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Counselors and Workplace Wellness Programs: A Conceptual Model

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Occupational stress is a top source of stress for over 65% of Americans due to extended hours in the workplace. Recent changes in health care have encouraged employers to build workplace wellness programs to improve physical and mental health for employees to mitigate the effects of occupational stress. Wellness programs focus on either disease management; treating chronic illnesses, such as hypertension and diabetes; lifestyle management; or preventing chronic illnesses through health promotion. This manuscript provides an overview of recent changes in health care and describes a conceptual framework, Steps to Better Health (S2BH), that counselors can use in workplace wellness programs. S2BH is an 8-week psychoeducational group based on the combination of motivational interviewing (MI) and the transtheoretical model of change (TTM).

Keywords: **wellness, health care, workplace, stress, Steps to Better Health**

Health and wellness are two concepts that have captured the attention of people throughout history. From Greek mythology to modern times, the idea of well-being has permeated society (Myers & Sweeney, 2007). Today, with the Patient Protection and Affordable Care Act (PPACA), health care is moving away from a disease treatment model and embracing a disease prevention model (PPACA, 2010). Although individuals typically do not invest in preventive health measures, many businesses and companies are eager to improve their health care programs for employees (Willis Towers Watson, 2017). These changes in health care are relevant to mental health providers, as a new focus on prevention has created opportunities for counselors to help effect lasting health changes among employees. Therefore, to fit into this paradigm shift, professional counseling should be strongly connected to prevention and wellness (Granello, 2013). This article discusses the changes in health care models, how those changes are creating spaces for mental health counselors to fill and implications for the counseling profession.

The Changing Landscape of Health Care

In 2015, the Kaiser Family Foundation released a report highlighting the rising cost of health care expenditures from 1960 to 2013. This report indicated that health care costs, which include total costs for hospital visits, physicians and clinics, as well as prescription medications, have risen from 27.4 billion dollars to over $2 trillion (Kaiser Family Foundation, 2015). Due in part to increases in the cost of health care and health insurance, the PPACA was passed into federal law in 2010. Mandates of the PPACA include: (a) preventing the denial of coverage for pre-existing conditions; (b) strengthening community health centers; (c) decreasing health disparities; (d) promoting integrated health systems; (e) connecting physician payments to the quality rather than the quantity of care provided; and (f) lowering long-term costs by providing free and more comprehensive preventive care (U.S. Department of Health and Human Services, Health Care, 2016). In a White House memo sent out during National Public Health Week in 2014, President Obama stated, "my administration is supporting efforts across our country to improve public health and shift the focus from sickness and disease to wellness and prevention" (Obama, 2014, p. 1).

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This shift is clearly seen in the PPACA. Section 4001 of the PPACA, entitled "Modernizing Disease Prevention and Public Health Systems," discusses ways in which health prevention should be carried out within the public sector (PPACA, 2010). This portion of the law includes a taskforce team that would: (a) evaluate wellness programs in 2013; (b) create the Prevention and Public Health Fund to distribute money to worksites establishing wellness programs; (c) further the education of health and wellness promotion; and (d) report on measures enacted that address lifestyle behavior modification (PPACA, 2010). Lifestyle behavior modification is defined as activities that include "smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings" (PPACA, 2010, p. 422). In other words, initiatives from the federal government highlight the emphasis on prevention in both community and clinical health venues and extend this focus by supporting research into workplace wellness initiatives (Anderko et al., 2012). Though the PPACA encourages workplace wellness programs, many employers see the benefits to their employees even without federal regulations. In a recent survey, employers indicated they are still committed to better workplace wellness programs despite the unknown future of the PPACA (Willis Towers Watson, 2017). One primary motivator behind these programs is a reduction of employee stress through health promotion.

Health Promotion in the Workplace

According to the 2015 Bureau of Labor and Statistics report, Americans spent 8.8 hours a day at work or doing work-related activities (U.S. Department of Labor, 2016). Therefore, it can be estimated that Americans spend much of their lives in workplace settings, which can lead to occupation-related stress. In 2012, the American Psychological Association's (APA) Stress in America Survey revealed that 65% of Americans reported work as a top source of stress (APA, 2016). Stress can affect a person's emotional state, and it also can weaken the body's ability to regulate itself after a stressful experience, which can eventually cause detrimental health consequences (Galla, O'Reilly, Kitil, Smalley, & Black, 2015). For example, the effects of chronic stress have been shown to lead to obesity and metabolic diseases (Razzoli & Bartolomucci, 2016). As a result, many individuals have resorted to maladaptive ways of coping with stress, highlighting the need for bringing stress management skills to the workplace (Galla et al., 2015). In addition, the World Health Organization has stated that health promotion in the workplace (promoting aspects of physical and emotional wellness) is beneficial in combating work-related stress (Jarman, Martin, Venn, Otahal, & Sanderson, 2015).

Finding ways to help employees manage their stress through health promotion in the workplace is typically conducted through workplace wellness programs, which include both lifestyle and disease management programs (Caloyeras, Hangsheng, Exum, Broderick, & Mattke, 2014; Kaspin, Gorman, & Miller, 2013; Mattke et al., 2013). Promoting positive health habits among employees maintains affordable health coverage and increases worker productivity (Anderko et al., 2012; Parkinson, Peele, Keyser, Liu, & Doyle, 2014; Shapiro & Moseley, 2013). Most workplace wellness programs focus on disease management, treating chronic illnesses such as diabetes and hypertension. Disease management programs also typically utilize health care professionals, such as nurses, to conduct face-to-face meetings or telephone consultations (Caloyeras et al., 2014). Conversely, lifestyle management programs prevent chronic illnesses by: (a) reducing stress; (b) lowering weight; (c) encouraging exercise; (d) promoting smoking cessation; and (e) fostering overall well-being (Caloyeras et al., 2014; Kaspin et al., 2013; Mattke et al., 2013).

Wellness Programs

Johnson & Johnson was an early pioneer in the creation and promotion of workplace wellness programs. In the 1970s, the company implemented a wellness program for employees called Live for Life (Ozminkowski et al., 2002). In 1993, this program was modified to integrate the following additional services: (a) employee health; (b) occupational medicine; (c) health promotion; (d) disability management; and (e) an employee assistance program. A modified program was rebranded with a new title: The Johnson & Johnson Health & Wellness Program (Ozminkowski et al., 2002). At the time of the program analysis, Johnson & Johnson employed approximately 40,000 people in the United States, 90% of whom participated in their wellness program. The program was evaluated by comparing outpatient doctor visits, hospital inpatient stays and mental health visits over the course of four years as compared to three years prior to the start of the wellness program. The worksite wellness program resulted in significant annual savings per employee/per year. On average, the study reported $45.17 savings for each outpatient visit, $119.67 per inpatient stays and $70.69 for mental health visits. In sum, Johnson & Johnson reported over $8 million in annual savings (Kaspin et al., 2013; Ozminkowski et al., 2002), creating a model wellness program that has been replicated in other organizations to varying degrees.

In contrast, PepsiCo offered a program in 2004 that did not produce similar results. Over 55,000 employees participated in a 3-year study, and it was determined that while costs were high in the initial year, it was the disease management portion of the program that lowered overall medical expenses by the third year (Liu et al., 2013). The disease management program was six to nine months in length and involved regular phone calls with a nurse for 15 to 25 minutes (Caloyeras et al., 2014). The program focused primarily on conditions such as asthma, coronary artery disease, congestive heart failure, hypertension and strokes (Caloyeras et al., 2014). Conversely, the lifestyle management portion of the program, which focused on weight management, nutrition management, fitness, stress management and smoking cessation, was described simply as involving a "series of telephonic calls with a wellness coach over a six-month period" (Caloyeras et al., 2014, p. 125). Training to become a wellness coach varies widely, ranging from a few days to 6 months. Training typically requires an associate degree and 18 weeks of classes conducted over the telephone or four full days of training in topics that include: (a) growth-promoting relationships; (b) expressing compassion; and (c) eliciting motivation to overcome ambivalence (Wellcoaches, 2016). The lack of sustainable changes in lifestyle wellness programs may be due to the variation and brevity of training for wellness coaches.

Hospitals have started employee wellness programs to lower employee health insurance costs, support mental health, and recruit and retain quality employees (Caloyeras et al., 2014; Hochart & Lang, 2011; Liu et al., 2013; Parkinson et al., 2014). Ironically, while the health care system is designed to help patients achieve good health, it often comes at the price of high stress levels and poor health for the employees (Chang, Hancock, Johnson, Daly, & Jackson, 2005; McClafferty & Brown, 2014; Smith, 2014). In fact, hospital employees tend to exhibit poorer health than other types of employees, which results in hospitals having the highest health care costs among employment sectors in the United States (Parkinson et al., 2014). As a result, some hospitals, such as the University of Pittsburgh Medical Center, are introducing the idea of employee wellness programs. In 2005, the University of Pittsburgh Medical Center utilized a prepackaged wellness program called MyHealth—a program that included both lifestyle and disease management components (Parkinson et al., 2014). Based on the number of requirements an employee met and activities he or she engaged in, the program provided credit that could be used to lower insurance deductibles (Parkinson et al., 2014). MyHealth consisted of online education materials, self-help tools, telephonic health coaching and support groups for lifestyle issues such as smoking cessation, depression, and emotional health and stress issues (Parkinson et al., 2014). Over a 5-year period, overall health care costs were lowered, but again, savings were attributed to the disease management portion of the program and not the lifestyle management portion (Caloyeras et al., 2014). Although there has been moderate success with wellness programs, the inclusion of counselors could make these programs more successful.

Need for Counselors in Wellness Programs

Changes in health care and increases in worksite wellness programs have created footholds for trained mental health professionals. As evidenced in the cases above, health care professionals, rather than mental health professionals, are facilitating lifestyle wellness programs. This is unfortunate, as professional counselors are trained in the skills of rapport building, demonstrating empathy and helping others achieve their goals. To build upon counselors' inherent training and strengths may reduce the need for additional support and behavior change training. Utilizing counselors may result in stronger program implementation and cost savings for companies (Groeneveld, Proper, Absalah, van der Beek, and van Mechelen, 2011). Furthermore, although there have been some promising results and modest savings due to wellness programs, the variability in the content of wellness programs ranges widely. Therefore, it is proposed that having a program designed and led by counselors may have the potential to create larger savings for the lifestyle management portion of worksite wellness programs. With counselors utilizing their skills and coupling these techniques with aspects of motivational interviewing (MI) and the transtheoretical model of change (TTM), they could strengthen the lifestyle management portion of wellness programs and build on the foundation of wellness in counseling. To this end, we propose a psychoeducational lifestyle management conceptual framework that combines both MI and the TTM in an 8-week program, entitled Steps to Better Health (S2BH), which is described in the following section.

Components of S2BH

MI is an approach that helps individuals motivate themselves to pursue the changes that they seek. The founders of MI, Miller and Rollnick (2013), defined MI as "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (p. 12). More precisely, MI is about skillfully arranging conversations so that people talk themselves into changing (Miller & Rollnick, 2013). Further, MI has been positively correlated with stress reduction, medication adherence, diet change and exercise participation (Rollnick, Miller, & Butler, 2008). Miller and Rollnick (2013) asserted that people from all backgrounds could be trained to use the tools of MI; however, they emphasize that MI is not simply a collection of techniques (Miller & Rollnick, 2013). Rather, MI should be applied in a context that is characterized by client-counselor collaboration, client independence, and empowering clients to find and use their own resources for change (Young, Gutierrez, & Hagedorn, 2012). In addition to MI, the proposed wellness program integrates the TTM, an evidence-based model for change, and research on effective group work.

The TTM was developed by Prochaska and DiClemente (1982) to facilitate behavioral changes for individuals (Campbell, Eichhorn, Early, Caraccioli, & Greeley, 2012). The TTM consists of five stages of change individuals experience when changing behavior. The five stages are: (a) pre-contemplative (not thinking about change); (b) contemplative (thinking about change); (c) preparation (taking steps to begin change); (d) action (making the change); and (e) maintenance (creating a habit of new change; Shinitzky & Kub, 2001).

Prochaska et al. (2008) reviewed employee health promotion interventions, and results demonstrated that both MI and the TTM individually can lead to effective change. Participants (N = 1400) at a major medical university were assigned to three treatment groups: brief health risk intervention (BHRI) only (n = 433), online TTM-tailored treatment (n = 504), and an MI treatment group (n = 433; Prochaska et al., 2008). The results of the study showed that both the MI and TTM treatment groups had more individuals participating in the action stage for exercise and indicated better management of stress along with less health risk behaviors in 6 months than the BHRI only group (Prochaska et al., 2008). This study suggests that if both MI and TTM are effective separately, then combining them could lead to further success. Additionally, utilizing this combination within the framework of a psychoeducational group for a workplace would create efficiency.

Psychoeducational group work is ideal for a wellness program as it is a "hybrid of an academic course and counseling session" (Brown, 2011, p. 8). This format allows participants to feel as though they are attending a class, which can help them focus on learning and implementing a specific task without the potential stigma of therapy. For working professionals who may not feel the need to participate in traditional counseling, a psychoeducational group provides opportunity for discussions and activities in which individuals can practice various wellness techniques in a safe setting. Additionally, groups can be more cost-effective for businesses and organizations, as a number of individuals can simultaneously accomplish goals in a shared timeframe.

For many wellness programs, the results have been mixed due to expensive training and inadequate application of behavior change principles. For the lifestyle management portion of these wellness programs to be successful, a stronger framework would need to be implemented along with the use of professionally trained counselors. Therefore, a conceptual framework that counselors can consider adapting for a wellness lifestyle management program is proposed. The intention is to emphasize critical theoretical components while integrating practical ideas for counselors to build upon and adapt into their own lifestyle and health management programs.

S2BH

The proposed intervention of S2BH is an 8-week pyschoeducational group that incorporates aspects of both MI and the TTM. Each session consists of a short lesson about a concept related to change followed by a discussion that progressively moves each participant toward making the decision to change and successfully enacting those changes. Devoting 1 hour per week over the span of 8 weeks would yield overall balance and wellness among employees, leading to higher work performance and lower absenteeism (Vitality Institute, 2014). In addition to group sessions, the counselor should be available for optional one-on-one follow-up sessions, up to two times after the initial 8 weeks, ideally at the employer's expense. These sessions would provide the opportunity for employees to address specific wellness concerns to help maintain changes. For demonstration purposes, below is a brief case example that demonstrates how S2BH could be utilized. In addition, Table 1 contains an overview of the program.

Case Illustration

Polly, a 46-year-old oncology nurse for 20 years, and Amelia, a 35-year-old oncology nurse for 9 years, work at Metro Hospital, a 2,000-bed acute care medical facility located in a busy downtown area. Both Polly and Amelia were frustrated about their workloads and felt burned out because of job stressors. They were both interested in joining the S2BH group, as it would give them more points in Metro's HealthyYou! Campaign. These additional points could later be translated into monetary bonuses to encourage employee participation. After gaining permission from their nurse manager to be part of the S2BH group, both women joined seven other nurses from different floors once a week for an hour during their lunch break. Both Polly and Amelia completed physicals as a part of the campaign, and despite weight and blood pressure issues, neither of the physicals for both women showed severe health concerns.

During their first meeting, Polly shared feeling fatigued and believing that her lack of exercise played a part in that. Amelia stated that though she managed to walk once a week, she still felt lethargic both emotionally and physically, but was not sure why. During this first group, the counselor utilized one of the central principles of MI, which reflects listening skills to express empathy and genuine caring for the nurses. To close the group, everyone received the S2BH Wellness Primer Worksheet as homework.

Table 1
Suggested Curriculum for Steps to Better Health

Weekly Session	Session Details	Activities in Session	Homework Assigned
Week 1: Rapport Building and Therapeutic Alliance	Counselor will welcome the group and explain the weekly format, with emphasis on goal attainment.	Participants will be encouraged to share work-related stressors and wellness goals.	A worksheet will be provided for participants to outline wellness goals, steps needed to achieve goals and identification of stressors.
Week 2: Wellness Education	Participants will explore reasons for change and discuss the homework from the previous session.	Participants will discuss potential pitfalls and necessary supports for successful change.	Participants will identify what problems they encountered with their last change attempts.
Week 3: The Stages of Change	Counselor will give lesson on TTM, focusing on the stages of change.	Participants will identify which stage of change they are in and work to develop stage-matched interventions.	Participants will write down the advantages and disadvantages of achieving their wellness goal(s).
Week 4: Exploring Ambivalence	Counselor will lead a discussion on ambivalence (Miller & Rollnick, 2013; Shinitzky & Kub, 2001).	Participants will discuss benefits and costs of not changing behavior.	Each participant will identify one to two new habits as they move toward their wellness goal(s).
Week 5: Habit Formation	Counselor will discuss how participants can create new habits.	Using homework, members will identify cues/routines/rewards for each new habit identified (Duhigg, 2012).	Each participant will bring to the next session a brief update on their wellness goal(s).
Week 6: Reframing & Risk Assessments	Participants will discuss triggers and potential tactics to adhere to personal goals.	Participants will identify and isolate potential triggers and solutions for the individual.	Participants will identify stressors from work and life that could jeopardize wellness goal(s).
Week 7: Stress Busters	Participants will discuss stress and ways to enhance coping skills (e.g., emotion-based and action-based).	Participants will use homework to identify appropriate coping skills for each stressor.	Participants will use one of the identified coping skills over the next week.
Week 8: Wrap-Up	Participants will discuss how to stay motivated and engaged with wellness plans.	Participants will discuss achievements followed by a termination activity.	**No homework assigned.**

Polly and Amelia came back to the second group with their S2BH Wellness Primer Worksheet results and were a little hesitant to begin discussing their results. After a few other members shared, Polly stated that the wellness primer made her more aware of her lack of exercise. Amelia then shared that this was the first time she had sat down and reflected on her health and well-being, and though she was not sure it was necessarily helpful, she was willing to try anything to stop feeling "blah." Following the discussion on the wellness primer, group members worked on developing a wellness plan for the areas they wanted to improve. To close the session, the counselor discussed with the members ways to begin working on their goals in incremental steps and noted different ways they had started addressing those steps.

After learning about the stages of change from the TTM in the third session, Polly was animated about which stage she was on in relation to her goal of exercising more. She shared that she had been stuck on the contemplative stage of change for more years than she could count. She stated that she wanted to lose weight but could not seem to motivate herself to walk before her shift started.

Amelia stated that she wanted to eat better and classified herself as being in the pre-contemplative stage of change. She reported that she needed to eat better because she relied too often on caffeine and sugary foods to keep her going throughout the work day. Several of the group members expressed hope in knowing that they were not just "being lazy," but were in a process of change. Amelia stated that just knowing that gave her a boost of energy.

After checking in during the fourth session and finding out where everyone was with their goals, the counselor led a discussion on the MI concept of ambivalence. Polly found this a little challenging, as she just wanted to list the pros and cons of her new health goals: exercising and eating better. Once she understood that she was to list both the benefits and costs of continuing her current behavior versus enacting her new health goal, she became more involved in the activity. As a result, Polly listed some pros of walking in the morning as being "it centers me as I release some of the frustration from the day before," and "I use this time to organize my mind for the upcoming tasks for the day." Amelia stated that some of her cons for not changing her behavior included "crashing hard around 4 p.m. in the afternoon" and "losing focus when working with patients."

For the fifth session, a discussion centered around Duhigg's (2012) book, *The Power of Habit: Why We Do What We Do in Life and Business*, and how members could apply the principle of cue, reward and routine to help them achieve their goals. Polly stated that she started putting her walking shoes out with her exercise clothes so that she could immediately see them when she woke up (cue). She would play her favorite podcast while walking (routine), and reward herself with a small low-calorie pastry for breakfast (reward). Amelia stated that she started to place almonds and other energy-boosting snacks at the nurses' station so she could easily see them (cue), then would snack on those items while talking with colleagues (routine). As a result, she felt her energy lasting longer throughout the day (reward).

The nurses enjoyed reframing their previous "relapses" in the sixth session. Amelia reported that she was aware it was normal to move back and forth between the stages and that this knowledge alleviated concerns about failure. The group had a lively discussion about what triggers or pitfalls stood in their way and what places or things they should avoid as a result. For example, Polly stated that if she hit the "snooze button," she would stay in bed and forgo her walk. Realizing this, she opted to place her alarm clock across the room so that she would have to get out of bed to turn off the alarm.

The seventh session on stressors became more emotional than anticipated as many of the nurses talked about their work and the unique stress they experience when taking care of ill and terminally ill patients. The group members talked about their thoughts and feelings and supported one another during this session. As a result, a spontaneous sharing of how nurses deal with the grief of losing patients occurred. Amelia shared that she had recently decided to join Team in Training for the Leukemia and Lymphoma Society and train for a half marathon in memory of one of her younger patients. She stated that letting the family know and beginning to raise money for research in this area was helping her to positively channel her grief. As a result of this discussion, several of the nurses stated that they left the group with hope, connectivity, and ideas for channeling their grief and stress.

The final session of the group focused on closure. Amelia shared that although she was initially dubious about the group, as a result of her sharing and the small changes she was making with her snacking, she was not feeling as "blah" anymore. Polly also shared that while she had not lost weight yet, she felt more motivated to continue walking and noticed that she felt more positive about walking.

Conclusion

Changes in health care have increased job opportunities in health care for counselors. The PPACA allows counselors the opportunity to expand their background of wellness while capitalizing on preventive health care initiatives (Barden, Conley, & Young, 2015; Granello & Witmer, 2013). With the interrelatedness between physical and mental health, counselors are ideally positioned to help clients achieve their wellness goals. Connections between physical activity and psychological well-being are well established, as are the potential benefits of improved coping with stress and adversity (Focht & Lewis, 2013). Because chronic stress has been shown to contribute to obesity and metabolic diseases (Razzoli & Bartolomucci, 2016), helping employees improve their coping skills can lead to adaptive ways of dealing with stress, which ultimately impacts chronic health conditions. To better manage occupational stress, counselors can fill the need for bringing stress management skills to the workplace (Galla et al., 2015).

In addition, wellness programs provide the ability for counselors to research their contributions to workplace wellness programs, thereby providing an opportunity to study counselor effectiveness. Research has shown that using health care professionals in disease management portions of wellness programs can lower costs. The focus of this manuscript has been to describe a framework for counselors to facilitate lifestyle management programs in corporate settings. Considerable sponsored research opportunities also are available, especially for worksite wellness programs targeted to underserved populations (U.S. Department of Health and Human Services Office of Minority Health, 2016).

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An Examination of Counselors' Religiosity, Spirituality, and Lesbian-, Gay-, and Bisexual-Affirmative Counselor Competence

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Counselors in school and community settings, counselor educators and counseling students (*N* = 453) participated in a study of self-perceived competence to serve lesbian, gay and bisexual (LGB) clients. Using the same large data set as Farmer, Welfare, and Burge (2013), the author examined different research questions focused on counselor religiosity and spirituality. Through multiple regression analysis, the following variables predicted LGB-affirmative counseling competence: counselors' self-identified religiosity, spirituality, education, number of LGB clients counseled and LGB interpersonal contact. Spirituality had a positive relationship with competence, whereas religiosity was negatively related. Further exploration of the intersection of counselor religiosity and spirituality as it relates to LGB-affirmative counseling is warranted.

Keywords: **LGB, lesbian, gay, bisexual, religiosity, spirituality, counselor competence**

Lesbian-, gay- and bisexual- (LGB-) affirmative counseling encompasses a broad base of knowledge, awareness of attitudes, and skills that affirm and honor the lived experiences of sexual orientation diverse individuals, representing the ethical standard of care for all non-heterosexual clients (Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2012; Israel & Selvidge, 2003). Whitman and Bidell (2014) defined LGB-affirmative counseling as "a practice that adopts a science-based perspective of LGB sexual (or affectional) orientations as normal and healthy expressions of human development, sexuality, relationship, and love" (p. 164). In the last decade, the issue of providing competent, affirming care to clients who identify as lesbian, gay and bisexual (LGB) has risen to the forefront of professional dialogue for counselors. Two legal cases (*Keeton v. Anderson-Wiley*, 2011; *Ward v. Polite*, 2012) inspired meaningful discussion about the intersection of counselors' religious and spiritual values and ethical counseling practices when working with sexual orientation diverse clients. The American Counseling Association (ACA) *Code of Ethics* (2014) mandates that counselors attend to value conflicts while working with clients to avoid the potentially harmful imposition of personal values (Kaplan, 2014). Still, some counselors are left with the task of integrating conflicting religious values with competent and affirming counseling practices with LGB clients (Herlihy, Hermann, & Greden, 2014; Robertson & Avent, 2016).

The political and social landscape surrounding LGB issues in the United States is in a state of flux. While the historic *Obergefell v. Hodges* (2015) decision established marriage equality for same-sex couples nationally, there have been conflicting influences on affirmative care. Conscience clause legislation, intended to protect mental health practitioners who deny services based on their own "sincerely held principles" (TN HB1840, 2016), has emerged in several states (e.g., Mississippi, Tennessee) as a response to the revised ACA *Code of Ethics* (2014). Conversion therapy or reparative therapy remains legal in 45 states despite being discredited and ethically opposed by all major mental health professions, including the ACA (American Psychological Association, 2017; Whitman, Glosoff, Kocet, & Tarvydas, 2013). Specifically, those ascribing to some religious affiliations assume a moral stance against non-heterosexual partnerships which is often rooted in narrow scriptural interpretations and traditional views on what constitutes a marriage (Lalich & McLaren, 2010). Smith and Okech (2016a) further probed professional discourse through their investigation of the Council

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for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation status of counseling programs housed within religious institutions that disaffirm or disallow diverse sexual orientations, initiating an exchange of dialogue in the *Journal of Counseling & Development* (Sells & Hagedorn, 2016; Smith & Okech, 2016b). These authors highlighted incongruencies between the policies and philosophical statements of religiously affiliated institutions and the values espoused by the ACA *Code of Ethics*. In light of these prominent events and professional dialogue, counselors' religious beliefs, as they relate to working with LGB clients, have received greater attention (Balkin, Watts, & Ali, 2014; Kaplan, 2014; Whitman & Bidell, 2014).

Spirituality, much like religion, is another complex facet of identity that contributes to counselor values. Although it has been established that counselors' conservative religious beliefs may impact LGB-affirmative counseling (Balkin et al., 2014; Bidell, 2014), the impact of counselors' spirituality is less understood. To date, no studies have investigated counselor religiosity and spirituality as potentially different aspects of identity that may relate to LGB-affirmative counselor competence, nor has the religious affiliation of counselors been explored. Therefore, the researcher sought to examine counselors' self-identified religiosity and spirituality, as they relate to LGB-affirmative counseling competence.

The author conducted a large study of LGB-affirmative counselor competence that found school counselors perceived themselves as having lower competence to serve LGB clients than community-based counselors (Farmer, Welfare, & Burge, 2013). Using the same data set, the lead author has examined several new variables for the current study, including counselors' self-identified religiosity, spirituality, education level, experience counseling LGB clients and LGB interpersonal contact. By examining these variables, new information is offered to the current professional discourse about the relevance of counselors' religious and spiritual beliefs when counseling LGB clients.

Defining Religiosity and Spirituality

There are diverse opinions regarding definitions of religiosity and spirituality (Zinnbauer, Pargament, & Scott, 1999). The inconsistency in definitions creates a complex problem for researchers of religiosity and spirituality because it is difficult to know what meaning participants attribute to these terms (Zinnbauer et al., 1997). Although religiosity and spirituality have been shown to coincide for some, they are distinctly separate aspects of identity for others (Pargament, Sullivan, Balzer, Van Haitsma, & Raymark, 1995).

Religiosity has been broadly defined as the degree to which individuals subscribe to institutionalized beliefs or doctrines (Vaughan, 1991). Among basic methods of measuring religiosity is the indication of whether or not one identifies with a religious affiliation (Clark & Schellenberg, 2006). The frequency of service attendance and engagement in religious behaviors (e.g., prayer, scripture reading) are other methods of measuring religiosity (Lippman, Michelsen, & Roehlekepartain, 2005; Piedmont, 2001; Whitley, 2009). Self-ratings of religiosity are widely used that involve asking people to identify the importance of religion in their lives (Rainey & Trusty, 2007; Whitley, 2009). Chatters, Levin, and Taylor (1992) proposed a 3-dimensional model of religiosity that included *organizational involvement* (formal church attendance), *nonorganizational involvement* (informal activities such as prayer or scriptural study at home), and *subjective religiosity* (personal beliefs, attitudes and perceived importance of religion in one's life). Aligning with these models, religiosity is understood in the current study as the degree of importance of religion in one's life; frequency of service attendance and religious behavior (e.g., prayer, scriptural reading); and identification with a religious affiliation.

Alternately, spirituality is considered to be unique to individuals' life experience and interpretation (Pargament, 2013). Spirituality is broadly described as an individual's internal orientation toward a greater transcendent reality that joins "all things into a more unitive harmony" (Piedmont, 1999, p. 988). To develop a definition of spirituality, a "Summit of Spirituality" included 15 ACA members with representatives from a cross-section of ACA divisions who began the process of forming the counseling profession's *Spiritual Competencies* (Association for Spiritual, Ethical, and Religious Values in Counseling, 2013). The summit resulted in the following description:

> Spirituality is a capacity and tendency that is innate and unique to all persons. The spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. ("Summit Results," 1995, p. 30)

Pargament claimed "spirituality is the core function of religion" (2013, p. 271). In other words, people become involved in religion as a way to connect to the sacred and support their spirituality. Therefore, spirituality is a distinct motivation and human process that may exist apart from religion (Pargament, 2013). The current study is grounded in this understanding by examining counselors' religious and spiritual identities as separate constructs (Pargament et al., 1995).

Counselors and Religiosity

Within studies of LGB-affirmative counselor competence, several factors have been shown to negatively influence counselor competence, such as religiosity, church attendance, political conservatism, and heterosexism (Balkin, Schlosser, & Levitt, 2009; Bidell, 2014; Rainey & Trusty, 2007; Satcher & Schumacker, 2009). Scholars have postulated that the way scriptural references are interpreted may account for this negative influence, specifically interpretations that deem non-heterosexual behavior as immoral and socially deviant (Altemeyer, 2003; Poteat & Mereish, 2012; Whitley, 2009). Alternate views on scriptural references such as these include an understanding of cultural context, analysis of contradictory messages, and consideration of the human lens through which scripture was written (Dewey, Schlosser, Kinney, & Burkard, 2014; Friedman, 2001).

Bidell (2014) explored religious conservatism as it relates to counselor competence with LGB clients in a study of 228 counseling students, counselor educators and counseling supervisors in university settings. Religious conservatism was defined as *religious fundamentalism*, or "the belief that there is one set of religious teachings that clearly contain the . . . inerrant truth about humanity and deity" (Altemeyer & Hunsberger, 1992, p. 118). Religious conservatism was a significant negative predictor of LGB-affirmative counselor competence ($\beta = -.532$), whereas LGB interpersonal contact ($\beta = .299$) and LGB-specific training ($\beta = .143$) were positive predictors. In the analysis of the Sexual Orientation Counselor Competency Scale (SOCCS) subscales for attitudinal awareness, knowledge and skill, Bidell (2014) found that the attitudinal awareness and skill subscales were significantly related to religious conservatism, whereas knowledge was not. Implications suggest that counselors are influenced by conservative religious beliefs and attitudes toward LGB individuals.

More evidence has emerged concerning counselor religiosity and prejudice toward LGB individuals. Higher frequency of church attendance was a significant predictor of counselors' negative attitudes toward LGB individuals (Satcher & Schumacker, 2009). Counselors who have more rigid and authoritarian orientations of religious identity exhibit more LGB prejudice (Balkin et al., 2009; Bidell, 2014; Sanabria, 2012). In light of these findings, more scholarly attention is focusing on ways to support "religiously conservative" counselors through the process of negotiating values conflicts (Choudhuri & Kraus, 2014; Fallon et al., 2013; Robertson & Avent, 2016; Whitman & Bidell, 2014).

Counselors and Spirituality

Ample research combines religion and spirituality, assuming these are synonymous aspects of identity or sources of values. However, some key studies have focused on the distinct contributions of spirituality in counselor development. Morrison and Borgen (2010) examined counselor empathy as it relates to and is influenced by counselor spirituality. Using the critical incident technique, 12 counselors with Christian beliefs identified 242 incidents where their spirituality helped their empathy toward clients and 25 incidents where their spirituality hindered empathy. Helping categories included counselors' empathic connection with clients, the ability to draw on values of compassion and acceptance, and understanding other cultures. Hindering categories included experiences in which the client's actions were contrary to the counselor's belief system and having limited empathy due to counselor biases. Implications highlight the important role of spirituality in counselors' felt empathy as well as the need for counselor training programs to create space for personal reflection on spiritual beliefs.

In a quantitative study, Saslow et al. (2013) sought to clarify meaning in the relationship between counselor spirituality and compassion while controlling for religiosity. Using an online sample from Amazon's Mechanical Turk ($n = 149$), a nationally representative sample ($n = 3{,}481$), and a college undergraduate sample ($n = 118$), the authors measured global religiosity and spirituality, religious and spiritual practices, religious fundamentalism, self-transcendence, spiritual identity, questing orientation, global positive affect, dispositional compassion, awe, and love. Using principal components analysis, religiosity and spirituality loaded as distinct factors. Spirituality significantly predicted compassion after controlling for religiosity and positive affect. Alternately, religiosity was not a significant predictor of compassion while controlling for spirituality. Implications suggest compassion is central to spirituality.

Although researchers have focused on the relevance of client spirituality in the counseling process (Cashwell & Young, 2011; Parker, 2011), empirical studies investigating the impact of counselor spirituality are lacking. To date, no studies have examined the relationship between counselors' self-identified spirituality, as differentiated from religiosity, and LGB-affirmative counselor competence. Therefore, the study was guided by the following research questions:

1) What are the relationships between counselors' (a) self-identified religiosity, (b) self-identified spirituality, (c) education level, (d) counseling experience with LGB clients, (e) LGB interpersonal contact, and (f) LGB-affirmative counselor competence?

2) How do the variables of (a) self-identified religiosity, (b) self-identified spirituality, (c) education level, (d) counseling experience with LGB clients, and (e) LGB interpersonal contact *predict* LGB-affirmative counselor competence?

3) Are there differences in counselors' (a) self-identified religiosity, (b) self-identified spirituality, and (c) LGB-affirmative counselor competence among religious affiliation groups?

The author hypothesized that higher levels of self-identified religiosity would predict lower LGB-affirmative counselor competence, as established in Bidell's previous study (2014). The author also hypothesized that all variables assessed would help explain the variance in counselors' LGB-affirmative counselor competence.

Method

Procedure

The author used the same data set reported in Farmer et al. (2013) using different research questions and examining five new variables. The sample (*N* = 1,480) consisted of members of a state-level professional counseling association located in the Southeastern United States, including licensed professional counselors, professional school counselors, counselors-in-residence (post-master's counselors working toward licensure), counseling graduate students and counselor educators. The researcher secured approval from the Institutional Review Board, obtained participant information from the state organization's membership directory, and sent a recruitment e-mail inviting participation in the anonymous online survey using SurveyMonkey. Two reminder e-mails were sent at five and 10 days after initial contact. There were 556 respondents, yielding a response rate of 37.5%. The final sample included 453 participants following data-cleaning procedures and eliminating those respondents whose practice setting could not be verified.

Participants

Of the 453 participants, 212 (46.8%) described their primary practice setting as school, 110 (24.3%) described their practice setting as community, 93 (20.5%) were described as counseling graduate students, and 38 (8.4%) were counselor educators. Participants' ages ranged from 22 to 75 years, with an average age of 41.5 years (*SD* = 13.5). Seventy-three participants (16.1%) identified as men and 379 (83.7%) identified as women (one participant omitted this item). With regard to race, 376 participants (83.0%) identified as Caucasian, 55 (12.1%) as African American, eight (1.8%) as Hispanic, eight (1.8%) as multiracial or other, three (0.7%) as American Indian, one (0.2%) as Asian, and one (0.2%) as Hawaiian or Pacific Islander (one participant omitted this item). Regarding sexual orientation, 425 participants (93.8%) identified as heterosexual, seven (1.5%) as lesbian, five (1.1%) as gay, five (1.1%) as bisexual, one (0.2%) as questioning, and four (0.9%) as other (six participants omitted this item). Participants were also asked to identify their religious affiliation (e.g., Protestant Christian, Catholic, Other Religious Affiliation, No Religious Affiliation). Table 1 displays descriptive data on religious affiliation and SOCCS scores.

Instruments

Two instruments and an information questionnaire were used to collect data. The SOCCS (Bidell, 2005) was used to assess LGB-affirmative counselor competence. The Marlowe-Crowne Social Desirability Scale—Short Form C (MC-C; Reynolds, 1982) assessed the authenticity of participant responses. An information questionnaire gathered demographic and personal background information, including items for counselors to indicate self-identified religiosity and spirituality.

Sexual Orientation Counselor Competency Scale. This instrument measures participants' self-perceptions of LGB-affirmative counseling competence including attitudes, knowledge and skills (Bidell, 2005). The SOCCS contains 29 items that are rated on a 1–7 scale (1 = *not at all true*, 7 = *totally true*). Ten items measure attitudes (e.g., "The lifestyle of an LGB client is unnatural or immoral"), eight items measure knowledge (e.g., "There are different psychological/social issues impacting gay men versus lesbian women"), and 11 items measure skill (e.g., "I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting"). Convergent validity was established for each of the three subscales (attitudinal awareness, knowledge and skill) using existing measures of LGB bias, multicultural knowledge and basic counseling skills, respectively. Bidell (2005) reported strong internal consistency for the SOCCS: .90 for the overall score, .76 for Knowledge, .88 for Attitudes, and .91 for Skill. In this sample (*N* = 453), the coefficient alphas are reasonably comparable: .87 for the overall score, .72 for Knowledge, .87 for Attitudes, and .87 for Skill.

Table 1
Mean Values for SOCCS Total and Subscales by Religious Affiliation

Group	**N**	**M**	Attitudes	Knowledge	Skill
Protestant Christian	**237**	**4.51**	6.17	4.04	3.34
Assembly of God	1				
Baptist	36				
Brethren	4				
Christian	82				
Church of Christ	1				
Disciples of Christ	4				
Episcopal	17				
Lutheran	9				
Mennonite	3				
Methodist	48				
Morman	2				
Non-Denominational	12				
Pentecostal	1				
Presbyterian	17				
Catholic	**88**	**4.70**	6.51	4.22	3.41
Roman Catholic	87				
Byzantine Catholic	1				
Other Religious Affiliation	**29**	**5.25**	6.85	4.69	4.19
Buddhist	4				
Jewish	9				
Native American	1				
Religious Soc. Friends	5				
Taoist	1				
Unitarian	9				
No Religious Affiliation	**99**	**4.95**	6.74	4.43	3.70
None identified	93				
Agnostic	5				
Atheist	1				
Total	**453**	**4.69**	6.41	4.20	3.49

Marlowe-Crowne Social Desirability Scale—Short Form C (MC-C). This 13-item self-report instrument measures participants' tendency to answer questions to portray oneself in favorable ways (e.g., "I am always willing to admit when I make a mistake."). The items are answered as true or false and then summed for a total score. Higher scores on the MC-C reflect higher levels of social desirability. In this sample, internal consistency of the 13 items in the MC-C was .77 ($N = 453$), which is comparable to previous tests of the internal consistency of the MC-C (Reynolds, 1982).

Information questionnaire. An information questionnaire was developed to gather basic demographic and background information. In addition to demographic variables of age, race, ethnicity, sexual orientation and gender identity, five additional variables were evaluated: (a) self-identified religiosity, (b) self-identified spirituality, (c) education level, (d) counseling experience with LGB clients (the number of LGB clients worked with), and (e) LGB interpersonal contact (the number of friends and relatives who identify as LGB).

A brief, 4-item measure of self-identified religiosity captured the importance of religion in participants' lives based on previous studies (Rainey & Trusty, 2007; Whitley, 2009) and census methods of measuring religiosity (Clark & Schellenberg, 2006; Lippman et al., 2005). Participants were asked to rate the importance of religion in their lives (0 = *not at all,* 1 = *somewhat,* 2 = *important,* 3 = *very important*), service attendance (0 = *never,* 1 = *few times a year,* 2 = *few times a month,* 3 = *once a week or more*), personal practices (0–7 scale = number of days per week spent engaging in religious behavior such as praying, reading scripture), and religious affiliation (open-ended*;* 0 = *no identified religious affiliation,* 1 = *identified religious affiliation*). Item scores were transformed into z-scores and then summed, where higher scores indicate higher levels of religiosity. In this sample, internal consistency of the four items in the religiosity measure was .82.

A brief, 5-item measure of self-identified spirituality was used to assess distinct aspects of spirituality from religiosity. A modified version of the Spiritual Transcendence Index (STI) was used, where spiritual transcendence refers to "a subjective experience of the sacred that affects one's self-perception, feelings, goals, and ability to transcend difficulties" (Seidlitz et al., 2002, p. 441). The STI demonstrated high consistency and validity across several samples in exploratory studies, including adaptations of the STI such as those employed in this study (Good, Willoughby, & Busseri, 2011; Kim & Seidlitz, 2002; Seidlitz et al., 2002). The modified version of the STI used four items that did not include the term "God." In this study, it was important that the concept of spirituality not be limited to only theists. For the four items, participants were asked to rate their experience of the following on a 1–6 scale (1 = *strongly disagree* to 6 = *strongly agree*): "My spirituality gives me a feeling of fulfillment," "Even when I experience problems, I can find a spiritual peace within," "Maintaining my spirituality is a priority for me" and "My spirituality helps me to understand my life's purpose." Finally, one question was posed in a similar format to Nelson, Rosenfeld, Breitbart, and Galietta (2002) asking respondents to rate the importance of spirituality in their lives (0 = *not at all*, 1 = *somewhat*, 2 = *important*, 3 = *very important*), which mirrors the wording of the parallel item in the religiosity measure. Item scores were transformed into z-scores and then summed, where higher scores reflect higher levels of self-identified spirituality. In this sample, internal consistency of the five items in the spirituality measure was .96 ($N = 453$), reflecting strong scale reliability. Validity of modified versions of the STI also has been established (Good et al., 2011; Kim & Seidlitz, 2002).

Data Cleaning

To ensure quality and rigor, participants who answered less than 70% of the items on the SOCCS or MC-C were eliminated from the sample, based on the methodology of Henke, Carlson, and McGeorge (2009) and Rock, Carlson, and McGeorge (2010). Of the 556 initial respondents, 61 did not complete the required 70% minimum (20 of 29 items) on the SOCCS. The religiosity and spirituality measures included only four and five items, respectively; therefore, if even one item was omitted from either measure, those participants were eliminated from the sample ($n = 15$). Finally, 27 respondents did not indicate their primary practice setting and were eliminated from the sample because the researcher could not confirm that they were a counselor.

Further data cleaning was necessary for participants who completed more than 70–100% of the SOCCS or MC-C. For those who omitted one to eight items (n = 89) on the SOCCS or one to three items on the MC-C (n = 8), mean imputation accounted for missing items (Montiel-Overall, 2006). Of those 89 cases that were modified using mean imputation for the SOCCS, 61 participants had omitted only one item and 12 omitted only two items. The remaining 16 participants omitted three to seven items.

Results

The purpose of the study was to investigate the following factors as they relate to and predict LGB-affirmative counselor competence: counselor self-identified religiosity, spirituality, education level, counseling experience with LGB clients and LGB interpersonal contact. To answer the research questions, correlational analysis, multiple regression and analysis of variance (ANOVA) were conducted. The researcher completed post-hoc power analyses using G*power at the .05 level of statistical significance. The effect size and achieved power is reported for each analysis.

For Research Question 1, a correlational matrix presents the relationships among all variables in Table 2. There was a significant, although weak, correlation between LGB-affirmative counselor competence and social desirability ($r2$ = -.15, p < .01). This suggests that the SOCCS results were not significantly inflated by social desirability.

Table 2
Correlation Matrix for Main Study Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. MC-C	-	-.15**	-.06	-.28**	-.05	.08	.10*	-.03	-.06	-.01
2. SOCCS Total		-	.57**	.62**	.88**	-.30**	-.04	.31**	.35**	.24**
3. Attitudes			-	.12*	.27**	-.47**	-.31**	.08	.11*	.18**
4. Knowledge				-	.35**	-.17**	.04	.16**	.05	.17**
5. Skill					-	-.11*	.08	.34**	.45**	.18**
6. Religiosity						-	.60**	-.01	.03	-.12*
7. Spirituality							-	.07	.11*	-.04
8. Education								-	.22**	.06
9. LGB clients									-	.10
10. LGB interpersonal										-

Note. MC-C = Marlow Crowne Social Desirability Scale - Short Form C; SOCCS Total = Sexual Orientation Counselor Competency Scale Total score; Attitudes = SOCCS Attitudinal Awareness Subscale; Knowledge = SOCCS Knowledge Subscale; Skill = SOCCS Skill Subscale; Religiosity = self-identified religiosity measure; Spirituality = self-identified spirituality measure; Education = highest degree earned in counseling; LGB clients = number of LGB clients counseled; LGB interpersonal = number of LGB friends/relatives

Among initial findings, religiosity had a significant negative relationship with SOCCS total scores ($r = -.30$, $p < .01$) including significant negative relationships for all three of the SOCCS subscales (Attitudes, $r = -.47$; Knowledge, $r = -.17$; and Skill, $r = -.11$). Spirituality was not related to SOCCS total scores ($r = -.04$, $p > .05$), yet spirituality was strongly correlated with religiosity ($r = .60$, $p < .01$).

For Research Question 2, multiple regression analysis was conducted to determine predictors of LGB-affirmative counselor competence. The criterion variable was total score on the SOCCS and the predictors were (a) religiosity, (b) spirituality, (c) education level, (d) counseling experience with LGB clients, and (e) LGB interpersonal contact. The results of the regression indicated that these five predictors explained 31% of variance in SOCCS scores ($R2 = .31$, $F(5, 391) = 35.31$, $p < .01$). All five variables significantly predicted SOCCS scores: religiosity ($\beta = -.40$, $p < .01$), spirituality ($\beta = .13$, $p < .05$), education ($\beta = .23$, $p < .01$), number of LGB clients worked with ($\beta = .28$, $p < .01$), and LGB interpersonal contact ($\beta = .13$, $p < .01$). Notably, there was a negative β value for religiosity, indicating an inverse relationship with SOCCS scores compared to a positive β value for spirituality and SOCCS scores. With a medium effect size of .45 (Cohen, 1992), achieved power for the multiple regression was 1.00.

For Research Question 3, ANOVA was used to examine differences in three variables (religiosity, spirituality, and LGB-affirmative counselor competence) across the following religious affiliation groups: Protestant Christian, Catholic, Other Religious Affiliation, and No Religious Affiliation. Table 1 displays the affiliations included in each group.

Religious affiliation and religiosity. A one-way, between-subjects ANOVA compared the effect of religious affiliation on religiosity in four groups: Protestant Christian ($n = 237$), Catholic ($n = 88$), Other Religious Affiliation ($n = 29$), and No Religious Affiliation ($n = 99$). There was a significant effect of religious affiliation on religiosity [$F(3, 449) = 156.69$, $p = .000$]. Post-hoc comparisons using Tukey HSD indicated that the mean score for No Religious Affiliation ($M = -4.12$, $SD = 2.30$) was significantly lower than Protestant Christian ($M = 1.61$, $SD = 2.20$), Catholic ($M = .45$, $SD = 2.39$), and Other Religious Affiliation ($M = -.73$, $SD = 2.11$). In addition, Protestant Christian ($M = 1.61$, $SD = 2.20$) was significantly higher in religiosity than Catholic ($M = .45$, $SD = 2.39$) and Other Religious Affiliation ($M = -.73$, $SD = 2.11$) groups. With a large effect size of 1.04 (Cohen, 1992), achieved power for the ANOVA was 1.00.

Religious affiliation and spirituality. A one-way, between-subjects ANOVA compared the effect of religious affiliation on spirituality in four conditions: Protestant Christian, Catholic, Other Religious Affiliation, and No Religious Affiliation. There was a significant effect of religious affiliation on spirituality [$F(3, 449) = 16.17$, $p = .000$]. Post-hoc comparisons using Tukey HSD indicated that the mean score for Protestant Christian ($M = 1.22$, $SD = 3.45$) was significantly higher than Catholic ($M = -.69$, $SD = 4.29$) and No Religious Affiliation ($M = -2.31$, $SD = 6.06$) groups. With a medium effect size of .31 (Cohen, 1992), achieved power for the ANOVA was 0.99.

Religious affiliation and LGB-affirmative counseling competence. A one-way, between-subjects ANOVA compared the effect of religious affiliation on LGB-affirmative counseling competence in four groups: Protestant Christian, Catholic, Other Religious Affiliation, and No Religious Affiliation. There was a significant effect of religious affiliation on LGB-affirmative counseling competence [$F(3, 449) = 12.98$, $p = .000$]. Post-hoc comparisons using Tukey HSD indicated that the mean score for Protestant Christian ($M = 4.51$, $SD = .77$) was significantly lower than No Religious Affiliation ($M = 4.95$, $SD = .78$). Furthermore, the mean score for Other Religious Affiliation ($M = 5.25$, $SD = .78$) was significantly higher than Protestant Christian ($M = 4.51$, $SD = .77$) and Catholic ($M = 4.70$, $SD = .75$).

Using G*Power, post-hoc power analysis was conducted. With a small effect size of .23 (Cohen, 1992), achieved power for the ANOVA was .98.

Discussion

Results of this study indicate that counselor religiosity and spirituality are each significant predictors of LGB-affirmative counselor competence. Counselor religiosity had a negative relationship with LGB-affirmative counselor competence ($\beta = -.40$, $p < .01$), whereas counselor spirituality had a positive relationship with LGB-affirmative counselor competence ($\beta = .13$, $p < .01$). Although counselors' self-identified spirituality and religiosity were correlated ($r = .60$, $p < .01$), the opposing directions of the relationship between counselor religiosity and spirituality with LGB-affirmative counseling competence is intriguing.

The current study examined counselors' self-identified religiosity as the degree of involvement in their religions, without knowledge of the specific nature of religious beliefs. It is possible that the negative relationship found between religiosity and LGB-affirmative competence is associated with conservative or fundamentalist beliefs, as found in Bidell's (2014) study. Nonetheless, the significance of counselors' self-identified spirituality as a positive predictor of LGB-affirmative counseling competence is new and useful information. Spirituality has been linked to empathy (Morrison & Borgen, 2010) and compassion for others (Saslow et al., 2013), which also may be factors related to LGB-affirmative counseling competence. Further empirical investigation of these variables is necessary to draw further conclusions.

The current study substantiates previous findings that education, the number of LGB clients worked with, and LGB interpersonal contact are positive predictors of LGB-affirmative counselor competence (Bidell, 2014). Reviewing the correlations of the SOCCS subscales (Table 2), education was most strongly related to skill ($r2 = .34$, $p < .01$), weakly related to knowledge ($r2 = .16$, $p < .01$) and unrelated to attitudes ($r2 = .08$, $p > .05$). It may be surmised that more education may move the marker on LGB-affirmative knowledge and skill, but is less related to affirming attitudes. Counseling experience with LGB clients was moderately correlated to skill ($r2 = .45$, $p < .01$), weakly related to attitudes ($r2 = .11$, $p < .05$), and unrelated to knowledge ($r2 = .05$, $p > .05$). Considering that counselors perceive themselves to have affirming attitudes toward LGB clients but have lower knowledge and skill (Bidell, 2012, 2014; Farmer et al., 2013; Graham, Carney, & Kluck, 2012), obtaining more counseling experience with LGB clients may be essential to strengthen self-perceived skill.

Finally, the ANOVA results suggest differences between religious affiliation groups in this study. Counselors in the "Protestant Christian" group were significantly lower in LGB-affirmative competence than counselors with "No Religious Affiliation." Likewise, counselors in the "Other Religious Affiliation" group were significantly higher in LGB-affirmative competence than the "Protestant Christian" and "Catholic" groups. Furthermore, there were no significant differences in spirituality between "Protestant Christian" and "Catholic" groups, yet there was a significant difference in the religiosity of these two groups. These results suggest that the two groups shared similarly high spirituality but did not share the same religiosity as it was measured in this study.

If religion is theorized as a function of spirituality (Pargament, 2013), then results of this study seem to support that counselor spirituality may facilitate LGB-affirmative dispositions. It is possible that only certain religious beliefs interfere with this relationship to negatively affect LGB-affirmative counseling. As further support, there was a significant difference between "Protestant Christian," "Catholic," and "Other Religious Affiliation" groups with regard to LGB-affirmative competence. No firm conclusions can be drawn, but these results provide fodder for those in the field of professional counseling to discuss and consider.

Limitations

When self-report measures are used in a study of multicultural competence, there is a risk that participants may respond more favorably due to the influence of social desirability. Furthermore, self-perceived LGB-affirmative competence was measured using the SOCCS, which may not reflect actual competence with LGB clients. There is a chance of sampling bias due to the possibility that those who had greater interest in the topic of the study self-selected to participate. Finally, the nature of participants' religious beliefs was not examined; therefore, there may be wide variability in beliefs within each of the religious affiliation groups examined (e.g., Protestant Christian, Catholic, Other Religious Affiliation).

Implications

Results of this study suggest that religiosity and spirituality both predict LGB-affirmative counselor competence, but in different ways. Spirituality was a direct, positive predictor of LGB-affirmative counselor competence, while religiosity was a negative predictor. Results align with previous findings that suggest for highly religious counselors, LGB-affirmative counselor competence is most impacted by attitudes as opposed to the development of knowledge and skill (Bidell, 2014).

Considerations for Counselors

Religiosity and spirituality may each provide structure or ideological substance needed to develop one's sense of values concerning counseling LGB clients. Whereas religion may derive ideological substance from certain doctrines, scriptures or teachings, spirituality is likely to derive ideological substance from more intuitive or nontangible forms of meaning-making that drive human connection (Zinnbauer et al., 1999). Considering this, it seems possible that counselors who identify as both highly religious and spiritual could experience inner conflict related to integrating LGB-affirmative values if their religious doctrines or teachings have been interpreted in such a way as to condemn same-sex relationships (Altemeyer, 2003; Poteat & Mereish, 2012; Whitley, 2009). In this case, such counselors may be trying to negotiate two important ways of knowing and making meaning about the world: one derived from religious teachings and the other from intuitive or heart-centered means. Thus, if a counselor is experiencing a values conflict between their personal religious beliefs and LGB-affirmative practices supported by the ACA *Code of Ethics* (2014), it may be mutually beneficial to explore the common thread of spirituality to forge empathic connection.

Practical suggestions for counselors include self-reflection on spiritual and religious values and beliefs, peer consultation, supervision, and seeking consult from a variety of religious and spiritual leaders. It may be helpful for counselors to consider values from their religious affiliations that are congruent with LGB-affirmation to encourage integration. Through these activities, counselors may develop a deeper understanding of the complex ideas, beliefs and values that are important to their religious and spiritual selves.

Counselor Educators and Supervisors

Whitman and Bidell (2014) offered recommendations to counselor educators and supervisors for training LGB-affirmative counselors, such as conducting a thorough and honest appraisal of the program's level of LGB-affirmative counselor education integration, providing clear informed consent to potential students regarding the LGB-affirmative approach infused into the curriculum, and encouraging student exploration of how personal values may affect worldview. As a pedagogical technique for encouraging self-exploration, Fischer and DeBord (2007) recommended evoking conversation with students when conflict is perceived between a student's religious values and professional obligations. Normalizing these experiences of struggle for students may be helpful, particularly for those whose religious beliefs are salient to their cultural identities (Robertson & Avent, 2016; Scott, Sheperis, Simmons, Rush-Wilson, & Milo, 2016). In these situations, students may be encouraged to explore and question the assumptions and beliefs that are involved in the perceived conflict with professional and ethical values (Whitman & Bidell, 2014). Kocet and Herlihy (2014) also proposed an ethical decision-making model and approach to managing values conflicts for counselors.

Finally, LGB interpersonal contact had a positive impact on LGB-affirmative counseling competence in this study. Learning activities designed to increase contact with LGB individuals, such as panel discussions or immersion experiences (e.g., Pride Festival attendance) may encourage students to consider personal views more deeply and develop new ways of understanding themselves and the world around them. Considering that counselors' self-perceived skill was correlated to the amount of counseling experience with LGB clients, it may be useful for counselor educators to find ways to diversify client demographics for practicum and internship students, including affectional orientation, to strengthen LGB-affirmative counseling skills.

Future Research

Although this study captured self-identified religiosity and spirituality through brief measures, a more robust and multidimensional measure of religiosity and spirituality is recommended for future studies. Further investigation of the intersection of counselor religiosity and spirituality is recommended because of the strong correlation between these variables, and might be best explored through qualitative studies. The specific nature of religious beliefs held by highly religious counselors was not verified and may be explored. Future researchers should also explore factors, such as developing empathy for clients, that potentially mediate the effect of prejudicial religious beliefs on LGB-affirmative counselor competence.

Conclusion

In this study, counselor spirituality was a direct predictor of LGB-affirmative counselor competence, evoking the question: What might contribute to a counselor's sense of spirituality, apart from religious doctrine or dogma that might otherwise compromise an affirming disposition toward LGB clients? Spirituality has been described as an innate capacity that moves us toward "knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness and wholeness" and contributes to our value system ("Summit Results," 1995, p. 30). Perhaps the spiritual experience of compassion and the desire for connection provides a broader understanding and embodiment of LGB-affirmative counseling practices at the human level. After all, it stands to reason that multicultural counseling competence across diverse populations stems from an inward striving for unconditional acceptance and validation of the unique experiences of others. To nurture these connections in ourselves and in our work is perhaps one of the greatest gratifications of being a professional counselor.

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Self-Efficacy, Attachment Style and Service Delivery of Elementary School Counseling

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This study explored the relationships between demographic variables, self-efficacy and attachment style with a range of performed and preferred school counseling activities in a national sample of elementary school counselors (N = 515). Demographic variables, such as school counselor experience and American School Counselor Association (ASCA) National Model training and use, were positively related to performing intervention activities that align with the ASCA National Model. Results of hierarchical regression analyses supported that self-efficacy beliefs also predicted levels of both actual and preferred service delivery of intervention activities. Interestingly, self-efficacy beliefs also predicted higher levels of performing "other" non-counseling activities that are considered to be outside of the school counselor role. An insecure attachment style characterized by high anxiety predicted a lower preference for intervention activities and also predicted the discrepancy between actual and preferred "other" non-counseling activities, revealing a higher preference for performing them.

Keywords: **school counselor, ASCA National Model, self-efficacy, attachment style, service delivery**

Professional school counselors are important contributors to education and serve an essential role in the academic, personal, social and career development of all students (American School Counselor Association [ASCA], 2012). Over the past decade, school counselors have been increasingly called upon to embrace data-driven, evidence-based standards of practice (ASCA, 2012; Erford, 2016) that bolster the achievement of all students (Shillingford & Lambie, 2010). Comprehensive developmental school counseling programs that are consistent with the ASCA National Model are currently considered best practice (ASCA, 2012) and identified as an effective means of delivering services to all students (Burnham & Jackson, 2000; Carey & Dimmitt, 2012; Gysbers & Henderson, 2012).

Data from school counseling research indicate that comprehensive developmental school counseling programs make a positive difference in student outcomes (Carey & Dimmitt, 2012; Scarborough & Luke, 2008). These programs are shown to impact overall student development positively, including academic, career and emotional development, as well as academic achievement (Fitch & Marshall, 2004; Lapan, Gysbers, & Petroski, 2001; Sink & Stroh, 2003). Furthermore, a range of individual school counselor activities and interventions is associated with positive changes in a number of important student outcomes, including academic performance, school attendance, classroom behavior and self-esteem (Whiston, Tai, Rahardja, & Eder, 2011).

However, studies examining actual school counselor practice indicate that school counselors spend a significant amount of time on activities that are not reflective of ASCA best practices, including clerical, administrative and fair share duties that take them away from performing essential school counseling activities (Bardhoshi, Schweinle, & Duncan, 2014; Burnham & Jackson, 2000; Foster, Young, & Hermann, 2005; Scarborough & Luke, 2008). A factor impeding school counselors' ability to perform activities that align with best practices includes being burdened with time-consuming tasks that are outside their scope of practice (Bardhoshi et al., 2014). This may stem from either the historically ambiguous school counselor role (Gysbers & Henderson, 2012) or from competing demands from numerous

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stakeholders who may not fully understand the components of an effective school counseling program (Bemak & Chung, 2008). Indeed, school counselors report not spending adequate time engaged in the professional activities that they prefer (Scarborough, 2005; Scarborough & Luke, 2008), even though these preferences are consistent with best practice recommendations (Scarborough & Culbreth, 2008). Therefore, for many school counselors, performing within their professional role and sticking to best practice recommendations regarding their service delivery can be challenging and stressful (McCarthy, Kerne, Calfa, Lambert, & Guzmán, 2010).

Given that school counseling program implementation and interventions that align with ASCA are associated with positive outcomes for students in a variety of domains, and that tension exists between the actual and preferred practice of school counselors, the question now becomes: What factors contribute to effective school counseling service delivery? Studies indicate a positive relationship between years of experience and school counselor practice (Scarborough & Culbreth, 2008; Sink & Yillik-Downer, 2001), as it may take several years of experience to implement the breadth and complexity of interventions in a programmatic manner. Research outside the field of school counseling also has expanded beyond demographic variables to indicate that a number of individual characteristics, such as attachment style (Dozier, Lomax Tyrrell, & Lee, 2001; Hazan & Shaver, 1987), emotional stability, locus of control, self-esteem (Judge & Bono, 2001) and self-efficacy (Judge & Bono, 2001; Larson & Daniels, 1998), are related to an individual's work performance.

To understand the underlying mechanisms that affect school counselor work performance, studies have explored potential organizational (e.g., school climate, perceived administration support), structural (e.g., training, supervision), and personal variables (e.g., experience, self-efficacy) related to counselor practice (Scarborough & Luke, 2008). Two school counselor interpersonal variables are of special focus in this study: self-efficacy and attachment. Individuals with higher levels of self-efficacy set higher goals for themselves and show higher levels of commitment, motivation, resilience and perseverance in achieving set goals (Bodenhorn & Skaggs, 2005), making the examination of school counselor self-efficacy important in investigating effective service delivery. On the other hand, attachment theory highlights the process by which early childhood development influences an individual's capacity to relate to others and regulate emotion. Many lines of theoretical and empirical research in education and psychology have examined how attachment characteristics influence adult functioning, supporting the introduction of school counselor attachment style as a factor relating to work performance (Desivilya, Sabag, & Ashton, 2006; Hazan & Shaver, 1987; Kennedy & Kennedy, 2004; Marotta, 2002). School counselor self-efficacy and attachment characteristics are personal attributes conceptualized to contribute to the ability of school counselors to perform intervention activities that align with ASCA recommendations and positively impact student development and achievement.

Self-Efficacy

Self-efficacy involves beliefs about one's own capability to successfully perform given tasks to accomplish specific goals (Lent & Hackett, 1987). As individuals confront important problems and tasks, they choose actions based on their beliefs of personal efficacy (Bandura, 1996). Self-efficacy may be a critical factor in school counselor work performance. Two meta-analytic studies of empirical research examining self-efficacy have shown that for a variety of occupations, there is a positive relationship between self-efficacy and work performance (Larson & Daniels, 1998; Stajkovic & Luthans, 1998). Studies examining school counselor self-efficacy have been a more recent addition to the literature, with reported results indicating that self-efficacy is related to school counselor gender, teaching experience (Bodenhorn & Skaggs, 2005), and supportive staff and administrators (Sutton & Fall, 1995).

In a study that extended the findings of previous self-efficacy research (Sutton & Fall, 1995), Scarborough and Culbreth (2008) examined factors that predicted discrepancies between actual and preferred practice in school counselors. Both self-efficacy beliefs and the amount of perceived administrative support predicted the difference between school counselors' actual and preferred practice, with higher levels of support and outcome expectancy predicting higher levels of preferred intervention activities performance. In the current study, we plan to extend Scarborough and Culbreth's work by examining the links between comprehensive elementary school counselor practice and overall school counselor self-efficacy while introducing attachment characteristics as a possible variable related to school counselor performance.

Attachment

Attachment theory describes how early experiences with attachment figures (e.g., mother) create inner representations referred to as *internal working models*. Those internal working models then shape patterns of behavior in response to significant others and to stressful situations (Mikulincer, Shaver, & Pereg, 2003). Adult attachment categories reflect those created in infancy and childhood and include secure, preoccupied (or anxious), dismissing (or avoidant), and fearful (both anxious and avoidant) styles (Bartholomew & Horowitz, 1991). In adults, attachment style encompasses affective responses in a variety of relationships, including co-workers, and can be activated by a number of stressful situations, including a stressful work environment (Mikulincer & Shaver, 2003, 2007).

Working effectively in a job or career contributes in meaningful ways to life satisfaction, self-esteem and social status, whereas not working effectively (and experiencing overload or burnout) can be extremely stressful and can cause serious emotional and physical difficulties (Mikulincer & Shaver, 2007). Specifically for school counselors, Wilkerson and Bellini (2006) reported that emotion-focused coping is a significant predictor of burnout, lending support to the examination of interpersonal factors in school counselor practice. To work effectively and not succumb to burnout, school counselors may have to activate self-regulatory skills associated with attachment, such as exploring alternatives, refining skills, adjusting to variation in tasks and role demands, and exercising self-control (Mikulincer & Shaver, 2007). In the field of school counseling, challenges include facing multiple demands and conflicting responsibilities (Cinotti, 2014); therefore, interpersonal communication, negotiation and adaptation become essential. Although attachment theory has received very little attention in school counseling literature (Pfaller & Kiselica, 1996), existing research suggests that various aspects of work are likely to be affected by individual differences in attachment style (Mikulincer & Shaver, 2007).

The purpose of this study was to explore demographic and interpersonal factors related to elementary school counseling practice. This research employed an associational survey research design to examine the relationships between school counselor overall self-efficacy, attachment style, and a range of performed and preferred activities in a sample of ASCA members who are elementary school counselors. Building on previous studies, we controlled for the anticipated variance in school counselor activities that might be contributed by previously identified demographic variables, including years of experience, ASCA National Model training and ASCA National Model use (Scarborough & Culbreth, 2008).

The first research question inquired about the relationship between self-efficacy beliefs and school counselor performed and preferred intervention activities that align with ASCA, controlling for the potential effect of the identified demographic variables. We hypothesized that self-efficacy beliefs would predict both school counselor preference and actual performance of these core activities, after controlling for the potential effect of relevant demographic variables. The second research question inquired about the relationship between attachment style and both counseling and non-counseling activities, controlling for the effect of the identified demographic variables. We hypothesized that school counselors who endorse higher levels of anxiety may prefer to engage in fewer intervention activities and more non-counseling activities. This could be in an effort to please others and conform to the administrative, fair share and clerical demands of the job. No hypothesis was forwarded on attachment avoidance and discrepancies between actual and preferred activities, as related research has not examined a possible relationship.

Method

Participants

The sample for this study consisted of elementary-level school counselors whose e-mail addresses were listed on the ASCA national database. We made the decision to select only elementary school counselors because of the unique emphasis on student personal and social development at this level (Dahir, 2004), as well as the distinct developmental needs of the student population that could potentially tap into school counselor attachment (Scarborough, 2005). Recruitment e-mails were sent to 3,798 ASCA member elementary school counselors through SurveyMonkey, employing a 3-wave multiple contact procedure. The original sample was adjusted to 3,550 because of undeliverable e-mail addresses. In total, 663 individuals responded to the survey, yielding a return rate of 19%. A priori power analysis using G*Power software determined that a minimum sample of 107 participants likely was necessary when conducting a multiple regression analysis with three independent variables. This G*Power calculation was based on an alpha level of .05, minimum power established at .80 and a moderate treatment effect size, and was conducted in the planning stages to inform needed sample size and minimize the probability of Type II error (Faul, Erdfelder, Buchner, & Lang, 2009). Therefore, surveys with incomplete data were completely removed from the analysis, resulting in a final sample size of 515 and a usable response rate of 14.5%.

The sample consisted of 89.6% females and 9.8% males (3 participants did not indicate gender). In terms of race and ethnicity, 86.6% were Caucasian, 6% African American, 2.9% Hispanic, 1.6% Multiracial, 1.4 % Asian/Pacific Islander, and 0.4% Native American (1.2% did not indicate race or ethnicity). The predominately female and Caucasian sample is consistent with school counseling research and reflective of the population (Bodenhorn & Skaggs, 2005).

Years of experience ranged from < 1 to 38, with a mean of 10.24 years. School enrollment ranged from 70 to 3,400 students, with a mean of 583.49 students. The large maximum enrollment number was caused by the inclusion of elementary-level counselors who were employed in K–12 schools. Counselor caseload ranged from 6 to 1,500, with the mean being 454.68 students. The mean age of respondents was 44 years, with a standard deviation of 11.02 years, and an age range spanning from 25 to 68 years. Regarding ASCA National Model (2012) training, only 8.5% reported not having received any training, with the overwhelming majority of the participants having received training from professional development opportunities sought on their own (67.6%), as part of master's-level coursework (53.2%), or through their school district (31.5%). Only 5.2% of respondents reported no use of the ASCA National Model, with 14% reporting limited use, 33.8% some use, 31.5% a lot of use, and 15% extensive use.

Instruments

Instrumentation consisted of four measures, including a demographic questionnaire, the School Counselor Activity Rating Scale (SCARS; Scarborough, 2005), the School Counselor Self-Efficacy Scale (SCSE; Bodenhorn & Skaggs, 2005) and the Experiences in Close Relationships Scale-Short Form (ECR-Short Form; Wei, Russell, Mallinckrodt, & Vogel, 2007).

Demographic questionnaire. A demographic questionnaire consisting of 14 questions collected relevant information regarding participant age, gender, ethnicity, region, school setting (i.e., private, public) and level (e.g., elementary, middle), student enrollment, counselor caseload characteristics, degree earned, licensure and certification, years of experience and training in and use of the ASCA National Model. Demographic data were selected for inclusion based on a literature review indicating important relationships between these variables and school counseling outcomes (Scarborough & Culbreth, 2008; Sink & Yillik-Downer, 2001).

School Counselor Activity Rating Scale (SCARS). The SCARS is a 48-item scale reflecting best practice recommendations for school counselors based on the ASCA National Standards (Campbell & Dahir, 1997) and the ASCA National Model (ASCA, 2003). It was designed to measure the frequency with which school counselors perform specific work activities, and the preferred frequency of performing those activities (Scarborough, 2005; Scarborough & Culbreth, 2008). The instrument contains five sections—counseling, consultation, curriculum, coordination and "other" activities. Participants indicate their actual and preferred performance of common school counseling activities on a frequency scale (1 = *rarely do this activity* to 5 = *routinely do this activity*), including "other" non-counseling activities that fall outside the school counselor role (e.g., coordinate the standardized testing program). A SCARS total score is calculated by adding the totals from each subscale or calculating mean scores, with higher scores indicating higher levels of engagement.

The SCARS validation study supported a four-factor solution representing the counseling, coordination, consultation and curriculum categories. Analysis on the "other" school counseling activities subscale, consisting of 10 items reflecting non-counseling activities, resulted in three factors: clerical, fair share and administrative. Convergent and discriminant construct validity also were reported (Scarborough, 2005). Cronbach's alpha reliability coefficients, as reported by Scarborough on the eight subscales of actual and preferred dimensions, were .93 and .90 for curriculum; .84 and .85 for coordination; .85 and .83 for counseling; .75 and .77 for consultation; .84 and .80 for clerical; .53 and .58 for fair share; and .43 and .52 for administrative. In the current study, the Cronbach's alpha coefficients for actual and preferred practice were .90 and .83 for curriculum; .84 and .86 for coordination; .80 and .81 for counseling; and .76 and .73 for consultation.

The intervention total subscale in our study consisted of the composite of the counseling, consultation, curriculum and coordination subscales, with Cronbach's alpha reliability coefficients of .91 on both the actual and the preferred use dimensions. Similar to Scarborough (2005), the "other" duties subscale, consisting of clerical, fair share and administrative duties, had moderate reliability, with Cronbach's alpha of .63 on the actual, and .68 on the preferred. The activities total subscale consisted of a combination of all SCARS subscales, with Cronbach's alpha being .89 on the actual and .90 on the preferred. Various studies have been conducted since the initial validation of the SCARS and support its use as a tool yielding valid and reliable school counselor process scores (Scarborough & Culbreth, 2008; Shillingford & Lambie, 2010).

School Counselor Self-Efficacy Scale (SCSE). The SCSE (Bodenhorn & Skaggs, 2005) is a 43-item self-report instrument designed to measure school counselor self-efficacy. The SCSE uses a 5-point Likert-type scale to measure responses (ranging from 1 = *not confident* to 5 = *highly confident*) and consists of five subscales: personal and social development; leadership and assessment; career and academic development; collaboration; and cultural acceptance. A composite mean is calculated to demonstrate overall self-efficacy. SCSE responses were evaluated for reliability, omission, discrimination and group differences (Bodenhorn & Skaggs, 2005), with results supporting high reliability for the composite scale (α = .95). Analyses also indicated group differences demonstrating score validity for the scale—

participants who had teaching experience, had been practicing for three or more years, and were trained in and used the ASCA National Standards reported higher levels of self-efficacy. The total scale SCSE alpha in the current study was .96.

Experiences in Close Relationships Scale (ECR)-Short Form. The ECR-Short Form (Wei et al., 2007) is a 12-item self-report measure designed to assess a general pattern of adult attachment. The ECR-Short Form is based on the longer Experiences in Close Relationship Scale (Brennan, Clark, & Shaver, 1998). Factor analysis revealed two dimensions of adult attachment, anxiety and avoidance, which have received professional consensus (Bartholomew & Horowitz, 1991; Mikulincer & Shaver, 2003). High scores on either or both of these dimensions are indicative of an insecure adult attachment orientation. Low levels of attachment anxiety and avoidance indicate a secure orientation (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Lopez & Brennan, 2000; Mallinckrodt, 2000).

Internal consistency was adequate with coefficient alphas from .77 to .86 for the anxiety subscale and from .78 to .88 for the avoidance subscale, and confirmatory factor analyses provided evidence of construct validity with a two-factor model (i.e., anxiety and avoidance), indicating a good fit for the data. Reported test-retest reliabilities averaged .83. For the current study, ECR-S alphas were .75 for the anxiety subscale and .81 for the avoidance subscale.

Data Analysis

Data were analyzed using the Statistical Package for Social Sciences (SPSS Version 18), with multiple hierarchical regressions used to answer both research questions. Hierarchical regression was selected to determine the relative importance of the predictor variables, over and above that which can be accounted for by other previously identified predictors regarding school counselor service delivery (i.e., years of experience, ASCA National Model training and ASCA National Model use). Predictor variables included self-efficacy beliefs (SCSE total score), attachment anxiety (ECR-Short Form Anxiety subscale) and attachment avoidance (ECR-Short Form Avoidance subscale). Outcome variables included actual (SCARS total Actual scale) and preferred (SCARS total Preferred scale) intervention activities, "other" non-counseling activities (SCARS Other Activities scale) and the discrepancy between actual and preferred intervention and "other" activities.

Prior to analysis of the research questions, correlations were conducted among the predictor and outcome variables. Identified predictors (i.e., years of experience, ASCA National Model training and ASCA National Model use) were also correlated with the SCARS criterion variables. For the hierarchical regression, identified predictors were entered first as a block, followed by the new predictors included in this study (Field, 2009). This predetermined order of entry is congruent with Cohen and Cohen's (1993) recommendations for using hierarchical regression and entering the demographic variables in the initial step. Additionally, the order of entry reflected the principle of presumed causal priority (Cohen & Cohen, 1993; Petrocelli, 2003). For the second step, we decided to enter attachment anxiety prior to avoidance, as we anticipated it would be more important in predicting the outcome variables (Field, 2009). Reported effect size estimates reflect the following guidelines: r of .1 (small), .3 (medium) and .5 (large); and R2 of .01 (small), .09 (medium) and .25 (large; Cohen, 1988).

Results

We first examined the correlation among the identified school counselor demographic variables (control variables) and the actual and preferred SCARS variables. Years of experience showed a small but significant positive correlation with actual intervention activities ($r = .20$, $p < .05$). ASCA National Model use showed a moderate positive correlation with actual intervention activities ($r = .44$, $p < .05$), but smaller relationships with preferred intervention activities ($r = .15$, $p < .05$). Additional correlation analysis revealed relationships among school counseling experience and the main predictor variables that were of interest in this study. For example, years of experience showed a significant, although small, negative correlation to attachment anxiety ($r = -.14$, $p < .05$). Both attachment anxiety and avoidance showed negative correlations to self-efficacy ($r = -.20$ and $-.15$, $p < .05$, respectively). Lastly, self-efficacy showed a small positive correlation with years of experience ($r = .25$, $p < .05$) and ASCA National Model use ($r = .27$, $p < .05$).

Self-Efficacy Predicting Actual and Preferred Intervention and Other Activities

Multiple hierarchical regression analyses were conducted to determine if self-efficacy was positively associated with actual and preferred intervention activities, after controlling for demographic variables (see Table 1). Self-efficacy was the predictor variable and actual and preferred intervention activities were the criterion variables in separate analyses. Because years of experience, ASCA National Model training and ASCA National Model use were correlated with the SCARS criterion variables, these control variables were entered as a block prior to entering self-efficacy beliefs. The model for actual activities was significant: $F(1, 506) = 112.37$, $p < .05$, supporting the hypothesis. The standardized beta between self-efficacy and actual intervention activities was .40 and the effect size based on the adjusted $R2$ statistic indicated that 37% of the variance in actual activities was accounted for by self-efficacy, after blocking for the control variables, a large effect size. Results for preferred school counselor activities showed a similar result, as the model for preferred activities also was significant: $F(1, 506) = 78.59$, $p < .05$. The standardized beta between self-efficacy and preferred intervention activities was .39, and the adjusted $R2$ indicated 15% of the variance in preferred activities was accounted for by self-efficacy, after blocking for the control variables, a medium effect size.

Table 1.

Results from hierarchical multiple regression using self-efficacy to predict SCARS actual and preferred intervention activities

	Block 1			Block 2		
Predictor Variable	B	SE B	β	B	SE B	β
Actual						
Experience (years)	0.01	0.00	0.20*	0.01	0.01	0.10*
A.N.M. Training	-0.02	0.03	-0.60	-0.02	0.03	-0.03
A.N.M. Use	0.22	0.02	0.44*	0.17	0.02	0.34*
Self-Efficacy				0.45	0.04	0.40*
R^2	0.23			0.37		
F for change in R^2	50.46*			112.37**		
Preferred						
Experience (Years)	0.00	0.00	0.04	-0.00	0.00	-0.05
A.N.M. Training	-0.00	0.03	-0.01	-0.01	0.03	-0.01
A.N.M. Use	0.06	0.02	0.15*	0.02	0.02	0.05
Self-Efficacy				0.37	0.04	0.39**
R^2	0.02			0.15		
F for change in R^2	3.92*			78.59*		

Note: Analysis $N = 511$ (actual & preferred); * $p < .05$. A.N.M. denotes ASCA National Model.

Similar hierarchical multiple regression analyses were conducted using school counselor self-efficacy as the predictor variable and "other" school counseling activities as the criterion variable, after controlling for demographic variables (see Table 2). The models for preferred and actual "other" activities were both significant; $F(1, 506) = 20.89$, $p < .05$; and $F(1, 506) = 13.60$, $p < .05$, respectively. The standardized beta for actual "other" activities was .21 and for preferred "other" activities was .17. Self-efficacy accounted for (R^2 =) 43% of the variance in actual "other" activities performed and (R^2 =) 33% of preferred "other" activities, indicating large effect sizes.

Table 2.

Results from hierarchical multiple regression using self-efficacy to predict SCARS actual and preferred "other" non-counseling activities

	Block 1			Block 2		
Predictor Variable	B	SE B	β	B	SE B	β
Actual						
Experience (Years)	0.00	0.00	0.02	-0.00	0.00	-0.03
A.N.M. Training	0.04	0.04	0.05	0.04	0.04	-0.05
A.N.M. Use	-0.04	0.03	-0.06	-0.07	0.03	-0.11
Self-Efficacy				0.29	0.06	0.21*
R^2	0.00			0.43		
F for change in R^2	0.63			20.89*		
Preferred						
Experience (Years)	0.01	0.00	0.07	0.00	0.00	0.03
A.N.M. Training	-0.02	0.04	-0.03	-0.02	0.04	-0.03
A.N.M. Use	-0.00	0.03	-0.0	-0.00	0.03	-0.00
Self-Efficacy				0.22	0.06	0.17*
R^2	0.02			0.33		
F for change in R^2	1.13			13.60**		

Note: Analysis $N = 511$ (actual & preferred); * $p < .05$. A.N.M. denotes ASCA National Model.

Attachment Predicting Actual and Preferred Intervention and "Other" Activities

Hierarchical multiple regressions were used to assess the ability of attachment style to predict school counselor interventions and "other" non-counseling activities, after controlling for demographic variables. In our study, attachment style was measured by the ECR-Short Form (Wei et al., 2007) on two dimensions—attachment anxiety and avoidance. As in the regression analyses for counselor self-efficacy, years of experience, ASCA National Model training and ASCA National Model use were entered as a block prior to entering attachment anxiety and avoidance. Attachment anxiety, but not attachment avoidance, revealed predictive utility for the SCARS preferred intervention subscale scores, showing a negative relationship: $F(1, 505) = 2.60$, $p < .05$. The standardized beta for preferred intervention activities was -.11 and attachment anxiety accounted for only 2% of the variance for preferred intervention activities, a small effect size.

To test whether attachment anxiety was associated with discrepancies between a range of actual and preferred school counseling activities, separate regression analyses were performed. We used attachment anxiety and attachment avoidance as the predictor variables and the discrepancy score variables that were created by subtracting the actual from the preferred scores for the actual and preferred intervention activities and "other" activities subscales. As before, years of experience, ASCA National Model training and ASCA National Model use were correlated with the SCARS criterion variables and were entered as a block prior to entering the attachment variables. For intervention activities, a relationship was not supported for either attachment anxiety or attachment avoidance. However for the "other" non-counseling activities, a relationship between attachment anxiety and the actual/preferred discrepancy revealed a statistically significant result over and above that accounted for by demographic variables: $F(1, 505) = 3.16$, $p < .05$ with a standardized beta of .12. Therefore, attachment anxiety predicted a discrepancy that revealed a higher preference for performing "other" non-counseling activities. However, the effect size showed that anxiety accounted for only 1% of the variance in the "other" activities discrepancy score (see Table 3).

Table 3

Results from hierarchical multiple regression using attachment to predict SCARS intervention scores and the actual/prefer discrepancy scores for intervention and "other" activities

	Block 1			Block 2			Block 1			Block 2		
Predictor Variable	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β
	Intervention Actual						*Intervention Discrepancy*					
Experience (years)	0.01	0.00	0.20*	0.02	0.00	0.19*	-0.01	0.00	-0.18*	-0.01	0.00	-0.18*
A.N.M. Training	-0.02	0.03	-0.03	-0.02	0.02	-0.02	0.01	0.03	0.02	0.02	0.03	0.02
A.N.M. Use	0.22	0.02	0.44*	0.22	0.02	0.44*	-0.16	0.02	-0.34*	0.16	0.02	0.34*
Anxiety				-0.03	0.02	-0.06				-0.01	0.02	-0.03
Avoidance				0.01	0.02	0.02				0.00	0.02	-0.01
R^2		0.23		0.00			0.15			0.00		
F for change in R^2	50.46*			0.34			29.69*			0.33		
	Intervention Preferred						*"Other" Discrepancy*					
Experience (years)	0.00	0.00	0.04	0.00	0.03	0.02	0.04	0.03	0.06	0.03	0.03	0.04
A.N.M. Training	0.00	0.03	-0.01	0.00	0.03	0.00	-0.61	0.31	-0.10*	-0.57	0.31	-0.09
A.N.M. Use	0.06	0.02	0.15*	0.06	0.02	0.14*	0.57	0.24	0.12*	0.57	0.23	0.12*
Anxiety				-0.05	0.02	-0.11*				-0.58	0.23	0.12*
Avoidance				0.01	0.02	0.02				0.29	0.25	0.06
R^2	0.02			0.01			0.02			0.01		
F for change in R^2	3.92*			2.6			3.21*			3.16*		

Note: Analysis $N = 511$ (actual & preferred); * $p < .05$. A.N.M. denotes ASCA National Model.

Discussion

To date, few studies have examined how school counselor personal characteristics are linked to successful programs (Scarborough & Luke, 2008). Using a nationwide sample, we examined how self-efficacy is related to a range of school counselor activities in elementary schools and introduced attachment style as a potential variable related to school counselor practice. Years of experience working as a school counselor as well as the training in and use of the ASCA National Model in program implementation were identified from the literature as variables of importance and were included in our analyses.

As anticipated the number of years of experience was related to actual performance of intervention activities by school counselors. Also, school counselors in this sample who had received more training in the ASCA National Model were more likely to perform the intervention activities of counseling, consultation, curriculum and coordination. These activities are considered core activities for effective program implementation. Furthermore, counselors who endorsed more fully implementing the ASCA National Model within their program were significantly more likely to perform these core intervention activities and also indicated a preference for spending their time in these activities. This result is in line with previous findings supporting that counselors who incorporated the National Standards for School Counseling Programs (Campbell & Dahir, 1997) into their programs were more likely to have preferences that aligned with professional standards and actually practiced as they preferred (Scarborough & Culbreth, 2008). It is promising that over 75% of school counselors in the current study reported *some use* to *extensive use* of the ASCA National Model. The large number of counselors who reported ASCA National Model use could be indicative of a recent focus to define standards of practice and increase positive student outcomes through systematic and programmatic delivery. With regard to non-counseling activities, results did not support a relationship with ASCA National Model training and use.

Looking beyond the demographic variables, the findings of the current study support previous research that found important links between school counselor self-efficacy beliefs and program implementation (Bodenhorn, Wolfe, & Airen, 2010). In the current study, overall school counselor self-efficacy beliefs predicted the delivery of activities aligned with the ASCA National Model above and beyond the demographic variables analyzed. School counselors who believed they were capable of performing in accordance with activities aligned with the ASCA National Standards were more likely to actually perform and want to perform school counseling intervention activities consistent with the ASCA National Model.

It is interesting to note that school counselors with higher self-efficacy beliefs were more likely to perform non-counseling activities when compared to counselors with lower self-efficacy. These results suggest that counselors with higher levels of self-efficacy beliefs may not discriminate between intervention and "other" non-counseling activities, by performing both more frequently. Highly efficacious school counselors may simply do more, whether or not the activity aligns with ASCA recommendations. As demands for school counselors increase and current expectations for school counselors do not perfectly align with professional best practices (Cinotti, 2014), highly efficacious school counselors may tackle all duties earnestly in order to address their responsibilities.

In the current study, attachment anxiety negatively predicted school counselor preferred engagement in intervention activities (i.e., counseling, consultation, curriculum, coordination), indicating that anxiously attached school counselors actually preferred to perform fewer intervention activities. Additionally, school counselor attachment anxiety predicted a discrepancy between actual and preferred activities that are considered outside the scope of school counseling practice, including clerical, administrative and fair share responsibilities. When considering the relationship between attachment anxiety and this discrepancy, which revealed a higher preference for performing these "other" activities, there are a few possible explanations. Perhaps anxiously attached counselors reporting a greater discrepancy on the "other" subscale find it more difficult to align their identity with the counseling professional identity model promoted by ASCA. Although these non-counseling activities do not align with ASCA recommendations, they are nevertheless expected and valued by supervisors. Research has suggested that anxiously attached individuals may tend to take on additional work obligations as a way to please others and tend to be motivated by approval of colleagues and supervisors (Hazan & Shaver, 1987). Additionally, anxiously attached workers seek close relationships with their colleagues and supervisors and have more difficulty resisting unreasonable demands in the workplace (Leiter, Day, & Price, 2015). Given that school administrators directly influence the assignment of inappropriate duties performed by school counselors, and that strong advocacy and leaderships skills are essential to negotiate an identity and role that is more aligned with ASCA recommendations (Cinotti, 2014), anxiously attached school counselors may find it more difficult to test those relationships and may instead endorse the identity expected by their supervisors. Indeed, the literature points out that school administrators perceive school counselors as operating mainly from an educator—versus a counselor—professional identity (Cinotti, 2014).

There was a low variability in attachment scores of this particular sample (i.e., school counselors endorsed relatively high levels of self-efficacy and low levels of attachment insecurity), which could have contributed to the results of this research. Within the clinical training component of their education, school counselors are taught the importance of ongoing self-exploration and to develop awareness of their responses within the context of clinical practice. It is possible that education and training in the importance of self-awareness could interrupt effects on school counselor practice that are related to higher levels of attachment anxiety.

Counselors in this sample consistently indicated that they preferred to spend more time in intervention activities that are in keeping with best practices and are related to positive outcomes for students and preferred to spend less time in non-counseling related activities. When compared to other research using the SCARS, they also reported engaging in fewer non-counseling activities. As performing non-counseling activities is associated with burnout in school counselors (Bardhoshi et al., 2014), this is a positive finding that might be reflective of the current direction of the profession.

Study Limitations

The potential for self-selection and social desirability bias was a limitation of this study. Only elementary school counselors who were ASCA members were invited to participate. It is possible that those members who did volunteer to participate may differ in a variety of ways from those individuals who did not respond. Given the $115 membership fee to join the association, it is possible that counselors from wealthier school districts, with higher salaries or access to a counseling budget assisting with the membership fee, are more heavily represented. School counselors who chose to become members of ASCA may vary distinctly in work-related performance, self-efficacy beliefs and attachment style than those counselors who chose not to become members of the association. ASCA members likely have more professional development opportunities and more exposure to information regarding best practices, which could impact both their self-efficacy beliefs and practice.

Despite our use of multiple contact procedures to obtain an acceptable response rate, a limitation worth noting is the lower response rate. Lower response rates are often noted for online surveys (Dillman, Smyth, & Christian, 2014), including in the field of counseling (Granello & Wheaton, 2004).

Although we received over 200 undeliverable e-mails, which reduced the original sample size, there is no way to accurately estimate how many individuals actually received the survey in their inbox (Granello & Wheaton, 2004). It is indeed possible that spam-filtering software resulted in many invitations not reaching their intended recipients. Therefore, our reported response rate represents a conservative estimate (Vespia, Fitzpatrick, Fouad, Kantamneni, & Chen, 2010). In addition, it was assumed that the attrition of 100 participants was likely the result of the time required to complete the survey. Our analysis supported that there were no statistically significant differences between the two groups (i.e., completers and non-completers) on demographic variables and that our final sample size was adequate for the selected statistical tests. However, readers should use caution when generalizing the results of this study to all elementary school counselors. A final consideration is that causal relationships cannot be derived from the results of this study, as the research design was relational in nature.

Implications for School Counseling Practice

Previous studies have indicated that higher levels of school counselor self-efficacy are positively associated with higher levels of comprehensive program implementation (Bodenhorn et al., 2010). For many, the route to increased self-efficacy is through personal and vicarious accomplishments (Bodenhorn et al., 2010; Scarborough & Culbreth, 2008; Sutton & Fall, 1995). Therefore, opportunities to learn and practice the skill set specific to school counseling must be promoted in the education and training of students.

School counselor educators have a crucial role in ensuring that future school counselors have a strong foundation with which to begin their careers. Counselor education programs have often not provided adequate preparation for school counselors because there has been incongruence between their training and their actual roles in schools (McMahon, Mason, & Paisley, 2009). A novice school counselor who has had education and training that is consistent with his or her actual work role will have greater chances of acquiring increased self-efficacy from the start. In a cascade, self-efficacy will likely promote stronger program implementation and, in turn, positive student outcomes.

More specifically, requiring trainees to provide a range of services will support the transition from training to work. Trainees need opportunities to provide specific interventions (e.g., counseling individuals and groups, teaching classroom lessons) while also evaluating the impact of these interventions, teaching them how to use data in their programs and potentially boosting self-efficacy beliefs (Akos & Scarborough, 2004). Trainees should also be given opportunities to engage in coordination activities to gain experience in the organizational aspects of a comprehensive developmental school counseling program. Finally, counselor educators who supervise internship courses must maintain strong communication with site supervisors to ensure continuity and appropriate trainee experiences.

Although effect sizes related to attachment characteristics in this study were small, they imply that attachment theory could be a useful adjunct to understanding school counselor practice. Using attachment concepts as a guide for supervision or structured professional development opportunities could assist school counselors' ongoing efforts to understand their own behavior and motivations in the work setting. Graduate coursework specific to attachment constructs has the potential to be a useful component of school counselor education, especially because the cultivation of healthy interpersonal relationships has a tremendous potential to facilitate positive change in schools.

Recommendations for Future Counseling Research

The moderately strong association in this study between school counselor self-efficacy and activities recommended by the ASCA National Model indicates that understanding the factors affecting school counselor self-efficacy warrants further attention. Research outside the field of school counseling has identified a positive relationship between attachment security and higher levels of competence and self-efficacy beliefs (Mikulincer & Shaver, 2007). Given that self-efficacy was significantly negatively correlated to both attachment anxiety and avoidance in this study, additional studies examining these relationships may clarify possible connections between school counselor self-efficacy beliefs and attachment characteristics. We did not examine whether SCSE subscales were differentially related to school counselor activities. Doing so could identify professional areas about which counselors feel most efficacious and those that need bolstering. Explaining the reasons some school counselors perform more successfully is an enduring goal of counseling research (Sutton & Fall, 1995).

Our results did indicate significant relationships between attachment anxiety and school counselor practice. Specifically, attachment anxiety predicted a lower preference for intervention activities, as well as a discrepancy between actual and preferred "other" non-counseling activities that revealed a higher preference for performing them. Although small, these results could lead to further understanding of the factors related to differences in school counselor practice. As this study has taken a broad view of how school counselor practice could be affected by attachment dimensions, qualitative studies examining the unique experiences of anxiously attached counselors in their work environment have the potential to reveal important perspectives. Identifying how attachment style may contribute to the endorsement and performance of specific intervention activities could lead to a greater understanding of school counseling practice.

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Metaphor in Professional Counseling

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Metaphors are linked to how individuals process information and emotions, and they are important to understand and utilize in counseling. A description of the structure of metaphors and metaphor theory is provided. The role of metaphors in emotional processing is explained, and the process of counseling is tied to the therapeutic usage of metaphors. Building from that information, approaches to using metaphors in counseling are described, and metaphors are divided into client-generated and counselor-generated categories, with corresponding information on how metaphors can be used in the counseling process. The counseling process is then separated into categories of exploration, insight and action, and descriptions of metaphor usage along with composite case examples are provided for each category to show how incorporating metaphors in clinical practice can be therapeutically beneficial in supporting positive client changes.

Keywords: **metaphor, exploration, insight, action, emotional processing**

Metaphorical language occurs commonly in communication, with a study by Steen, Dorst, Herrmann, Kaal, and Krennmayr (2010) finding that metaphoric language is used 18.6% of the time in academic writing, 11.8% in fiction and 7.7% in conversation. Examples of types of metaphoric language that may commonly appear in conversation are: *she rushed to his defense* (in the context of arguing on his behalf), *she broke down and cried* and *when I walked into the house, she attacked me for not calling to say I would be late* (in this case meaning that she was upset and spoke in a harsh manner). In these examples, the metaphors are *rushed to his defense*, *broke down*, and *attacked*. These words are not literal descriptions but instead use descriptions of physical processes to metaphorically describe emotional and verbal activities. These metaphors might appear in clients' normal speech and may be commonly overlooked as being metaphoric. The frequency of these metaphors in language provides opportunities for greater exploration and understanding of clients. Research findings also support metaphors occurring at a higher rate when describing emotions and discussing emotional experiences, making metaphors even more important for counselors to recognize and address (Fainsilber & Ortony, 1987; Lubart & Getz, 1997; Samur, Lai, Hagoort, & Willems, 2015; Smollan, 2014).

Metaphors are not simply a linguistic or literary device; they play an important role in learning and cognitively organizing an understanding of the world (Aragno, 2009; Evans, 2010; Lakoff & Johnson, 1980). The importance of metaphors for learning and understanding is a prime reason for counselors to be conversant in metaphors and their uses in counseling. Counseling involves supporting clients in learning and understanding so they can make changes that enable them to reach their goals. Recognizing and working with client metaphors can be beneficial for professional counselors, as there is research supporting metaphor frequency and types varying in relation to emotional changes (Gelo & Mergenthaler, 2012; Tay, 2012; Wickman, Daniels, White, & Fesmire, 1999). Therefore, clients' metaphors can provide insight into their emotional states and how they are conceptualizing their situations. In addition, metaphors can be used in treatment interventions and for monitoring changes in client conceptualizations and emotions over the course of treatment (Gelo & Mergenthaler, 2012; Kopp & Eckstein, 2004; Lakoff & Johnson, 1980; Sims, 2003; Tay, 2012). However, to effectively use metaphors in counseling practice, it is helpful to understand the basic

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terminology and structure of metaphors, as this allows the counselor to recognize metaphor types associated with increased emotional processing and the integration of new awareness (Gelo & Mergenthaler, 2012; Lakoff & Johnson, 1980; Tay, 2012). Therefore, this manuscript begins with a brief description of metaphor structure and forms so that the later sections linking metaphors to emotional states and changes and providing approaches for working with metaphors in counseling are more understandable and useful.

Metaphor Structure

Metaphors are a symbolic approach for implying similarity between experiences, thoughts, emotions, actions or objects (Evans, 2010; Seitz, 1998). The structure of a metaphor can be broken down into two domains, the target domain and the source domain. The target domain refers to the concept the metaphor is being used to *explain*. The source domain is the concrete topic to which the target domain is being *linked*. By combining the two domains in a metaphoric expression, an understanding of the target domain's properties is established. The description of properties through the relationship between domains is referred to as *conceptual mapping* (Tay, 2012). For example, within the metaphor, *she is on fire*, *she* is the target domain and *fire* is the source domain. Through the linkage of these domains, the *she* referred to is understood to have qualities like that of a *fire*—in this case, an intense energy.

Metaphors are further classified as having forms that are either simple or complex and either conventional or unconventional. Simple metaphors have one target and one source domain, and complex metaphors have one target with more than one source domain (Lakoff & Johnson, 1980). Conventional metaphors are those that are commonly used within a culture, and unconventional metaphors are those that are not commonly used (Lakoff & Johnson, 1980).

Metaphors and Emotional Change

The process of counseling requires a focus on the emotional experience of clients. Clients' emotions guide the counselor to what is most affecting and important to clients, so the counseling process often involves developing clients' recognition of emotional patterns and needs, as well as the generation of new emotional perspectives. Because emotions are at the heart of counseling, the specific connection between emotions and metaphors needs exploration. Research has shown that metaphor usage is connected to emotional change, and specifically, there is support for an increased occurrence of metaphors when talking about emotions, especially intense emotions (Crawford, 2009; Fainsilber & Ortony, 1987). Lakoff and Johnson (1980) described metaphor as an approach for conceptualizing the experience of emotion in a form that is relatable to other individuals. Metaphor is viewed as a way to cognitively organize the emotional experience (Crawford, 2009; Lakoff & Johnson, 1980). It is possible that intense emotions are an experience not directly relatable to other individuals without references, and this may explain research evidence supporting an increased use of metaphor when describing intense emotional experiences (Crawford, 2009; Smollan, 2014). In addition to the possible need for source domains as references to describe intense emotions, metaphors may be ideal for relating emotional experiences because of their ability to encapsulate specific and content-rich information in a concise and broadly understandable manner (Fainsilber & Ortony, 1987).

The link between metaphor and emotion is supported by a number of studies showing that when comparing literal and metaphoric language with the same intended meaning and emotional valence, metaphoric language is related to greater activation of brain regions (particularly the left amygdala) associated with emotion (Bohrn, Altmann, & Jacobs, 2012; Citron & Goldberg, 2014; Citron, Güsten, Michaelis, & Goldberg, 2016) along with higher participant ratings of the emotion contained in metaphor (Fetterman, Bair, Werth, Landkammer, & Robinson, 2016; Mohammad, Shutova, & Turney, 2016). Connecting these findings more directly with counseling practice, Fetterman et al. (2016) found that having participants write metaphorically about personal experiences significantly reduced negative affect in comparison to a control condition in which participants were writing literally about personal experiences. For those participants who wrote metaphorically, there was an increased preference for metaphor usage. These findings support the theory that metaphors are linked to emotional processing and provide more backing for counselors addressing and working with metaphors in counseling.

One additional study that provides a lens into metaphors in counseling practice was conducted by Gelo and Mergenthaler (2012). They performed single-subject research investigating whether the type of metaphor (unconventional or conventional) and frequency of metaphor use were related to client change in counseling. This research was based on previous studies suggesting that unconventional metaphors occur more frequently when clients are involved in emotional and cognitive change processes (Gelo & Mergenthaler, 2012). Gelo and Mergenthaler found that client metaphor usage was associated with periods of emotional and cognitive change, and the client used more unconventional metaphors when *reflecting* on emotional change, but not while *experiencing* emotional change. Though it is hard to generalize from a small study, this is an important observation that supports the conceptual idea that metaphors are used to organize emotional experiences and integrate the experiences with the cognitive domain (Crawford, 2009; Lakoff & Johnson, 1980).

Taken in combination, studies examining the relationship between metaphor and emotion indicate that metaphors are linked to processing and communicating emotion, which makes metaphors important for counselors to understand, address and utilize. These studies also suggest that metaphors may have an important role for counselors who are supporting emotional change in clients. Therefore, these research findings inform recommendations for integrating metaphors into counseling.

Metaphor Sources and Approaches

Metaphors in counseling come from two sources, the client and the counselor. The source of the metaphor is important to consider when describing approaches to working with metaphors in clinical practice; thus, client-generated and counselor-generated metaphors will be discussed separately.

Client-Generated Metaphors

The nature of client-generated metaphors can allow for assessment of clients (Gelo & Mergenthaler, 2012; Stewart & Barnes-Holmes, 2001; Wickman et al., 1999). This assessment may only consist of recognizing how clients are conceptualizing experiences, but it also may involve working directly with metaphors to better understand relationships. Noticing the increased usage of complex and unconventional metaphors may be helpful for recognizing when clients may benefit from greater support and conceptual assistance to integrate new concepts or behaviors and explore emotions (Gelo & Mergenthaler, 2012).

To work directly with metaphors in counseling, several approaches are helpful. Kopp and Craw (1998) and Sims (2003) offered similar models with steps to facilitate insight using client-generated metaphors. Both models begin by having the counselor ask the client to elaborate on the metaphor and then follow up by asking the client questions to provide more detail, including emotions connected to the metaphor. Following client elaboration, additional questions and reflections from the counselor support the generation of client insight. To reinforce insight and apply it to the current situation, Kopp and Craw's model has the client imagine changes in the metaphor that support counseling goals, whereas Sims' model directs the client to connect the metaphor with past experiences and future goals. Both models describe the use of basic counseling skills to address client metaphors and are easily incorporated into counseling work. An important takeaway regarding client metaphors is that metaphors have significance for the client and are appropriate for exploration in counseling (Tay, 2012; Wickman et al., 1999).

Another approach for working with metaphors in counseling practice was described by Tay (2012), who identified two types of metaphor processing in counseling that can be selectively used based on the purpose of the metaphor exploration. The first type is *correspondence processing*. Correspondence processing requires exploring the entailments of metaphors. The term *entailments* refers to a layering and transfer of meaning in the relationship between the symbols in the metaphor. The entailments are the associations and properties of the domains in the metaphor that are not specifically used in the metaphor (Lakoff & Johnson, 1980). For instance, *she is on fire* might be used to indicate that *she* is energetically accomplishing a lot, but could also have entailments of meaning related to *fire* being culturally associated with destruction and being difficult to control.

Correspondence processing describes the cognitive combining of properties between target and source domains as a conceptual mapping that equates the entailments of both domains to facilitate thinking about and using the metaphor in a variety of forms. An exploration of the entailments of those metaphors is often necessary for correspondence mapping and is accomplished by expanding upon the metaphor. To expand on the metaphor, additional descriptions of content related to the metaphor are generated. For example, if the metaphor, *love is a journey*, is used for correspondence processing, then the expansion might include asking the client for descriptions of journeys that may elicit information such as: *there are rough roads in the journey*, *there are fellow travelers* and *sometimes it is necessary to find shelter*. These descriptions could map back to love to indicate that, respectively, relationships can be emotionally difficult, two people come together when in love, and breaks from relationships are sometimes necessary.

The second type of cognitive processing is *class inclusion*. Class inclusion refers to a linking of the target and source domain through the core conceptual properties of the domains without expanding the metaphor to understand entailments (Tay, 2012). For instance, in the metaphor example used above, *love is a journey*, a class inclusion processing would involve asking the client what is important about a journey. Those responses might include *needing time to get to a destination* and *the acceptance of risk in moving toward the destination*, and then those responses would be applied to love. This would indicate that love requires an acceptance of risk and a willingness to put in the time in order to achieve love. In this process, the linking of each entailment of the source domain to the target domain is not necessary; instead, broader concepts that connect the domains are the focus.

Counseling use of these approaches is based on client and therapeutic needs. For complex concepts that need to be better understood, metaphors may be shaped in a manner consistent with correspondence and processed as such, whereas for communicating core messages and principles, class inclusion may be preferable (Tay, 2012). These two approaches are both important for metaphor-based interventions because they provide two directions for exploration—understanding core messages or increasing understandings of the relationships and context surrounding the concept being described in metaphor (Tay, 2012). Exploring client metaphors using counseling skills and guided by the conceptual frameworks described above can increase understanding and awareness in both clients and counselors.

Counselor-Generated Metaphors

Counselor-generated metaphors involve the use of metaphors to intentionally support the therapeutic process. The application of metaphors by counselors can occur through the reintroduction of metaphors first generated by clients but with changes to support therapeutic growth, or the sharing of new metaphors as a way to help clients recognize thoughts, feelings and behaviors, or understand and integrate new concepts and behaviors (Millikin & Johnson, 2000; Tay, 2012; Wickman et al., 1999). The metaphors may be short and involve a very clear target and source domain, or they can be as long and complex as stories. In addition, depending on a client's ability to understand and recognize metaphor and the purpose for which the metaphor is intended, the exploration of the metaphor may be brief or more involved (Millikin & Johnson, 2000; Tay, 2012; Wickman et al., 1999).

One specific type of introduced metaphor is the *disquisition*, a narrative form of metaphor (Millikin & Johnson, 2000). Disquisitions are stories that involve similar interactions and concerns as those of clients because they are developed or adopted specifically for the therapeutic needs of the client. These stories take many forms, including fictional stories of other clients in counseling and fairy tale-type stories, though the stories need to closely relate to the client's issue. The purpose of these stories is to normalize the client's experience, increase insight, deepen emotions and facilitate new perspectives (Millikin & Johnson, 2000). This is a very deliberate therapeutic usage of metaphor that generally requires a reservoir of stories to draw from for particular situations or the very adaptive and creative generation of appropriate stories.

Another approach is to use client-generated metaphors as a starting place for generating therapeutic, counselor-adapted metaphors. The appeal to this approach is the direct connection of client conceptualizations, represented within their metaphors, to new concepts through metaphoric imagery. With the introduction of this type of metaphor, it is often necessary to help clients reformulate relationships from the original metaphor to the new metaphor. This reformulation may be used in support of change that has occurred or as a tool to help clients generate new concepts and behaviors (Gelo & Mergenthaler, 2012; Tay, 2012; Wickman et al., 1999). As with disquisitions, this is also a very deliberate use of metaphor for specific therapeutic effect.

Metaphors and Contraindications

Before transitioning from approaches to using metaphors in counseling to the application of those approaches, it is important to briefly discuss whether metaphor-based approaches should be avoided with some types of clients or situations. A review of research produces no clear contraindications for using metaphors in client interventions, even with those experiencing psychotic disorders. In fact, a recent systematic review by Mould, Oades, and Crowe (2010) of 28 studies of clients with psychotic disorders found support for metaphors as a useful intervention with psychotic clients and describes metaphors as a tool for reorganizing clients' cognitive understanding in a way that is grounded in reality. In addition, though metaphors seem to present a challenge for some individuals with learning disabilities and autism, interventions to help them understand metaphors have been successfully introduced into counseling (Mashal & Kasirer, 2011). It would be advisable to use caution when introducing metaphors in counseling and to tailor metaphor work to clients' cognitive abilities and ability to evaluate reality, but with that said, there is no clear evidentiary reason precluding metaphor interventions across mental health diagnoses and therapies. In fact, metaphors are considered a ubiquitous and foundational aspect of cognitive and emotional processing and communication (Blasko, 1999; Evans, 2010; Steen et al., 2010; Tay, 2012).

Therapeutic Metaphors

To create a clearer sense of the use of metaphor in counseling, the three-part model of counseling described by Hill (2009) will be used. The model describes counseling as involving the self-explanatory stages of *exploration*, *insight* and *action*, with the recognition that these stages are not linear, the stages may overlap and not all stages will be incorporated in all counseling approaches. In the following sections corresponding to the three stages, there are descriptions of metaphor usage appropriate to the purpose of those stages.

Exploration

In counseling, the development of a therapeutic alliance is paramount (Baldwin, Wampold, & Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). The generation of an effective therapeutic alliance is achieved by communicating to clients that they are safe, heard and understood and by establishing a shared purpose for counseling (Flückiger et al., 2012). One approach is through empathic reflection. With research and theoretical support for metaphors being used to communicate emotions (Crawford, 2009), the reflection and exploration of metaphors and emotions connected to metaphors is appropriate (Tay, 2012; Witztum, van der Hart, & Friedman, 1988). Understanding the client-generated metaphors in this step also may become useful later in the therapeutic process, as the metaphors can then be transformed and reintroduced to support positive changes.

In exploring client-generated metaphors, the counselor will want to be aware of the type of metaphor being used and how it relates to what the client is working to address. Particular attention should be paid to the complex and unconventional metaphors of clients, as those metaphors may be indicative of areas that are challenging, confusing or emotionally difficult for the client. If the counselor recognizes that the client may be seeking to better understand a concept for which the client provided a metaphor, the correspondence mapping approach to exploring the metaphor may be particularly useful. For clients who seem to be using metaphor to describe beliefs or rules, class inclusion may be the more appropriate approach (Tay, 2012).

The choice between class inclusion and correspondence mapping will be influenced by the content of the metaphor and client willingness to engage in the exploration. If the client is willing and able to explore the metaphor and it seems therapeutically appropriate to expand understanding related to the target domain, then the correspondence approach can facilitate that exploration. For example, if a client says about her partner, *he is a turtle hiding in his shell*, responses based on a correspondence approach could be *what makes a turtle go into its shell* and *what makes up your partner's shell*? Depending on the response to the questions, it may be possible to make more connections between the metaphor and specific aspects of the client's situation. One way to strengthen the use of this approach in counseling is to reflect back client-generated elaborations in a form that links elements of the metaphor with clients' emotions and concerns (Greenberg, 2010; Johnson, 2004; Kopp & Craw, 1998; Sims, 2003; Tay, 2012). The correspondence approach can be very helpful as a way to explore important aspects of the client's situation and challenges.

In a class inclusion approach, the process might look a little different. Rather than discussing specific elements of the imagery, the theme or message of the metaphor is the focus. Taking the same metaphor of the turtle, the message that she cannot reach her partner and believes he is avoiding her becomes the focus. Responses to this message might be: *you feel you can't reach him*; *how do you feel when you can't reach him;* and *what would it look like if he didn't hide in his shell*? This is an approach addressed to the primary message of the metaphor, but it moves away from the metaphor itself to access other metaphors and understandings related to the message. The class inclusion approach allows for an exploration of core messages, emotional reactions and beliefs.

Insight

The insight stage of counseling involves expanding a client's awareness to recognize patterns, effects of thoughts, emotions, behaviors and possibilities. Unconventional metaphors, complex metaphors or metaphor clusters may occur more frequently during the insight stage as the client develops new awareness (Crawford, 2009; Gelo & Mergenthaler, 2012; Lakoff & Johnson, 1980). It also is important to note that during the experiencing of emotion, it is likely that there will be less metaphor usage than when clients are working to explain and integrate emotions (Gelo & Mergenthaler, 2012). The client-generated metaphors, particularly the unconventional and complex metaphors, in addition to indicating expanding perspectives, can be a tool for furthering clients' insights and integrating those insights in a way consistent with their counseling goals.

Working with metaphors in this stage expands on the metaphor work in the exploration stage by focusing on metaphors in relation to goals and patterns related to clients' situations (Tay, 2012). Reflections and questions are often helpful to use in response to clients' complex and unconventional metaphors, as reflections and questions may encourage the continued development of new awareness and incorporation of new awareness into different aspects of clients' lives (Hill, 2004; Kopp & Craw, 1998; Tay, 2012). In addition, clients can be encouraged to develop new insights by having the counselor ask the client to change the metaphor to how he or she would like it to appear and then exploring the new metaphor through class inclusion, correspondence mapping or both (Hill, 2004; Kopp & Craw, 1998). The changed metaphor can be used to deepen feelings, clarify goals and recognize patterns (Tay, 2012). To illustrate this process, a composite dialogue from a case example is provided.

Client (Cl): *I'm caught in a whirlwind that's spinning my head in a circle.*
Counselor (Co): *Say more about being caught in a whirlwind that's spinning your head in a circle.*
Cl: *I just do not know what to do, the relationship still is not changing.*
Co: *So you're afraid that the whirlwind will carry you away?*
Cl: *Not exactly, more that I'll just stay right where I am.*
Co: *The whirlwind blocks everyone else from getting to you.*
Cl: *Yes, I'm all alone in it.*
Co: *Could you describe how this metaphor might change if you didn't feel alone?*
Cl: *Well, I guess I would be holding my partner's hand in the eye of the whirlwind where we are safe and together.*
Co: *How does that feel?*
Cl: *It feels really good.*
Co: *You really want that connection, but right now you feel scared, alone and trapped in the cycle.*

In this example, a complex and unconventional metaphor, composed of two combined metaphors, that the client spontaneously introduced into the session became a tool to deepen and expand awareness concerning the challenges experienced in her current relationship. In the first part of the metaphor, the target domain is the client's current situation and the source domain is a whirlwind. In the second part of the metaphor, the target domain is the client's head and the source domain is spinning in a circle. In the example, the client was first asked questions following a class inclusion approach, which allowed for the identification of the important concepts with which the client is struggling—namely, feeling stuck in her current situation and alone in her relationship. Then, by asking the client to change the metaphor based on changing the feelings she identified as particularly concerning, a clearer awareness of her goal to be connected and feel safe with her partner was identified. The utility of this approach is made clear in this example, and it is also important to emphasize that this approach, by changing the context of clients' descriptions from their everyday life to the imagined, may enable clients to provide descriptions that are outside what they currently view as possible. In the above example, it may have been difficult, given the client's current frustrations and challenges, to clearly describe what she wanted in her relationship, but in relation to the metaphor of the whirlwind, she could directly and simply state a transformation in the metaphor that spoke to her goal. The insight from this metaphor exploration provides a focus for future therapeutic counseling work.

Another way of promoting client insight is through counselor-generated metaphors. Disquisitions, as described above, are a narrative form of metaphor introduced by the counselor. The use of disquisitions may be particularly appropriate when there are fewer metaphors being used, perhaps indicating either active emotional experiencing or a lack of cognitive and emotional change, because the disquisitions can both highlight the need for change and direct the form it takes (Gelo & Mergenthaler, 2012; Millikin & Johnson, 2000). The way these metaphors are processed with clients depends on therapeutic needs. A composite case example of a class inclusion approach to a disquisition about relationship interactions in couples counseling follows. (It is important to note that in this example, male and female genders were assigned to match with the genders of the couple, but these genders can be changed to fit the situation.)

> Co: *This reminds me of a story. There once was a lonely skunk. He lived all alone in the forest and desperately wanted a friend. One day he came upon a solitary porcupine. The porcupine also was lonely and looking for a friend. The skunk started walking up to the porcupine softly grunting his hello. The porcupine backed away in terror, showing her teeth. The skunk thought this was a friendly greeting, so he kept approaching. The porcupine was backed against a rock and kept showing her teeth in warning. The skunk came close and just out of reach sat down, prepared to make a new friend. As soon as he sat, the porcupine shoved her way past, fleeing into the forest and leaving quills stuck in the skunk, who out of instinct sprayed the porcupine. The skunk was left lonely, confused and in pain, and the porcupine was terrified and alone, with her eyes burning in pain. Now why do you think I told this story?*
> Client 1 (Cl1): *Because we don't communicate well.*
> Client 2 (Cl2): *And because we hurt each other when we try to connect.*
> Co: *Yes, but that's not what either of you want. In fact, I suspect that just like in the story, you both want a close friend and partner.*
> Cl1 and Cl2: *Yes.*
> Co: *So, it sounds like the real problem for you two isn't that you both want something different. It's that, like the skunk and porcupine, the interaction between you and your interpretation of that interaction keeps you both from getting what you want—a loving, connected partner.*

The disquisition provides a powerful image that represents the interaction cycle of the couple. The message of the story is discussed, and through this discussion there is recognition and awareness of a problem in the relationship that has similarities with the story. However, to bring out the specifics of the relationship interaction cycle, it is necessary to go into more detail. To do that, the metaphor can be left at this point to focus on the specifics of how each partner contributes to the interaction cycle in the relationship, but another option is to take a correspondence approach and tie specific behaviors to specific parts of the story. There are several positive benefits of the correspondence approach. First, there is already agreement that the story is related to what is happening in their relation-ship, so it provides an agreed-upon story with which details can be linked. It also gives a strong image that can be used throughout counseling to reinforce awareness and contrast change. Finally, it can create a feeling of more safety because details of interactions that are uncomfortable to acknowledge can first be discussed based on the imagery (Romig & Gruenke, 1991). The correspondence approach can facilitate going into more detail and emotion more quickly with resistant clients than would otherwise be possible, and through that more detailed exploration it can then be used to generate shared insight into patterns of thoughts, emotions and behaviors that are problematic for the couple.

Action

The *action* stage is focused on behavioral change and is often based on what has been learned in the *exploration* and *insight* stages. It is likely that client-generated metaphors at this stage may become more simple and conventional, though their metaphors also are likely to be changed from those at the beginning of counseling. Metaphors are likely to become less common and take simpler forms at this stage, which may be an indication that the client is incorporating a new awareness of his or her situation (Crawford, 2009; Gelo & Mergenthaler, 2012). At this point in the counseling process, metaphors may be useful for clarifying behavioral changes to be implemented and considerations for their implementation. As an aside, it is important to pay attention to the types of client metaphors at this point, and if the counselor observes unconventional metaphors and complex metaphors, it may be appropriate to work on exploration and insight rather than action. This is because unconventional and complex metaphors are more likely to occur when the client is struggling through emotional and cognitive change (Crawford, 2009; Gelo & Mergenthaler, 2012; Lakoff & Johnson, 1980), which would indicate that the client may not have developed the perspective necessary to implement changes.

In generating action plans, a helpful approach is to use metaphors to provide a different perspective related directly to the client's experience. If a client has been using a metaphor related to an issue that is the focus of behavioral planning, then asking the client what change they would make to the metaphor and then linking that change back to the client's life can generate new ideas. The following is a composite case example of that approach.

> Co: *You are saying that your goal is to not fight with your mother anymore. As we focus on how that might happen, I am reminded of the metaphor you gave earlier about the conflict with your mother. You said that your mother is smothering you. That she holds you so close that you can't breathe. Did I say that right?*
> Cl: *That's what it feels like.*
> Co: *Well I am wondering what would you change in that metaphor?*
> Cl: *I would have my mother not hold me so tight that I can't breathe.*
> Co: *So having a little more room to breathe would really change things.* (Client nods)
> Co: *I also notice that you are not saying that you want your mother far away from you or to ignore you; you just want her to give you a little more space.*
> Cl: *Yes.*
> Co: *So, what you are looking for is a way to not feel controlled by her and still feel connected to her.* (Client nods)
> Co: *How might you do that?*
> Cl: *Well I guess I could move out of the basement of her house.*

In the example above, it would have been possible to generate an action plan without using a metaphor, but it can be observed that the metaphor added a strong connection to the emotional experience of the client and helped to open the client to identifying a change that made sense based on his goal. The ability to generate a greater connection with clients through the use of clients' metaphors can empower clients to make changes directly connected to what is most affecting them. There also are times when clients have difficulty making changes because of fear, and in those situations, providing a path to identifying potential changes indirectly through metaphor can be very beneficial and can allow ideas to be discussed in a manner that may provoke less fear in the client.

Conclusion

Metaphors often seem simple, but they have a deeper conceptual role, and through observing metaphor usage in clients, actively exploring metaphors with clients and generating metaphors to address therapeutic goals for clients, metaphors can become a valuable tool in counseling. The above descriptions and examples provide some practical ways that understanding and using metaphors can positively impact counseling work. Client-generated metaphors provide a lens into the internal world of clients that combines their emotional reactions and experiences in an understandable manner and creates a bridge so clients' internal worlds can be shared with the counselor. Counselor-generated metaphors provide a tool to further guide and support clients in the pursuit of their goals. Through both client-generated and counselor-generated metaphors, the inner experience of clients can be more directly accessed and positive change can be facilitated. Therefore, the recognition and incorporation of metaphors can be an incredibly valuable tool for counselors. It is hoped that the information provided in this manuscript will serve as a foundation for incorporating metaphor awareness and usage into counseling practice and will stimulate counselors to seek out additional training and information and develop research on the application and effectiveness of using metaphors in counseling.

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Perceived Helpfulness of Teachers in Clinical Courses

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Clinical courses are important in the development of students pursuing a master's degree in clinical mental health counseling (CMHC). Despite the importance of clinical courses, little is known about what CMHC students perceive as being helpful about their teachers of clinical courses. To investigate this, we sought the viewpoints of beginning counselors who were in their first four years of working as licensed counselors post-graduation. Thirty-two beginning-level counselors completed a Q sort that assessed the perceived helpfulness of their teachers of clinical courses in their CMHC master's degree program. Three different learning preferences—application-oriented learners, intrinsically motivated learners, and affective-oriented learners—were observed among participants in the study.

Keywords: **clinical courses, beginning counselors, Q sort, learning preferences, learners**

Counselor educators who teach in clinical mental health counseling (CMHC) master's degree programs are responsible for preparing counselors-in-training to acquire important content knowledge and develop competent clinical skills (Schwitzer, Gonzalez, & Curl, 2001). Didactic-oriented courses in CMHC curricula (e.g., ethics, diagnosis, cultural diversity, career counseling) tend to emphasize the acquisition of important content knowledge and are often associated with larger class sizes (Sperry, 2012). Clinical courses (e.g., skills, practicum, internship) emphasize development of clinical skills through experiential and applied learning opportunities and are typically associated with smaller class sizes. Although experiential and applied learning can be infused into didactic-oriented courses, they are fundamental to the pedagogy of clinical courses.

For students, engagement in clinical courses requires a shift from passive to active learning, with an increased emphasis on putting what they have learned into action (Auxier, Hughes, & Kline, 2003; Skovholt & Ronnestad, 1992). Clinical courses require students to engage in activities such as role plays, case formulizations and skill demonstrations (Young & Hundley, 2013). Although these types of learning experiences tend to be impactful for students (Furr & Carrol, 2003), they can also pose new emotional and cognitive challenges. Students in clinical courses are frequently observed by peers and instructors demonstrating skills, techniques and clinical thinking, which may be anxiety-provoking for students who are unsure of themselves as counselors-in-training.

We believe counselor educators encounter different types of pedagogical challenges teaching clinical courses when compared to didactic courses. For example, teachers interact closely with students in clinical courses on account of classroom dynamics that are more up close and personal. Additionally, there is an increased need for teachers to help students overcome emotional (e.g., feeling anxious about being observed by peers during a counseling demonstration) and physical (e.g., difficulty demonstrating a basic skill) challenges that arise through curricula focused on skill development. Further, teachers of clinical courses are challenged to evaluate students and provide feedback based on their direct observation of trainees' ability to perform basic skills, advanced techniques and clinical-thinking abilities.

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Unfortunately, little empirical research is available to counselor educators to inform their pedagogical choices in clinical courses (Barrio Minton, Wachter Morris, & Yaites, 2014). We believe that better understanding students' viewpoints of their teachers in clinical courses and what they perceive as beneficial for their clinical practice could provide counselor educators with valuable information to inform their pedagogy in these courses. The current study was designed to contribute in this regard by exploring what aspects of teachers of clinical courses were perceived as helpful by recent graduates of CMHC programs who were working as beginning counselors.

Teaching in Higher Education

Higher education researchers have focused on personal characteristics of teachers as a way to explore what students perceive as effective teaching; results of such research suggest that students attribute several different characteristics to their teachers' effectiveness. Examples include perceptions of teacher warmth (Best & Addison, 2000), compassion and interest in students (Sprinkle, 2008), rapport with students, effective delivery of information, focus on interpersonal relationships with students in the classroom (Goldstein & Benassi, 2006), and effective course organization and usefulness (Young & Shaw, 1999). Students additionally believed that effective teachers sparked interest in the course material and were accessible for support as needed (Feldman, 1988). From this research, it appears students value and perceive teacher effectiveness through both teachers' relational abilities and their effective delivery of course material.

In addition to studying personal characteristics of teachers, some higher education researchers have conceptualized different models of teaching styles. One notable model of teaching styles was created by Grasha (1994) through analysis of interviews with higher education faculty members. Grasha identified five teaching styles among faculty members: expert, formal authority, personal model, facilitator and delegator. An expert style refers to the direct transfer of knowledge to students through teaching modalities such as lecture. The formal authority style refers to defining clear expectations and learning objectives for students, which are based on an instructor's perceived authority on a subject, and providing direct feedback. A personal style refers to instructors teaching by personal example and encouraging students to learn appropriate behaviors through observation. The facilitator style refers to teachers serving as a guide and consultant, encouraging students to move toward independent learning. Finally, the delegator style refers to a hands-off approach in which students are given freedom to function independently. Rather than the teaching styles being exclusive, Grasha noted that teachers display varying degrees of each of the styles within their classrooms. Consequently, different combinations of teaching styles create a unique learning experience for students.

Another stylistic aspect of teaching that has been categorized in higher education literature is teacher-centered and learner-centered pedagogy. Instructors who use teacher-centered approaches are characterized by working in an expert role to disseminate knowledge to students. Conversely, teachers who utilize learner-centered approaches take the role of facilitator and aim to create an active learning environment (Smart, Witt, & Scott, 2012). Research on the effectiveness of these two approaches remains inconclusive, and some researchers have suggested that a teaching approach that utilizes both teacher- and learner-centered styles is probably ideal (Baeten, Dochy, & Struyven, 2012).

Teaching in Counselor Education

Little research exists that examines pedagogy within counselor education programs. Barrio Minton et al. (2014) completed a content analysis of published articles related to teaching and learning within counseling and found a clear focus on techniques and content rather than pedagogical practices and students' learning experiences. Further, only a third of the articles were empirically based, and less than 15% had clear pedagogical foundations, indicating that the majority of the literature available on teaching in counselor education is conceptual in nature. Among these conceptual pieces, Malott, Hall, Sheely-Moore, Krell, and Cardaciotto (2014) aimed to bridge evidence-based practices of teaching in higher education with best practices in counselor education. Malott and colleagues affirmed that although counselor-based characteristics (e.g., empathy, positive regard) are essential for effectiveness in teaching counseling courses, they are not sufficient. They suggested that counselor educators should create effective learning environments characterized by creating strong rapport with students, engaging students in active learning (e.g., case studies, role plays) and providing opportunities for feedback throughout the course. Pietrzak, Duncan, and Korcuska (2008) examined factors that impacted counseling students' perceptions of teaching effectiveness and found that students rated an entertaining delivery style and perceived knowledge of the teacher as the most influential factors.

An examination of the limited literature that exists on pedagogy within counselor education programs identified three important theoretical perspectives: developmental, constructivist and contextual teaching. The developmental approach to teaching suggests that teachers should alter their teaching style and techniques to meet the changing developmental needs of students, progressing from a content-oriented and highly structured emphasis to facilitating active learning experiences (Granello & Hazler, 1998). According to the constructivist perspective, it is important for counselor educators to facilitate students' engagement in reflective thinking and the personal construction of knowledge (McAuliffe & Eriksen, 2010; Nelson & Neufeldt, 1998). Similarly, the emphasis on contextual teaching is to help students find personal meaning in what they are learning by placing information within a context of how it is relevant to them (Granello, 2000). Although the reviewed literature adds important context to the area of teaching in counselor education, none of the research specifically examines the unique nature of teaching in clinical courses.

Purpose of the Study

The current study is the first to explore beginning counselors' perceptions of helpful aspects of teachers of clinical courses in CMHC. Clinical courses were selected as a focus in this study because of their key role in student development of skills needed for professional practice and the lack of information on teaching clinical courses within the counselor education literature. We believed exploring the perspectives of beginning professional counselors, rather than students, was valuable for two important reasons: (a) beginning counselors are close enough to their master's degree program experiences to be reflective about their teachers and (b) beginning counselors are able to consider helpful aspects of their teachers in light of their real-world experiences as professional counselors.

Method

We used a Q methodology to investigate aspects of counselor educators of clinical courses in CMHC that were perceived to be helpful by beginning-level counselors. Q methodology embraces both the analytic rigor of quantitative methodologies and the richness and depth of qualitative methodologies (Watts & Stenner, 2012). We selected Q methodology for this study because it was designed for systematic exploration of subjective human phenomena (i.e., people's preferences) on topics such as teaching (Ramlo, 2016).

Phase 1: Concourse Development

This study was completed in two phases. The first phase involved developing the concourse. In Q methodology a *concourse* represents a collection of ideas that is composed around a topic (Stephenson, 1978). The concourse for this study was generated in two ways. First, we conducted a literature review and selected important themes for inclusion in the concourse. Second, after obtaining Institutional Review Board approval, we conducted interviews with five participants and then included statements from the participant interviews into the concourse. Five beginning-level professional counselors were interviewed and asked the following question: "What was it about teachers of your clinical classes during your program that was most helpful in becoming the professional counselor you are today?" To ensure a diverse range of viewpoints would be represented in the second phase of the study, we interviewed different gendered individuals (i.e., two male counselors, three female counselors) who worked in a variety of professional settings (i.e., two counselors worked in a private practice, one counselor worked in a community agency, and two counselors worked in a hospital setting) and who had differing racial identities (i.e., two Caucasian counselors, one African American counselor, one Asian American counselor, one Hispanic counselor).

The lead researcher then analyzed all of the statements in the concourse (from the literature and participant interviews) and began identifying unique statements, grouping similar statements together. Groups of similar statements were further analyzed by the lead researcher, and one statement was selected from each group. Participant statements selected for inclusion were edited to abbreviate long statements or to change the tense of statements. The co-researchers then reviewed the lead researcher's analysis to ensure that each remaining statement was distinct from other statements and relevant to the study. This process culminated in a 34-item instrument that would be used in the Q sample (see Table 1).

Phase 2: Q Sample and Q Sort

The second phase of this study entailed constructing a Q sample and administering Q sorts to participants. A Q sample is a composite of stimulus items administered to participants for rank-ordering during the Q sorting process (Stenner, Watts, & Worrell, 2008). Thirty-two participants were given the Q sample and were asked to rank order 34 items in the Q sample on a 9-point scale in the shape of a normal distribution. Prior to rank ordering statements for the Q sort, participants were prompted to reflect on teachers they had in clinical courses during their master's degree programs and then to reflect on what it was about those teachers that had been most helpful to them in becoming the counselors they are today. Participants were then directed to read all statements and rank order them on a response grid that ranged from +4 (*most helpful*) to -4 (*most unhelpful*). After rank ordering the statements, participants were asked to provide written responses to several post-Q sort questions designed to elicit qualitative data about why certain items were important to them. Two examples of post-Q sort response questions were as follows: (a) "describe how the two items you ranked at 4 (*most helpful*) were helpful to the counselor you have become," and (b) "describe how the two items you ranked at -4 (*most unhelpful*) were not helpful to the counselor you have become."

P Sample

The P sample refers to the participants sampled for the Q sort, which in the case of this study were beginning-level professional counselors. Participants were required to meet the following criteria in order to be eligible for this study: (a) were a graduate of a counselor education master's degree program in CMHC, (b) accrued at least 400 direct hours of post-master's clinical service working with clients as a licensed counselor and (c) were no more than four years removed from graduating with their degree. After obtaining a second IRB approval to collect data using the Q sort, participants were recruited in several ways. The researchers called on the telephone and sent general recruitment e-mails to supervisors and directors of counseling agencies, private practices and in-patient

Table 1
34-Item Q Sample and Factor Arrays

Item	Statements	Factor 1	Factor 2	Factor 3
1	A professor created opportunities for me to get feedback from my peers.	-3	1	0
2	A professor encouraged group discussions about relevant topics.	0	0	-2
3	A professor modeled behaviors that I could use with clients.	4	2	0
4	A professor used role plays in class to explain things.	3	2	-1
5	A professor created a safe classroom environment where it felt OK to make mistakes.	3	-1	1
6	A professor required me to self-critique my counseling skills by observing video/audio tape of myself.	-1	3	2
7	A professor required me to show video/audio tape of my counseling skills to my classmates for feedback.	-4	4	0
8	A professor challenged me in uncomfortable, yet helpful ways.	0	0	-2
9	A professor helped me to make connections between counseling theories and my clinical practice.	0	3	-1
10	A professor helped me to develop my ability to conceptualize clients.	2	4	1
11	A professor demonstrated that he/she was open-minded.	1	-2	1
12	A professor discussed ethical issues that related to students' clinical experiences working with clients.	1	0	-1
13	A professor who I knew was currently working with clients, or had significant experience as a practicing counselor.	1	2	2
14	A professor helped students in the class cultivate close relationships with one another.	-2	-4	-3
15	A professor was open, empathetic, and authentic in their interactions with students.	4	-2	4
16	A professor shared "in the moment" struggles they faced as a counselor.	2	0	-1
17	A professor gave me direct feedback where they made it clear what I was doing well, and what I was not doing well.	1	3	0
18	A professor gave me strength-based feedback.	2	0	1
19	A professor incorporated multiculturalism and issues of diversity into class.	0	-1	0
20	A professor encouraged students to share differing viewpoints on a topic/discussion.	-1	1	0
21	A professor helped me to see the purpose in what I was learning by explaining "how" and "why" it would be useful to me in the future.	2	1	-3
22	A professor I could sense was passionate about what they were teaching.	0	-1	2
23	A professor expected a high standard of performance from me.	-3	1	-1
24	A professor was readily accessible to give me extra help when I needed it (e.g., office hours, e-mail, phone).	-1	-3	-2
25	A professor I could sense was fully present during my interactions with them.	0	-2	1
26	A professor created in-class activities that helped me to become a more reflective thinker.	1	2	-2
27	A professor streamlined course readings and assignments down into what was essential.	-2	-3	-4
28	A professor held me and other students accountable for our actions.	-3	-1	-3
29	A professor had an engaging personality.	-1	-2	3
30	A professor used technology to enhance my learning experience.	-4	-4	-4
31	A professor I believed was probably a good clinician.	-1	0	4
32	A professor who I liked as a person.	-2	-3	3
33	A professor I sensed was an expert on what they were teaching.	-2	-1	2
34	A professor used examples from their clinical experiences to explain things.	3	1	3

hospitalization units in Ohio and Texas, requesting that they forward recruitment information for the study to potential subjects. Snowball sampling was also used to recruit participants when participants who had completed the study recommended colleagues who might be willing to participate in the research. Data were collected from participants by sending packets in the mail that consisted of an informed consent, demographic questionnaire, Q sort, post-Q sort questions and a postage prepaid return envelope.

Thirty-two participants met the criteria for inclusion in the study and completed the Q sorting process. In Q methodology a sample size only needs to be large enough for factors (i.e., groups of shared viewpoints) to emerge and is typically 20 and 60 participants (Brown, 1980). Seventy-two percent (n = 23) of the participants in the study were 20–30 years old; 28% (n = 9) were between 31–40 years old. Seventy-two percent (n = 23) of the participants identified as female and 28% (n = 9) of the participants identified as male. Fifty-nine percent (n = 19) of the participants reported they worked in a community counseling agency; 22% (n = 7) reported they worked in a private practice; and 19% (n = 6) reported they worked in a hospital setting. Thirty-eight percent (n = 12) of the participants indicated they had accrued 400–1,000 direct clinical hours working with clients; 22% (n = 7) indicated they had accrued 1,001–1,500 direct clinical hours working with clients; 3% (n = 1) indicated they accrued 1,501–2,000 direct clinical hours working with clients; 9% (n = 3) indicated they accrued 2,001–2,500 direct clinical hours working with clients; and 28% (n = 9) indicated they had accrued more than 2500 direct clinical hours working with clients. Eighty-two percent (n = 26) of participants identified as Caucasian, 9% (n = 3) of participants identified as African American, and 9% (n = 3) of participants identified as Hispanic.

Data Analysis

Data were entered into the PQMethod software program (Schmolck, 2014) and were factor analyzed using principle components analysis (PCA). After the PCA was initiated, a varimax rotation was used to determine reliability, scores and factor loadings. A 3-factor solution was selected for the data because it accounted for each participant loading onto at least one factor. Due to each participant being accounted for by a 3-factor solution, it was unnecessary to search for a fourth factor.

In Q methodology, factor scores are used for interpretation rather than factor loadings. The factor narratives presented in the results section were created through a factor interpretation method developed by Watts and Stenner (2012). This method was designed to consistently approach each factor in the context of all other factors and to provide a holistic factor interpretation by taking into consideration all differences between factors. First, a worksheet was created from the factor array for each individual factor. The worksheet contained the highest (+4) and lowest (-4) ranked items within the factor (note: items of consensus were not included and were analyzed separately) and those items ranked higher or lower within the factor compared to the other two factors. Second, items in the worksheet were compared to participants' demographic information and qualitative responses associated with that factor to add depth and detail before the final step. Finally, the finished worksheet was used to construct the factor narratives, which were written as stories that reflected the shared viewpoint of each factor.

Results

Of the three factors produced by the PCA of the 32 Q sorts, Factor 1 contained 12 of the participants and accounted for 17% of the variance; Factor 2 contained nine participants and accounted for 13% of the variance; and Factor 3 contained nine participants and accounted for 14%

of the variance. There were two Q sorts that were mixed cases (i.e., they had significant loadings on more than one factor) and were removed from the study.

Factor 1: Application-Oriented Learners

A total of 12 participants loaded onto Factor 1, accounting for 17% of the variance, and their demographic traits were unremarkable when compared to the other two factors. Participants of Factor 1 were application-oriented learners who preferred their professors to be pragmatic, supportive and active leaders during class.

Factor 1 individuals preferred it when their professors demonstrated specific techniques or skills they could envision directly applying to their counseling practice. As one participant noted: "I am a visual learner, so seeing helpful behaviors and how I could act with a client helped me visualize what a therapy technique could be like [in session]. I feel like I was used to seeing good counseling behaviors so it felt more natural to do them myself." When introducing a new concept in class, individuals of Factor 1 perceived it as more helpful when their teachers provided context of why and how it would be useful to them as a professional counselor (item 21). Individuals of Factor 1 also perceived it as helpful when they were able to hear relevant clinical anecdotes from their teachers (items 12, 16), as they served as a practical way of remembering important lessons that applied to real-world counseling situations. This was described by a Factor 1 participant: "Learning by hearing about my professors' experiences is the easiest way for me to apply information and the easiest way for me to remember it." Another participant broadly stated, "Real life examples were the biggest influence on my education."

Persons of Factor 1 preferred it when their teachers were active leaders in the classroom and used their knowledge and experience to efficiently instruct students. They perceived teachers as having a more credible viewpoint than themselves or their classmates because of their advanced training and experience in counseling. Factor 1 individuals did not perceive it as important that their teachers be experts (item 33) or skilled clinicians (item 31), so long as they could effectively lead class by teaching practical information, demonstrating relevant clinical skills and providing them with strength-based feedback. This preference was evident in a desire for receiving strength-based feedback from their instructors (item 18) rather than engaging in self-critique (item 6) and receiving feedback from their peers (items 1, 7). A Factor 1 participant elucidated, "Getting feedback from peers is not effective, mostly because they didn't know any more than I did about the subject matter and I don't value their opinion as much as the professors."

In addition to the belief that peer feedback was unhelpful, persons of Factor 1 also expressed concern about being critiqued by their peers: "I hated showing my video/audio tapes to others because I felt like I was being judged by peers and not being provided helpful suggestions." Factor 1 individuals also expressed that high expectations from their teachers (item 23) provoked worries of "not being able to measure up" and were perceived as less helpful. One participant narrated, "The words 'high expectation' really struck me as negative. I feel afraid that I won't be able to meet those expectations. I want my professor to be hopeful about my development as a counselor and not have high expectations." Teachers who created a safe space for mistakes (item 5) through having a person-centered way of being (item 15), were transparent about their own difficulties as a counselor (item 16) and used strength-based feedback (item 18) were perceived as being more helpful, as they helped mitigate worries present in the Factor 1 viewpoint. Describing this viewpoint, one participant responded:

> I appreciated knowing that making mistakes was part of the class and that any expectation to be perfect was unreasonable. Also, it felt safe to grow and take risks when I feel empathy and

> authenticity from my instructors. This allowed me to be vulnerable and share my thoughts and feelings.

Overall, representatives of Factor 1 perceived it as important that their teachers provide them with a safe and encouraging environment in clinical courses.

Factor 2: Intrinsically Motivated Learners

A total of nine participants loaded onto Factor 2, accounting for 13% of the variance, and demographic traits were unremarkable when compared to the other two factors. Participants of Factor 2 were independent, intrinsically motivated and reflective learners who preferred to learn through considering different points of view about a topic.

In contrast to Factor 1 individuals' preference for concrete and specific practical knowledge, Factor 2 individuals preferred to learn about conceptual topics that were more abstract and through activities that stimulated reflective thinking. This is evident in the Factor 2 participants' preference for teachers who helped them hone their ability to conceptualize clients (item 10) and who helped facilitate connections between theoretical concepts and clinical practice (item 9). One participant remarked about item 9, "My theoretical orientation is the biggest part of my counseling identity. Having those initial connections made for me helped solidify my understanding of clients." Individuals of Factor 2 perceived it as helpful when their teachers created activities that prompted reflective thinking (item 26), as this is a foundational component of how they work with clients. One participant noted, "I feel as though I have to reflect 100% of the time in my job. It helps me take a step back to think of what the client is really trying to say." Persons of Factor 2 also perceived it as helpful when their instructors prompted them to self-reflect through critiquing their counseling skill. As one participant described, "The self-critique of my video tapes was by far my most memorable learning experience. Watching video of myself challenged my self-concept and gave me opportunities to see what I could do to improve."

Receiving frequent and direct feedback from teachers and peers was perceived as particularly helpful to representatives of Factor 2. Unlike Factor 1, Factor 2 individuals preferred it when their professors held them to high standards (item 23) and provided them with feedback that was clear and direct (item 17) rather than strength-based. A participant elaborated on their preference for direct feedback: "I liked knowing where I stood, so I could try to improve in areas where I was weak. It was refreshing when professors offered this instead of sugar coating things." Individuals of Factor 2 indicated a strong preference for teachers who required them to show tapes of their clinical work to classmates (item 7). This activity gave them the opportunity to consider a "broad base of opinions," which they found to be important to their learning; as one participant explained, "I learned the most when I heard different ideas. Then I had to figure out what I thought was true."

Persons of the Factor 2 viewpoint were independent learners in clinical courses and preferred when their teachers assumed more facilitative roles on the periphery of the learning environment. Their teachers' personality characteristics (items 11, 15, 25, 29, 32), enthusiasm for teaching (item 22) and ability to create a safe learning environment (item 5) were perceived as less important than their propensity for facilitating dialog among students. This can be seen in the Factor 2 preference for teachers that facilitated group discussions (item 20) and created ample opportunities for peer feedback (item 1). Although Factor 2 individuals valued their teachers' forthright feedback, they did not place the high level of importance on the teacher's perspective that Factor 1 did. Instead, Factor 2 representatives regarded their teachers' perspectives as one of many useful perspectives present in the classroom. One participant seemed to capture the essence of the Factor 2 viewpoint, remarking:

"I learned just as much from my interactions with peers in clinical classes as I did from instructors. I believe in these classes teachers can act as facilitators and help students that way, just as much as they can interacting [with students] or lecturing."

Factor 3: Affective-Oriented Learners

A total of nine participants loaded onto Factor 3, accounting for 13% of the variance, and demographic traits were unremarkable when compared to the other two factors. Participants of Factor 3 were oriented toward affective and relational qualities of their teachers and were inspired to learn through their admiration and respect for their teachers.

It was paramount for Factor 3 individuals to have a positive appraisal of their teachers as human beings so that they could develop an affinity for them. When Factor 3 individuals liked their teachers (item 32), they were able to form strong relationships with them, and these relationships acted as a catalyst for their learning. As one participant explained, "I am much more likely to grow and learn from someone I like." Another participant shared a similar sentiment in regards to item 32: "I think my relationship with the professors and how I perceived them were just as important, if not more important, than what they taught me or the feedback they gave me." Persons of Factor 3 strongly preferred when their teachers had a person-centered way of being (item 15), as this helped them feel like their teachers were good people who cared about them: "Having a kind and understanding professor is key! That is a huge make-it-or-break-it thing for me. I wanted my professors to be people I liked, respected and enjoyed being around, and who I sensed cared about me." Further, Factor 3 representatives perceived it as helpful when they could sense their teachers were fully present with them (item 25), as this indicated to them that their teachers cared for them and were invested in their learning.

In addition to the importance of having a positive appraisal of their teachers as human beings, it was also important for representatives of Factor 3 to believe that their instructors were skilled teachers and counselors. Factor 3 individuals perceived it as helpful when they could sense that their teachers were skilled clinicians (item 31) and were experts on what they were teaching (item 33) in clinical courses. When persons of Factor 3 held positive beliefs about their instructors as human beings, teachers and counselors, it inspired them to emulate their instructors as clinicians. Elucidating this notion, one participant remarked, "It [item 31] gave me greater respect and admiration for them, which motivated me to be influenced by them." Similarly, another participant stated, "I remember feeling inspired and wanting to 'just be like' certain professors as I entered practicum." After teachers earned Factor 3 individuals' respect and admiration they were ascribed credibility, which made it less important for them to provide context for what was being taught (item 21) or to streamline assigned readings (item 27). That is, when a teacher they valued taught something in class or assigned reading, those things were immediately assumed to be important.

It was important to persons of Factor 3 that their teachers had charisma during class, which captivated their attention and motivated them to learn. As such, Factor 3 individuals preferred when their teachers were the active figures in the classroom and led class through having an engaging personality (item 29). Elaborating on the importance of this perspective, one participant explained, "It [item 29] helped me to get excited about what I was doing and learning and helped me to get engaged in discussions and activities." Representatives of Factor 3 also perceived it as helpful when they could sense their teachers were passionate about what they were teaching (item 22). As one participated remarked, "I experienced several professors who loved what they were teaching. This attitude ignited my excitement for counseling and inspired me." Summarizing Factor 3 representatives' emphasis on relational characteristics of their teachers, one participant noted, "My relationships with professors had the greatest impact on my growth; more so than any technique they used or material they covered."

Consensus Statements

There were two items of consensus on which all three factors agreed. It was of moderate importance to all three factors that their teachers were currently working with clients or possessed significant experience working with clients (item 13). Qualitative data seemed to suggest this item enhanced a counselor educator's credibility when teaching students in clinical courses, providing them with experiences to draw on when demonstrating a technique. One participant explained: "I felt I received more honest and pragmatic lessons from professors that had recent stories, feedback and teachings from being up-to-date and current with everyday practice. Their knowledge meant more to me and left a longer-lasting impression."

Representatives of the three factors also perceived it as particularly unimportant that counselor educators incorporate technology into clinical courses to enhance learning (item 30). Qualitative feedback from respondents seemed to focus on two different themes in regards to item 30. One, respondents considered technology unnecessary in clinical courses, as they did not perceive that it was relevant to their work as professional counselors: "Technology does not affect how I practice as a counselor. I actually felt that I wasted much time in fighting with technology during my education that could have been better spent further developing my skills." Two, respondents suggested that technology was perceived as less helpful when it came at the expense of clinical learning occurring in the classroom: "Technology is nice and all, but I appreciated clinical moments in the classroom with my professor and peers."

Discussion

An important finding of this study was that three different shared viewpoints (i.e., application-oriented learners, intrinsically motivated learners, affective-oriented learners) exist among beginning-level clinical mental health counselors about helpful aspects of teachers in clinical courses. When considering the different teaching preferences that emerged in this study, it may be helpful for counselor educators to conceptualize each factor as a student-learner archetype present in CMHC clinical courses. An example of the Factor 1 application-oriented archetypal student is as follows: a student focused on becoming a competent professional counselor who is apprehensive about his or her lack of knowledge and experience. This student's ideal teacher explicitly articulates and demonstrates what he or she needs to do to become a competent professional counselor, while providing supportive feedback as he or she tries to achieve that goal. An example of the Factor 2 intrinsically motivated archetypal student is as follows: a student who is a reflective thinker with a broad enjoyment of learning, motivated to become an excellent counselor. His or her ideal teacher helps to develop deeper personal understandings and wisdom through creating opportunities to hear diverse opinions and feedback. An example of the Factor 3 affective-oriented archetypal student is as follows: a student who wants to feel cared for and valued by a teacher as a means of developing a transformational relationship with him or her. His or her ideal teacher is a person he or she admires who inspires the student to want to become a professional counselor.

The preferences of the Factor 1 student-learner archetype are congruent with counselor educators of clinical courses who use developmental (Granello, 2000) and teacher-centered (Baeten et al., 2012) pedagogies. Students from the Factor 1 archetype are unsure of themselves because of their lack of knowledge and experience in counseling. Thus, it may be helpful when counselor educators use their advanced knowledge and experiences as formal authorities to disseminate essential foundational knowledge and skills (Grasha, 1994). These Factor 1 students also may find it helpful when counselor educators use a personal model of teaching to demonstrate how something should be done, which has the dual benefit of helping students learn through observation and creating a clear objective for which to strive (Grasha, 1994). Additionally, the Factor 1 archetype prefers teachers who introduce new information and skills using a contextual approach (Granello & Hazler, 1998) in which they take time to explain how and why what is being taught is relevant to the goal of becoming a competent professional counselor. These approaches to teaching may quell developmental anxieties experienced by Factor 1 students, and counselor educators can encourage further growth through providing strength-based feedback as students perform clinical learning tasks.

The preferences of the Factor 2 student-learner archetype are closely aligned with counselor educators who use constructivist (Nelson & Neufeldt, 1998) and learner-centered pedagogies (Baeten et al., 2012) while teaching clinical courses. The Factor 2 archetype prefers for minimal class time to be used for teacher-led instruction and the majority of class time to be used for reflective learning activities, discussion and exchanging feedback. These Factor 2 students prefer for counselor educators to operate on the periphery of the classroom in the style of a facilitator and delegator, acting as a catalyst who orchestrates a rich learning environment (Grasha, 1994). A rich learning environment from the Factor 2 perspective is a classroom with many active voices openly sharing different points of view, providing one another with candid feedback about their clinical work. An important task then is for counselor educators to create relevant learning activities in class that provoke discussion and reflection. One example of this could be requiring the Factor 2 archetype to present videos or case vignettes of their clinical work with clients in which they are required to conceptualize the client with their classmates. During such an activity, counselor educators may be helpful to Factor 2 students by offering candid feedback, sharing (potentially) alternative viewpoints and prompting them to justify clinical interventions based on their theoretical orientation(s).

The preferences of the Factor 3 student-learner archetype are focused on the personality and relational qualities of counselor educators. This orientation toward the personality qualities of the teacher is congruent with research from undergraduate populations that found instructors with warmth-inducing behaviors (Best & Addison, 2000) and who demonstrated enthusiasm about course content (Feldman, 1988) were associated with effective teaching. Similarly, it is important to the Factor 3 archetype that they perceive their instructors as kind, genuine and passionate about what they are teaching because these personal qualities kindle their interest for learning. Factor 3 students are further motivated to learn when they develop respect and admiration for counselor educators, which can be achieved through expert and formal authority styles of teaching (Grasha, 1994). Factor 3 prefers for counselor educators to lead class in a teacher-centered fashion so that their teachers' personal qualities are at the forefront of the learning environment. However, dissimilar to teacher-centered approaches that emphasize the importance of mastering course content, the Factor 3 archetype learns primarily through the relationship developed with counselor educators. Their ideal teacher is affable, demonstrates charisma in the classroom and is an exemplar of personality qualities they perceive as important for a counselor to possess. Observing and experiencing these desirable characteristics in counselor educators inspires Factor 3 students to emulate them in their clinical work. Several examples of how counselor educators can engage Factor 3 students are as follows: (a) ethically sharing candid anecdotes that may directly or tangentially relate to course material; (b) asking students how they are feeling about their experiences in the class or in clinical situations; and (c) using humor as a pedagogical tool.

It is interesting to consider results from this study in light of a similar Q study that explored what beginning professional counselors perceived as helpful about teachers from didactic courses

(Moate, Cox, Brown, & West, in press). In both studies, three factors emerged from the data that bear great similarities to one another, despite each study being comprised of different participants and Q sort items. This may suggest that to some degree a commonality exists between CMHC students' perceptions of what is helpful about teachers in both clinical and didactic courses. However, unlike the previous study that found a high level of agreement among the three factors about the helpfulness of counselor educators of didactic courses, the factors in this study demonstrated three distinct viewpoints about their preferences. This may suggest that it is more challenging for counselor educators in clinical courses to find a pedagogical middle ground that is mutually pleasing to each student-learner archetype. Thus, counselor educators may need to spend more time in clinical courses considering how they can accommodate the different learning perspectives present in their classroom.

Limitations and Future Research

This study used Q methodology to explore different shared viewpoints that exist among beginning-level counselors about their perceptions of helpful aspects of counselor educators teaching clinical courses in CMHC. Although we believe that student learning preferences are an important perspective for counselor educators to consider, we also recognize that this represents only one side of a coin. It would be helpful for future research to explore what counselor educators perceive as being important for CMHC students to learn in clinical courses to prepare them for the rigors of being professional counselors. This added perspective could elucidate important pedagogical items that were not accounted for in this study.

Implications for Teaching Practice

Because of the three distinctive teaching preferences among CMHC students in clinical courses, counselor educators may need to spend more time considering how they can accommodate diverse student learning needs when teaching clinical courses. An important first step may be for counselor educators to reflect on their teaching and learning bias by considering the following questions: (a) with which student-learner archetype did they most closely identify as a student; (b) which student-learner archetype's teaching preferences most closely align with their style of teaching; and (c) to which student-learner archetype do they prefer to teach? Counselor educators who possess self-awareness of their teaching and learning biases in relation to the student-learner archetypes presented in this study may be better able to make pedagogical adjustments that are beneficial to students who are most unlike their preferences. For example, a counselor educator who identifies as having a pedagogical style that they believe aligns with the Factor 1 (application-oriented) preferences might consider ways to better engage Factor 2 and Factor 3 learners. This could entail structural considerations when designing the course and lesson planning for each class or being intentional about emphasizing or de-emphasizing certain personality characteristics during class.

We also believe that counselor educators can use the findings of this study as a tool to conceptualize students with whom they work in clinical courses. Having such a conceptualization tool may help counselor educators modify their pedagogical approach when working with students individually in a classroom setting. Smaller class sizes and interactive environments in clinical courses provide counselor educators with greater opportunities to communicate directly with students. Consequently, counselor educators have greater potential in clinical courses to make adjustments based on the perceived needs of the individual students. For example, rather than working in the same way with all students (e.g., providing strength-based feedback), a counselor educator who notices that a student has traits of the Factor 2 archetype may consider providing feedback that is corrective in nature.

The findings from this study highlight different teaching preferences that exist among beginning counselors about helpful aspects of teachers in clinical courses. It is probably unrealistic and unnecessary for counselor educators to make drastic changes to their pedagogy in pursuit of perfectly meeting the learning preferences of all CMHC students in a clinical class. Rather, we broadly suggest that counselor educators should be reflective of their own teaching characteristics and biases and consider making small modifications to their pedagogical approach that will be more inclusive for students with preferences different than their own.

Conflict of Interest and Funding Disclosure
The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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The Effect of a School-Based Transitional Support Intervention Program on Alternative School Youth's Attitudes and Behaviors

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This investigation examined the potential impact of a school-based youth intervention program on the attitudes and behavioral patterns of at-risk youth. The sample size used in this study was 52; 24 participants received the school-based intervention and 28 participants did not receive the intervention. A two-group pretest-posttest design approach was implemented. A two-phase behavioral intervention was used with at-risk youth who were returning from a remanded period at an alternative school in lieu of expulsion from school. After the conclusion of the intervention program, school attitudes, behavioral indicators and academic success indicators were evaluated. The results of this study revealed that there was a significant treatment effect on youth's school attitudes.

Keywords: **school-based youth intervention, at-risk youth, alternative school, transitional support, behavioral intervention**

According to the National Center of Education Statistics (2016), in the United States, almost 7% of students drop out of high school. Evaluations of on-time graduation rates reveal that approximately 30% of students fail to graduate in the traditional 4-year time frame (Berger, 2011; Kelchner, 2015; Levin, 2009; Stout & Christenson, 2009). There are some common predictors of high school dropout. Suh, Suh, and Houston (2007) identified 16 predictors of school dropout. Of those 16 predictors, low socioeconomic status, academic failure and behavior problems were the primary risk factors. Academic failure was found to have the most significant impact. Suh, Suh, and Houston (2007) determined that (a) early intervention (prior to a student accumulating multiple risk factors) is more easily targeted and effective and (b) multiple interventions may be necessary to keep students with multiple risk factors in school. Youth who have been suspended from school are twice as likely to drop out (Smith & Harper, 2015). Often, youth who have been sent to alternative schools have incurred multiple suspensions, making the likelihood of dropping out of school even greater. Academic failure can lead to repeating courses, grade retention, and academic apathy, and ultimately may lead to dropping out altogether (Berger, 2011).

Frequently, students who are the most susceptible to dropping out are those who are in or have attended alternative schools (Kelchner, 2015). Alternative education proliferated in the 1960s and early 1970s as educational priorities shifted to the progressive education movement (Kim, 2006). Alternative schools were initially designed to provide a positive alternative to conventional learning environments for students who were unable to succeed in traditional learning environments, but the trend today is for alternative schools to function as separate retributory schools for undesirable children (Prior, 2010; Richardson, 2012). Originally, people who were dissatisfied with traditional curricula welcomed alternative public schools that subscribed to the ideas of progressive education, which called for a free, open policy that emphasized the development of self-concept, problem solving and humanistic

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approaches (Conley, 2002). Alternative schools tried to offer more freedom and prospects for success for students. However, most alternative schools from this era were short-lived.

In the mid-1990s, alternative learning environments started providing programs to schools (including public and private voucher programs, charter schools, and magnet programs) in an effort to solve issues of poor student achievement, ineffective pedagogical methods, and an increasing inability to meet the needs of diverse families (Kim, 2006). Two pieces of legislation were introduced that modified the number and types of students being served by alternative education settings. The first legislation was the Gun Free Schools Act of 1994, which mandated that students who brought weapons to school be expelled and/or sent to alternative educational settings for a period of 1 year (Prior, 2010; Stone, 2003). Zero tolerance policies were a product of this legislation and created the stage for a dramatic increase in student suspensions and expulsions from school. These referrals led to more placements in alternative education schools. The second piece of legislation introduced was the Individuals with Disabilities Act of 1997, which allowed individualized education program teams to place students with disabilities in appropriate interim alternative education settings for up to 45 days (Prior, 2010).

According to Prior (2010), Richardson (2012), and Stone (2003), there are three types of alternative schools: Type I alternative schools are schools of choice that mimic magnet schools; Type II alternative schools are last-chance programs; and Type III alternative schools are disciplinary programs that focus on remediation or rehabilitation. Typically, the goal of Type II and Type III schools is to return students to their home schools after successful treatment (Stone, 2003). Today, alternative schools are often viewed by the public as places for students who are disruptive, deviant and dysfunctional, rather than as positive alternative solutions for students whose needs are not being met by traditional schools. Many believe these schools exist to segregate troublemakers in one place to better protect the students in traditional schools (Conley, 2002; Kim, 2006).

Out-of-school suspension and expulsion are widely used practices in American school systems, which only further isolate students from education. As a result, more than 3.3 million students are suspended each year and these students are at greater risk of not remaining in school (T. Lee, Cornell, Gregory, & Fan, 2011; Smith & Harper, 2015). Students who have received disciplinary infractions for excessive absenteeism, disrespectful behavior, disrupting class, fighting, profanity, refusal to obey, tardiness, theft, truancy and verbal altercations may be recommended for expulsion from school. In lieu of expulsion, students may be allowed to attend an alternative academy within the school district. One of the goals of alternative schools is to provide students with a second chance (Kim, 2006). The alternative academy is a smaller, more supportive Type III environment that focuses on providing students with academic and behavioral skills. In some alternative schools, short-term placements are utilized for students who are suspended or expelled, offering the students opportunities to return to traditional school settings (Blythewood Academy, 2013; Richardson, 2012). The eligibility for the student to return to the traditional school setting is based on fulfillment of certain requirements or assessments (Richardson, 2012).

Students returning from alternative academies to their home schools may face an array of challenges. The transition back to the home school can be difficult for a number of reasons. Students returning from an alternative school setting to a traditional school setting have to readjust to the larger classroom sizes and less one-on-one assistance with their academic studies. The students are often behind in their studies because they are placed in classes at their home schools that are further along than the classes they were taking at the alternative academies. In addition, they tend to be labeled "at-risk" for school failure because of their attendance at an alternative school, no matter how much academic potential they may possess (Kim, 2006). Likewise, there is a sense of disconnectedness to the home school and its faculty and staff (Boutelle, 2010; Kelchner, 2015). Students' performance tends to be greater when they bond with their school, are connected and feel someone at the school cares about them (Flower, McDaniel, & Jolivette, 2011). Many at-risk youth are not given compulsory support and are not nominated to receive remedial services (Kayler & Sherman, 2009). Because the transition back to their home schools can be very challenging, students who fail to make this transition either are sent back to the alternative academy, expelled from school or drop out. Rumberger and Lim (2008) classified the reasons students leave high school before completion into individual predictors and institutional predictors. There are four major categories of individual predictors: (a) academic failure, (b) expectations (e.g., future academic success), (c) behaviors, especially engagement, and (d) background and life experiences (Rumberger & Lim, 2008). Students who are sent to an alternative school are more than twice as likely to drop out of school as students who have not been sent to an alternative school setting, and support with this transition is needed for students returning to their home schools (Berger, 2011; Brownstein, 2010; Kelchner, 2015; Stone, 2003).

Alternative School Transition

The literature was reviewed to assess interventions for use in our study. The primary goal of alternative programs is to transition students back to their traditional educational environment, the home school. There is little research about this transition and how to best meet the needs of transitioning youth. Coordinated planning can minimize the anxiety and negative elements experienced by students, families and teachers that can accompany the transition from one educational setting to another (Kelchner, 2015; Richardson, 2012; Wolf & Wolf, 2008). A lack of appropriate transition and support programming can negate the benefits received from the alternative school. Students have the potential to regress to prior negative behaviors and poor performance because of the loss of support, a return to the environment that already failed them, negative peer influences, and labeling and stigmatization by both peers and school personnel, which may lead to re-suspension (Stone, 2003; Valore, Cantrell, & Cantrell, 2006; Wolf & Wolf, 2008). As a result, students who attend an alternative school and have the fortitude to improve behavior, improve school relations and catch up academically often return to the prior negative conditions in their home school that caused them to fail in the first place. Because of an apparent lack of support and services throughout the transition, many students return to the alternative schools or end up in more restrictive placements, such as juvenile detention or jail (Berger, 2011; Richardson, 2012; Stone, 2003).

School-Based Transitional Support Intervention

Exiting an alternative school and re-entering a traditional school setting can present many stressors for youth. The purpose of this study is to provide an intervention to support youth returning to a traditional educational setting from alternative school to assist in preventing youth from dropping out of school. The intervention in this study, focused on the area of the individual and how the individual accesses systemic supports within the school community, local community and family. Empowerment, school engagement and academic success were the three major variables focused on in the development of this intervention. The final intervention was based on 10 systemic reviews of intervention programs, eight meta-analyses of various school interventions for at-risk youth, 25 various studies of design, six articles describing implementation of specific programs and six components articles relevant to one or more of the identified key variables. Interventions had to encompass the following criteria to be included in the development of the intervention: target at least one of the factors identified by the target population, be deliverable in a group format, not require direct teacher involvement, and not require unavailable resources.

The theoretical foundation for this research was an ecosystemic approach. This approach was chosen because it is important to look at all of the systems that support the youth, such as the school community, social community, family community and local community. The ecosystemic approach offers perspective on emotional and behavioral difficulties in schools by offering a particular analysis of the interactional patterns observable in social systems (Cooper & Upton, 1990; Wolf & Wolf, 2008). Ecosystemic theory takes into consideration all parts of the students' systems and how these systems can assist students to have a successful transition to a traditional educational setting and high school experience. A smoother transition also may be promoted by empowering students.

Empowerment

Empowerment is a way people gain control over their lives through actively participating and focusing on their strengths and not their weaknesses, while embracing diversity and using the language that reflects empowerment ideals (Chinman & Linney, 1998). Empowerment is a cyclical process in which adolescents develop their identity variables, including self-efficacy, self-confidence, self-esteem and self-acceptance (Berger, 2011; Chinman & Linney, 1998). Students are given a sense of control through this process. Empowerment shapes how youth interact with their entire environment, including their school environment, while facilitating attitudes and motivation.

The empowerment component of our intervention was based on the intervention program Empowerment Groups for Academic Success (EGAS; Bemak, Chung, & Siroskey-Sabdo, 2005). The EGAS intervention was initially used with African American female students who were referred because of extremely poor academic performance, behavior issues and a lack of desire to finish high school (Bemak, Chung, & Siroskey-Sabdo, 2005). The authors only retrieved qualitative data through taped interviews with students 6 months post-intervention and follow-up surveys at 1 year (Bemak et al., 2005; Berger, 2011). Empirical evaluations of the study were planned and approved, but because of administrative changes, researchers were prohibited from collecting empirical data. EGAS was initially designed for use with African American females (Bemak et al., 2005) and later adapted for use with African American middle school females (Hilton-Pitre, 2007). Weekly group sessions provided support throughout the school year in a format in which group members chose the discussion agenda and facilitators guided the discussion, while the overarching goal was academic success. Bemak and colleagues (2005) proposed to empower group participants by acknowledging their ability to evaluate their own needs and implement topics for discussion. EGAS was designed to encourage empowerment through the group process and move away from the psychoeducational format, with the goal of facilitating self-efficacy and empowerment (Bemak et al., 2005; Berger, 2011). The group was also aimed at improving attendance and academic performance.

During the weekly EGAS group meetings, care was taken to make sure that the group session was not held within the same class period from the previous week. A university professor facilitated the group and the co-facilitator was a school counselor. The facilitator worked closely with the school counselor to implement the group process. The program used five graduate student interns to co-lead during the semester. Participants acknowledged improved school attendance, behavior and grades. They discussed that they were better able to communicate and had improved relationships at home. Prior to participating in EGAS, students believed they would not graduate from high school. Upon completion of the program, students expressed the desire to attend college.

The intervention was conducted with a population demographically similar to the target population in this study with the exception that there were no male students. The intervention's primary objective was to enhance student empowerment with the expected antecedent that empowered youth would self-correct academic and behavioral barriers to high school graduation

(Bemak et al., 2005; Berger, 2011). The intervention in this study was designed to support students for an entire year and embraced an ecosystemic approach. All systems of the students were involved in the process to encourage success. Students' teachers, administration, families, counselors, community and peers worked collaboratively in the intervention. The descriptive evidence provided in support of the treatment is promising and is reinforced by similar findings in the Hilton-Pitre study (Berger, 2011; Hilton-Pitre, 2007). Additionally, successful utilization of empowerment strategies by other adolescent group intervention designs targeted for the treatment of various youth populations maintains the adaptability of EGAS to a diverse population group format (Berger, 2011).

Bemak and colleagues (2005) were only able to use self-reported improvements to illustrate the effectiveness of the EGAS approach, and they limited their research to females. These limitations weaken the ability to generalize to other populations. The intervention in our study used empirical data to examine effectiveness and a control group. Our study also used a sample that included both females and males from more diverse backgrounds, which promoted the generalizability of this study to other populations. Each of the interventions designed to facilitate empowerment in adolescents was evaluated for efficacy, feasibility and ecosystemic suitability. EGAS was recommended for inclusion in the transition intervention.

School Engagement

Many terms define *school engagement*: school connectedness, school bonding, school attachment and school belonging (Berger, 2011; Boutelle, 2010; Caraway, Tucker, Reinke, & Hall, 2003; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Christenson & Anderson, 2002; Flower et al., 2011; Frydenberg, Care, Freeman, & Chann, 2009; Reschly & Christenson, 2006; Stout & Christenson, 2009). Stout and Christenson (2009) suggested utilizing interventions designed to help students develop analytical skills and develop serviceable goals to increase academic performance. Behavioral engagement is an external indicator of school engagement that makes it directly observable by an array of indicators: attendance, time on tasks, classroom behavior, interpersonal relationships and participation (Berger, 2011; Jimerson et al., 2003; Stout & Christenson, 2009).

The transition to high school is a challenge for many students and is one of many developmental tasks for adolescents (Kayler & Sherman, 2009). Positive intrinsic motivation and positive self-attributes help adolescents achieve developmental tasks, such as academic achievement, transition to secondary school, forming close friendships and forming a sense of self. Kayler and Sherman (2009) implemented a psychoeducational study skills intervention with ninth-grade students whose academic performance was in the bottom 50th percentile ($N = 90$). The American School Counselor Association (ASCA) National Model was used as a framework for development, delivery and evaluation.

Kayler and Sherman found that a small group counseling intervention strengthened study behaviors. Increasing school counselor visibility and increasing positive relationships with parents and other stakeholders was also important to students' success. The study skills program focused on three main skill sets that research has indicated contribute to improved academic performance: (a) cognitive and metacognitive skills, such as goal setting, time management and study skills; (b) social skills, including listening and teamwork; and (c) self-management skills, including motivation (Berger, 2011; Kayler & Sherman, 2009). The small group format permitted students to meet standards for the ASCA National Model in the academic, career, personal and social domains. Each theme of the ASCA National Model was expressed: leadership, collaboration, systemic change and most notably, advocacy (Kayler & Sherman, 2009).

Groups consisted of 12 students of both mixed gender and race and two counselors. The authors used a pretest-posttest study designed to evaluate the program. Data was collected utilizing the "How do you study?" survey (J. L. Lee & Pulvino, 2002) at both the second session and final session to evaluate the program's effect on seven areas: time usage, persistence, organization, concentration, note-taking skills, reading skills and test-taking skills. Additionally, participants were asked for their input regarding the program at the final session. This study was implemented from a systemic perspective. School counselors collaborated with invested parties in the students' lives, such as administration, families, peers, teachers and university partners. All of the systems were interactional and reflective of the ecosystemic approach. Posttest scores for all subscales were significantly higher than pretest scores, except in the area of concentration, signifying that students were using significantly more study skills after the program than before. Students' GPAs also were compared and showed a significant increase in a number of individual students' grades, but improvement was not significant overall. The authors discussed the possibility that GPAs were taken too soon after completion of the group and noted that there was no control group to offer a true comparison. The results of this study demonstrate that the use of study skills improved dramatically after participation in the group. Opening communication between students and parents was a significant outcome of the program (Kayler & Sherman, 2009), and provides evidence that utilization of a cognitive-behavioral grounded psychoeducational group to teach study skills can be effective (Berger, 2011; Kayler & Sherman, 2009). The intervention fits the needs of our target population. The study was conducted with ninth graders in the bottom half of their class; most students returning from alternative schools are true ninth graders or repeat ninth graders. Therefore, this intervention was recommended for inclusion in our final intervention.

EGAS and Kayler and Sherman's psychoeducational study skills intervention encourage cultivation of self-regulation skills. One effective strategy in developing self-regulatory processes is goal setting (Bandura, 1991; Berger, 2011; Zimmerman, 2000). Short-term goals can be used to help students receive feedback success in a shorter time frame, which enables students to learn to adjust to meet desired goals (Berger, 2011). Goal setting as a group topic helps students learn from one another and understand other experiences while recognizing commonalities. Goal setting is a feature of the psychoeducational study skills intervention (Berger, 2011; Kayler & Sherman, 2009). Students who are empowered through the EGAS experience may increase confidence in their ability to employ self-regulation techniques in other areas of their lives (Bemak et al., 2005; Berger, 2011). This increased confidence may aid students in academic success.

Academic Success

When students struggle to maintain positive academic self-perceptions, it can inhibit their abilities to succeed in academic environments. Inadequate academic competence has been shown to be the strongest predictor of high school dropout (Battin-Pearson et al., 2000; Berger, 2011; Newcomb et al., 2002). Goal setting, progress monitoring, memory skills, interpersonal skills, problem-solving skills, listening, teamwork, regulating attention, and regulating emotions and motivation are important skills that help facilitate students' academic competence (Berger, 2011; Hattie, Biggs, & Purdie, 1996; Masten & Coatsworth, 1998). Berger (2011) reported that there are numerous variables that are attributed to academic success and related to students' willingness and ability, including academic self-perception, cognitive ability, engagement, importance of education to the student, and academic self-identity. Longitudinal research has established correlations between early student behavioral patterns (i.e., absenteeism, lack of engagement, behavioral problems), academic performance and later dropping out of school (Alexander, Entwisle, & Kabbani, 2001; Archambault, Janosz, Morizot, & Pagani, 2009; Berger, 2011; Connell, Halpern-Felsher, Clifford, Crichlow, & Usinger, 1995; Fleming et al., 2005; Frydenberg et al., 2009).

Adult support is continuously present in research relating to dropout prevention interventions. Numerous studies have discussed the positive effect of adult support on academic achievement (Berger, 2011; Blount, 2013; Croninger & Lee, 2001; Kayler & Sherman, 2009; Klem & Connell, 2004). Adult support may be given through teachers, administration, counselors, mentors and school staff. Students feel support when there is a caring relationship within the school context (Blount, 2012). Adult support is a key element of the interventions reviewed in either the form of group facilitators or one-on-one mentors or counselors (Bemak et al., 2005; Berger, 2011; Flower et al., 2011; Hilton-Pitre, 2007; Kayler & Sherman, 2009). The EGAS and the psychoeducational study skills intervention employ adult support through school counselors, facilitators, graduate interns and mentors. Therefore, our intervention included adult support in the form of group facilitators, mentors and a school advocate.

The three major variables of this study—youth empowerment, school engagement and academic success—were revealed in the literature and thus should be considered in the development of an intervention for transitioning at-risk youth. Youth empowerment helps youth explore positive self-variables. Empowerment enables youth to feel hopeful and confident in discovering roles during development. Empowerment shapes how youth interact with their entire environment, including their school environment, while facilitating attitudes and motivation. School engagement influences students' attitudes, perceptions and feelings about school. School engagement also shapes youth behavior within the school context. Empowerment and school engagement are connected to academic success. The relationship of these variables is illustrated in Figure 1.

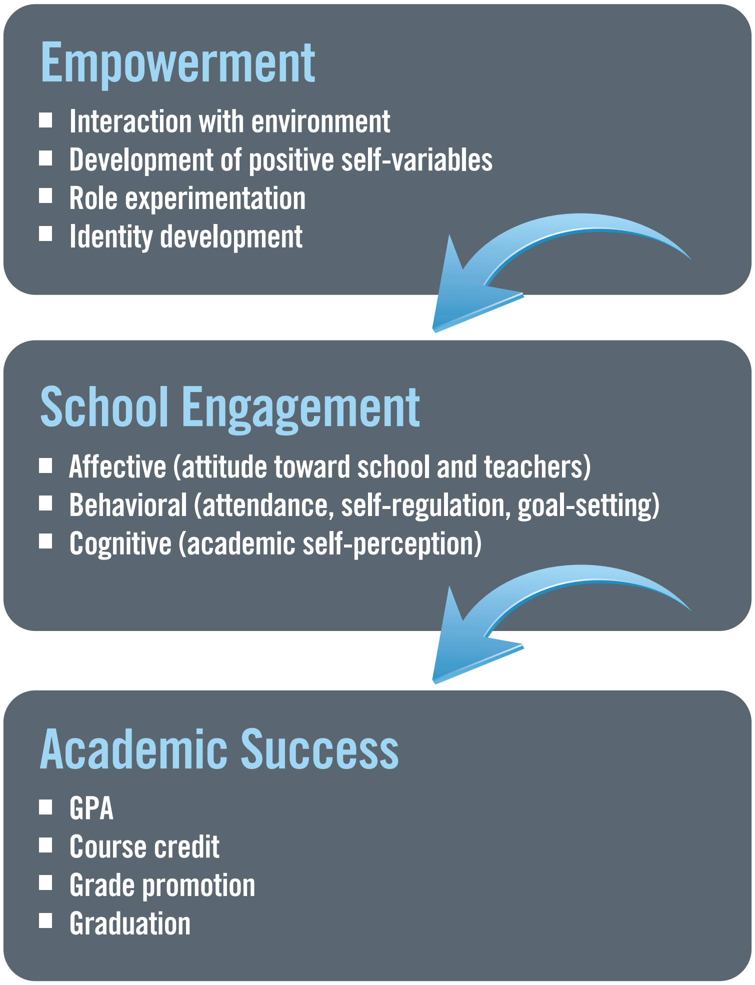

Figure 1. Variables connected to school success.

Based on the evaluation of research and the ability to fit in the parameters of this study, the decision was made to incorporate two interventions in our final treatment. Our final treatment was composed of a study skills intervention and an empowerment intervention. The intervention aimed to provide three foundational supports for the returning alternative academy students: group, mentor and advocate. The treatment was provided in a group format and students were supported by individual mentors and an advocate housed at their home school. Graduate student interns working toward their master's, Ph.D. or Ed.S. degrees provided the mentoring. The advocate was a school counselor and designated point of contact in the home school system.

The group treatment consisted of two phases. The first phase was a psychoeducational study skills group consisting of six modules covered over 8 weeks: (a) goal setting, (b) self-regulation, (c) organizational strategies, (d) study strategies and directions, (e) note-taking strategies and (f) test-taking strategies/managing test anxiety. When Phase I was completed, students transitioned immediately into Phase II, the EGAS model developed by Bemak et al. (2005). Even though this model was originally implemented with African American students, it was chosen because often students with multiple risk factors can be marginalized and can benefit from empowerment (Berger, 2011), and a majority of students returning from the alternative academy were African American. During Phase II, students continued to meet weekly through the duration of the school year. The EGAS setting was student-driven in that students presented the topics while leaders facilitated the group discussion. Each week, the students chose as the group topic personal problems that impacted their academic success.

Ultimately, the four research questions guiding our investigation were: (1) What is the effect of a school-based youth intervention program on at-risk youth's school attendance transitioning from an alternative educational setting to a traditional school setting as measured by number of periods absent? (2) What is the effect of a school-based youth intervention program on at-risk youth's school disciplinary actions transitioning from an alternative educational setting to a traditional school setting as measured by number of discipline referrals? (3) What is the effect of a school-based youth intervention program on at-risk youth's credit accrual transitioning from an alternative educational setting to a traditional school setting as measured by the percentage of classes passed? And (4) what is the effect of a school-based youth intervention program on at-risk youth's school attitudes transitioning from an alternative educational setting to a traditional school setting as measured by the School Attitude Assessment Survey-Revised (SAAS-R)?

Methodology

Procedure and Participants

A two-group pretest-posttest design, which included collecting data at two time points over the course of the school year, was utilized to investigate the effectiveness of the school-based transitional support intervention program on the youth's attitudes and behavior. Prior to the recruitment of participants, we received approval from our university's Institutional Review Board and from the school district to conduct the study. The setting for the treatment and control groups were in high schools in the southeastern United States. The high school within one school district with the highest number of expulsions was selected as the treatment site. The other high schools in the school district's alternative school returnees were used as a control group for the study. The at-risk youth targeted for this study were students returning from at least a 45-day remanded period at the school district's alternative academy. There were a total of 100 participants ($N = 100$), including 50 treatment and 50 control participants. Because of missing data, the sample size was reduced to 52 participants ($N = 52$). There were 24 participants (N = 24) in the treatment group and 28 participants (N = 28) in the control group. Although the initial sample was 100, with statistical listwise deletion the sample was reduced to 52. This study utilized a multivariate analysis of variance, an analysis that is unable to use datasets with missing data points because a likewise deletion is utilized (Pallant, 2016). When using listwise deletion, a case is dropped from an analysis because it has a missing value in at least one of the specified variables (e.g., attendance, grades, discipline, SAAS-R). When conducting research with this population, there is always the risk of not being able to obtain all needed data because a participant is no longer in the same school or school district.

The ethnicity of participants was as follows: 85% Black, 5% Hispanic, 6% White, 2% Multiracial and 2% Asian. Seventy-two percent of the participants were male and 28% were female. The ethnicity of the sample was aligned with the ethnicity of the students who attended the alternative school. The majority of students who attended the alternative school were Black. Sixty-eight percent of participants were receiving free lunch, 12% were receiving reduced fee lunch, and 20% were paying full lunch fees. The participants' ages ranged from 14 to 19 years old. The demographics of the sample were representative of the alternative school demographics.

Recruitment of participants was facilitated through the alternative school exit interviews. All students exiting the alternative school must partake in an exit interview to ensure they have met all requirements to return to their home school. Parents and students were informed about the intervention program. They also were informed about which group the student would qualify to be in, which was determined by the home school the student attended. Parents and students were informed that students' grades, attendance and behavioral information would be collected as part of an ongoing evaluation to determine the effectiveness of the program. Parents and students were made aware of the attitude assessments students would complete two separate times during the school year. They were provided with an information packet with consent forms, an explanation of the program and contact information. If consent was obtained, the participants were given the SAAS-R.

Behavioral and School Attitude Outcomes

The data collection packet consisted of one measure, the SAAS-R (McCoach & Siegle, 2002). The SAAS-R was administered during the exit process at the alternative school and after participants completed the intervention. In addition, the school district provided the attendance records (measured by individual class periods missed), discipline records (measured by discipline infractions [e.g., warnings, school suspension, out-of-school suspension, Saturday school detention]) and credit accrual (measured by the percentage of courses passed the school year prior to exiting the alternative school and the exiting school year) for the students in both the treatment and control groups.

School Attitude Assessment Survey-Revised (SAAS-R). The SAAS-R (McCoach & Siegle, 2002) is a 35-question assessment with five subscales, including students' academic self-perceptions, attitudes toward teachers, attitudes toward school, goal valuation and self-regulation. Students were assessed pre-treatment (pretest) and at the end of the school year and conclusion of the treatment group (posttest). Both groups were assessed pre-return to their home school during exit interviews (pretest), which served as the baseline pretest, and again at the end of the school year (posttest). Students answer the 35 questions on a 6-point Likert scale (1 = strongly disagree; 6 = strongly agree). Subscales were scored by totaling the response value of each question and then dividing that by the number of questions. The scores range from one to six. Scores of one to three suggest negative attitudes, and scores of four to six suggest positive attitudes (Berger, 2011; McCoach & Siegle, 2002; Suldo, Shaffer, & Shaunessy, 2008). McCoach and Siegle (2003) investigated the validity of the SAAS-R with 176 high school students while Suldo and colleagues (2008) investigated the validity of the SAAS-R with 321 high school students. Both found evidence of adequate construct validity, criterion-related validity and internal consistency reliability (McCoach & Siegle, 2002; Suldo et al., 2008).

Data Analysis

SAAS-R scores, attendance, discipline and credit accrual pre- and post-intervention data, and control data were entered into Statistical Package for the Social Sciences (SPSS Version 21) for analysis. Next, we screened for missing data. Then we conducted preliminary analyses to examine statistical assumptions (e.g., normality, outliers, linearity, homogeneity of regression, multicollinearity and singularity, and homogeneity of variance-covariance matrices). A repeated measures multivariate analysis of variance was performed to determine if there was a significant difference in participants' school attitudes, credit accrual, discipline and attendance scores pre- and post- intervention intervals and control intervals (Pallant, 2016). Four dependent variables were used: SAAS-R (assessment), percentage of courses passed (credit and grade accrual), discipline referrals (incidents), and attendance. There were two forms of independent variables: treatment and control, and Time 1 and Time 2. Treatment and control were the between-subjects independent variables and Time 1 and Time 2 were the within-subjects independent variables. This study had four dependent variables (e.g., assessment, grades, incidents, attendance) and one grouping variable with two levels (time and control). The dataset should include more cases than dependent variables, which we satisfied (Pallant, 2016). The power analysis helped to decrease the probability of a Type II error (Balkin & Sheperis, 2011; Cohen, 1992; Faul, Erdfelder, Lang, & Buchner, 2007). For these reasons, a post hoc power analysis was conducted for the means of this study and established sufficient power for the overall model (.98).

Results

There was no significant main effect due to treatment (time by treatment/control): Wilks' Lambda = .890, $F(4, 47) = 1.451$, $p = .232$. However, the multivariate test did reveal a significant main effect for time: Wilks' Lambda = .654, $F(4,47) = 6.219$, $p < .001$ (see Table 1.1). Because of the significant main effect for time, each dependent variable was investigated further by reviewing the univariate results. Examination of the simple effects indicated a significant difference between pre- and post-values for grades: $F(1,50) = 13.178$, $p < .001$. Both treatment and control grades decreased between pre- and post-grades. The simple effects indicated a significant difference in pre- and post-values for discipline: $F(1,50) = 6.206$, $p < .05$. Both treatment and control had a decrease in discipline referrals between pre- and post-values. All univariate effects are reported in Table 1.2. Overall multivariate results revealed that time was significant and time by treatment and control was not significant. The test of between-subjects effects results show that there was a significant effect of treatment on SAAS-R: $F(1,50) = 5.159$, $p < .027$. All between-subjects univariate effects are reported in Table 1.3. The effect of treatment on SAAS-R revealed a significant result, which indicated that participants who received the intervention scored higher on the SAAS-R at the end of the school year. The participants in the treatment group had higher attitudes toward school than the participants who did not receive the intervention.

Table 1.1

Multivariate Effects

	Wilks' Lambda	$F(4,47)$	p
Time	.654	6.219	.001
Time by Treatment/Control	.890	1.451	.232

Table 1.2

Univariate Effects for Time 1 and Time 2

Dependent Variables	Mean Square	$F(1,50)$	p
Assessment	232.154	.311	.580
Grades	.514	13.178	.001*
Discipline	114.434	6.206	.016*
Attendance	11698.959	2.840	.098
Error	747.339		

*Significant ($p < .05$)

Table 1.3

Between-Subjects Effects for Treatment and Control

Dependent Variables	Mean Square	$F(1,50)$	p
Assessment	5268.134	5.159	.027*
Grades	.007	.090	.765
Discipline	11.385	.474	.494
Attendance	1210.554	.235	.630

*Significant ($p < .05$)

Discussion

Implications for Practice

The aim of this study was to determine the effect of a school-based youth intervention program on the attitudes and behavioral patterns of at-risk youth. The intervention did not have an effect on the youth's school attendance. There was no significant difference between the treatment and control groups. Overall there was an increase in the number of periods missed for both the treatment and control groups. One of the most important predictors of academic success is remaining engaged in academic instruction (Berger, 2011; Kelchner, 2015); thus, if students are missing classes, they also are missing instructional time. After transitioning back to the traditional school setting, the participants' attendance decreased, resulting in less time in the classroom to receive academic instruction and ultimately lower grades. Results from other research support these findings. Students who are regularly absent from school have less than a 10% chance of graduating and are disengaged, creating academic and behavioral issues (Allensworth & Easton, 2007). Students who are suspended or expelled are at greater risk of not going to classes and dropping out of school (Brownstein, 2010; T. Lee et al., 2011; Smith & Harper, 2015). Even though the intervention was not found to have an effect on attendance, the percentage of students remaining in school who attended the alternative school was higher than the percentage of students remaining in school the year prior to implementing the intervention. In the school year prior to the intervention, 59% of students returning from the alternative school setting to the home school were no longer in school at the end of the year. At the end of the school year after the intervention took place, the number of students returning from the alternative school setting that were no longer in school was reduced to 14%.

Other researchers have found that students returning from alternative school placement may have the tendency to revert back to prior negative behaviors, resulting in reoccurring suspension (Richardson, 2012; Stone, 2003; Wolf & Wolf, 2008). Many students return to the alternative school or end up in more restrictive placements like juvenile detention or jail (Berger, 2011; Richardson, 2012; Stone, 2003). This intervention had no significant effect on discipline. However, there was a decrease in the number of discipline referrals from Time 1 to Time 2. Both the treatment and control groups experienced a decrease in the number of discipline referrals received. The researcher met the control group participants during exits and established a relationship with the participants. This could have contributed to gains the controls made simply because the participants may have felt someone cared about them. It is important to find ways to sustain positive gains when students leave an alternative school setting. This can be facilitated via support through the transition from alternative educational setting to the traditional school setting (Berger, 2011; Stone, 2003; Valore et al., 2006; Wolf & Wolf, 2008).

The participants in the treatment and control group did not exhibit gains in credit accrual. This finding is supported by other research. School transitions are associated with absenteeism, re-suspensions, disengagement to the school community and poor academic performance (Berger, 2011; Richardson, 2012; Stone, 2003; Wolf & Wolf, 2008). School transition also can affect social relationships that enhance academic accomplishments (Richardson, 2012; Stone, 2003). It is difficult for some students to re-integrate in a traditional school setting and do well academically. The decrease in credit accrual may be a reflection of this difficulty.

What our intervention did obtain was a positive effect on school attitudes as measured by the SAAS-R. There was a significant effect of treatment on assessments. The control group assessment scores remained almost exactly the same, whereas the treatment group assessments scores increased. This is an indication of more positive attitudes toward school. One component of the intervention was empowerment. Empowerment shapes how youth interact with their environment and facilitates improvement in attitudes and motivation (Berger, 2011). Interventions that promote empowerment promote positive self-perception and help develop self-esteem (Berger, 2011; Thomas, Townsend, & Belgrave, 2003). Another component of the intervention was engagement. Participants in the treatment group were taught strategies to facilitate engagement. School engagement influences students' attitudes (Stout & Christenson, 2009). The increase in the assessment scores within the treatment group is reflective of this. The treatment group was given the assessment at the end of the year by facilitators and mentors the participants had developed a relationship with. This could be a reason the participants had higher scores. They may have better attitudes toward school because they have someone they know who cares about them and they interact with this mentor at least twice a week, if not more often (during group sessions and during individual counseling sessions). Supportive relationships can help promote students' success in school (Berger, 2011; Richardson, 2012; Stone, 2003). Our findings lend support for the use of school-based transactional supports for youth returning to a traditional education environment from an alternative school to increase positive school attitudes.

Limitations of the Study

Although measures were taken to ensure the fidelity of the study, there were limitations because of the nature of the research. An important strength of the study was the fact that it was *effectiveness research* in a real-world, everyday setting (Singal, Higgins, & Waljee, 2014). The sample used in this research is a community sample and the intervention took place in an actual school setting. The nature of this setting creates limitations because a number of factors were out of the researchers' control and created an inability to control for any independent variables. When conducting research with this population, there is always a risk of not being able to obtain all needed data because some participants are no longer in the same school or school district, reflecting a high attrition rate. This resulted in incomplete data sets and drastically reduced our sample size. Overall, this sample is not representative of the entire population because it was studied in one school district in the southeastern United States, which may have unique qualities as compared to other school districts and high schools. Lastly, fidelity can be a challenge in research. The intervention delivery involved several people. Even though every measure was taken to properly train facilitators and oversee all aspects of the research, fidelity in this area may have been an issue.

Recommendations for Future Research

Previous researchers have neglected to look at the most effective way to support youth transitioning from an alternative school setting back to a traditional education setting. There is research on youth who are involved in the juvenile justice system, but researchers have neglected to investigate youth who are transitioning to traditional educational settings and who are not engaged with the justice system. Often, students who have been placed up for expulsion or received out-of-school suspensions will inevitably become a part of the juvenile justice system (Berger, 2011; Blount, 2012; Kelchner, 2015). This research has demonstrated to some extent the importance of developing caring relationships with youth. The intervention employed in this study facilitated a change in the school attitudes of at-risk youth. The results provide evidence for the need for more research in the area of interventions to prevent school dropout or reduce justice system involvement, creating an environment in which fewer youth would end up incarcerated.

Our utilized intervention included empowerment strategies to encourage youth to feel connected with others in school and the community. Adult support through facilitators, mentors and advocates helps to change school attitudes with at-risk youth transitioning back to the traditional educational setting. Adult support creates positive effects on academic achievement for at-risk youth (Berger, 2011; Blount, 2012; Croninger & Lee, 2001; Kayler & Sherman, 2009; Klem & Connell, 2004).

In summary, this study of high school youth returning from an alternative school environment to a traditional school setting found that school-based transitional support intervention was effective in changing school attitudes of at-risk youth. There is a great need for additional research to investigate ways to support this vulnerable population, but this study is a step in the right direction.

Conflict of Interest and Funding Disclosure
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Inconsistent counselor professional identity contributes to issues with licensure portability, parity in hiring practices, marketplace recognition in U.S. society and third-party payments for independently licensed counselors. Counselors could benefit from enhancing the counseling profession's identity as well as individual professional identities within the counseling profession. A random sample of 472 independently licensed counselors self-rated and then documented their individual professional identity via their occupational role discussions with others. Results demonstrate that independently licensed counselors rarely accurately self-evaluate their occupational role communications. Further, counselors rarely establish the counseling profession's identity when discussing their occupational role. Participants' responses guided the creation of a model that can guide counselors in evaluating and improving the communication of their professional identity to clients, other professionals and the general public.

Keywords: **counselor professional identity, licensed counselors, occupational role, parity, structural coding**

Authors have expressed concerns about counselor professional identity for over 10 years (Gale & Austin, 2003; Gibson, Dollarhide, & Moss, 2010; Kaplan & Gladding, 2011; Mellin, Hunt, & Nichols, 2011; Myers, Sweeney, & White, 2002). An inconsistent counselor professional identity contributes to issues with licensure portability, parity in hiring practices, marketplace recognition in U.S. society and third-party payments for independently licensed counselors (Calley & Hawley, 2008; Myers et al., 2002; Reiner, Dobmeier, & Hernández, 2013). Additionally, the lack of counselor professional identity has been a factor related to students with master's degrees in psychology becoming licensed as counselors in many states (Lincicome, 2015). If the profession of counseling appears the same as all the other mental health professions, legislators struggle to understand how specific licenses tie to specific professions that have specific graduate education programs. Licensure boards protect the public from harm by ensuring that counselors have appropriate graduate degrees based on relevant curricula and direct application experiences under supervision (Simon, 2011). Licensing boards require uniform standards to measure minimum training criteria for a profession to assist in expeditious reviews of licensure applications (Mascari & Webber, 2013). A strong counselor professional identity increases counselors' ability to work with their client populations of interest, receive third-party reimbursement, offer all of the appropriately trained services afforded in their scope of practice and make a greater impact when advocating for clients (Calley & Hawley, 2008; Myers et al., 2002; Reiner et al., 2013).

Apprehensions exist about counselors articulating their profession in generic, non-counseling terms such as *therapists* or *psychotherapists* as a method for establishing their ability to diagnose and treat mental and emotional disorders. Confusion increases because other health providers, such as physical therapists, respiratory therapists, speech therapists, occupational therapists, massage therapists, psychologists, social workers and psychiatrists, also utilize the same generic descriptors (Lincicome, 2015). The profession of counseling lacks a consistent identity in U.S. society (Myers et al., 2002); thus, counselors must establish the counseling profession's identity as well as counselors'

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unique role within the counseling profession. This requires clearly articulating the counselor's client population of interest and specific counseling techniques utilized and articulating the unique identity of the profession of counseling when discussing their occupational role with others (Simpson, 2016). Counselors who are strong in their professional identity understand how counselors differ from other mental health professions (Remley & Herlihy, 2014) and are able to clearly articulate how the profession of counseling is distinguished from other professions when communicating their occupational role.

The Profession's Mandate for Counselor Professional Identity

In order to achieve parity with other mental health professions, the American Association of State Counseling Boards (AASCB), the American Counseling Association (ACA), the Council for Accreditation of Counseling and Related Education Programs (CACREP), and the National Board for Certified Counselors (NBCC) have taken up the call to promote counselor identity and the profession of counseling (Mascari & Webber, 2013). Additionally, Chi Sigma Iota (CSI; 1998), the counseling profession's honor society, has taken steps to promote the profession of counseling and counselor identity. The following sections outline how these various organizations document counselor professional identity.

Section C of the ACA Code of Ethics (2014) articulates that counselors are to join local, state and national counseling associations and appropriately communicate their roles and scope of practice. In addition, ACA has endorsed principles directly tied to counselor professional identity through the 20/20: A Vision for the Future of Counseling workgroup. Part of that vision declares that "sharing a common professional identity is critical for counselors" and "presenting ourselves as a unified profession has multiple benefits" (Kaplan & Gladding, 2011, p. 372).

The 2016 CACREP Standards (2015) stipulate student training in the history, ethical standards, professional roles and responsibilities, professional associations, credentialing and licensure processes, professional advocacy, wellness and public policy issues relevant to the counseling profession. The CACREP Standards also require core faculty members be graduates of counselor education programs and hold counseling profession-specific memberships, certifications and licenses to strengthen counselor professional identity and the profession of counseling. These standards exist because counselor educators with dual or non-counseling identities can confuse master's students' professional identity in counselor education programs (Emerson, 2010; Mascari & Webber, 2006; Mellin et al., 2011).

Lastly, ACA, AASCB, CSI, and NBCC have identified CACREP accreditation as a foundation for solidifying counselor professional identity and achieving parity for counselors. CSI (2016) requires CACREP accreditation to establish a new CSI chapter. Further, starting January 2022, NBCC will allow only graduates of CACREP-accredited programs to apply for the National Certified Counselor credential (NBCC, 2014a). Additionally, securing a state counseling license often requires understanding and articulating the history and values of the profession of counseling (Emerson, 2010). The National Counselor Examination for Licensure and Examination (NCE; Loesch & Whittinghill, 2010), used in most states as the examination to obtain a counseling license, includes knowledge of the counseling profession in the professional orientation section.

The Counselor's Development of a Professional Identity

Sweeney (2001) stated that counselor professional identity concerns how the counseling profession's values and philosophy impact the counselor's behaviors with clients. He noted that counselor professional identity is not based on the profession of counseling owning specific techniques. For example, cognitive behavioral therapy (CBT) is used in the professions of counseling, psychology and social work. CBT is not owned by any one profession but is used differently by the professions because of differences in each profession's values and philosophy. Similarly, human development is not owned by any of the three professions. However, the emphasis and application of human development in each profession is different. This is like MRIs being used by oncologists, physical therapists and neurosurgeons. Although all three professions use MRIs, each profession is using that assessment differently to gather information pertinent to their specific occupational role. As such, counselor professional identity is based on the counselor embracing the distinct philosophy and values of the counseling profession.

Components of Counselor Professional Identity

Counselor professional identity first centers on distinguishing the counseling profession's unique philosophy and values from those of other mental health professions (Calley & Hawley, 2008; Choate, Smith, & Spruill, 2005; Puglia, 2008; Remley & Herlihy, 2014; Weinrach, Thomas, & Chan, 2001; Woo, 2013). Normal development, prevention, advocacy, wellness and empowerment are hallmarks of the unique philosophy and values of the counseling profession (Healey & Hays, 2012). A summary of the five distinct hallmarks and the differentiation from other mental health professions follows.

First, counselors consider that the client's human growth and development is ultimately positive and often expected when conceptualizing changes and challenges in clients' lives (Remley & Herlihy, 2014). This hallmark can be found in the Preamble, Purpose, and Section A of the ACA Code of Ethics (2014). The Preamble of the ACA Code of Ethics lists "enhancing human development throughout the life span" as the first core professional value for the counseling profession (p. 3). Additionally, this hallmark is found in several 2016 CACREP Standards: five standards under *Human Growth and Development*, six standards under *Career Development*, two standards under *Counseling and Helping Relationships* and two standards under *Assessment and Testing*. Lastly, this hallmark is tested in the NCE under Counseling Process (assessing the course of development), Diagnostic and Assessment Services (assessing client's educational preparation, conducting functional behavioral analysis, observing non-verbal behaviors, and performing a mental status exam), and Professional Practice (applying multicultural counseling models; NBCC, 2014b). In comparison, the National Association of Social Workers (NASW) Code of Ethics (2008) indicates that "Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments" (Section 6.01, Social Welfare). Although both professions talk about development, counselors are applying development in the context of the client (individual, couple or family) while social workers focus on development in the context of local to global societies. Lastly, the American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (2010, p. 3) states: "Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society." In psychology, development is researched to provide information to ultimately improve conditions for individuals, organizations, and society.

Prevention services occur when counselors provide psychoeducation, help clients increase resilience and encourage healthy client development throughout the lifespan to prevent, delay or reduce the severity of client symptoms (Granello & Young, 2011). This hallmark can be found in the Preamble and Section A of the ACA Code of Ethics (2014). Section A states: "Counselors facilitate client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships" (p. 3). Additionally, this hallmark is found in two 2016 CACREP *Counseling and Human Relationship* standards. Lastly, this hallmark is tested in the NCE under Counseling Process (conducting school/community outreach, consulting with client's support system, directing community initiatives/programs, facilitating client access to community resources, helping clients develop support systems, identifying client support systems and providing psychoeducation) and Professional Practice (conducting school/community outreach and directing community initiatives/programs; NBCC, 2014b). In comparison, the NASW Code of Ethics (2008) states that "Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people" (Ethical Principles Section). Differences exist in how the two professions talk about prevention. Counselors apply prevention in the context of the client (individual, couple or family) while social workers focus on prevention in the context of local to global societies. Lastly, APA's Ethical Principles of Psychologists and Code of Conduct (2010) states: "They strive to help the public in developing informed judgments and choices concerning human behavior" (p. 3). In psychology, prevention occurs when psychologists offer the public accurate information, which leads to better choices and judgments about aspects of human behavior in specific contexts.

Advocacy occurs when counselors defend both clients and the profession of counseling in the face of oppressive systems (Erford, 2013). This hallmark can be found in A.7.a and the Section C Introduction of the ACA Code of Ethics (2014): "When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (p. 5). Additionally, this hallmark is found in several 2016 CACREP Standards (2015): one standard in the *Faculty and Staff* section, two standards in the *Professional Counseling Orientation and Ethical Practice* section, one standard in the *Social and Cultural Diversity* section, one standard in the *Career Development* section and one standard in the *Clinical Mental Health Counseling Practice* section. Lastly, this hallmark is tested in the NCE under Counseling Process (facilitating client access to community resources, identifying barriers affecting client goal attainment, identifying dynamics, obtaining pre-authorization from third-party payors, and providing adequate accommodations for clients with disabilities) and Professional Practice (advocating for client needs, advocating for the professional of counseling, participating in media interviews, providing expert testimony, consult with justice system, consult with providers about medication, consult with school staff, and participate in multidisciplinary team meetings; NBCC, 2014b). In comparison, the NASW Code of Ethics (2008) states: "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice" (Ethical Principles Section). Counselors advocate for the client (individual, couple or family) and the profession of counseling. Social workers advocate for local to global societies. Lastly, APA's Ethical Principles of Psychologists and Code of Conduct (2010) indicates: "Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (p. 3). In psychology, advocacy occurs when the research created by and the services provided by psychologists are available to all members of society.

Fourth, counselors promote wellness when helping clients establish affirmative attitudes, create self-care plans and design life balance strategies (Granello & Young, 2011). This hallmark can be found in the Preamble, Section A Introduction, A.1.a, A.1.c, A.2.c, Section C Introduction, C.2.g, Section E Introduction, F.1.a., F.5.b, F.6.b, F.8 and Section I Introduction of the ACA Code of Ethics (2014). In the Preamble, it states: "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 3). Additionally, this hallmark is found in one standard each in the *Professional Counseling Orientation and Ethical Practice*, *Social and Cultural Diversity*, *Human Growth and Development*, and *Career Development* sections of the 2016 CACREP Standards. Lastly, this hallmark is tested in the NCE under Counseling Process (assessing one's appropriateness for working with a specific client, consulting with client's support system, consult with school staff, determining need for referral for other services, facilitating client access to community resources, helping client develop support systems, identifying client concerns, identifying client's support system, providing adequate accommodations for clients with disabilities, providing client follow-up, and triage clients for service), Diagnostic and Assessment Services (assessing potential for harm to self and others, conducting functional behavioral analysis, and using test results to facilitate client decision making), Professional Practice (applying multicultural counseling models, reporting abuse to the proper authorities, and supervising contact/visitation between family members), and Professional Development, Supervision, and Consultation (consult with justice system, consult with prescribers about medication, maintain appropriate boundaries, monitor and address personal compassion fatigue, monitor personal strengths and limitations, and monitor self-reflective versus self-absorbed states of mind; NBCC, 2014b).

In comparison, the NASW Code of Ethics (2008) states that "Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities" (Ethical Principles Section). Counselors promote wellness in both the client (individual, couple or family) and the counselor while social workers focus on wellness with the client and local to global societies. Lastly, APA's Ethical Principles of Psychologists and Code of Conduct (2010) indicates: "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research" (p. 3). In psychology, the wellness of the client is safeguarded by the psychologist.

Lastly, empowerment occurs when counselors encourage client autonomy, self-advocacy, self-validation and self-determination (Erford, 2013). This hallmark can be found in the Preamble and A.1.d of the ACA Code of Ethics (2014). The Preamble states the following as a core professional value: "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; promoting social justice" (p. 3). Additionally, this hallmark is found in several 2016 CACREP Standards: five standards in the *Social and Cultural Diversity* section, three standards in the *Human Growth and Development* section, seven standards in the *Career Development* section, four standards in the *Counseling and Helping Relationships* section, and one standard in the *Assessment and Testing* section. Lastly, this hallmark is tested in the NCE under Counseling Process (exploring cultural values and mores, facilitating client access to community resource, facilitating conflict resolution, facilitating interpersonal feedback, helping the client develop support systems, identifying barriers affecting client goal attainment, identifying client concerns, identifying the client's support system, obtaining informed consent, providing adequate accommodations for clients with disabilities, and providing counseling services in the client's preferred language), Diagnostic and Assessment Services (implementing tests for client decision making and using test results to facilitate client decision making), Professional Practice (advocating for client needs, applying multicultural counseling models, developing referral sources, empowering clients, collaborative goal setting, and decision-making skills), and Professional Development, Supervision, and Consultation (consult with justice system, consult with prescribers about medication, consult with school staff, and maintain appropriate boundaries; NBCC, 2014b).

In comparison, the NASW Code of Ethics (2008) states that:

> Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession (Ethical Principles Section).

Although both professions empower clients, counselors focus on empowering the client (individual, couple or family) while social workers additionally consider how an individual's empowerment impacts society. Lastly, the APA's Ethical Principles of Psychologists and Code of Conduct (2010) states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (p. 3). In psychology, empowerment of clients includes the right to make their own decisions, respecting cultural differences and safeguarding their welfare.

This section has demonstrated that no mental health profession exclusively owns the rights to the words *human development*, *prevention*, *advocacy*, *wellness* and *empowerment*. At the same time, this section has clearly outlined how the profession of counseling views these five values differently from psychologists and social workers. It becomes imperative that counselors understand how the profession of counseling views these five values in order to create a counselor professional identity.

Creating a Counselor Professional Identity

A strong counselor professional identity reportedly increases ethical behavior, counselor wellness and an accurate understanding of the counselor's scope of practice (Brott & Myers, 1999; Grimmit & Paisley, 2008; Ponton & Duba, 2009). Many authors have discussed ways counselors can establish their professional identity. Puglia (2008) suggested behaving in harmony with the philosophy of counseling, becoming licensed and or certified as a counselor, and engaging in professional counseling associations. Calley and Hawley (2008) recommended counselors identify with the distinct values of the counseling profession, engage in professional counseling associations, disseminate scholarship for and about the profession of counseling, utilize theoretical orientations that align with the values of the counseling profession, understand the history of the counseling profession and obtain training, licensure and certifications in the profession of counseling. Remley and Herlihy (2014) identified familiarity with current and historical contexts of the profession of counseling, knowledge of the unique philosophy of counseling, understanding counselors' roles and functions, utilizing counselor ethical codes, and obtaining memberships in professional counseling associations as six ways counselors could establish their professional identity.

Even with these recommendations, membership in ACA and being licensed as a counselor do not guarantee the ability to articulate a strong counselor professional identity (Cashwell, Kleist, & Scofield, 2009; Mascari & Webber, 2006). Several other factors also could impact counselor professional identity development. Contact with other professional counselors who have a strong counselor professional identity (such as supervisors, contemporaries and counselor educators) increases the development of an appropriate counselor professional identity (Luke & Goodrich, 2010; Puglia, 2008). Additionally, a mixture of self-reflection and connection to the unique philosophies and values of the profession of counseling drives counselor professional identity (Brott & Myers, 1999). Further, holding the counseling profession in high regard combined with a connection between the self and the profession of counseling contributes to a strong counselor professional identity (Brott & Myers, 1999; Gale & Austin, 2003; Sweeney, 2001). CSI supports this premise and states that counselor education students should graduate with pride in the profession of counseling and a strong counselor professional identity as outlined in one of the six key themes from the Counselor Advocacy Leadership Conferences in 1998 (CSI, 1998). This theme stands today as a call to action for CSI members and chapters. This combination purportedly leads to counselors who passionately defend the counseling profession against inaccuracies (Remley & Herlihy, 2014).

Purpose of the Research

Master's counselor education students have been the focus of prior studies on counselor professional identity (Coll, Doumas, Trotter, & Freeman, 2013; Gibson et al., 2010; Healey & Hays, 2012; Luke & Goodrich, 2010; Moss, Gibson, & Dollarhide, 2014; Nelson & Jackson, 2003; Prosek & Hurt, 2014). Over half (55%) of 203 master's-level counseling students found it of considerable importance and 28% found it of great importance to better understand the counseling profession and how to identify as a professional counselor (Busacca & Wester, 2006).

Fewer studies have focused on the articulation of professional counselor identity with independently licensed counselors. Rønnestad and Skovholt (2003) found that expressing a strong counselor professional identity required postgraduate counselors to assimilate the personal self and the professional self. Moss and colleagues (2014) stated that client contact was essential to counselor identity development along with an integration of the personal and professional self over the course of a counselor's career. Mellin and colleagues (2011) found that independently licensed counselors developed a strong counselor professional identity when they aligned with the counseling profession's unique philosophy and values.

Although each of these studies touches on some aspect of counselor professional identity with independently licensed counselors, none of these studies offers a concrete understanding of how independently licensed counselors articulate their professional identity to others. Further, ACA, AASCB, CACREP, CSI, NBCC have taken steps to attempt to secure a strong counselor professional identity. However, there is no understanding as to whether these efforts impact how independently licensed counselors articulate their professional identity with others. Although there is much discussion about clearly establishing a strong counselor professional identity, there is no systematic way for independently licensed counselors to determine if they articulate a counselor professional identity to others and, if not, what adjustments might be made to improve their communications.

The purpose of this study was to answer the following research questions: (a) what are the different ways (formulas) independently licensed counselors use to articulate their professional role to others, (b) would we assign more advanced professional identity formulas to independently licensed counselors who have recently graduated, (c) would we assign more advanced professional identity formulas to independently licensed counselors licensed in a specific state or region, and (d) would an independently licensed counselor's self-ranking as consistently identifying professionally as a counselor to others agree with our classification of that counselor with an advanced counselor professional identity formula? To answer these questions, we surveyed independently licensed counselors from across the United States.

Method

Participants

We defined independently licensed counselors as counselors who have graduated with at least a master's degree, obtained postgraduate clinical supervision and have a license to practice as a counselor without supervision in their state. Participants were 472 *independently licensed counselors* with a mean age of 41 (*range* = 25–69, *SD* = 10.5) who completed all sections of the survey. A majority identified as female (*n* = 392, 83%) and European American (*n* = 396, 84%). Other races represented included: African American (*n* = 24, 5%); Hispanic (*n* = 19, 4%); Biracial (*n* = 14, 3%); No Response (*n* = 9, 2%); Asian American (*n* = 5, 1%); and Native American (*n* = 5, 1%). All participants were currently independently licensed as a counselor by a state counseling licensure board; however, 14 (3%) also were licensed marriage and family therapists, nine (2%) also were licensed psychologists, and five (1%) also were licensed social workers. Thankfully these individuals comprised only 6% of the total sample. We included these 28 dually licensed participants as they are independently licensed counselors in their state and represent independently licensed counselors in the United States. These individuals are tied to counselor professional identity in the United States as well as represent independently licensed counselors to other mental health professionals, legislators, clients and society. Participants worked in various settings: counseling agency (*n* = 170, 36%), private practice (*n* = 118, 25%), state and federal governments (*n* = 47, 10%), hospitals and clinics (*n* = 42, 9%), college settings (*n* = 33, 7%), not currently working as a counselor (*n* = 28, 6%), K–12 settings (*n* = 24, 5%), managed care (*n* = 5, 1%) and unemployed (*n* = 5, 1%). The mean year of master's graduation for participants was 2005 (*SD* = 6.08).

Data Collection Procedures

SurveyMonkey's (2016) power analysis calculator for survey designs identified a need for at least 384 survey respondents given a 95% confidence level, 135,000 population size (United States Bureau of Labor Statistics, 2016) and confidence interval of +/- 5%. Two state counseling licensure board lists in each of the four ACA regions (eight states total) were randomly selected. The combined lists from the eight state counseling licensure boards generated a total list of 72,436 independently licensed counselors. A total stratified random sample of 2,144 participants was randomly selected with 268 participants selected from each state to ensure that the same number of participants were randomly selected from each of the four ACA regions. Because many counselors had moved from one of the eight states and were now practicing in another state, independently licensed counselors from 49 states and the District of Columbia were part of the final sample; North Dakota was not represented. Four hundred seventy-two participants completed the study, resulting in a 22% response rate.

Each participant received a postcard of explanation that included a link to a webpage. Participants received one of eight URLs to participate in the study corresponding to the state issuing the independent counseling license to participants. On the webpage, participants responded to five sections when participating in the study. They (a) consented to the informed consent form, (b) answered questions about their demography, (c) rated one Likert scale question, (d) completed the open text box prompt and (e) had the option of providing their name and e-mail address to receive a $5 e-gift card to Amazon.com, Starbucks, or Target on a separate website.

Measure

A search of the literature failed to yield examples of existing measures relevant to the topic. We established content validity before the use of this new and untested instrument. Ten experts from the counseling field completed the instrument and rated items for clarity, representativeness and appropriateness. They rated the one Likert scale question asking about the participant's clarity in consistently identifying professionally as a counselor as well as the open text box asking participants to write how they describe their occupational role as a professional counselor to others. These 10 experts had published on counselor professional identity or served on state or national counseling professional identity committees.

Three sections comprised the survey: (a) questions about participants' demography, (b) one Likert scale question asking about the participant's clarity in consistently identifying professionally as a counselor, and (c) an open text box asking participants to respond to the prompt: "Please write below how you describe your occupational role as a professional counselor to others (clients, other professionals, and the public)." The demographic variables included the following: gender identity, age, all licenses held with a state licensure board, year of graduation from master's counseling program, current employment setting, and ethnicity and race.

One Likert scale question asked about the participant's professional identity: "I am consistently clear in my language with clients, other professionals, and the public that I am a counselor (as opposed to saying I am a psychotherapist, therapist, etc.)." Participants responding "Never Clear" scored a 0 and those responding "Always Clear" scored a 5.

Data Analysis Procedures

We performed several data analysis procedures. First, structural coding allowed for the creation of categories that summarize the different formulas used by independently licensed counselors to talk about their profession with others (Saldaña, 2013). Additionally, it allowed for the detection of the number of individual participants who endorsed each formula. We first analyzed the data using structural coding separately, and then we reevaluated the data simultaneously to check for agreement. In the separate analyses, we each found that all 472 responses naturally categorized into six different formulas. We then re-reviewed our separate analyses jointly and found complete agreement.

After utilizing structural coding, we re-analyzed the data using magnitude coding (Miles & Huberman, 1994). Magnitude coding adds a symbol (such as a number or character) to existing code to indicate the code's intensity, direction or valuation (Saldaña, 2013). We used magnitude coding to add a numeric value to the six formulas with 0 denoting the formula with the least amount of counselor professional identity to 5 denoting the formula with the greatest amount of counselor professional identity.

Further, we performed structural coding again within each of the six main formulas to create sub-formulas that would further explain nuances found within each of the six main formulas. We separately analyzed sub-formulas for each of the six formulas. Later, we reevaluated the results simultaneously to check for agreement. We found that there were four sub-formulas within each of the six main formulas. Magnitude coding was performed by adding a numeric value to the four sub-formulas generated in this study, with a value of "a" denoting the formula with the least amount of counselor professional identity to a value of "d" denoting the formula with the greatest amount of counselor professional identity. Hence, a participant rated as a 5d demonstrated the greatest amount of counselor professional identity, and a participant rated as a 0a demonstrated the least amount of counselor professional identity (Table 1). Further, a participant rated as a 1d demonstrated more counselor professional identity than a participant rated as a 1c.

Next, we used descriptive statistics to explore survey responses from independently licensed counselors using a mail survey design (Fink & Kosecoff, 1998; Heppner, Kivlighan, & Wampold, 1992) to understand our study subjects better. Additionally, we used descriptive statistics to see how closely participants' ratings of their expressions of professional identity matched our ratings of their professional identity statements. To determine if ratings improved with more recent graduates, we ran a Mann-Whitney *U* test to see if our ratings varied by participant date of graduation from their master's counseling program. To determine if different ACA regions obtained better ratings, we performed a Kruskal-Wallis test to see if our ratings varied based upon the state that issued the independently licensed counselor's license. Finally, we calculated Cohen's kappa to determine the interrater agreement between participants' self-rating about identifying consistently as a counselor to others and our ratings of their description of their occupational role as a professional counselor to others.

Results

We identified six different ways (formulas) that independently licensed counselors communicate their professional role to others; a narrative description of each of the six formulas and their four corresponding sub-formulas follows. Table 1 outlines direct quote examples, including the number and percentage of participants using the six formulas and four corresponding sub-formulas. Additionally, Figure 1 displays graphically the total number of participants in each of the six formulas as well as the number of participants in each sub-formula a–d. As noted in the literature review, the counseling profession does not own specific techniques and tools, such as CBT, the Minnesota Multiphasic Personality Inventory or the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*). However, counselors articulating their counselor professional identity will likely refer to their connection to specific counseling tools and techniques to help others understand their services.

Table 1
Direct Quote Participant Examples for Each of the Six Formulas With Corresponding Sub-Formulas

n, %	*Formula*	*Quotes*
256, 54%	**Formula 0**	**No mention of the word counselor or counseling**
164, 64%	Formula 0a	No title, ambiguous clients and/or techniques *"A person who walks with a client to help achieve the specified goals of a client."* *"I assess, diagnose and treat clients presenting mental health issues."*
51, 20%	Formula 0b	No title, specific clients and/or techniques *"I am a psychotherapist for children 5–12 living in a psychiatric community residence."* *"I assist people with disabilities with obtaining and maintaining employment."*
10, 4%	Formula 0c	Title, ambiguous clients and/or techniques *"I am a mental health therapist working with children, adults, couples, and families."* *"I am a program director and clinical supervisor at a mental health agency."*
31, 12%	Formula 0d	Title, specific clients and/or techniques *"I am an In-Home Intensive Multisystemic Therapist working with willfully defiant adolescents and their families."* *"I am a Unit Manager in a treatment center for adult male inmates."*
19, 4%	**Formula 1**	**Generic mention of the word counselor or counseling along with other terms such as therapist, psychotherapist, etc.**
7, 37%	Formula 1a	Ambiguous title, ambiguous clients and/or techniques *"I am a private practice clinician, counselor and therapist. I work in my community serving adults."* *"I provide individual, group, couples, and family therapy to those seeking counseling."*
3, 16%	Formula 1b	Ambiguous title, specific clients and/or techniques *"I am an independent clinician who works with people 15 and up doing individual and group counseling. I specialize in substance abuse, eating disorders, BPD, co-occurring diagnosis, and trauma."* *"I work in a school setting as a mental health therapist. The school invites our agency in the building and we provide outpatient counseling to children."*

5, 26%	Formula 1c	Title, ambiguous clients and/or techniques *"You can call me a Licensed Professional Counselor, Behavioral Therapist, Mental Health Therapist, or Psychotherapist. I am a helping professional in the health care field."* *"I am a therapist and counselor at a community hospital and cancer center."*
4, 21%	Formula 1d	Title, specific clients and/or techniques *"I am a Trauma Specialist. I provide counseling in grief and loss, couples counseling and assistance with gay and lesbian issues."* *"I am a dual-role counselor. I work as an Infant Mental Health Therapist with children ages 0–6 and their families. I also work as a Maternal and Infant Health Therapist working with mothers of all ages and providing them with therapeutic services and case management."*
52, 11%	**Formula 2**	**Identifies generically as a counselor or someone doing counseling**
14, 27%	Formula 2a	No title, ambiguous clients and/or techniques *"I provide professional counseling skills for individuals, couples, and groups."* *"My role is to skillfully help clients meet their goals regarding the issues that brought them to counseling."*
19, 36%	Formula 2b	No title, specific clients and/or techniques *"I provide crisis intervention counseling to children and families."* *"I offer strength-based, solution-focused cognitive behavioral therapy but draw from a variety of theories and foundations to provide individualized counseling and assessment services."*
15, 29%	Formula 2c	"Counselor" title, ambiguous clients and/or techniques *"As a counselor I diagnose and treat mental and emotional disorders as well as give people empathy, feedback, advice, and guidance in dealing with life issues. In addition, I provide a safe place for people to process thoughts and emotions in an effort to come to a deeper understanding of themselves, others, and the world."* *"I am a counselor providing counseling in a safe environment to people struggling with mental health issues."*
4, 8%	Formula 2d	"Counselor" title, specific clients and/or techniques *"I am a counselor for a hospice agency, providing emotional support to patients and their families as the patient faces end of life."* *"I am a full-time counselor on a small, private college campus working only with students."*
9, 2%	**Formula 3**	**Identifies generically as a counselor or someone doing counseling along with discussing at least one or more distinct hallmarks of the profession of counseling**
4, 45%	Formula 3a	No title, ambiguous clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"I provide counseling services (diagnostic and biopsychosocial assessments, treatment planning, individual, group, couples counseling) and practice from a wellness model and advocate for clients as needed."* *"I provide counseling as well as advocacy for those individuals who are seeking help for a variety of issues in their lives."*
1, 11%	Formula 3b	No title, specific clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"I provide counseling to children, adolescents and families contracted through the juvenile justice system. I also advocate for clients with community resources."*
3, 33%	Formula 3c	"Counselor" title, generic clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"As a counselor, I help people learn more about themselves and the things which promote their well-being. I educate people about mental illness and mental well-being."* *"As a counselor, I provide various services in the field of mental or emotional health. At times this means being a source of support, other times it's a source of information and empowerment. Ultimately I believe I'm there to serve the client, not to force them into my plan."*
1, 11%	Formula 3d	"Counselor" title, specific clients and/or techniques, identifies one or more hallmarks

		of the profession of counseling *"I am a counselor for individuals who have committed domestic violence offenses and sex offenses. I provide mental health therapy to these individuals as well as psychoeducational groups about tools to help make healthier choices."*
94, 20%	**Formula 4**	**Identifies specifically as a counselor**
27, 29%	Formula 4a	"Professional counselor" or "mental health counselor" title, ambiguous clients and/or techniques *"As a professional counselor I assist people in navigating their complex worlds in order to live a healthier, happier life."* *"As a professional counselor, I diagnose and treat mental and emotional disorders and addictive disorders."*
20, 21%	Formula 4b	"Professional counselor" or "mental health counselor" title, specific clients and/or techniques *"I am a professional counselor at an incarceration facility and I work primarily with federal inmates and U.S. probation clients."* *"As a professional counselor, I primarily offer career counseling with employees in transition."*
24, 26%	Formula 4c	Identifies as their state counseling license title, ambiguous clients and/or techniques *"I am a Licensed Mental Health Counselor in private practice."* *"I am a Licensed Professional Counselor. I see my role as coming alongside people and helping them cope with difficulties in life, or helping them manage emotions."*
23, 24%	Formula 4d	Identifies as their state counseling license title, specific clients and/or techniques *"I am a Licensed Mental Health Counselor (LMHC) who works in the correctional setting by working to rehabilitate inmates."* *"I am a Licensed Mental Health Counselor working with adolescents on a U.S. military base conducting individual, group, and family therapy."*
42, 9%	**Formula 5**	**Identifies specifically as a counselor as well as identifies one or more hallmarks of the profession of counseling**
33, 79%	Formula 5a	"Professional counselor" or "mental health counselor" title, ambiguous clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"As a professional counselor, I help clients reach their personal goals with a focus on wellness, client empowerment, developmental awareness, and prevention."* *"As a professional counselor, I offer counseling, psychoeducation, and empowerment in addition to advocating for my clients in areas where they may need assistance."*
1, 2%	Formula 5b	"Professional counselor" or "mental health counselor" title, specific clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"I am a professional counselor working with children and their parents to help them improve their relationships and reduce habits that get in the way of positive healthy lives as a means of increasing client wellness."*
2, 5%	Formula 5c	Identifies as their state counseling license title, ambiguous clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"My role as a Licensed Mental Health Counselor is to provide guidance, increase empowerment, and promote wellness for clients."* *"My goal as a Licensed Professional Counselor is to help people maximize their full potential and wellness through advocacy, empowerment, and self-determination."*
6, 14%	Formula 5d	Identifies as their state counseling license title, specific clients and/or techniques, identifies one or more hallmarks of the profession of counseling *"I am a Licensed Professional Counselor specializing in working with women healing from abuse and trauma. I focus on empowerment and wellness with my clients."* *"I'm a bilingual Licensed Mental Health Counselor who works with Latino families in an outpatient setting. My role is to provide counseling services as well as to advocate on behalf of my clients so that they can maximize their well-being."*

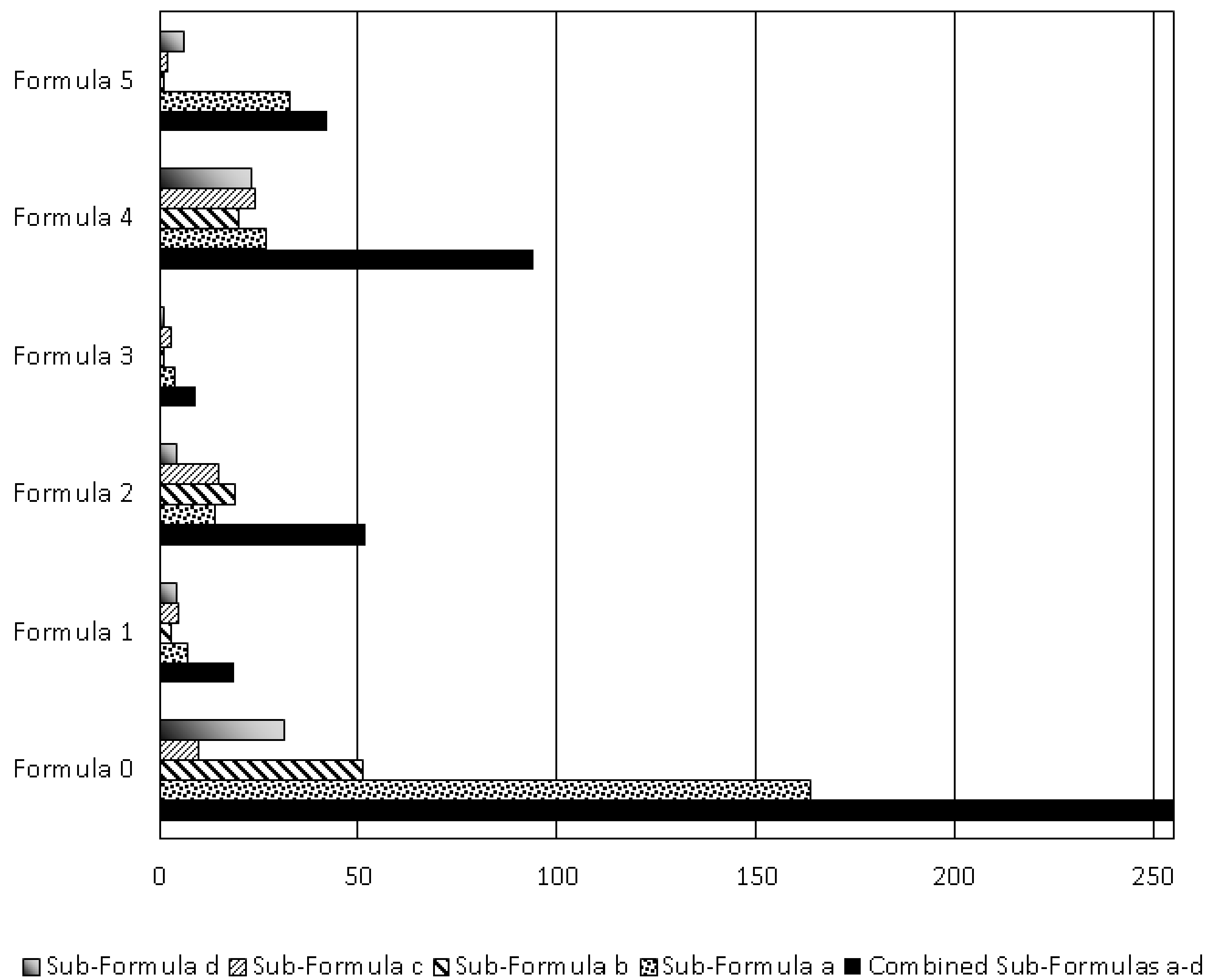

Figure 1. Total number of participants in each of the six formulas as well as the number of participants in each sub-formula a–d.

Formula 0 participants, the lowest rated on the scale, never used the term “counselor” or “counseling” when talking about their role in the counseling profession with others. The majority of participants categorized into this formula. There were four main ways participants expressed themselves in Formula 0 when talking about their role in the counseling profession with others. Formula 0a did not offer a title and was ambiguous about clients and techniques. Formula 0b did not offer a title and was specific about clients and techniques. Formula 0c offered a title, but ambiguously discussed clients and techniques. Formula 0d offered a title and was specific about clients and techniques.

Formula 1 participants generically used the term “counselor” or “counseling” somewhere in their formulations, along with the titles clinician, specialist, social worker, educator, coordinator, administrator, coach, therapist or psychotherapist, when talking about their role in the counseling profession with others. Few participants categorized into this formula. There were four main ways participants expressed themselves in Formula 1 when talking about their role in the counseling profession with others. Formula 1a offered an ambiguous title and was ambiguous about clients and techniques. Formula 1b offered an ambiguous title but discussed specific clients and techniques. Formula 1c offered a title but ambiguously discussed clients and techniques. Formula 1d offered a title and was specific about clients and techniques.

Formula 2 participants generically used the term "counselor" or "counseling" in their formulations. This was the third largest category. There were four main ways participants expressed themselves in Formula 2 when talking about their role in the counseling profession with others. Formula 2a offered an ambiguous title and was ambiguous about clients and techniques. Formula 2b offered an ambiguous title but discussed specific clients and techniques. Formula 2c offered the generic title "counselor" but ambiguously discussed clients and techniques. Formula 2d offered the generic title "counselor" and discussed specific clients and techniques.

Formula 3 participants generically used the term "counselor" or "counseling" in their formulations along with discussing at least one distinct hallmark of the profession of counseling (normal development, prevention, wellness, advocacy or empowerment). This was the smallest category. Among the nine participants, there were at least five mentions of the concepts of wellness and empowerment along with four mentions of the concept of advocacy. There were four main ways participants expressed themselves in Formula 3 when talking about their role in the counseling profession with others. Formula 3a offered an ambiguous title and was ambiguous about clients and techniques but did mention at least one or more hallmarks of the profession of counseling. Formula 3b offered an ambiguous title, discussed specific clients and techniques and stated at least one or more hallmarks of the profession of counseling. Formula 3c offered the generic title "counselor," ambiguously discussed clients and techniques and stated at least one or more hallmarks of the profession of counseling. Formula 3d offered the generic title "counselor," discussed specific clients and techniques and stated at least one hallmark of the counseling profession.

Formula 4 participants identified specifically as counselors. This was the second largest category. There were four main ways participants expressed themselves in Formula 4 when talking about their role in the counseling profession with others. Formula 4a offered "professional counselor" or "mental health counselor" as a title but was ambiguous about clients and techniques. Formula 4b offered "professional counselor" or "mental health counselor" as a title and discussed specific clients and techniques. This formula offered a state counseling license title but used ambiguous descriptions of clients and techniques. Formula 4d offered a state counseling license title and used specific descriptions of clients and techniques.

Formula 5 participants identified specifically as counselors along with discussing at least one distinct hallmark of the profession of counseling (normal development, prevention, wellness, advocacy or empowerment). This was the fourth largest category. Among the 42 participants, there were at least 18 mentions of empowerment, 13 mentions of advocacy, 10 mentions of wellness, nine mentions of prevention and seven mentions of normal development. There were four main ways participants expressed themselves in Formula 5 when talking about their role in the counseling profession with others. Formula 5a offered "professional counselor" or "mental health counselor" as a title, was ambiguous about clients and techniques and discussed at least one distinct hallmark of the profession of counseling. Formula 5b offered "professional counselor" or "mental health counselor" as a title, discussed specific clients and techniques and stated at least one distinct hallmark of the profession of counseling. Formula 5c offered a state counseling license as a title, used ambiguous descriptions of clients and techniques and discussed at least one distinct hallmark of the profession of counseling. Formula 5d offered a state counseling license as a title, used specific descriptions of clients and techniques and discussed at least one distinct hallmark of the profession of counseling.

We further wanted to investigate differences between participant self-ratings about identifying consistently as a counselor to others and our ratings of their professional identity statements to determine the level of counselor professional identity actually expressed by the participant.

Overall, participant scores fell in the range between "Mostly to Frequently Clear" when asked about identifying consistently as a counselor to others (N = 472, M = 3.40, SD = 1.51). We next grouped all self-ratings together from "Never Clear" (0) to "Always Clear" (5). We separated these five groups and then calculated the means and standard deviations of our ratings of the statements for each of the six self-rated groups. We rated the statements of the 38 participants who self-rated a 0 as having formulations with a mean of 1.20 (at the level of Formula 1) and a standard deviation of 1.79. We rated the statements of the 33 participants who self-rated a 1 as having formulations with a mean of 1.02 (at the level of Formula 1) and a standard deviation of 1.64. We rated the statements of the 47 participants who self-rated a 2 as having formulations with a mean of 1.57 (between Formula 1 and Formula 2) and a standard deviation of 1.93. We rated the statements of the 90 participants who self-rated a 3 as having formulations with a mean of 1.54 (between Formula 1 and Formula 2) and a standard deviation of 1.89. We rated the statements of the 108 participants who self-rated a 4 as having formulations with a mean of 1.58 (between Formula 1 and Formula 2) and a standard deviation of 1.95. We rated the statements of the 156 participants who self-rated a 5 as having formulations with a mean of 1.74 (between Formula 1 and Formula 2) and a standard deviation of 1.95. Figure 2 is a bar chart showing in black the total number of participants for the six levels of clarity in consistently communicating a professional identity to others by formula rating each participant's statement.

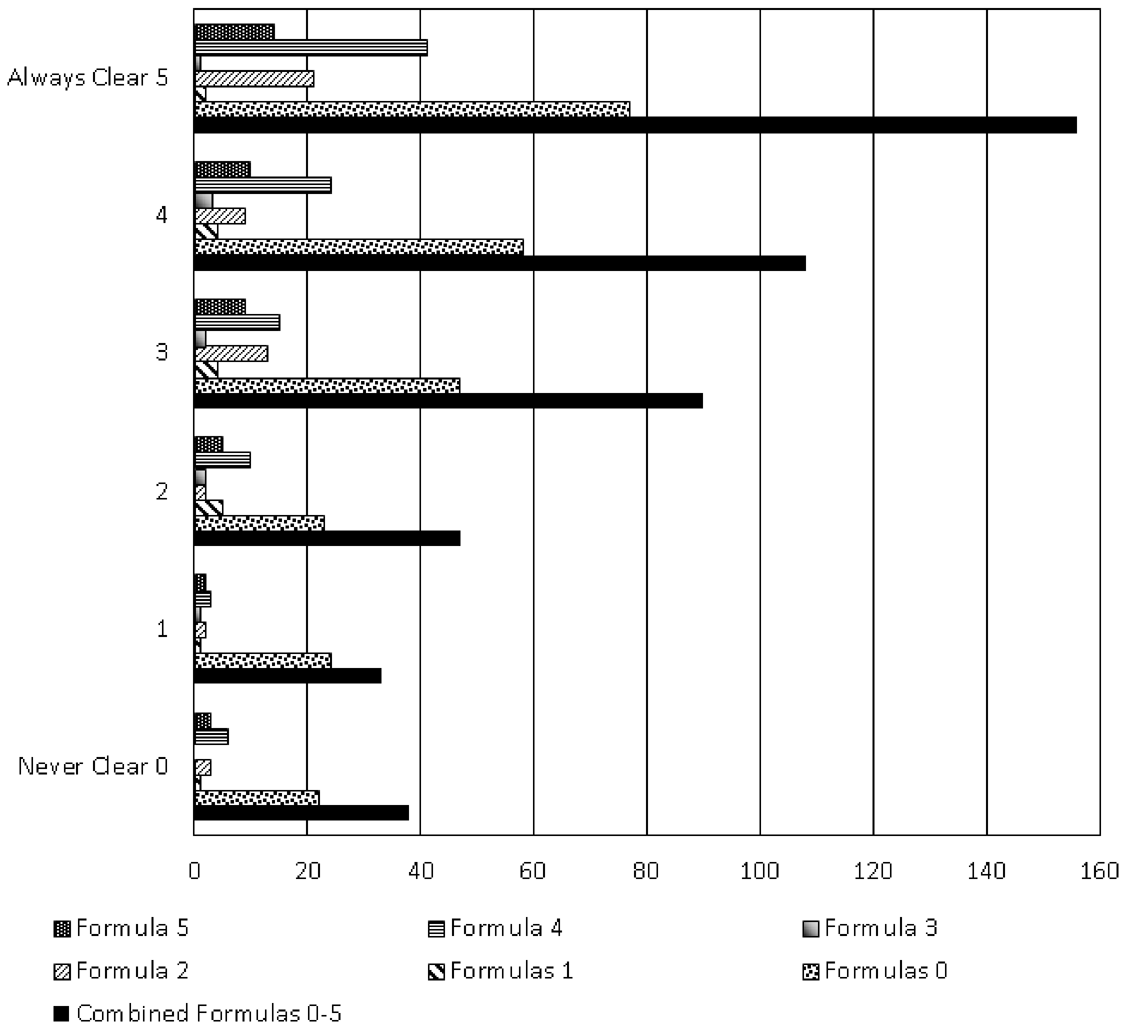

Figure 2. Total number of participants' clarity in consistently communicating a professional counselor identity to others by formula rating of each participant's statement.

We conducted a Mann-Whitney *U* test to see if our rating of participants' statements changed based upon the participant's date of graduation: 1969–1999 ($n = 57$, $M = 1.97$, $SD = 2.03$) and 2000–2012 ($n = 415$, $M = 1.50$, $SD = 1.90$). The year 2000 saw the release of the 2001 CACREP Standards (CACREP, 2001), which emphasized student and faculty professional identity and professional orientation. Individuals graduating up to 1999 rated at Formula 2 and individuals graduating 2000 and after rated between Formula 1 and Formula 2. Median researcher ratings for participants graduating with their master's degree from 1969–1999 (272.91) and participants graduating with their master's degree from 2000–2012 (244.12) were not statistically different: $U = 11170.5$, $z = -1.585$, $p = .11$. We did not assign more advanced professional identity formulas to independently licensed counselors who had graduated more recently.

We conducted a Kruskal-Wallis test to see if our rating of participants' statements changed based upon the state issuing the independent counseling license to participants: North Atlantic state 1 ($n = 54$, $M = 1.96$, $SD = 2.07$), North Atlantic state 2 ($n = 68$, $M = 1.10$, $SD = 1.71$), Southern state 1 ($n = 47$, $M = 2.00$, $SD = 2.02$), Southern state 2 ($n = 64$, $M = 1.58$, $SD = 1.93$), Midwestern state 1 ($n = 65$, $M = 1.66$, $SD = 1.91$), Midwestern state 2 ($n = 71$, $M = 1.63$, $SD = 1.89$), Western state 1 ($n = 53$, $M = 1.52$, $SD = 1.94$) and Western state 2 ($n = 50$, $M = 1.10$, $SD = 1.83$). Participants from one North Atlantic state rated highest with Formula 2 while participants from one Western state and one North Atlantic state rated lowest with Formula 1. When the mean was computed by region, the two Southern states rated highest with a 1.79, and the two Western states rated lowest with a 1.31. However, both ratings fell between a Formula 1 and Formula 2. Median researcher ratings for participants by state were not statistically different: $\chi 2(7) = 11.88$, $p = .11$. We did not assign more advanced professional identity formulas to independently licensed counselors licensed in a specific state or region.

We calculated Cohen's kappa to determine the interrater agreement between the participants' Likert scale self-rating about identifying consistently as a counselor to others and our rating of that participant's discussion of their occupational role as a professional counselor to others. A kappa value of less than .20 represents poor agreement; between .21 and .40 represents fair agreement; between .41 and .60 represents moderate agreement; between .61 and .80 represents good agreement; and between .81 and 1.0 represents very good agreement beyond chance (Landis & Koch, 1977). The interrater reliability indicated $k = 0.003$ (95% CI, .000 to .034, $p = .84$). Participants' self-rating of "Always Clear" identifying to others as a professional counselor did not agree with our ratings of these participants' formulas. Participants' self-rating of "Never Clear" identifying to others as a professional counselor did not agree with our ratings of these participants' formulas. An independently licensed counselor's self-ranking as consistently identifying professionally as a counselor to others did not agree with classification as an advanced counselor professional identity formula.

Discussion

Participants' scores fell in the "Mostly to Frequently Clear" range when self-rating as clearly articulating to others as a professional counselor. As 56% of the participants rated themselves with the two highest ratings on the scale, it would seem that counselor professional identity is not a serious issue. However, when we evaluated participants' narratives about their occupational role, we placed only 29% of counselors in the two highest formulas, 4 and 5. As 54% of participants never used the term "counselor" or "counseling" when discussing their occupational role with others, the continued concerns about counselor professional identity are warranted (Gale & Austin, 2003; Gibson et al., 2010; Kaplan & Gladding, 2011; Mellin et al., 2011; Myers et al., 2002). As counselors rated themselves high and the articulations shared rated low, it is not surprising that there was little agreement between a high or low self-rating of articulation and our assigning a high or low formula level to descriptions of their occupational role to others. Results also demonstrated that counselor professional identity articulations have not improved over time. We rated counselors who graduated before 2000 at a Formula 2 and those graduating 2000 and after between Formula 1 and Formula 2. There was no statistical difference between the two groups. Additionally, this study identified that all ACA regions performed on average between a Formula 1 and Formula 2.

Researchers and the major professional counseling organizations agree that counselor professional identity centers on distinguishing the counseling profession's unique philosophy and values from other mental health professions (Calley & Hawley, 2008; Choate et al., 2005; Puglia, 2008; Remley & Herlihy, 2014; Weinrach et al., 2001; Woo, 2013). Mellin and colleagues (2011) reported that counselors naturally distinguish the counseling profession from other mental health professions by being grounded in a developmental, preventive and wellness orientation despite practicing in different counseling subspecialties. It would appear that the profession and its members have agreement on the counseling profession's distinct hallmarks of prevention, advocacy, wellness, empowerment and normal human development. However, results from our study indicated that only 11% of participants alluded to one or more of the counseling profession's distinct hallmarks when articulating their occupational role to others. It does not appear that independently licensed counselors are communicating how the counseling profession's unique values and philosophy shape their professional practice (Sweeney, 2001). Clearly the ACA Code of Ethics, the NCE and the 2016 CACREP Standards are all guided by these five hallmarks of the profession of counseling. However, independently licensed counselors are not connecting consciously to the philosophy and values of the counseling profession. Once they evolve into clinical practice, independently licensed counselors severely struggle to articulate not only a counselor professional identity, but also to clearly articulate their services. Although this is a problem for the profession of counseling, this is a greater potential problem for the counselor who cannot clearly articulate why they should be hired, why a client should choose their services, why a legislator should listen to their point of view or why an individual from another health profession should make a referral.

The majority of participants (65%) used ambiguous terms to describe clients or techniques used in their counseling practice. Further, over half of the participants (54%) did not offer any title when discussing their occupational role to others. A few participants (5%) used a title that did not mention the word "counselor." Roughly 8% of participants used their job title, which did not include the word "counselor." Approximately 5% titled themselves only as a "counselor" while 17% titled themselves a "professional counselor" or a "mental health counselor." About 11% identified themselves by their state counseling license. This study supports the premise that being licensed as a counselor does not guarantee a strong counselor professional identity (Cashwell et al., 2009; Mascari & Webber, 2006).

Within each of the six distinct formulations independently licensed counselors used to discuss their occupational role with others, there was a pattern of progression from the ambiguous to the specific. This progression happened in two ways; titling as well as describing clients and techniques. First, the profession of counseling in many respects "owns" the words *counselor* and *counseling*. In the ACA Code of Ethics, the word *counselor* or *counseling* occurs over 600 times. It should, as counselors are licensed at the state level as counselors and receive specialized training in providing counseling. This is a major reason that there is a license at the state level for counselors as opposed to being licensed at the state level as a psychologist or social worker. The word *counseling* appears in the NASW Code of Ethics four times and the APA Code of Conduct five times. It is extraordinarily problematic that 54% of participants never even used the generic terms *counselor* or *counseling*. Further, it is troubling that only 29% of participants gave themselves at least the generic "title" of *professional counselor*. Additionally, it is troubling how often counselors did not describe the typical types of clients they see or their expertise in working with specific counseling techniques. The inability to articulate their expertise negatively impacts their occupational role. Namely, the progression moved from (a) a weak or nonexistent title with an ambiguous discussion of clients and techniques to (b) a weak or nonexistent title with a specific discussion of clients and techniques to (c) a stronger title with an ambiguous discussion of clients and techniques to, finally, (d) a stronger title with a specific discussion of clients and techniques. Over half (52%) of participants offered some form of a weak or nonexistent title with an ambiguous discussion of clients and techniques. One fifth of the participants communicated some form of a weak or nonexistent title with a specific discussion of clients and techniques. Around 13% of participants used a stronger title with an ambiguous discussion of clients and techniques, and 15% of participants used a stronger title with a specific discussion of clients and techniques.

Implications

A poor counselor professional identity in the United States has been blamed for issues with licensure portability, parity in hiring practices, marketplace recognition in U.S. society, psychologists being licensed as counselors, and third-party payments (Calley & Hawley, 2008; Myers et al., 2002; Reiner et al., 2013). A strong counselor professional identity reportedly remedies these issues and allows counselors to take full advantage of securing their ability to work with a wide range of client populations, receive third-party reimbursement, offer all of the services afforded in their scope of practice and make a greater impact when advocating for clients (Calley & Hawley, 2008; Myers et al., 2002; Reiner et al., 2013). There is clearly much room for improvement in counselor professional identity when independently licensed counselors discuss their occupational role with others.

ACA, AASCB, CACREP, CSI and NBCC have all taken steps to attempt to secure a stronger counselor professional identity. With only 11% of participants mentioning even one of the hallmarks of the profession of counseling, it is imperative that counselors learn one unified message about the hallmarks of the profession of counseling. Healey and Hays (2012) have identified these hallmarks as normal development, prevention, wellness, advocacy and empowerment. These hallmarks are commonly found in the ACA Code of Ethics, CACREP Standards, the NCE, counselor professional identity research, and counselor professional issues and ethics textbooks. The question arises whether counselor educators are teaching counselor professional identity in ways that impact how counselors articulate their occupational role with others. Although the CACREP Standards require documentation that counselor professional identity is taught to students as well as requiring that those same standards be measured, the quality of the measurement of those standards is not under CACREP's purview. The results of this study suggest that all of the counselor professional identity efforts of ACA, CACREP, NBCC and counselor educators have made little impact on independently licensed counselors when 54% of them do not use the generic terms *counselor* or *counseling* and only 29% assign themselves the title *professional counselor*. There has been much talk about counselor professional identity, but the outcomes suggest that most independently licensed counselors have no connection to counselor professional identity.

A systemic problem exists in the counseling profession's training of counselors to adopt and articulate a counselor professional identity. It seems as if the organizations of the profession of counseling (ACA, CACREP, NBCC and CSI) know counselor professional identity is the foundation of the profession and have integrated these concepts into the ACA Code of Ethics, 2016 CACREP Standards, the NCE, and CSI's Six Advocacy Themes. What is not known is what they mean when counselor educators state that they adopt a counselor professional identity. Do counselor educators who say they adopt a counselor professional identity actually understand how the five hallmarks of the profession of counseling are foundationally tied to the ACA Code of Ethics, the 2016 CACREP Standards, and the NCE? If counselor educators fail to tie counselor professional identity to the foundational blocks, and teaching students counselor professional identity amounts to encouraging membership in ACA and state counseling associations, it is little wonder that students graduate not tied to the foundations of the profession of counseling. As discussed in the literature review, many authors have discussed methods to support counselors in establishing their professional identity: behaving in harmony with the philosophy of counseling, becoming licensed and/or certified as a counselor, engaging in professional counseling associations, disseminating scholarship for and about the profession of counseling, understanding the history of the counseling profession, understanding counselors' roles and functions and utilizing counselor ethical codes. The profession of counseling clearly lacks a concrete understanding of what is truly required to create a counselor professional identity with independently licensed counselors. What is apparent is that the status quo in developing counselor professional identity is not working.

The biggest threat to counselor professional identity is that over 54% of participants did not use the words *counselor* or *counseling* when discussing their occupational role. The word *counselor* can be used by attorneys, camp counselors, debt counselors and others. It is possible that independently licensed counselors are avoiding using the term because they do not know how to distinguish those words from other, unrelated professional roles. This is certainly an issue for independently licensed counselors which does not occur for psychologists or social workers. The reality is that independently licensed counselors are licensed at the state level as counselors and have specialized training to provide counseling. The words *counselor* and *counseling* cannot effectively be abandoned by independently licensed counselors.

More resources need to be made widely available to make an impact on how independently licensed counselors articulate their occupational role with others. They need tools to help them effectively discuss their occupational role as a counselor doing counseling. In the past, there has been no systematic way for independently licensed counselors to evaluate their counselor professional identity when communicating their role to others. Further, if the counselor is off track, there has been no resource to help them understand what adjustments could be made to improve their communication. Independently licensed counselors could use guidance to evaluate their ability to articulate a strong counselor professional identity to others.

The coding strategies identified through this research may help independently licensed counselors to evaluate their current narratives and make improvements when communicating their occupational role with others. Counselor educators may use the six formulations with their corresponding four sub-formulas in classes to help students develop their counselor professional identity statements. Lastly, professional counseling associations may use the six formulations and corresponding four sub-formulas to help professional members develop their counselor professional identity statements.

Further, Burns (2017) created a 7-step format to craft a One-Minute Counselor Professional Identity Statement. The tool helps counselors articulate a succinct and powerful counselor professional identity statement that showcases the unique contributions of the counselor as well as the field of counseling. Here is an example of a One-Minute Counselor Professional Identity Statement for an independently licensed counselor introducing themselves to a psychiatrist for referrals:

> I'm Susan Jones, a Licensed Professional Counselor. I'd appreciate your consideration of my counseling services for your patients experiencing eating disorders in Detroit. My counseling practice helps clients achieve their optimal level of development and wellness through a focus

on client empowerment, prevention and advocacy. I have used evidence-based treatment approaches over the last 7 years such as the Maudsley approach, a family-based therapy, and cognitive behavioral approaches. I also assist clients negotiating the use of antidepressant medications with their prescriber. I am trained to use a variety of assessment, diagnostic and counseling techniques specific to individuals experiencing eating disorders in individual, family and group settings. I promote a healthy relationship with food and others as well as help to overcome barriers to goal attainment. I am a member of the American Counseling Association, as well as the American Mental Health Counselors Association, and am bound by their codes of ethics.

This 7-step format can be used by counselors at all developmental levels and adjusted for various audiences. The 7-step format can help define counselor professional identity to ensure global audiences hear a unified voice of the hallmarks of the counseling profession.

Future Research and Limitations

Future research could examine how independently licensed counselors use the six formulations presented in this study to evaluate their professional identity statements, if they use them at all. Additionally, research could discern how independently licensed counselors view the importance of moving from lower to higher formula levels. Finally, research could determine how independently licensed counselors connect with the distinct hallmarks of counseling.

Limitations of this research include: Likert scale-based surveys suffer from self-report and social desirability bias, recruiting participants from the state counseling boards lists of only eight states across the United States, the $5 incentive could have influenced participant responses or attracted a certain type of participant, and a certain type of participant may have been drawn to respond to the survey topic. Additional limitations include the use of non-parametric data, which may lack power as compared with more traditional approaches. There is a potential bias of interpretation and research embeddedness in the topic with qualitative coding. Lastly, we do not know if any study participants hold doctorates in counselor education.

Conclusion

As inequities exist for independently licensed counselors, there has been much discussion for five decades about counselor professional identity, along with many attempts by various counseling constituencies to address this critical issue. We investigated how independently licensed counselors expressed their role as a professional counselor to others and evaluated their consistency in expressing a counselor professional identity. This study provides a concrete description of how independently licensed counselors are expressing their professional identity when describing their role as a counselor to others. Counselors may wish to review the various formulations outlined to evaluate their own communications to see if and how counselor professional identity can be strengthened.

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