' impairment and burnout and can negatively impact quality of client services (Lambie, 2007). Furthermore, counselors who are unwell have the potential of acting unethically and may in turn harm their clients (Lawson, 2007). Thus, it is imperative that helping professionals' wellness be examined.

More specifically, counseling professionals are required to follow guidelines that support a wellness paradigm. ACA (2014) states that counselors should monitor themselves "for signs of impairment from their own physical, mental, or emotional problems" (Standard C.2.g.). In addition, counselors are instructed to monitor themselves and others for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm a client or others" (ACA, 2014, F.5.b.). The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) supports counselors having a wellness orientation and a focus on prevention

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(Section II.5.a.) and that counselors promote wellness, optimal functioning and growth in clients (Section II.2.e.). Thus, prevention of impairment and a wellness focus are intertwined throughout the standards of the counseling profession. Consequently, it is unethical for counseling professionals to operate while personally or professionally impaired.

Wellness and Supervision in Counseling

In the following section, the importance of wellness and potential impacts of unwellness in the counseling profession will be discussed. Specifically, stressors contributing to impairment will be highlighted. In addition, supervision within a counseling context and general information regarding the supervisory experience will be reviewed.

Wellness and the Counseling Profession

The counseling profession was founded on a wellness philosophy, with holistic wellness including personal characteristics, such as nutritional wellness, physical wellness, stress management and self-care (Puig et al., 2012), and other realms including spiritual, occupational and intellectual well-being (Myers & Sweeney, 2008). According to Carl Rogers (1961), personal characteristics influence counselors' ability to help others. For instance, individual wellness may influence how knowledgeable, self-aware and skillful supervisees are in relation to working with clients (Lambie & Blount, 2016). Counselors who are well are more likely to be helpful to their clients (Lawson & Myers, 2011; Venart, Vassos, & Pitcher-Heft, 2007), and counselors' mental health and wellness impacts the quality of services clients receive (Roach & Young, 2007). Therefore, counselor preparation programs and supervisors should discuss wellness and areas in which impairment could arise when training students to become counselors and supervisors (Roach & Young, 2007). Though wellness is a core aspect of counselor training and preparation, many practicing counselors report their colleagues to be stressed (33.29%), distressed (12.24%) and impaired (4.05%; Lawson, 2007).

Individuals who are attracted to and enter into helping fields often appear to have severe adjustment and personality issues, and these individuals may range from students entering into programs to faculty members employed by institutions (Witmer & Young, 1996). In addition, counselors are often remiss about taking their own advice about wellness (Cummins, Massey, & Jones, 2007) and frequently preach wellness to their clients but do not practice wellness personally (Myers, Mobley, & Booth, 2003). Many counselors do not see their own impairment or are unwilling to take the steps to get help (Kottler, 2010), supporting the importance of supervisors identifying and addressing their supervisees' impairment. Consequently, counselors seeing clients in agency settings, private practices and other settings may experience stressors that are influencing their wellness and, in parallel, the wellness of their clients.

With the counseling profession having a wellness undertone, counselors are expected to promote well-being in their clients and model appropriate wellness lifestyles. Nevertheless, counselors experience job stressors that impact their abilities to be effective helping professionals (Puig et al., 2012). Counselors face several stressors within their career such as managed care, financial limitations, high caseloads, severe mental disorders in clientele and lack of support (O'Halloran & Linton, 2000). Other factors impacting counselors and mental health professionals include: (a) compassion fatigue (Perkins & Sprang, 2012), (b) unhappy workplace relationships (Lambie, 2007), (c) vicarious trauma (Trippany, White Kress, & Wilcoxon, 2004), and (d) general fatigue (Lambie, 2007). Moreover, these systemic factors contribute to increased likelihood for counselors to experience burnout and impairment, impacting their clients' therapeutic outcomes (Puig et al., 2012). Furthermore,

counselors may not disclose their impairment because of denial, shame, professional priorities, lack of responsibility and fear of reprisal (Kottler & Hazler, 1996).

Counselor impairment occurs when counselors ignore, minimize and dismiss their personal needs for health, self-care, balance and wellness (Lawson, Venart, Hazler, & Kottler, 2007). Lawson and colleagues (2007) stated counselors need awareness of their personal wellness and should work to maintain their wellness. In addition, ACA (2014) states that counselors are responsible for seeking help if they are impaired and that it is the duty of colleagues and supervisors to recognize professional impairment and take appropriate action (Standard C.2.g.). Thus, counselors and supervisors are responsible for not only maintaining their personal wellness, but are also responsible for monitoring the wellness or impairment of their colleagues. One of the platforms for monitoring counselor wellness is supervision.

Supervision

ACA (2014) stipulates that supervision involves a process of monitoring "client welfare and supervisee clinical performance and professional development" (Standard F.1.a.). Supervision is an integral component of the counseling profession, involving a relationship in which an experienced professional facilitates the development of therapeutic competence in another (Bernard & Goodyear, 2014). Furthermore, supervision is fundamental in developing and evaluating counselors': (a) skills (Borders, 1993), (b) wellness (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012), and (c) development into competent and effective counselors (Swank, Lambie, & Witta, 2012). Clinical supervisors are tasked with evaluating their supervisees' effectiveness in addition to their level of wellness (Puig et al., 2012). Consequently, stressors, such as personal and cultural issues, addictions, burnout, and other counseling-related occupational challenges, may negatively influence supervisees' wellness and ability to be effective helping professionals.

Supervision "provides a means to impart necessary skills; to socialize novices into particular profession's values and ethics; to protect clients; and finally, to monitor supervisees' readiness to be admitted to the profession" (Bernard & Goodyear, 2014, p. 5). Supervisors have the unique opportunity to operate from a wellness paradigm, socialize their supervisees to wellness practices, monitor supervisee wellness, and gauge how supervisees' wellness influences client outcomes (Lambie & Blount, 2016). As a result, supervisors who operate from a wellness paradigm and evaluate their supervisees' wellness may influence the wellness of supervisees' clients by encouraging positive client outcomes (Lawson, 2007; Lenz & Smith, 2010). As such, supervisee and supervisor wellness is an important component of counselor preparation programs and clinical supervision (Lenz et al., 2012).

Counselor educators (Wester, Trepal, & Myers, 2009), clinical supervisors (Lenz & Smith, 2010; Storlie & Smith, 2012), counselors-in-training (Myers & Sweeney, 2004; Smith, Robinson, & Young, 2007), and licensed counselors (Lawson, 2007; Myers et al., 2003) face challenges in obtaining optimal well-being (e.g., high caseloads, proximity to client trauma, empathizing with students and clients). Supervisors play an integral role in counselor trainee development and can model appropriate wellness behaviors for their supervisees. Furthermore, supervisors have the unique opportunity to work closely with their supervisees and provide an in-depth look at how emerging counselors are learning about wellness behaviors, partaking in wellness actions and promoting wellness in their clients. Nevertheless, no available research has examined experienced clinical supervisors' perceptions of their supervisees' wellness. Because clinical supervisors have a close relationship with their supervisees, their perceptions of their supervisees' wellness can provide important information for the counseling profession. Therefore, the following research question guided our investigation: What are clinical mental health supervisors' experiences with their supervisees' wellness?

Methodology

Identifying themes related to clinical supervisors' experiences of their supervisees' wellness provides insights for both supervisors and supervisees. The researchers followed a psychological phenomenological methodology (Creswell, 2013a; Moustakas, 1994), allowing for both the meaning (themes) and the essence (experience) of the participants to be examined. In phenomenological research, researchers attempt to identify the essence of participants' experiences surrounding a phenomenon. By developing interview questions and using an interview protocol technique (Creswell, 2013b), the researchers petitioned participants' (i.e., clinical supervisors) direct and conscious experiences (Hays & Wood, 2011) to assess their perceptions of their supervisees' wellness (see Table 1). The following section includes discussion on: (a) epoche and bracketing, (b) participants, (c) procedure, (d) qualitative data analysis and (e) trustworthiness.

Epoche

The first course of action in phenomenological analysis is called *epoche* (Patton, 2015); therefore, the research team members are described with some of their potential biases. The research team consisted of two counselor educators, a counselor education doctoral candidate, and a counseling master's student (one man and three women), all of whom identify as Caucasian. All of the researchers were affiliated with the same institution, a large, public, CACREP-accredited university located in the Southeastern United States. In addition, biases relating to the effectiveness of supervisory styles were discussed, and bracketing throughout the data analysis was implemented in order to minimize bias and allow for participant perspectives to be at the forefront. Participant experiences were documented in personal interviews and in the form of collaborative discussions.

Participants

The participants consisted of clinical supervisors who were purposefully selected from a Department of Health and Human Services counseling professional list from a large, southeastern state. Initial criteria for participation in the investigation included: (a) being clinical supervisors for 10 or more years and (b) being in an active supervisory role (i.e., providing supervision). Twenty-six participants initially responded, with 17 individuals meeting the necessary requirements for participation. The final sample consisted of six clinical supervisors, based on individuals who agreed to participate.

Criterion were established to support interviewing only "experienced" supervisors (i.e., supervisors with extensive supervision experience) and participants' mean number of years of experience as clinical mental health supervisors was 21.2 years. Four of the experienced supervisors identified as female and two identified as male, and their ages ranged from 49 years to 63 years (M = 56.5 SD = 4.93). In addition, four of the participants identified as Caucasian (n = 4), one participant identified as Hispanic (n = 1), and one participant identified as Other (n = 1; i.e., chose not to disclose). The participants represented the following theoretical approaches: humanistic/Rogerian (n = 3), integrative/eclectic (n = 2) and cognitive-behavioral (n = 1). Primary supervision models for the clinical supervisors included: eclectic/integrative (n = 4), person-centered (n = 1) and solution focused (n = 1). The participants served as clinical supervisors at six different mental health agencies throughout a large southeastern state, supporting transferability of the findings.

In reference to wellness, the participants were asked to evaluate their level of wellness prior to participating in the interview process. Specifically, participants were asked to define what wellness meant for them as well as elaborate on the specific areas they felt influenced their wellness. Participants then rated on a 5-point Likert scale their level of overall wellness (i.e., 1 indicating very

low wellness, 5 indicating very high wellness). Four of the six participants rated their overall wellness as 5 (very high wellness), while the remaining two individuals rated their overall wellness as 3 (average wellness) and 4 (high wellness) respectively. Thus, the participants reported having average to high levels of personal wellness.

Procedure

Before conducting the investigation, Institutional Review Board (IRB) approval was obtained. Following IRB approval, the researchers employed purposeful sampling (Hays & Wood, 2011) to recruit participants by accessing a public listing of all mental health practitioners in a southeastern state in the United States. The Department of Health and Human Services counseling professional list was utilized, which included e-mail addresses, telephone numbers and mailing addresses of potential participants. Twenty-six participants met the initial response criteria (i.e., 10 or more years of supervisory experience). Snowballing also was used to recruit additional participants (i.e., asking participants for a name of an individual who might fit the study criteria). However, of the 26 participants, 17 supervisors responded with complete general demographic questionnaires and sufficient number of years as supervisors (i.e., minimum of 10 years). Six individuals fit the final purposive sampling criteria for participating in the investigation (e.g., had over 10 years of clinical mental health supervisory experience, still practicing as supervisors in diverse agencies, and having a complete general demographic form).

The first round of data collection was essential in confirming the eligibility of the participants (e.g., completion of the general demographic questionnaire and informed consent form). The demographic questionnaire consisted of questions about personal wellness, ethnicity, theoretical orientation, age, gender and primary population served. Following completion of the initial documents, individual interviews were scheduled. The second round of data collection involved face-to-face or Skype interviews with each participant, where participants were asked the general research question: What are your experiences with your supervisees' wellness? The researchers also had nine supporting interview questions, which were developed through a rigorous process involving: (a) researchers' development of an initial question blueprint derived from the literature reviewed for the study, (b) experts' review and modification of the initial questions, and (c) an initial pilot group testing the questions. The experts were comprised of educators with experience in conducting qualitative research, experience providing supervision and familiarity with the wellness paradigm.

The interview protocol included instructions for the interviewer, research questions, probes to follow the research questions (if needed), space for recording comments, and space for reflective comments to ensure all interviews followed the same procedure (Creswell, 2013a). The general interview questions were developed to aid in addressing the overall question of supervisors' perceptions of their supervisees' wellness and all individual interviews were audio recorded and then transcribed. The final list of interview questions is presented in Table 1. The researchers conducted all interviews individually, and to support the effectiveness of gathering the participants' experiences, member checking was implemented (Creswell, 2013a). Specifically, all participants were e-mailed a copy of their interview transcription, along with a statement of themes and interpretation of the interview's meaning. All participants ($N = 6$) responded to member checking and stated that their transcribed interview was accurate and agreed with the themes derived from their interviews.

Table 1

Interview Question Protocol

Data and Rationale	Draft Interview Questions	Prompts and Elicitations
Values (gaining perceptions)	1. What does wellness mean to you?	Wellness, health, well-being
Beliefs, Values (learning expectations, perceptions)	2. What influences wellness in counselors?	Counselor-specific wellness
Values (gaining perceptions)	3. What is the most important aspect of wellness?	Crucial component(s)
Values, (gaining perceptions, opinions)	4. Is wellness the same or different for everyone?	Wellness looks like . . . individualized
Experiences, Values (what influences clients)	5. Does wellness influence your supervisees' client(s)?	Wellness impacts clients, or supervisees' clients
Experiences, Values (gaining information on standards of wellness and if they are being upheld)	6. Do you feel your supervisees uphold to standards of wellness in the counseling field?	Meeting standards, CACREP, ACA Ethics
Beliefs, Experiences (expectations of supervisors, experiences)	7. What does unwellness in counseling supervisees look like?	Depiction of unwellness
Beliefs, Experiences (expectations, experiences of seasoned counselors)	8. What does unwellness in counselors-in-the field look like?	Unwellness "picture"
Values, Beliefs (gaining other information relating to wellness)	9. Is there anything else you would like to tell me about wellness?	Personal wellness philosophy

Note: Draft Interview Questions were used in all participant interviews.

Data Analysis

The researchers followed Creswell's (2013a) suggested eight steps in conducting phenomenological research: (a) determining that the research problem could best be examined via a phenomenological approach (e.g., discussed the phenomenon of wellness and its relation to the counseling field and in the supervision of counselors); (b) identifying the phenomenon of interest (wellness); (c) bracketing personal experiences with the phenomenon; (d) collecting data from a purposeful sample; (e) asking participants interview questions that focused on gathering data relating to their personal experiences of the phenomenon; (f) analyzing data for significant statements (horizontalization; Moustakas, 1994) and developing clusters of meaning; (g) developing textural and structural descriptions from the meaning units; and (h) deriving an overall essence. In order to maintain organization, the researchers implemented color-coding of statements by selecting one color for initial significant statements or codes (e.g., step f), another color for textural descriptions (e.g., what participants experienced in step g) and a final color to represent structural descriptions (e.g., how participants experienced the phenomenon in step g) of the data (Creswell, 2013a). Finally, the researchers determined an overall essence (step h) based on the structural descriptions of the participants' interview transcriptions.

Following individual coding (i.e., steps f, g, and h), the researchers discussed their initial results and discrepancies, evaluating these discrepancies until reaching consensus.

Trustworthiness

The researchers established trustworthiness by bracketing researcher bias, implementing written epochs, triangulating data, implementing member checking, and providing a thick description of data (Creswell, 2013a; Hays & Wood, 2011). Coinciding with Denzin and Lincoln (2005), the researchers triangulated data collection using (a) a general demographic questionnaire, (b) semi-structured interviews and (c) open-ended research questions. Epochs allowed the researchers to increase their awareness on any biases present and set aside their personal beliefs. Member checking was employed in order to confirm the themes were consistent with the participants' experiences. As such, participants were provided the opportunity to voice any concerns or discrepancies in their interview transcripts and in their derived meaning statements. The participants indicated *no* discrepancies or concerns. A thick description (detailed account of participants' experiences; Lincoln & Guba, 1985) of the data was supported by the participants' statements and derived themes. In addition, an external auditor was used to evaluate the overall themes and essence of the interviews and to mitigate researcher bias. The external auditor examined the transcripts separate from the other research members in order to evaluate the effectiveness of the derived themes and participant experiences.

Results

Following audio recording and transcription of the participant interviews, the researchers examined the participants' responses and generated narratives of the emergent phenomena. As a result, themes of supervisees' wellness from the clinical mental health supervisors' experiences were derived and included: (a) intentionality, (b) self-care, (c) humanness, (d) support and (e) wellness identity. The themes are discussed in detail below.

Intentionality

Intentionality was defined as the supervisor purposefully utilizing supervisory techniques and behaviors that elicit self-awareness and understanding in their supervisees (i.e., both of self and of their clients). The process of intentionality involved the supervisor actively engaging supervisees in discussions about wellness as well as actively modeling for the supervisees. Within the interviews, supervisors alluded to a parallel process that occurred between the supervisor–supervisee and supervisee–client dyads. When the supervisor intentionally modeled appropriate wellness between self and supervisee, the supervisee could then implement similar wellness activities between self and client. Reflecting on the process of supervisory modeling, Supervisor #1 stated:

> The supervisor . . . has a lot . . . a lot of influence . . . checking in, what are you doing to take care of yourself? You seem really stressed, what is your wellness plan? What is your stress management? How do you detach yourself and unplug yourself from your responsibilities with your clients at work . . . to take care of you?

As depicted, the supervisor intentionally asked the supervisee questions relating to personal wellness and started a conversation about supervisees separating themselves from their work life. Supervisor #2 confirmed the importance of modeling as evidenced by the statement, "you can't preach to someone to do something if you are not doing it yourself." In other words, the supervisor alluded to the idea that supervisors must model appropriate professional and personal behaviors to their supervisees. Additionally, the supervisors discussed the impact of a trickledown effect (e.g., parallel

process): how the supervisor approaches supervisees in turn affects how supervisees approach their clients. For instance, if the supervisor exhibited signs of burnout, then the behaviors would directly impact their relationship and understanding of the supervisee, which would indirectly impact their supervisee's clients. Supervisor #3 noted that the wellness of supervisees influenced client wellness by saying "Oh, I can definitely see when my supervisees are unwell and how that directly influences their work with clients. It's like they're (supervisees) not on top of their game . . . like they're not as effective with clients." Furthermore, supervisors noted the use of direct interventions to help supervisees gain increased self-awareness after recognizing supervisees' potential unwellness. Supervisor #5 stated in reference to a conversation with a supervisee, "I want you to be in the field to better help people by helping yourself and looking at your own issues." Thus, supervisors need to be intentional when helping supervisees become more effective and more well in both their personal and professional lives.

Self-Care

Self-care was defined as the necessity of taking care of one's *self* in order to be a better asset to supervisees and clients. The self-care theme supported the idea that "you cannot give away that which you do not possess" (Bratton, Landreth, Kellam, & Blackard, 2006, p. 15), which is consistent in the counseling and other helping professional literature (Lawson, 2007). In other words, we must take care of ourselves before we are able to care for others. Self-care is delineated from the theme of intentionality in this investigation in that supervisors reflected the importance of their own self-awareness to gauge wellness, especially to alleviate the potential for burnout. For example, Supervisor #4 stated, "If I'm not well, I can't really help someone else get well." Whereas the theme of intentionality reflects encouraging supervisees' self-awareness, the self-care theme notes the importance of supervisors being self-aware and the specific actions supervisors felt they and their supervisees could take to promote self-care in their own lives. As Supervisor #6 said, "it's an incredible field and it can be a very, very draining field if you aren't careful, if you don't take care of yourself." Through the supervisors' process of reflection and recognition, they were able to respond with care and compassion to their supervisees. However, as Supervisor #5 indicated when reflecting on counselor and supervisor burnout,

> [It] happens to every single counselor, they're going to experience compassion fatigue at some point in their career because it is a burnout job, and so to recognize . . . the signs . . . sometimes it takes someone else to point it out to us.

It is crucial to take care of oneself in counseling and be open to feedback from others who may see our behaviors from an objective standpoint. Furthermore, the supervisors noted the critical impact of taking care of themselves through activities outside of the workplace and leaving client and supervisee concerns at work. For example, Supervisor #3 noted:

> I feel you need to take care of yourself, you need to do stuff for you . . . I'm clear to sit down with all of them [supervisees] and say . . .what are you going to . . . do good for yourself today . . . what are you going to do for you?

By creating differentiation between personal and professional life, supervisors and supervisees are able to rejuvenate, leading to better care for supervisees as Supervisor #1 indicated:

> I do feel there are many ways to go about it . . . there's a whole mindfulness movement, and yoga . . . animals . . . those are all ways we can go ahead and keep ourselves well. I think play

> is a component of keeping yourself well and . . . there are different definitions of play, but I would define it as when you're so involved in doing something that you lose track of time. That could be art activities . . . dancing, doing something fun with your dog . . . playing games . . . being involved in something where time stands still and you're totally in the moment. . . . I think that's another key piece of really staying well.

As a result, the self-care theme involves supervisors identifying and implementing strategies to keep themselves well, as well as supervisees engaging in activities to support their own self-care journeys. Similar to other wellness research in the helping professions (Lawson, 2007; Myers & Sweeney, 2005b; Skovholt, 2001), self-care is paramount to supporting personal wellness, as well as having the capacity to promote wellness in others—supervisors with supervisees and in parallel, supervisees with clients.

Humanness

Humanness was defined as the supervisors' and supervisees' culture, history, background and the influences of previous life experiences on the therapeutic relationship. Our past actions, memories and families of origin influence our worldview and current functioning. As Supervisor #3 noted, "I define wellness on a personal level, it has to do with me and my personhood, it is unique and is based on my wants and needs." In reference to the influence of individuals' history and background, Supervisor #2 stated, "for myself definitely it was pretty much the way I grew up . . . it depends on the population, it depends on where they were raised. . . . There's just too many dependent variables for it." At times, supervisors noted that these factors lead to unintentional blindness between and within the dyad (i.e., supervisor–supervisee, supervisee–client). Supervisor #3 noted that "we all have biases, we all have prejudices on some level. Are you willing to acknowledge that you are struggling with this, but I am willing to work on this, willing to go to workshops or go into therapy?" Without reflection or self-awareness, supervisors and supervisees are susceptible to similar roadblocks and "stuckness" as their clients. For instance, Supervisor #4 noted the influence of current life events impacting her overall wellness:

> I think to add to that, it is the nature of our human experience. . . . we are going to go through phases in our lives where things are affected to the point to where you would say this aspect of my life is not well right now.

Thus, supervisors perceive both their humanness (e.g., backgrounds and cultures) and their supervisees' humanness qualities as influential to the therapeutic relationship and important in supervisees' actions in counseling situations as well as personal settings (Lambie, 2006).

Support

Support was defined as leaning on and connecting with others (e.g., peer-to-peer, colleagues, friends, partners). Supervisors emphasized the importance of both themselves and their supervisees developing and maintaining significant relationships within the context of their job and outside the work setting. Supervisor #6 reflected that "support is integral to . . . overall wellness and, being that we are social creatures . . . support [is] really important for us." Relationships at work can be crucial for processing tough client cases and personal issues that appear to be encroaching upon work with clients. For example, Supervisor #3 emphasized, "I think there has to be a support system of counselors who have been in the field . . . and having your own therapist." At the same time, social relationships outside work are equally important. Similar to self-care and intentionality, separating personal life and professional life aids the supervisor and supervisee in leaving client cases at work and enjoying life beyond the role as a counselor. Within the literature, the influence of support

aids supervisors and supervisees in achieving wellness and minimizing the likelihood of counselor burnout (Lambie, 2007; Lee, Cho, Kissinger, & Ogle, 2010).

Wellness Identity

Wellness identity was defined as the supervisors and supervisees operating from a wellness platform. Supervisors noted the necessity of holding this wellness platform in the forefront of conversations with students, other supervisors, and other therapists and counselors. As Supervisor #3 reflected,

> We practice a strengths-based model and we see that the wellness model is depicted much, much more not only in the literature but also in the things that come about. . . . I'd rather see research in wellness rather than case research in defects.

Through attaching wellness to one's identity as a counselor, supervisors and supervisees are compelled to continuous self-reflection on how external factors impact their work with supervisees and clients. Supervisor #1 stated "wellness is who we are, if we find ourselves straying, we probably need to re-evaluate things." Furthermore, supervisors indicated in their interviews that wellness is an important topic for counselors and counselor educators to reflect upon and teach and discuss with students and supervisees. For instance, Supervisor #2 stated in relation to the idea of a wellness identity: "It comes from the teaching that one receives in the classroom. . . . I think that the issues have really brought it to the forefront and it has allowed us to teach wellness and to talk about it. I think teaching is the driving force."

As shown in the *wellness identity* theme, all of the supervisors supported the idea that having a wellness base from which helpers operate is important. Additionally, the participants noted the importance of an open dialogue on wellness between supervisors and supervisees and, coinciding with Granello (2013) and Roach and Young (2007), stressed the idea that as a supervisor, wellness education can play a key role in promoting healthy helping professionals.

Discussion

The results from this study provided the data to answer the research question: What are clinical mental health supervisors' experiences with their supervisees' wellness? Experienced supervisors (e.g., 10 or more years of supervisory experience) discussed areas that influenced their wellness as well as their supervisees' wellness. Furthermore, several themes that supported an essence of supervisee wellness (Hays & Wood, 2011; Moustakas, 1994) were derived. In interviewing the supervisors, the themes of (a) intentionality, (b) self-care, (c) humanness, (d) support and (e) wellness identity were derived from the data analysis. From the results of this study, implications for clinical supervisors and counselor educators, limitations of the research investigation, and areas for future research were derived.

Implications for Clinical Supervisors and Counselor Educators

The counseling field is grounded in holistic wellness (Myers & Sweeney, 2004). Therefore, our findings reflected the theme that wellness is important to the counseling profession and in supporting supervisors' and supervisees' overall growth. Scholars in the helping fields (Keyes, 2002, 2007; Myers, Sweeney, & Witmer, 2000) and professional guidelines (ACA, 2014; CACREP, 2015) support the necessity of a wellness focus, identifying that a lack of a wellness focus may lead to unwellness and burnout (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003). Thus, creating and maintaining a

wellness identity in supervision can aid in supporting holistic wellness in supervisees. In addition, self-care can be important for counselors, as they are not immune to difficult experiences and life events faced by their clients (Venart et al., 2007). Supervisor #6 noted that burnout was an inevitable part of working as a counselor and, similarly, researchers have identified that burnout can influence counselors' work with their clients (Lambie, 2007; Puig et al., 2012). Thus, wellness provides the foundation of helping professionals' work with clients (Venart et al., 2007), and exploration of counselor burnout and other negative consequences of counselor unwellness warrants attention.

The clinical supervisors in our investigation indicated a need for counselor educators to be more intentional in their focus and inclusion of wellness with the therapeutic relationship. In order to mitigate the effects of burnout and unwellness in supervisees, a wellness course or a wellness plan for counselors-in-training over the duration of their preparation program is suggested to support counselor educators in preparing future clinicians with a mindset of reflection, process and activities to enhance wellness. By implementing a wellness focus throughout preparation programs, supervisees can learn about the positive and negative influence of their wellness choices, as well as the effects their wellness may have on their colleagues and clients. Furthermore, wellness plans could be implemented throughout the program to promote wellness awareness in supervisees. Classroom discussions and wellness groups could also aid in supporting students in their wellness growth and development throughout their program while providing counselors-in-training with the tools to share their knowledge and promote wellness in others.

Supervisors also can mitigate the effects of unwellness by continuously evaluating their current levels of functioning through formal assessments such as the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005a), or the Helping Professional Wellness Discrepancy Questionnaire (HWPDS; Blount & Lambie, in press) or informal assessments such as wellness journaling or implementing wellness plans. Supervisors also may choose to include wellness in their supervision sessions by assessing pre- and post-wellness levels in supervisees, operating from a wellness-supervision paradigm (e.g., the Integrative Wellness Model; Blount & Mullen, 2015; Wellness Model of Supervision; Lenz & Smith, 2010), having educational discussions on the holistic components of wellness, and modeling appropriate wellness behaviors. Thus, there are numerous actions supervisors can take to promote individual wellness, include wellness in their supervision, and promote wellness in their supervisees.

Supervision is crucial to counselor development (Bernard & Goodyear, 2014). CACREP (2015) Standards and licensure requirements emphasize the importance of supervision throughout trainees' growth and establishment as a professional counselor. ACA (2014) emphasizes additional professional development and supervision throughout counselors' careers, stating that counselors should "regularly pursue continuing education activities including both counseling and supervision topics and skills" (Standard F.2.a.). Even though the field of counseling is grounded in a wellness paradigm (ACA, 2014; CACREP, 2015), the process of supervision does not always support a wellness focus, as supervisors do not model wellness for their supervisees or stress the importance of counselor well-being. According to the supervisors in our investigation, wellness should be integrated and discussed within the supervision realm. Further, clients are more likely to benefit from a well counselor (Lawson, 2007) and as such, counselor educators and supervisors face the challenge of promoting effective, well therapists-in-training. The wellness process, however, typically occurs in a negative trickledown method (e.g., burned out supervisors modeling inappropriate wellness behavior for trainees who in return model inappropriate wellness for clients).

Counselor educators can break the cycle of negatively modeling wellness by incorporating wellness throughout the trainees' experience in their preparation programs and by modeling wellness and self-care. Through the wellness paradigm, counselor educators can begin to change the thought process of trainees' own reluctance to engage in self-care and work to change the "do as I say" mentality (i.e., telling clients or trainees to be well when we are *not* well ourselves), which is present throughout the helping professions (Lawson, 2007; Witmer & Young, 1996). Based on our results, the counseling profession should embrace the belief that "you cannot give away that which you do not possess" (Bratton et al., 2006; p. 238). By adapting a wellness framework, the benefits of the wellness paradigm at the beginning of trainees' careers is significant, impacting other counselors and clients that enter into their path in a positive way.

Expanding beyond supervisors, therapists-in-training and practitioners, wellness practices can be influential on a larger scale. Counseling and counselor education programs, as well as respective professional organizations, can use wellness philosophies and practices to promote self-care in their members. In addition, organizations can support strong wellness identities in their helping professionals by upholding their ethical standards, promoting wellness-related actions, and educating new professionals on the importance of practicing wellness in their personal and professional lives. As voiced by many of the supervisors interviewed in our study, professional organizations can support their members by encouraging wellness identities and offering platforms for individuals to form relationships with other practitioners in the field. Practitioners can use the connections to exchange wellness ideas and practices, and offer support as professionals. Finally, supervisors can be integral in promoting their supervisees' wellness throughout the career, supporting the services they provide to diverse clients.

Limitations

We followed steps to support the trustworthiness of the data; however, some limitations are noted. Given that the first author is invested in the wellness approach to counseling, researcher bias may have occurred. However, the research team implemented steps to mitigate the role of bias. For instance, researcher bias was bracketed at the forefront of the interviews and an external auditor reviewed interviews to note themes separate from the research team. As with *all* qualitative research, the results from our study are *not* generalizable. Nevertheless, the six clinical mental health supervisors worked in six different mental health agencies, supporting the transferability of the findings (Yardley, 2008). In addition, the sample size for the investigation met the criteria outlined for qualitative analyses (5–25 participants; Polkinghorne, 1989), yet all of the participants volunteered for participation and may have had a greater interest in wellness than those who did not volunteer. Finally, even with a small sample size ($N = 6$), the researchers believed that saturation of the themes occurred by implementing rigorous data analytic procedures (i.e., coding for themes and essence) and reaching an inability to glean new information from the coding (Guest, Bunce, & Johnson, 2006).

Areas for Future Research

In relation to future research endeavors, participants in this study emphasized the importance of wellness-related research in counseling. Given that the counseling field is grounded in a wellness model (Myers & Sweeney, 2005b; Witmer, 1985) and that limited studies on wellness are available, quantitative and/or qualitative studies examining the overall effect of wellness within the supervisory relationship are needed. Further, researchers might assess the degree to which supervisors or supervisees actually engage in wellness behaviors. As with most qualitative studies, our findings reflect a starting point for quantitative research, focusing on the identified themes across supervisors and supervisees. Future researchers could examine the parallel process between (a) educator and

student and (b) supervisor and supervisee that takes place when trusting and safe relationships are established (Bernard & Goodyear, 2014). Furthermore, future researchers could assess differences in supervisors or supervision styles in supervisors with formal supervision courses versus *no* formal experience; or similar studies with supervisors who have participated in a wellness course versus those who have not. In addition, future research could focus on client outcomes when one party (i.e., counselor) models appropriate wellness and a different counselor does not model these qualities. Future researchers are also encouraged to assess the effect of the five identified themes on client outcomes and/or student progress within counselor education programs.

In summary, "it is not possible to give to others what you do not possess" (Corey, 2000, p. 29); therefore, we must take care of ourselves before we are fully capable to help others. As such, it is important to bring wellness to the forefront of clinical supervision and remain engaged in promoting personal wellness and the wellness of others. Thus, assessing and evaluating wellness in *all* supervisors and supervisees (counselors) is integral in providing quality supervision and efficacious counseling services and protecting client welfare. By increasing awareness on wellness themes, such as self-care, support, wellness identity, and humanness, along with operating intentionality, clinical supervisors can support their supervisees in achieving greater levels of wellness.

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Analyzing CACREP-Accredited Programs' Utilization of Criminal Background Checks

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The use of objective methods in gatekeeping processes has become increasingly more important due to legal and ethical implications and consequences. For example, the medical field has utilized criminal background checks (CBCs) as a gatekeeping assessment of a student's ability to best serve future patients. This article focuses on the current use of CBCs by master's-level counselor education programs (*N* = 83) accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). A significant implication from this study is the need for counselor education to consider best practices and guidelines for the use of CBCs.

Keywords: **criminal background, criminal background checks, gatekeeping, counselor education, counseling programs**

Counselor educators and supervisors are ethically bound to not endorse any counselor-in-training (CIT) for certification, licensure, employment or completion of an academic program when they believe a CIT is not qualified for the endorsement (American Counseling Association [ACA], 2014). In particular, educators are required to screen all counseling program applicants prior to admission and to continually and thoroughly evaluate and appraise students during their progression through the program (Erwin & Toomey, 2005). It has been suggested that utilizing criminal background checks (CBCs) with students should be part of the gatekeeping process in behavioral health programs (Brodersen, Swick, & Richman, 2009; Cowburn & Nelson, 2008; Erwin & Toomey, 2005). In fact, government agencies and private and public employers are increasing their use of CBCs as a screening mechanism (Sheets & Kappel, 2007). CBCs may be conducted to determine if an individual is a potential threat to clients, vulnerable populations or fellow employees. According to Sheets and Kappel (2007), "Because most consumers are not in the position to run CBCs . . . they depend on professional licensing boards to conduct appropriate screening of applicants" (p. 64). This could be a concern, however, because CITs work with clients while they are in their training program. Counseling programs that do not have access to CBC data may be left without critical information to help best protect vulnerable populations. Therefore, the responsibility of having CBC results might more appropriately fall on counselor educators (ACA, 2014).

All 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands require a CBC for school counselors (American Counseling Association, Office of Public Policy and Legislation, 2011). According to ACA (2010), as of 2010 six states (i.e., Arizona, Maine, Mississippi, Missouri, Montana, Tennessee) required a CBC as part of the licensure application process. North Carolina requires applicants to sign a statement authorizing the licensing board to conduct a full criminal record search, including state and federal records (North Carolina Board of Licensed Professional Counselors 2013). The state of Washington requires applicants to submit fingerprints as a means to perform a professional criminal background check. Given that passing a CBC is a criterion for certification or licensure for professional counselors in some jurisdictions, it seems important to examine if counselor education programs are utilizing CBCs as part of the admission process, student evaluation for CITs, and ultimately as a tool for gatekeeping.

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Gatekeeping in the Field

According to Kerl and Eichler (2005), "In the field of counselor education, gatekeepers are the professionals whose responsibility it is to open or close the gates on the path toward becoming a counselor" (p. 74). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires counseling programs to start the gatekeeping process at the onset of screening applicants for admission. Unfortunately, there is ambiguity about specific ways to gatekeep during the admission process, which may prompt inconsistencies between those operating as gatekeepers. Several studies have examined barriers to effective gatekeeping (Brear & Dorrian, 2010; Brodersen et al., 2009; Brown-Rice & Furr, 2014). Some of the barriers include a need to meet desired enrollment, inconsistent screening procedures, likability effect, inadequate training on how to be a gatekeeper, social loafing, the leniency effect, and the empathy veil effect (Brear & Dorrian, 2010; Brown-Rice & Furr, 2014). The previous findings support the need to examine the current use of objective measures that may diminish some of these described obstacles.

Swank and Smith-Adcock (2014) examined the screening and gatekeeping methods used by 79 master's- and doctoral-level CACREP-accredited counseling programs. Specifically, they asked programs about their use and perceived effectiveness of objective (e.g., grade point average [GPA]) and subjective (e.g., interviews) methods of gatekeeping during the admission process. The majority of surveyed programs placed higher weight on GPA and letters of recommendation during the admission process. Participants described their methods as inefficient and stressed the need to use consistent evaluation to reduce the impact of subjectivity. They also described a desire to use reliable assessments such as formal background checks to better assess psychological fit (Swank & Smith-Adcock, 2014).

Brear and Dorian (2010) conducted a study to examine how 63 counseling educators experienced their training and training as gatekeepers. Their respondents indicated a commitment to be effective gatekeepers, but they had difficulties minimizing their subjectivity because of vague guidelines and written policies. Many of their participants stated they observed other faculty being lenient and failing to capitalize on key moments when students were displaying behaviors of concern. Brear and Dorrian suggested that programs use objective procedures for gatekeeping and provide ongoing training to help faculty better understand their gatekeeper roles and related policies.

Brown-Rice and Furr (2014) discussed the role empathy can play in the gatekeeping process. Ultimately, the authors suggested that counselor educators benefit from finding a balance between being empathic and evaluative in their roles. Brown-Rice and Furr described that empathy may impact how counselor educators gatekeep and intervene with problematic behavior. They coined the term *empathy veil effect* and suggested that it is compounded by factors such as lack of consistent standards across faculty, lack of scholarly sources to refer, and fears of legal retaliation made by students. Although these factors have historically been barriers, the field of counselor education is at a critical point to establish well-documented, researched and supported screening procedures for potential CITs. This study aims to provide a greater description of how counseling programs currently use CBCs in the process of gatekeeping.

Criminal Background Checks

Literature searches revealed only one study that explored the use of CBCs by counseling programs (Erwin & Toomey, 2005). This is concerning given that some states require CBCs of school counselors and licensure candidates. Over 10 years ago, Erwin and Toomey (2005) conducted a study of 50

CACREP-accredited counseling programs to examine use of CBCs. Specifically, they sought to gather data about how counseling programs use criminal background checks and what resources are consulted when deciding how and when to use CBCs. At the time of their study and within their sample, five CACREP-accredited counseling programs were utilizing CBCs. Alarmingly, none of the programs that indicated use of CBCs answered the question about having established criteria to decide how criminal background check results are used.

Scholars within other human services fields have provided commentary or empirically explored the use of CBCs in their related training programs. Burns, Frank-Stromborg, Teytelman, and Herren (2004) wrote about the use of CBCs in the field of nursing. At the time of their commentary, most state nursing licensure boards made CBCs mandatory for nurses in order to practice. In contrast with nursing licensing boards, most *nursing training programs* had not made CBCs a requirement due to not having sufficient guidance in how to use the results of CBCs.

Farnsworth and Springer (2006) empirically investigated the use of CBCs by nursing programs. They surveyed 258 nursing schools from across the United States and found that fewer than 50% of the surveyed schools required background checks. Only 8% of the schools that conducted CBCs used them as a part of the admission process. For those that did obtain background checks, there was no standard way to process the results and no universal guidelines were available on how to interpret results. Farnsworth and Springer suggested that schools considering CBCs should seek legal counsel and communicate with other programs using CBCs. They also recommended programs require a criminal self-disclosure in addition to a background check to determine consistencies between self-disclosures and the results of CBCs (Farnsworth & Springer, 2006).

According to Kleshinski, Case, Davis, Heinrich, and Witzburg (2011), approximately 113 medical schools used background checks at the time of their commentary. Medical schools have benefitted from using CBCs by detecting patterns of behaviors that may impede a student's ability to practice and best serve future patients. Kleshinski and colleagues found that common patterns across medical schools using CBCs included: (1) individually considering each situation by factoring in variables such as date and nature of offense; and (2) asking students about past criminal behaviors on admission applications. Importantly, there may be discrepancies between what students report on applications and what their CBCs show; therefore, solely relying on self-report could be problematic.

Within the field of sports science, Weuve, Martin, and White (2008) described many of the same concerns and uncertainties. They suggested that common reasons to conduct CBCs include "promotion of a safe school environment, protection of patients, clients, and student-athletes, because it is required of clinical facilities, and it enhanced student advisement and compliance with state or federal law" (Weuve et al., 2008, p. 28). These authors also speculated that programs may not conduct CBCs because of certain state and federal law, fear of further marginalizing minorities, and due to minimal resources to help the process be informed. Although these suggestions and concerns seem to be well-conceptualized across fields, few studies have taken the next step to empirically examine these issues.

Based on previous literature, there is consistent concern with a lack of universal policies across graduate training programs related to the use of CBCs. Additionally, only one study has empirically investigated how often and in what ways CBCs are being used with counseling graduate school applications (Erwin & Toomey, 2005). Unfortunately, this study is outdated and may leave the field of counseling without adequate evidence-based support to enhance their gatekeeping processes.

Currently, when programs are deciding to use CBCs, they will find minimal information about key aspects such as what company or vendor to use when conducting CBCs; who is financially liable for the CBC; when a CBC should be required; how information from CBCs are used; how students are informed about CBCs; and how to decide if an offense is related to the counseling profession (Weuve et al., 2008). Counseling programs could be held liable for not conducting CBCs, especially if the safety of others is compromised. At the same time, counseling programs also could face liability for using CBCs when guidelines are unclear, applicants are not informed, and policies are not in place about how CBC results may be used.

Given the limited research on this issue, the purpose of this study was to determine how CACREP-accredited master's programs are utilizing CBCs regarding applicants and current students. Specifically, the following research questions were addressed: (a) Do CACREP-accredited master's programs require applicants to undergo a CBC? (b) What are the program's procedures for performing the CBC of applicants? (c) Do programs have established protocols regarding how the results of CBCs affect applicants? (d) Do CACREP-accredited master's programs require current students to undergo a CBC? (e) What are the program's procedures for performing the CBCs of current students? (f) Do programs have established protocols regarding how the results of CBCs affect current students? and (g) What do CACREP program representatives believe are their legal and ethical obligations related to performing CBCs with applicants or current students?

Methodology

Participants and Procedures

Participants were the program contacts for the 270 CACREP-accredited master's programs listed on the official CACREP Web site in summer of 2013. Due to the small size of this population, the entire population was sampled to provide the best approximation of the population's true characteristics (Gay, Mills, & Airasian, 2009). Recruitment of participants was conducted via an e-mail to each program contact inviting them to participate in the study and including a link to an online survey. The sample size decreased due to invalid e-mail addresses, which resulted in the final sample of 261 CACREP-accredited program contacts. A total of 86 participants completed the survey; however, respondents with missing or invalid data ($n = 3$, less than 2%) were eliminated via listwise deletion, leaving a total number of 83 participants included in this study. Although there are multiple options for dealing with missing data, listwise deletion was used by eliminating participants with missing data on any of the variables in this study (Sterner, 2011). This resulted in a final response rate of 32%, which falls within the acceptable 30% response rate for online surveys (University of Texas at Austin, Division of Instructional Innovation and Assessment, 2011). Of the 86 program contacts who provided usable data, 29 indicated their programs were in the South, 28 defined their program being in the Northeast, 17 stated their program was in the Midwest, and 9 indicated that their program was in the West. The majority of the participants reported that their programs offered degrees in both the clinical mental health/community track (84%) and the school track (83%). Further, 17% offered the marriage, couple, and family track, 13% offered the student affairs/college track, 6% had the addiction track, and 4% reported offering the career track to students. Table 1 provides a breakdown of specialty track programs offered by participants.

The survey for the current study was designed based on the Criminal Background Check Survey developed by Erwin and Toomey (2005) related to admissions and CACREP-accredited programs performing CBCs. The 13 questions from the original Erwin and Toomey survey were used as a foundation for 30 questions that were created for the online survey utilized to gain information from CACREP-accredited program contacts. Participants were asked to identify if their programs

required CBCs as part of admission to their program. Participants who responded in the affirmative then responded to six multiple choice items related to which specialty tracks required a CBC, type of CBC, who performs and pays for the CBC, how applicants are notified that the CBC is required, and whether the programs have established procedures for deciding non-admission based upon the results of the CBC. Further, two qualitative questions provided an opportunity to learn how CBC information is obtained and used.

Next, participants were asked to identify if their programs required CBCs of current students. Participants who responded in the affirmative then responded to seven multiple choice items related to which specialty tracks required the CBC, type of CBC, who performs and pays for the CBC, how applicants are notified that a CBC is required, at what time in the program CBCs are performed, and whether the programs have established procedures based upon the results of the CBC. Further, two qualitative questions requested information about how CBC information is used and protocols for removal of students. The final part of the survey consisted of 11 questions regarding ethical and legal issues (i.e., CBC required for certification, licensure, or employment as a professional counselor, privacy issues, client welfare, legal consequences of performing CBC, CACREP-standards, potential for screening out minority applicants and students). This section contained five multiple choice questions and six questions based on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree).

To establish content validity and reliability, a pilot study of the survey was completed. The pilot study included two former CACREP-accredited program contacts who were asked to look for clarity and conciseness of the survey questions and provide feedback and suggestions for improvement. Based upon the responses of the pilot participants, the survey was edited to provide a more conducive and efficient design.

Data Analysis

The Statistical Package for Social Sciences (SPSS) software (version 21) was utilized to screen and analyze the data. The participants' responses to the survey questions were subjected to both descriptive and correlational analyses. First, a descriptive analysis of multiple choice responses was conducted to produce a set of summary statistics related to each of the seven research questions. Next, a Fisher's Exact Test (a variant of a chi-square test for independence for small sample sizes) with an alpha level of .05 was used to determine if there was an association between the region of the country where participants' programs were located and whether CBCs are required for applicants or current students.

Results

Applicants and Criminal Background Checks

Regarding the first research question, of the 83 participants, 27.7% (n = 23) reported that their programs required applicants to undertake CBCs. Table 1 provides a breakdown of the specialty track that program contacts specified as requiring applicants to undergo CBCs. The Fisher's Exact Test to determine an association between location of program and requiring applicants to have a CBC was found to be not significant (p = .426).

Table 1

Number and Percentages by Specialty Track and Criminal Background Required

Specialty Track	Offered by Program				Criminal Background Required for Program Admission				Criminal Background Required for Current Students in Program			
	Yes		No		Yes		No		Yes		No	
	n	%	N	%	N	%	N	%	n	%	n	%
Clinical Mental Health/ Community	70	84.3	13	15.7	16	22.9	54	77.1	26	37.1	44	62.9
School	69	83.1	14	16.9	15	21.7	54	78.3	33	47.8	36	52.2
Marriage, Couple, Family	14	16.9	69	83.1	2	14.3	12	85.7	9	64.3	5	35.7
Student Affairs/College	11	13.3	72	86.7	3	27.3	8	72.7	5	45.5	6	54.5
Addiction	5	6.0	78	94.0	1	4.5	4	95.5	1	4.5	4	95.5
Career	3	3.6	80	96.4	0	0.0	3	100	0	0.0	3	100

Procedures for applicants. Table 2 provides a breakdown of the type of CBCs performed, who performs the applicants' CBCs, and who paid for the applicants' CBCs. All programs that required CBCs informed students of the CBC through at least one avenue: 45% (*n* = 10) reported notice was given only via the program's Web site; 18% (*n* = 4) said they gave notice via program Web site, verbal discussion (i.e., interview), and written correspondence (i.e., e-mail, letter, handbook); 14% (*n* = 3) stated they gave notice by written correspondence only; 9% (*n* = 2) gave notice by verbal discussion only; 9% (*n* = 2) gave notice by both program Web site and written correspondence; and 5% (*n* = 1) gave notice via both verbal and written notification. An open-ended format was used to learn about how programs use information from the applicants' CBCs. Thirty-five percent (*n* = 8) of the participants shared that they used results in different ways depending on if there was a criminal offense, the level of offense, and the date of offense. One participant reported their program uses the results to determine fit for their program and the counseling profession:

> The nature of the crime and the time that has passed since then, and the applicant's explanation (is it sincere, logical, etc.) will help faculty determine if the person will be considered or not. Also, we think about whether or not this person is likely to get certified as a school counselor or licensed as an LPC, or will be able to obtain liability insurance is all considered.

Established protocols for applicants. Regarding research question three, 59% (*n* = 13) of the 23 CACREP-accredited programs who reported requiring applicants to undergo CBCs had established procedures for deciding about the non-admission of an applicant in their program based on the CBC results. Twenty-three percent (*n* = 5) provided that their program had not established procedures and 18% (*n* = 4) reported that they did not know if their program had a recognized policy. Thirty-nine percent (*n* = 9) of the participants shared that they used professional standards for deciding about the non-admission of an applicant. One participant described, "We would not accept an applicant who had a background inconsistent with our discipline, and we would not accept an applicant who would not be able to obtain a license."

Table 2

Number and Percentages by CBC Procedures and Applicants and Current Students

	Applicants		Current Students	
	n	%	n	%
Type of CBC Performed				
Local (i.e., city, county), state, and federal	10	45	14	37
State	3	14	5	14
Federal	3	14	6	16
State and federal	1	4	3	8
Cities of residency over last 7 years and sex offender data base	2	9	0	0
Did not know	3	14	6	16
Who Performed CBC				
Outside private independent agency	8	36	7	19
Program's university/college	7	32	6	16
Government agency	6	27	19	52
Multiple entities (i.e., state, federal, private agency)	0	0	2	5
Did not know	1	4	3	8
Who Paid for CBC				
Separate fee to applicant/student	17	77	33	89
Applicant paid as part of their application fee	2	9	0	0
University/college paid	2	9	2	5
No charge, university police department conducts	0	0	1	3
Did not know	1	4	1	3

Current Students and Criminal Background Checks

Regarding research question four, of the 83 participants, 45% (n = 37) reported that their programs required current students to undertake CBCs. Table 1 provides a breakdown of the specialty track(s) that program contacts reported requiring students to undergo CBCs. The Fisher's Exact Tests to determine an association between location of program and requiring applicants to have a CBC was found to be not significant (p = .500).

Procedures for current students. Table 2 provides a breakdown of the type of CBCs performed, who performs the current students' CBCs, and who paid for the students' CBCs. Further, two participants (5%) defined specific CBCs for certain specialty tracks: (a) state for all tracks plus federal for school students (3%, n = 1); and (b), state for college and marriage and family tracks, and state and federal for school students (3%, n = 1).

When asked when students' CBCs are conducted, 35% (*n* = 13) reported it was before students are enrolled in internship, 27% (*n* = 10) reported during students' first year, 19% (*n* = 7) reported before practicum, 8% (*n* = 3) reported before practicum and renewed for internship if the initial clearance was more than one year old, 5% (*n* = 2) reported during students' second year, 3% (*n* = 1) reported at admission and then every two years after that, and 3% (*n* = 1) reported that CBCs are done every semester a student is enrolled in prepracticum, practicum, and internship. Participants reported various ways of letting students know that CBCs are a part of the program requirement. Twenty-seven percent (*n* = 10) reported that notice is given via the program's handbook; 24% (*n* = 9) give it through orientation (i.e., new student, clinical), written correspondence (i.e., e-mail, letter), handbooks (i.e., program, clinical), and program Web site; 19% (*n* = 7) give it only through a verbal discussion (i.e., orientation, interview); 14% (*n* = 5) by give it by program's Web site only; 11% (*n* = 4) through multiple methods of orientation (i.e., new student, clinical), written correspondence (i.e., e-mail, letter), handbooks (i.e., program, clinical), program Web sites and written correspondence; and 5% (*n* = 2) only via written correspondence (i.e., e-mail, letter, application).

Established protocols for current students. Sixty-eight percent (*n* = 25) of the 37 CACREP-accredited programs who reported requiring students to undergo CBCs had established protocols for deciding what action to take toward a student based on the CBC results. Twenty-seven percent (*n* = 10) provided that their program had not established a procedure and 5% (*n* = 2) reported that they did not know if their program had a recognized policy. Although 25 participants reported that their programs had established procedures, a few responses suggested processes might be informal. For example, one participant stated, "Nothing formal. We hold informal conversations amongst faculty."

Legal and Ethical Obligations

The following information was collected to answer the final research question. Of the 83 participants, the majority (64%, *n* = 53) reported that licensure or certification was dependent upon a successful CBC for students who graduate from their programs. Twenty percent (*n* = 17) of the respondents indicated that passing a CBC was not necessary for licensure or certification, leaving 16% (*n* = 13) who did not know if licensure or certification was contingent on having a successful CBC. The majority (89%, *n* = 74) believed that it was the program's obligation to notify students that CBCs can be required as part of certification, licensure or employment as a professional counselor; however 5% (*n* = 4) believed it was not the program's responsibility and 6% (*n* = 5) provided they did not know. Eighty-seven percent (*n* = 72) reported that their programs notified students that a CBC may be required to obtain certification, licensure or employment, leaving 13% (*n* = 11) of the programs saying they did not notify their students. When program contacts (*n* = 72) were asked how students are notified of this, 34% (*n* = 25) stated during orientation, 25% (*n* = 18) provided this information during the application process, 14% (*n* = 10) reported the information is continually given throughout the program (i.e., admission, orientations, before field placements), 10% (*n* = 7) stated the information was shared sometime during the first year of the program, 3% (*n* = 2) provided the information during field placement orientation for practicum and internship, 3% (n = 2) indicated information is given via student handbook, and 7% (*n* = 5) provided information was given via other means (i.e., during field placement discussions, when students apply for licensure due to licensure requirements varying by state).

When program contacts were asked if they believed it is ethical for their programs to perform CBCs on applicants or students, 41% (*n* = 34) believed it was ethical to perform CBCs on applicants and students, 29% (*n* = 24) felt it was not ethical for applicants or students, 19% (*n* = 16) responded it was ethical only for current students, and 4% (*n* = 2) said it was ethical only for applicants. Eight percent (*n* = 7) responded to this question by providing an alternate response.

All participants' (n = 83) responses for *strongly agree* and *agree* were combined to report the subsequent findings. Sixty-six percent (n = 55) believed that counseling programs' use of CBCs on applicants and students is important to ensure future clients' welfare and safety. When asked if counseling programs completing CBCs on applicants and students violate the privacy rights of applicants and students, 17% (n = 14) either agreed or strongly agreed that it did not. Thirty-six percent (n = 30) believed that counseling programs can face legal consequences if CBCs are *not* conducted on applicants or students. Further, 24% (n = 20) responded that they believed that counseling programs can face legal consequences by performing CBCs on applicants or students. Thirty-three percent (n = 27) believed that there should be a CACREP standard regarding CBCs of applicants and students to ensure consistency and provide an established protocol. When asked if performing CBCs on applicants and students will result in a disproportionate screening-out of minority applicants and students, only 14% (n = 12) believed it would.

Discussion

There were two primary aims of this study: (1) to assess the current use of CBCs by CACREP-accredited master's counseling programs and (2) to offer current information for programs to reference when considering the use of CBCs and creating relevant policies. Within the field of counseling, few studies have explored the use of CBCs and related policies (Erwin & Toomey, 2005; Swank & Smith-Adcock, 2014). As aforementioned, Erwin and Toomey conducted a study in 2005 with only 50 programs that responded. Additionally, only five of the programs that responded used CBCs, which limited the utility of their findings. Swank and Smith-Adcock (2014) surveyed counselor educators about the effectiveness of their current screening procedures for applicants. Their participants reported wanting to use more reliable and objective methods such as background checks, but were unsure how to do so with minimal guidance in the literature.

In the present study, 27.7% (n = 23) of respondents reported requiring applicants to undertake CBCs. Although this may seem like a small portion of the sample, it still offers the field knowledge that can augment findings by Erwin and Toomey (2005). This result is not surprising given that there are so few guidelines for programs to use when considering CBCs as a screening and gatekeeping tool. The use of CBCs also remains underdeveloped in other fields such as nursing, medicine and sports science (Farnsworth & Springer, 2006; Kleshinski et al., 2011; Weuve et al., 2008). In fact, Farnsworth and Springer (2006) reported that fewer than 50% of the medical programs they surveyed reported using CBCs. They found this extremely concerning as the field of nursing requires all graduates to pass a CBC in order to become licensed. This is a related issue for those wanting to become a licensed mental health counselor as 17 states report requiring an applicant to pass a CBC in order to become licensed. All the states that do not require CBCs ask for the applicant to describe any criminal offenses on their application and provide further documentation when necessary.

Although 41% of the participants surveyed in the present study reported the use of CBCs as ethical, this finding did not correspond with actual use of CBCs (26.5%). One factor may be related to fear of potential liability when using CBCs. In a study conducted by Swank and Smith-Adcock (2014), participants, who are educators, stated that they would like to use background checks, but they felt hesitant due to the litigation that can come with such methods. These fears may be exacerbated by the fact that the use of CBCs is not universal across university programs and there may be little knowledge about how to seek out university lawyers when developing these requirements. At this time, most university guidelines around CBCs focus on use with employees (Swank & Smith-Adcock, 2014). Weuve et al. (2008) described that lack of guidance and misuse of results continues to keep graduate programs from using CBCs. In the present study, only 13 of the 23 programs who reported

using CBCs had an established procedure for how to use the results. Ultimately, since few resources are available to assist in these decision-making processes, it would be important for programs to seek university counsel. For example, it would be important to seek legal counsel when deciding how requirements and standards should read on program Web sites, how to use the results, and how to inform students about the use of the CBC results.

It also is important to consider other related liability issues such as faculty subjectivity. Previous research indicated faculty subjectivity may interfere with gatekeeping fidelity (Brear & Dorrian, 2010). In the current study, only 13 participants reported their program had an established procedure for deciding about the non-admission of applicants based on CBC results. When procedures are not in place, there may be a greater potential for phenomena such as the empathy veil effect, leniency effect or likability effect. Such phenomena may prompt some faculty to look the other way if not held accountable to exercise a specific policy.

This research also has implications for counseling students. Given that not all programs execute CBCs, students may not understand the consequences of their legal violations until seeking licensure. Currently, 17 state licensing boards require CBCs and all states ask applicants to attest to criminal violations (ACA, 2010). There is potential for a student to get through his or her training program and be ineligible for licensure due to their criminal background. A need exists to consider how CBCs may be used to help students gatekeep themselves and be more conscious of barriers that may ultimately interfere with their professional goals.

Limitations and Areas for Future Research

This study has five basic limitations. First, the sample was obtained from program contacts of CACREP-accredited master's counselor education programs. This approach omitted programs that were not CACREP-accredited. Therefore, generalizability of the results is limited to CACREP-accredited programs. Further, this study did not delineate whether the programs were housed in private or public institutions. Future research focused on investigating all professional counseling programs would be beneficial. The third limitation is that volunteers may have answered the survey questions differently than those members of the population who did not agree to participate (70%). The fourth limitation is associated with the survey being a self-report measure; some participants may have provided responses considered to be socially desirable. Even though the participants were informed in advance that their responses would be kept anonymous, they may have responded in a manner that was not representative of their true feelings or knowledge. The final limitation is related to instrumentation. The findings could have been expanded upon by including questions on the survey about consequences programs have experienced when using or not using CBCs. For example, have any programs been sued for using or not using CBCs?

Given the minimal amount of research in this area, there are multiple directions for future research. One suggestion is to qualitatively explore programs that have used CBCs for several years to get a more thorough understanding of how their processes have evolved. This may help programs understand the elements to consider when using CBCs as part of the screening and gatekeeping processes. It also may support programs in understanding how to protect themselves from liability concerns related to using CBCs. Another future study may involve surveying doctoral-level counseling programs to examine differences across training levels. Further research could examine student perspectives of the use of CBCs. It might be possible that students would welcome the use of CBCs at the program level so they are aware of legal standards at the start of pursuing a professional counselor license.

Conclusion

Since screening and gatekeeping is such an important role of a training program, the use of CBCs is an important topic for counselor education. The use of CBCs may assist counselor educators in executing their ethics related to not endorsing CITs they believe to be unqualified (ACA, 2014). The consequences of graduating a student with a criminal history could be great and ultimately put future clients at risk for harm. Perhaps CACREP could assist programs in understanding if and how to use CBCs by adding ideas for best practices in their accreditation standards. Previous literature has indicated that the field of counseling may benefit from creating more formalized screening procedures that include objective and reliable measures (Swank & Smith-Adcock, 2014). The current study offers support that programs are using CBCs as a part of the admission process and to continually evaluate their students. Given this is a trend, it may be important to establish best practices and policies around CBCs so that programs are using them in consistent ways.

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A Comparison of Telemental Health Terminology Used Across Mental Health State Licensure Boards

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Telemental health—also known as online counseling or online therapy—has become a solution for increasing the public's access to mental health care. Mental health state licensure boards have lacked consistency in the adaptation of laws and the use of language within these laws. Policies are examined from the mental health state licensure boards in all 50 U.S. states for counselors, psychologists, marriage and family therapists and social workers. The determination of whether a policy existed was made. If so, the terminology was compared across professions. Results indicated that fewer than half of mental health licensure boards included telemental health-related terminology in their policies, indicating the absence of telemental health policies. Future research, implications for counselors and limitations are discussed.

Keywords: **state licensure boards, policies, telemental health, online counseling, health terminology**

Mental health care professional shortage areas fall across the United States (Rural Assistance Center, 2015). According to the Health Resources and Services Administration, there is an immediate need for approximately 4,000 mental health providers nationwide (Kaiser Family Foundation, 2014). According to the Bureau for Labor Statistics (2014), the mental health counselor workforce is not distributed in proportion to the need. The National Institute of Mental Health (2014) estimated 43.6 million adults aged 18 or older in the United States suffered from some form of mental illness in the past year. Many individuals' mental health needs go untreated due to gaps in resources or delivery of services (Brown, 1998; Gibson, Morley, & Romeo-Wolff, 2002; Modai et al., 2006).

The U.S. government has demonstrated a strong commitment to the development, promotion and integration of technology-assisted care into the U.S. health care system through ongoing work in telemental health (Godleski, Nieves, Darkins, & Lehmann, 2008; National Center for Telehealth & Technology, 2011, 2015; Pruitt & Woodside, 2015). In addition, the government has issued numerous grants for telemental health and other health services for license reciprocity (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2015), established the Office for the Advancement of Telehealth, and published the 2015 Treatment Improvement Protocol (Substance Abuse and Mental Health Services Administration, 2015).

Pruitt, Luxton, and Shore (2014) stated that "home-based telemental health has several important benefits for both patients and clinical practitioners including improved access to services, convenience, flexibility, and potential cost savings" (p. 340). Policymakers and advocates view telehealth technology as particularly promising given the continuing shortage of mental health clinicians and long travel distances to obtain care (Lambert, Gale, Hansen, Croll, & Hartley, 2013).

With advancements in technology and the availability of the Internet, mental health care providers have sought new ways to integrate technology into practice (Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005), including implementing technology in scheduling appointments, distributing assessments and providing treatment services. Using Internet-based videoconferencing,

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mental health care providers can easily connect with clients without requiring in-office meetings (Baker & Bufka, 2011). Some individuals will not or cannot seek mental health services when in-person services are needed; therefore, the in-person treatment process becomes a treatment barrier (Bensink, Hailey, & Wootton, 2006). According to Brown (1998), some individuals fail to seek mental health services due to geographical restrictions. Other individuals may struggle with physical health restrictions, preventing them from seeking traditional, in-office services. Mental health conditions such as panic disorder (Klein, Richards, & Austin, 2006), agoraphobia and eating disorders (Zabinski, Celio, Wilfley, & Taylor, 2003) may restrict individuals from receiving traditional services. Using Internet-based services, mental health practitioners can reach clients who are in rural locations, who are seriously ill or who do not seek traditional counseling.

While the use of technology increases access to care, the technology itself creates new, unique challenges and potential risks for mental health providers (Baker & Bufka, 2011). Fifteen years ago, Riemer-Reiss (2000) discussed utilizing distance technology in mental health practice, listing foreseeable concerns for practitioners. More recent publications (Barnett & Kolmes, 2016a, 2016b) present similar concerns and questions for mental health providers. Counselors must attain competency in working with special populations or in specific practice areas, including the use of telemental health services (Baker & Bufka, 2011; Barnett & Kolmes, 2016a, 2016b). Yet, counselors are faced with a lack of clear guidance on ethical, legal and regulatory requirements for telemental health services, including security, assessments and best practices (Ostrowski, 2014).

A Brief History of Telemental Health

In September 1997, the National Board for Certified Counselors (NBCC) became the first organization to adopt standards for telemental health (Shaw & Shaw, 2006). At that time, NBCC called telemental health *WebCounseling*, defined as "the practice of professional counseling and information delivery that occurs when client(s) and counselor are in separate or remote locations and utilize electronic means to communicate over the Internet" (NBCC, 1997, p. 3). In October 1999, the American Counseling Association (ACA) released the Ethics Standards for Internet Online Counseling in order to "establish appropriate standards for the use of electronic communications over the Internet to provide online counseling services, [which] should be used only in conjunction with the ACA Code of Ethics and Standards of Practice" (p. 1). For psychologists, the American Psychological Association (APA) released a statement in 1997 regarding the use of services by telephone, teleconferencing and the Internet, urging psychologists to use the existing APA Ethics Code and the appropriate licensure board rules for services provided (Shaw & Shaw, 2006). The Clinical Social Work Federation (CSWF) issued a position paper in 2001 on Internet text-based therapy, stressing that practitioners must follow their CSWF code of ethics and all state licensing laws (Lonner, 2001; Shaw & Shaw, 2006).

Nearly 20 years have passed since NBCC broke ground by providing initial guidance for Web-based counseling. The ethical guidance for mental health professionals has continued to evolve as the body of research is growing and telemental health services are becoming more prominent. Several studies have discussed the ethical codes for mental health practice for counselors, psychologists, social workers, and marriage and family therapists (Alleman, 2002; Barnett & Scheetz, 2003; International Society for Mental Health Online, 2000; Mallen, Vogel, & Rochlen, 2005; Manhal-Baugus, 2001; Midkiff & Wyatt, 2008; Recupero & Rainey, 2005). However, while most major mental health organizations have released ethical guidelines for telemental health practice, counselors also must seek guidance from state mental health licensing boards to comply with state licensure laws. Competency requires more than familiarity with state licensure laws; counselors must understand

the guidelines and be able to correctly apply the guidelines to clinical practice. As Pabian, Welfel, and Beebe (2009) discovered, 76.4% of surveyed clinicians were misinformed about their state laws concerning duty to warn. If the majority of counselors did not fully understand their state guidelines for practice on this single issue, there are serious concerns about ethical telemental health practice regarding numerous licensure issues across state lines. These concerns highlight the need for clarity and understanding on licensure guidelines. For the purposes of this paper, the authors examine the current telemental health terminology used in state licensure laws located on their Web sites.

Telemental Health Terminology

As telemental health technology has become a promising option, new descriptive terminology has been developed. Several major organizations use the term *telemental health*. The U.S. Department of Veterans Affairs describes telemental health as "behavioral health services that are provided using communication technology" (U.S. Department of Veterans Affairs, 2015, para. 3.). The U.S. Department of Health and Human Services' Health Resources and Services Administration Office for the Advancement of Telehealth funds 14 Telehealth Resource Centers located across the United States (Telehealth Resource Centers, 2015). Telehealth Resource Centers use the terms *telemental health* and *telebehavioral health*. The National Center for Telehealth and Technology uses the term *telemental health* in the Department of Defense Telemental Health Guidebook (National Center for Telehealth & Technology, 2015). The American Telemedicine Association, a primary force of the telemedicine industry, uses the term *telemental health* (American Telemedicine Association, 2015). Thus, the term *telemental health* is used henceforth to broadly describe using the Internet to provide mental health care.

In the professional and academic literature and on the Internet, numerous terms are used to describe technology- or Internet-based mental health care including: online counseling, online therapy, video therapy, telemental health, telebehavioral health, e-therapy, cybertherapy, telepsychology, telecounseling, Internet therapy, Internet counseling, video counseling, video chat, e-mail therapy, clinical video therapy and Web therapy (Backhaus et al., 2012; Barak, Klein, & Proudfoot, 2009; Castelnuovo, Gaggioli, Mantovani, & Riva, 2003; Center for Substance Abuse Treatment, 2009; Day & Schneider, 2002; Maheu et al., 2005; Suler, 2004; Yellowlees et al., 2010). Some terms describe the medium used (e.g., e-mail therapy, clinical video therapy), while other terms describe the broad use of mental health services over the Internet (e.g., telemental health, online therapy).

Inconsistent terminology among organizations or state licensure boards can lead to a number of problems for mental health providers, as well as researchers, educators and other mental health workers. Using varying terminology, mental health providers must identify and follow state laws regarding telemental health practice, in addition to ethical guidelines. The purpose of this research was to (a) determine whether individual mental health state licensure boards (counseling, psychology, social work, and marriage and family therapy) have a policy or service provision regarding telemental health services, (b) identify the terminology used in the state licensure board policies, and (c) compare the differences in terminology used in licensure board policies across mental health professions.

Method

Procedure

Various terms, such as *online therapy*, *telemental health* and *online counseling*, were searched on the Internet and in the professional literature. We identified related terms in the search results and in the

citations of articles; these additional terms were searched until no more semantically-related terms could be found. The initial generated list and the accumulated terms were compiled and used to begin data collection.

We searched state mental health licensure board Web sites (N = 151) in all 50 states for the counseling, marriage and family therapy, psychology and social work professions. State licensure boards' Web sites were accessed and we reviewed telemental health-related laws, statutes, rules, policies (which will all be referred to as *policies* henceforth) and newsletters. In addition, the first author called and sent e-mails to state licensure board personnel to verify whether telemental health policies existed when policies were not located on the Web site. All terms related to telemental health services were collected and added to the initial list, resulting in a final list of 42 terms. We broadly defined the presence or existence of telemental health policies as the use of one or more of the 42 terms. Research assistants searched each state licensure board Web site with the final list of terms to ensure a thorough search.

We collected the terms used on each state board Web site to examine the consistency in term usage across all state licensure boards. Next, we categorized the terms used on all state licensure boards' Web sites by mental health profession (counseling, marriage and family therapy, psychology and social work). The data was then analyzed for themes.

Results

State Board Policies

We analyzed the data collected from state mental health licensure board Web sites. We identified the state mental health licensure boards with telemental health policies. Sixty-five mental health licensure boards had specific telemental health policies. In the following 14 states, not one of the licensure boards had issued a policy about telemental health: Connecticut, Florida, Idaho, Illinois, Indiana, Kansas, Maine, Minnesota, Mississippi, Missouri, New Jersey, Rhode Island, Washington and Wyoming.

Next, we examined the data across mental health professions. The existence of state board policies varied widely for each profession within most states. The number of state licensure boards that had issued telemental health policies for each profession was nearly evenly represented among the first three disciplines as follows: counseling (n = 22), psychology (n = 22), social work (n = 21), and marriage and family therapy (n = 1). We found that only 14 states had telemental health policies for all mental health professions: California, Colorado, Kentucky, Louisiana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Utah and West Virginia.

State Terminology Used for Telemental Health

We identified the terms found on state licensure board Web sites. The following 19 unique terms were used across the 65 state licensure boards that had issued policies: distance counseling, distance therapy, electronic-assisted counseling, electronic means, electronic practice, electronic telepractice, electronic transmission, Internet counseling, Internet practice, online counseling, online psychotherapy, remotely, technology-assisted, teleconferencing, telehealth, telemental health, telepractice, telepsychology and teletherapy.

E-mails were sent to 40 state board personnel because telemental health-related laws or policies were not located on the state licensing board Web site. In these cases, 16 state licensure board staff

members provided guidance that conflicted with policies published on their Web site or in their newsletter. For instance, many state board personnel who were contacted indicated that telemental health services were permitted as long as state laws were followed. In all 16 cases, the licensure board staff added information not available publicly. This information was excluded from the data, as it was not representative of an official, public policy. Only one state, New Mexico, explicitly prohibited professional counselors from providing mental health services online.

Lastly, we compared the terms used in state licensure board policies across mental health professions. The term used most often by counseling ($n = 7$) and social work ($n = 8$) state licensure boards was *electronic* counseling or therapy ($n = 7$). The term most prevalent among psychology state licensure boards was *telehealth* ($n = 6$).

Discussion

With only 43% of mental health state licensure boards issuing at least a minimal policy regarding the use of telemental health services, mental health professionals are left without clear guidelines for acquiring proper training, educating clients and following sound procedures for using telemental health services to work with clients. Support and education may be warranted for licensure boards whose members may not have the time or expertise to craft policies based on evidence-based practice or best practice guidelines.

Among the states that do have policies, the data demonstrate that state licensure boards' policies differ in terminology. With 19 telemental health-related terms identified in state licensure boards' policies, the mental health profession lacks consensus as telemental health services have grown over the last decade. Agreement or consistency is needed for effective conversations among researchers, educators and mental health providers to ultimately provide clear guidance to clinicians and clinicians-in-training.

Mental health providers seeking to identify state policies regarding telemental health may search for *online therapy*, when their state uses one of 19 broader terms such as *electronic means*. The average mental health provider is likely unaware that nearly 20 different terms are used among state licensure boards, let alone aware of which term may be used to identify the laws in their respective state. Researchers, educators and state licensure board staff members should consider selecting the terms they use to include the common language of mental health providers. By narrowing the use of terms, state licensure boards would ensure mental health providers greater access to policies.

Inconsistent terminology leads to a number of problems. Since telemental health has grown over time and been through several iterations of research and development, some terms may be associated with one or more periods of development. Employers posting jobs in telemental health may identify the position with one term (e.g., telebehavioral health therapist) while a job seeker may use another search term (e.g., online counselor). Researchers also may have difficulty finding related research on telemental health services when there are many terms used for the same concept (e.g., cyberpsychology, Internet therapy, online counseling, Web therapy, e-counseling). Inconsistent terminology could hinder the development and dissemination of the body of research supporting telemental health services.

In addition, state licensure boards may consider how restrictions meant for one mode of services (e.g., text-based counseling) will impact another mode (e.g., video-based counseling). State licensure

boards may use language to be as inclusive as possible, yet the specific types of telemental services permitted may be unclear to mental health providers. When identifying policies in different states, mental health providers may be confused when state licensure boards use the same terminology to refer to different services. For example, practitioners may use telephone, e-mail, text, smartphone apps, or interactive videoconferencing to provide counseling services and be unaware that certain formats are permitted where others are not. Implementing changes in terminology will assist mental health providers in finding the policies pertaining to telemental health as well as reduce confusion and hesitancy to provide services via the Internet.

Future Research

Future research is recommended to identify competencies for telemental health services for adults, children and special populations. Guidelines and ethical standards have been developed using reviews of the literature and consensus among a limited number of professionals in their respective associations (American Association for Marriage and Family Therapy, 2015; ACA, 2014; American Mental Health Counselors Association, 2015; APA, 2013; National Association of Social Workers, Association of Social Work Boards, 2005; NBCC, 2016). No formal study has yet to be conducted on the competencies of a telemental health provider or on the effects of counselor competency training on providing telemental health services. Professional communities and independent continuing education providers around the United States provide training services for counselors, and some graduate counseling programs offer students an elective course in technology and counseling. While these efforts provide counselors with training, research and advocacy are needed to identify competency areas related to ethical telemental health practice. Counselors may be extremely skilled in in-person counseling, yet unable to successfully transfer these skills to an online environment (Mallen et al., 2005). Established professional competencies in telemental health would inform educators and policymakers in future endeavors.

It is important for telemental health training to draw from outcome studies, lending direction for best practices in telemental health regarding ethical and therapeutic guidelines. Ford, Avey, DeRuyter, Whipple, and Rivkin's (2012) survey provided insights into the biggest successes and challenges of integrating telemental health services into practice. They noticed the success of being able to reach an underserved population. They echoed the need for outcome research to inform practices and ethics, as well as a need for outcome research to inform sound cultural and contextual practice for counselors. In addition to counselor educators and researchers, it is important that clinicians currently engaged in telemental health practices inform colleagues of benefits and challenges through professional publications (Sude, 2013). Once further research outcome data are acquired and proposed counselor training competencies are in place, state licensure boards will have comprehensive best practice guidelines for creating more detailed information for licensees, leading to improved counseling practices and better results for clients.

Implications for Counselors

Counselors should be aware that their licensure board policies and ethical codes may include different telemental health terms than those with which they are familiar. Identifying the telemental health terms is a counselor's first step toward locating telemental health guidelines, understanding the specific policies and developing beginning competencies for an online, electronic practice.

Counselors are encouraged to consult ethical guidelines for practice before engaging in telemental health activities. Important ethical considerations include duty to warn, scope of practice, confidentiality, record keeping and marketing (Mallen et al., 2005), among others. Other

considerations that are unique to telemental health practice include legal and ethical requirements for training, protocols for emergency services, location and identity verification, and an informed consent process that is specific to telemental health (NBCC, 2016). Some state licensure boards require documentation of informed consent in addition to other security requirements, such as identifying the client's local emergency services and verifying the client's identity and age. Barnett and Kolmes (2016a, 2016b) discussed the risks associated with telemental health practices based on two cases and provided suggestions for practice, including specific competencies in telemental health, technology, general telemental health, multicultural practice, clinical practice for telemental health (e.g., assessing client's appropriateness for telemental health), process of informed consent (e.g., fees, confidentiality, verification of legal consent), licensing issues, ethical issues (e.g., duty to warn, reporting abuse), and adequate liability insurance coverage. The number of telemental health competencies and concerns, including the use of technology (e.g., encryption), indicates a need for counselors to seek telemental training and guidance before engaging in telemental health services. In a recent survey, Ford et al. (2012) discovered that clinicians reported the need for training on equipment use as one of the biggest challenges for effective service delivery.

With sound training and competencies in place, counselors can take advantage of the benefits of telemental health by providing care for people who are not able to seek face-to-face counseling services (e.g., rural and frontier clients). Mental health professions are increasing the capability to reach the underserved through technology and telemental health practices. As technology and policies change, professional counselors are encouraged to become and stay literate in the efficacy and best practices for telemental health services.

Professional counselors are challenged to be aware that telemental health in general is growing rapidly, and the dynamics of the profession (e.g., laws, ethics, technology and reimbursement) are increasing counselors' capability to serve the underserved through technology. Counselors who do not incorporate telemental health services into their practice may limit their practice as clients may seek accessible online providers in the near future (Myers & Turvey, 2013). Also, counselors who adopt telemental health services will capture more market share as the medical community heeds the incentives to make electronic service referrals and integrate telehealth and telemental health into medical practice.

Conclusion

Telemental health is no longer something of the future (Mallen et al., 2005). Telemental health is occurring now and rapidly expanding. Professional counselors, counselor educators, leaders in the counseling profession and state licensure boards are encouraged to consider the terminology used when creating regulations and how these decisions may impact the application of counseling services. Also, licensure boards may feel compelled to use all-inclusive language to cover future possibilities of telemental health practice. Broad terms such as *electronic* may be all-inclusive but are not aligned with common vernacular among practitioners and do not reflect the research or terminology used by associated entities (e.g., insurance companies that reimburse for services).

However, common terminology such as telemental health and online counseling could be used to help counselors identify these policies within professional codes of ethics, state licensure laws, and other documents. In addition, researchers must consider the terminology used within publications to increase understanding among readers and minimize confusion in the profession.

Professional counselors, counselor educators and counseling leaders are challenged to forge ahead, advocating for clear guidelines from their state licensure boards, debating what is sufficient for training guidelines and advocating to use technology to reach underserved clients with professional counseling services. Without exposure to research and best practices, licensure boards may be led to create overly restrictive regulations that prevent the benefits of telemental health from being possible and unintentionally limit access to mental health care for people who cannot seek face-to-face counseling. There is a need for specific communications about telemental health practices between different functional components of the counseling profession (i.e., practitioners, educators, leaders, state board personnel). For example, state licensure boards and counselors who are grounded in telemental health research and best practices can work together to form clear, all-encompassing information for licensees.

As mental health professions forge ahead with telemental health practice, counselors should continue to develop this important treatment medium to capture the clientele and referrals from the participating medical community. Failure to do so may leave counselors at a disadvantage in the marketplace. As the U.S. government moves forward to meet the mental health treatment needs of millions of Americans, counselors are encouraged to take a leadership role in this movement to reach the underserved with professional counseling services.

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