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# Indiscriminate Friendliness in Children Adopted From China to the United States: A Mixed Methods Study



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Indiscriminate friendliness (IF) is a prominent issue with children adopted from China to the United States. Through a mixed methods design, the authors explored four Chinese adoptees' experiences of IF within their real-life context, investigated potential factors associated with IF, and examined the IF–attachment relationship. This mixed methods study consisted of a qualitative case study of four children adopted from China and a quantitative investigation into IF using a sample of 92 adoptive parents with Chinese adoptees. The qualitative findings revealed crucial propositions related to children's IF, and the quantitative results provided further evidence to corroborate the qualitative findings. This study reinforced the stance that IF should be treated as a distinct construct from attachment. Researchers and professional counselors can benefit from the results of this study to better serve Chinese adoptive families.

**Keywords:** indiscriminate friendliness, children, China, adoptive families, mixed methods

According to intercountry adoption statistics, the United States welcomed 261,728 children across the world from 1999 to 2015 (U.S. Department of State, Bureau of Consular Affairs, 2016). Among these adopted children, 76,026 (approximately 30%) came from China, which made China the largest country of origin for intercountry adoption. A majority of Chinese adoptees were under 3 years old at the time of adoption (U.S. Department of State, 2016). Numerous issues have been detected related to the intercountry adoption process (Kreider & Cohen, 2009; van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009). A prominent issue is children's *indiscriminate friendliness* (IF; Bruce, Tarullo, & Gunnar, 2009; Chisholm, Carter, Ames, & Morison, 1995; van den Dries, Juffer, van IJzendoorn, Bakermans-Kranenburg, & Alink, 2012). IF refers to children's excessively friendly behaviors toward adults (other than their primary caregivers) without appropriate screening of the adults (Tizard, 1977). IF has been consistently identified in post-institutionalized children (Bruce et al., 2009; Chisholm et al., 1995) and has been viewed as pathological in nature (American Psychiatric Association [APA], 1994, 2013).

Previous research studies have yielded different post-adoption adjustment outcomes in Chinese adoptees compared to domestic adoptees or other internationally adopted children, including optimal behavioral adjustment (Cohen, Lojkasek, Zadeh, Pugliese, & Kiefer, 2008), successful attachment formation (Liu & Hazler, 2015), and positive academic performance (Tan & Marfo, 2006). The distinction between Chinese adoptees and their research counterparts entails a closer look at this population. Investigation into IF in children adopted from China became important, as the majority of them had experienced pre-adoption institutionalization in China. Consistent with earlier findings about post-institutionalized children (Bruce et al., 2009), IF has been identified as a significant issue in children adopted from China and was supported by the only study targeting Chinese adoptees in the United States (van den Dries et al., 2012).

A dearth of knowledge on IF in Chinese adoptees in the United States necessitated an in-depth qualitative investigation into this phenomenon in the adoptees' real-life context (Yin, 2014). However, a single qualitative study cannot offer a comprehensive view of IF, nor can it thoroughly address all

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research questions for this study; thus, by adding a quantitative investigation, this study sought to compensate for the inadequacy of the qualitative methodology and allow researchers to triangulate and compare dissonant data between the two research approaches (Plano-Clark, Huddleston-Casas, Churchill, Green, & Garrett, 2008).

### **Indiscriminate Friendliness (IF)**

IF, alternatively termed *indiscriminately friendly behavior* or *indiscriminate overfriendliness*, refers to a behavioral tendency for children to seek attention and approval from adults, including strangers (Hodges & Tizard, 1989; Tizard & Hodges, 1978). IF is also referred to as *disinhibited attachment behavior* or *disinhibited social behavior*, evidencing post-institutionalized children's overfriendly behavior toward unfamiliar adult figures (Bruce et al., 2009). IF does not fall into the traditional sense of being *friendly*, which is associated with a positive human trait; instead, it is deemed behaviorally inappropriate when children actively approach strangers, without a reasonable assessment of whether or not it is safe to do so (Bruce et al., 2009; O'Connor et al., 2003).

Researchers have noted that children's institutionalization experiences play a significant role in IF development, albeit adopted children are able to form strong attachments with their adoptive parents given adequate time (Chisholm, 1998; Hodges & Tizard, 1989; Tizard & Hodges, 1978). Post-institutionalized children with IF tend to approach, make personal comments to, and initiate physical contact with strangers, and children with a high level of IF are often willing to leave locations with strangers (Bruce et al., 2009). They also allow unfamiliar adults to put them to bed and comfort them when they are hurt (Tizard & Hodges, 1978). A multitude of adoptive parents have had concerns about their children's safety as a result of their IF behaviors (Bruce et al., 2009).

In Tizard and Hodges' (1978) follow-up study in the United Kingdom, one third of formerly institutionalized children exhibited excessive attention-seeking behaviors and a tendency to be overfriendly to adults. A few children, from ages 4 to 8, presented indiscriminate affection toward adults. In Bruce et al.'s (2009) sample of internationally adopted children in the United States following institutionalization, 65% displayed IF characteristics. Likewise, in Chisholm's study (1998), Romanian adoptees in Canada exhibited significantly more IF behaviors than the two comparison groups: (a) Canadian-born, non-adopted, and non-institutionalized children; and (b) early-adopted Romanian children who were adopted before the age of 4 months. In contrast to institutionalization's role as a risk factor of IF, adoptive parents' responsive parenting was assumed to be a protective factor for children's post-adoption behavioral adjustment (van den Dries et al., 2012). Responsive parenting entails a high level of warmth and nurturance in the process of caretaking, including offering timely attendance to children's needs (Darling & Steinberg, 1993).

### **Attachment**

Theorists have examined the relationship between IF and attachment (Bowlby, 1982; Sabbagh, 1995). For example, Bowlby (1982), defining attachment as a child's behavior to seek physical proximity to his/her primary caregiver, claimed attachment as a correlate to IF. Attachment, viewed as a social behavior, occurred as a result of certain behavioral systems activated when infants interact with the "environment of evolutionary adaptedness" and the mother figure in the environment (Bowlby, 1969, p. 179). The first two to three years are the most critical period for children to develop relationships with caregivers and to develop the aforementioned behavioral systems (Bowlby, 1969). Given an environment in which evolutionary adaptedness is absent, such as an institutional rearing environment, atypical discriminating attachments may ensue (O'Connor et al., 2003). Although many securely attached children displayed IF behaviors, their unattached counterparts demonstrated a higher likelihood of being overfriendly (Bowlby, 1982).

## Evolution of Diagnostic Criteria

In addition to the heated dispute on whether or not IF is related to attachment patterns, the clinical perspective on IF has been evolving. In the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; APA, 1994), IF was termed the *disinhibited type* (i.e., indiscriminate sociability), as opposed to *inhibited type* (i.e., social withdrawal), under the Reactive Attachment Disorder diagnostic criteria. Similarly, the *International Statistical Classification of Diseases and Related Health Problems* (10th rev.; *ICD-10*; World Health Organization [WHO], 1992) named IF as a *disinhibited attachment disorder*. Both the *DSM-IV* and *ICD-10* described IF as an abnormal pattern of relatedness that begins before the age of 5 years (APA, 1994; WHO, 1993). Nevertheless, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013) redefined IF as a *disinhibited social engagement disorder*, which is a trauma- and stressor-related disorder derived from severe neglect in the first two years of life. Hence, IF was separated from reactive attachment disorder, where it had been categorized.

The mixed findings on potential contributors to IF and the lack of in-depth qualitative input on IF reinforce the need to address IF in children adopted from China, which has rarely been discussed in counseling journals. Prevalence of IF in Chinese adoptees in the United States remains unknown, and no study was found exploring the experiences of children with IF. The purpose of this study was to better understand IF in children adopted from China by U.S. families. The authors conducted a case study on four Chinese adoptees through two in-depth semi-structured interviews with two U.S. adoptive mothers. To ensure the robustness of this study, the authors conducted a follow-up quantitative investigation into IF using a sample of 92 adoptive parents with children adopted from China. This study addressed three research questions—RQ1: How do parents perceive IF in children adopted from China?; RQ2: What are some potential factors that are associated with IF?; and RQ3: Is IF related to children’s attachment? The overarching goal of the current study was to provide an in-depth understanding of Chinese adoptees’ IF in its real-life context, to probe into the potential predictors of IF, and to examine the relationship between IF and attachment.

## Method

### Participants

Participants for qualitative and quantitative investigations were drawn from U.S. adoptive parents with children adopted from China. Participants for the qualitative case study did not participate in the quantitative stage of investigation. The recruitment of participants represented a parallel relationship between qualitative and quantitative samples (Leech & Onwuegbuzie, 2010), ensuring the comparability of the two data sources. The same datasets have been investigated with different emphases, by one earlier submitted manuscript investigating child-parent attachment (Liu, 2017). The quantitative dataset was also used by another study that followed a hierarchical regression analysis on IF associative factors (Liu & Hazler, in press). Research questions for this study were distinctly independent from previous studies. Participants were recruited based on the following criteria: (a) participants were U.S. citizens who adopted children from China; (b) children adopted by participants were 3 years old or younger at the time of arrival (U.S. Department of State, 2016); and (c) children were younger than 6 years old at the time of data collection (APA, 1994, 2013; WHO, 1992).

Two White mothers, Amy and Tina, were recruited for a qualitative case study from the first author’s network from her previous work with adoptive families. Amy and Tina each adopted two children from China. The case study focused on the four children’s IF behaviors and related experiences. Parents, instead of the children, were selected as the participants, as all of the four children were under 6 years old and had limited ability in comprehending and articulating the phenomenon. Both participants were married and had tried to have biological children. Natural

conception was not a possibility, so adoption became the alternative to fulfill the desire for parenthood. Amy was in her late 40s at the time of the interview. Amy had been a stay-at-home mother for her children, Amelia and Beatrice. Tina was around 50 years old at the time of the interview. Tina worked full-time at a research organization, while her husband had been the primary caregiver of their two children, Rebecca and Joshua. The ages of the four children at the time of arrival in the United States were: Amelia, 10 months; Beatrice, 3 years; Rebecca, 11 months; and Joshua, 2 years and 10 months.

Participants for the quantitative investigation consisted of 92 White parents who adopted children from China. Participants ranged from 31 to 59 years old ( $M = 46$ ;  $SD = 6.4$ ). Eighty-six (94%) of the participants were adoptive mothers of the children, and six (6%) were adoptive fathers. Sixty-two participants (67%) had two or more Chinese adoptees. A majority of participants (86%) held a bachelor's degree or higher. More than half (70%) of the participants identified themselves as primary caregivers of the children, and the rest reported as equal caregivers (i.e., the participants and their spouses take an equivalent amount of caregiving responsibilities). Over half of the participants (53%) worked 20 hours or below per week or held no employment, and 47% of the respondents worked more than 20 hours per week. The average age of the children at the time of arrival in the United States was 19 months.

### **Sampling and Recruitment**

Two separate Institutional Review Board approvals, for the qualitative case study and the quantitative investigation, were obtained from the first author's institution where the study was conducted. The authors used the purposeful sampling method (Teddlie & Yu, 2007) to recruit the case study participants following the aforementioned screening criteria. The first author's previous encounters with Chinese adoptees and adoptive families evoked her research interests in this population. The first author was transparent about her role as a researcher, distinct from her other roles (i.e., as a previous counselor for the children), when communicating with the participants. Amy and Tina each endorsed an informed consent form prior to their participation in the study. The form detailed the purposes and significance of this study, risk of participation, and confidentiality.

The 92 participants for the quantitative investigation were randomly recruited through adoption networks and professional organizations. The authors contacted all Children from China local chapters across all U.S. states, consisting of families with children adopted from China, and several online adoptive parent organizations. The study was endorsed by several Children from China chapters and one Chinese adoption agency. The study was also shared by administrators of several online organizations, including *Chinese Adoptive Families*, *China Report*, and *Chinese Adoption*. Parents who were interested in participating in the study e-mailed the first author; the first author then checked the eligibility of interested parents and provided a letter detailing the purpose, significance, risks, and confidentiality related to participation into this study. Participants were directed to the selected surveys (under the Instrumentation section) posted on PsychData. Participants of the study represented a wide geographic coverage.

### **Instrumentation**

A semi-structured interview was conducted with Amy and Tina, separately, to understand their children's IF and to gain a totally fresh perspective toward IF, bracketing researchers' worldviews (Creswell, 2013). Both interviews were performed by the first author, via phone with Amy, and in person with Tina. Each interview lasted for about one and a half hours. The interviewer asked open-ended interview questions to encourage participants to expand on answers related to IF (Creswell, 2013). The interview included five open-ended questions and allowed participants to expand on any

area in which they felt it useful to communicate their understanding and children's experiences of IF. For example, the interviewer asked: How has IF been demonstrated in your children?; What have you noted in terms of your children's friendly behaviors?; and what has influenced your children's behaviors based on your perceptions?

Quantitative data were generated from a self-report questionnaire posted on PsychData, consisting of measures for attachment and IF along with items measuring children's former institutionalization experiences and parents' caregiving quality. Attachment was measured by the adapted Attachment Q-Sort (AQS; Chisholm et al., 1995), which was based on the original AQS developed by Waters and Deane (1985). The adapted AQS contained 23 items measured by a 5-point scale, from 1 = *very unlike my child* to 5 = *very like my child*. A sample item from the adapted AQS was: "Your child clearly shows a pattern of using you as a base from which to explore, that is, he/she moves out to play, returns, and then moves out to play again." Scores for the 23 items were summed, leading to a total attachment score. A higher attachment score means that a child was better attached with the respondent. Van IJzendoorn, Vereijken, Bakermans-Kranenburg, & Riksen-Walraven (2004) reported a modest stability of AQS for the first five years of children's lives. In the Netherlands, Pool, Bijleveld, and Tavecchio (2000) applied the instrument to assess attachment security in 45 children with ages ranging from 2 to 6 years old. Good convergent validity of AQS has been established, with a .50 correlation ( $r$  score) between AQS and the Strange Situation Procedure (Vaughn & Waters, 1990). Reliability of the adapted AQS was manifested through Cronbach  $\alpha$  coefficients, ranging from .65–.72 (Chisholm et al., 1995) to .77–.80 (Chisholm, 1998). The Cronbach  $\alpha$  value for this study was .83.

IF in this study was measured by the frequently used Five-Item Indiscriminately Friendliness Measure (i.e., the 5-item IF measure; Chisholm et al., 1995). The five items represent uncommonly friendly behaviors exhibited by children. The five items measure children's friendliness level to strangers; whether or not the children were shy/behaved in a strange manner; children's reactions to newly met adults; children's willingness to go home with newly met adults; and children's tendency to wander. Respondents selected 1 = *Yes* if the child showed the described behavior in the item; if no untypical friendly behavior was detected in the child, a 0 = *No* was chosen. A higher IF score indicates that the child displayed a higher level of IF behaviors. The Cronbach  $\alpha$  coefficients of the measure were .58–.72 in Chisholm (1998) and .78–.81 in Pears, Bruce, Fisher, and Kim (2011). The Cronbach  $\alpha$  value of the measure in this study was .58. The internal consistency was relatively low but acceptable based on similar values generated in earlier studies by the same measure (Chisholm, 1998; van den Dries et al., 2012).

In addition to the two existing measures, a demographic survey was included in the quantitative questionnaire, including questions asking children's ages and institutionalization experiences. Children's institutionalization experiences were assessed using questions on children's physical growth statuses when arriving in the United States (i.e., weight), their length of institutionalization, and participants' perception of the institutional care that their children had received prior to adoption (i.e., 1 = *was not in an orphanage*; 2 = *high quality care*; 3 = *acceptable quality care*; 4 = *poor quality care*). A higher total institutionalization score implied more positive institutionalization that a child had experienced. Parents' caregiving quality/responsive parenting was measured by the authoritative parenting subscale of the Parenting Styles and Dimensions Questionnaire (Robinson, Mandlco, Olsen, & Hart, 2001), with a Cronbach  $\alpha$  value of .84 for the present study.

## Research Design

The current literature on IF indicates the complexity of the phenomenon because of its frequent



occurrence in post-institutionalized children and its intertwined relationships with children's nurturing environments (APA, 1994, 2013). A mixed methods study provides a better understanding of a complex phenomenon than either a single qualitative or quantitative study (Creswell, 2013). Specifically, this study utilized a sequential mixed methods design to explore Chinese adoptees' IF within their real-life context. It comprised a two-part process, with an initial case study exploring four Chinese adoptees' experiences of IF and a further quantitative investigation following the propositions generated from the case study. The authors consider a qualitative case study appropriate because a case study is a robust empirical approach investigating a case unit in its real-world context (Yin, 2014). The case unit includes, but is not limited to, an individual, a group, a family, a geographic region, or a particular phenomenon that is worthy of thorough investigation. It is considered an ideal methodology when "how" or "why" research questions are asked (Yin, 2014). The case unit for this study is the four Chinese adoptees' experiences of IF. Yin (2014) defined a proposition as an essential component within a case study, guiding data collection and analysis to avoid superfluous information. Propositions are generated through literature review and/or experiences of the researchers and/or participants (Yin, 2014). The propositions from the qualitative case study guided the quantitative investigation. Both types of findings were triangulated and integrated in the Results section (Plano-Clark et al., 2008).

## Procedures

**Trustworthiness.** Researcher reflexivity, peer debriefing, and data triangulation ensured the trustworthiness of the qualitative case study (Hunt, 2011). The authors attained researcher reflexivity through examining and suspending personal beliefs (Hunt, 2011). Qualitative data in this study were triangulated through quantitative data (Leech & Onwuegbuzie, 2010). One procedure to ensure the trustworthiness of case study methodology is to incorporate data from multiple sources (Yin, 2014). Data from the two semi-structured interviews served as the primary data source, and memo writing by the first author offered a supplemental data source. Memo writing was a documentation of the researcher's reflections or reactions while reviewing the raw interview transcripts (Creswell, 2013). The qualitative data were transcribed by the first author and were independently analyzed by the first, second, and third authors. All three authors then thoroughly reviewed each other's coding and reached a consensus on data categorization. An expert in adoption research served as the external reviewer of the qualitative results to ensure that data interpretations were reasonable.

**Data Analysis.** The authors followed the recommended data analysis strategy of pattern matching (Yin, 2014). Synthesizing the current literature and information pertaining to participants' experiences, the research team generated five propositions: (a) children immediately bonded with adoptive parents soon after adoption; (b) children initiated IF behaviors to newly met adults; (c) children responded to affectionate behaviors by newly met adults; (d) age, institutionalization, and adoptive parents' love/responsive parenting were potentially associated with children's IF behaviors; and (e) there was no clear conclusion on whether children's IF was related to their attachment to parents, which warranted a further examination of the IF-attachment relationship.

Each of the authors used the propositions to organize raw data, perform coding and data reduction, and categorize meaningful units (Creswell, 2013). The authors carefully examined all meaning units and performed pattern matching to link the meaningful data units with the propositions (Yin, 2014). Full descriptions were provided on each of the propositions with supportive data from the two in-depth interviews. The researchers analyzed the quantitative data using SPSS Statistics 20. Researchers conducted univariate, bivariate, and multiple regression analyses on the quantitative dataset, examining potential factors associated with IF, as well as the IF-attachment relationship.

## Results

Results of this study included both qualitative and quantitative findings in response to the five propositions; both types of findings were triangulated, compared, and integrated into this section. Both datasets shed light on the three research questions. Each proposition was discussed and supported by qualitative data. Quantitative evidence was integrated into this section as a way to corroborate qualitative findings. Consistencies and discrepancies were identified between the two sets of data.

### Research Question 1: How do parents perceive IF in children adopted from China?

Participants Amy and Tina reported IF as a prominent issue in all four of the children. The first three propositions were highlighted in the answer to Question 1. Quantitative results were consistent with qualitative findings, both of which are discussed in depth in the following paragraphs.

*Children immediately bonded with adoptive parents soon after adoption.* Adoptive parents were not considered as a child's primary caregivers back to the time of adoption because of the brief time they had spent with the child. Adoptive parents, under that circumstance, were categorized as newly met adults. Amy shared that Amelia bonded immediately with her, followed by a successful adjustment. Amy further described that, in the very first night after they adopted Amelia, "she was laughing with us, smiling, giggling, and hugging us." Tina shared similar patterns from Rebecca, who immediately bonded with her and her husband and presented as happy despite the fresh separation from her orphanage caregivers.

*Children initiated IF behaviors to newly met adults.* Initiating affectionate behaviors to newly met adults was a significant indicator of IF (Tizard & Hodges, 1978). Amy and Tina shared this pattern as a common concern, with the fear that children were likely to be taken away by strangers. Participants characterized children's behavior or tendency to show friendliness to strangers as *boundary issues*. These boundary issues were manifested vividly in Joshua. Tina reflected that Joshua would wander off and approach anybody, even though he was aware of the family's presence. Tina provided several concrete examples to explain Joshua's IF behaviors, including his actively seeking proximity specifically to women whom he first met. Tina recalled that Joshua approached a newly met woman at an airport. He also walked up to another woman at the beach, sat down next to the woman, and demonstrated a high level of physical affection toward her (e.g., running his hands through the woman's hair). Tina added that Joshua was never hesitant to ask for food from strangers and often managed to get snacks from people from his stroller when they were in China.

*Children responded to affectionate behaviors by newly met adults.* Children's friendly behaviors also were manifested through their reactions to strangers' affectionate behaviors. Both participants indicated that although parents were sensitive to children's initiation of friendly behaviors, children's reactions to strangers were not given equal attention. It could be a risk factor depending on who the stranger is and the underlying drive that the stranger had in approaching a child. Participants noted that children would accept food from unknown adults. Tina responded that it was common to witness Joshua walking to strangers and returning with food or snacks. Affectionate reactions to strangers happened frequently among the four children at different places. Tina recalled that at a local grocery store, a cashier picked up Joshua and showed him her computer screen, and Joshua responded with excitement and joy, without any sense of reservation. The participants indicated that even though children's friendly reactions to strangers may not necessarily mean that they were indiscriminately friendly to all adult figures, the unreserved friendliness revealed a sign of social limitation.

In addition to the friendly behavioral patterns, Amy and Tina offered further explanations on the four children's IF behaviors. The two participants offered three rationales in explaining these behaviors: (a) children's personalities; (b) their developmental stages; and (c) their desire to have basic needs met. Being an extrovert was linked to children's friendly behaviors, as Tina expressed that Joshua may be the most extroverted person that she could think of, just based on the fact that he always enjoyed being with people. Both participants defined some of the children's friendly behaviors as developmentally appropriate. Particularly, expressing a high level of friendliness was not atypical for younger children. In other words, it was reasonable that children under 5 years old consistently exhibited more friendly behaviors than those who were 8 years old or above. Both participants noted that the children mostly regarded themselves as the center of the universe and assumed that others would always be interested to hear everything they had to say. Amy indicated that friendliness may simply serve as a tool for children to have their basic needs met. The friendly tendency was obvious in Beatrice, as whenever she was hungry, she would request food from strangers. Participants did not view this tendency as pathological in speaking of children's desire to meet their internal drive.

Responses from participants for the quantitative stage echoed the qualitative findings. IF indicators were reinforced by participants' responses to the 5-item measure. Eighty-five percent of the participants ( $n = 78$ ) selected 1 for item 1, indicating that their children were friendly (i.e., sometimes or always very friendly) with new adults. Fifty-seven percent of the participants ( $n = 52$ ) reported the lack of shyness or misbehaving in the presence of strangers. Twenty-five percent of the participants ( $n = 23$ ) identified 0, meaning "the child has always been shy or behaved in a strange manner," and approximately 18% ( $n = 17$ ) indicated that children exhibited a reasonable level of shyness since their arrival in the United States but could not speak to children's former friendly behaviors back in China.

For item 3, examining children's behaviors when meeting with new adults, 27% of the participants ( $n = 25$ ) selected 1, specifying that children always approached new adults, showing toys, speaking or asking questions. About 60% of parents ( $n = 54$ ) indicated that children would screen new adults (i.e., observing and evaluating) prior to taking actions. The remainder ( $n = 13$ ; 13%) indicated fears or indifference toward new adults. For item 4, approximately 41% of the participants ( $n = 38$ ) chose 1, identifying that their children have exhibited some tendency of going home with a newly met adult. With regard to item 5, 23% of the participants ( $n = 21$ ) reported that their children displayed a tendency to wander, without being subsequently distressed after realizing they were away from their parents.

### **Research Question 2: What are some potential factors that are associated with IF?**

The fourth proposition guiding the qualitative case study was that age, institutionalization, and adoptive parents' love and responsive parenting were potentially associated with children's IF behaviors. Amy and Tina asserted that children's behavioral adjustments were related to children's ages at the time of arrival in the United States; specifically, younger children demonstrated better behavioral adjustments compared to children adopted at an older age. Comparing the behaviors of Amelia and Beatrice, Amy mentioned that Beatrice, who was adopted at the age of 3, experienced a more challenging time bonding and adjusting in comparison to Amelia, who was adopted at a younger age. Both participants maintained that children adopted at a younger age generally transitioned smoothly and quickly, because children adopted as infants were not old enough to remember their previous experiences, despite the fact that adoption involves separation and loss and itself could be considered as trauma.

The participants connected children's institutionalization experiences with their later IF behaviors. Children's IF behaviors were speculated to be a consequence of earlier institutionalization that children

had experienced. Amy and Tina viewed IF as one of the institutionalization issues rather than an attachment issue. Amy suggested that children who were previously institutionalized mostly lacked child-parent relationships and failed to form a routine early on in life. It was assessed that something might have happened in children's brains that made it difficult to learn to interact in later relationships. Tina assumed that Joshua's IF behaviors represented his life experiences at the orphanage from which he was adopted. She speculated that the overfriendliness had become a pattern in his first three years in the orphanage where he had no clue about whom his next caregiver would be, and a rational way for him to gain attention from others was to be friendly (e.g., giving a hug).

The participants also tied children's IF behaviors with the news report about suspected child abuse in the orphanage where Joshua was adopted. There was a lack of knowledge and evidence regarding the institutional care that children had received prior to adoption, but the participants held the assumption that children's weight could be an indicator of the quality of care provided at orphanages, which might be indirectly tied to children's behaviors of reaching out to strangers for food or other basic needs. All four children's weight was below the average when adopted, according to the participants. This was the most evident for Joshua, as he weighed only 23 pounds when he was 2 years and 10 months old. His numbers fell off the growth chart for his developmental stage.

Both Amy and Tina highlighted the role of love and responsive parenting as a protective factor of IF behaviors and in counteracting children's previous institutionalization experiences. In this study, parents' love and responsive parenting were delivered through understanding of the complexity of IF, accepting the child, and attending to the individual needs of the child. Both participants perceived IF as a concern, yet understood that going through abandonment and institutionalization may have contributed to children's IF behaviors. Adopting a child meant, according to Amy, not only bringing a child home, but also caring for the child in one's heart. Strong emotions were provoked when participants recalled children's atypical experiences compared to their non-adopted peers. The participants reiterated that love should be unconditional to all children, no matter by birth or adoption. Amy firmly believed that whether a child is biological or adopted, it should make no difference in terms of parenting because each child deserves high-quality love. All children should be considered as "our" children, and the love is "our" love.

Separation is what adoptees go through. With strong emotions, Amy highlighted the *goodbyes* that the adoptees had to say in their lives, all of which apparently were out of their control. Amy elaborated that a child's life started in the mother's room for months, and the child was used to the mother's presence and voice, and then had to tell the mother goodbye. That was the child's first loss in life. The child was then delivered to the orphanage, labeled as one of many orphans, and taken care of by orphanage staff. Shortly after forming an attachment with orphanage staff and peers (referred to as "crib-mates" by Amy), the child was matched with an adoptive family from overseas and had to say goodbye again. The multiple losses and separations solidified the critical role that adoptive parents may play, so that the child is nurtured in a steady and consistent environment.

Participants believed that showing responsive parenting was vital in helping children work on IF behaviors because changes could not be made on children's pre-adoption experiences, but could be made on post-adoption caregiving. Tina reinforced that parents should not just take a child away from strangers; a more compelling need for the child was to learn how to act appropriately with strangers. The participants emphasized the importance of selective attending, meaning that parents attend to a child when he/she was in true need (e.g., when a child wanders off without checking in) and ignore behaviors that did not matter to the child's safety or growth. Participants suggested several techniques for fostering parental attending to children's needs, including singing children's

tunes, encouraging eye contact, strictly following routines, and offering hugs. These techniques helped instill in the children security and stability.

Age, institutionalization, and love and responsive parenting were included in the quantitative investigation. Bivariate analyses were conducted between each of the variables and IF scores. A higher institutionalization score was significantly correlated with a lower IF score ( $r = -.24; p < .05$ ); namely, the more positive institutionalization experiences a child had, the fewer IF behaviors the child exhibited (Liu & Hazler, in press). No significant correlations were identified between age and IF ( $r = -.10; p > .05$ ) or responsive parenting and IF ( $r = -.04; p > .05$ ). A multiple regression analysis yielded a significant model, with institutionalization as the significant predictor of IF. The results showed that institutionalization explained 9% variance in IF scores ( $R^2 = .09, F(1, 88) = 4.16, p < .05$ ) (Liu & Hazler, in press). Responsive caregiving was nonsignificant in predicting IF.

### **Research Question 3: Is IF related to children's attachment?**

In answering this question, data were matched with the fifth proposition: there was no clear conclusion on whether children's IF was related to their attachment to parents, which warrants a further examination of the IF–attachment relationship. Neither qualitative nor quantitative results provided evidence to support a relationship between children's attachment and IF behaviors. Amy and Tina shared an interesting fact that the children seemed to attach well with them in spite of frequent IF behaviors directed to adults other than the primary caregivers. All four children were reported to form successful attachment with their adoptive parents; in the meantime, they displayed different levels of IF toward strangers. The two participants held the opinion that IF may not necessarily be categorized as an attachment disorder. This was echoed by previous analysis concerning institutionalization, in which parents speculated that IF behaviors might be more appropriately treated as an institutionalization versus attachment issue. Tina disclosed that Joshua's IF behaviors were described by a clinical practitioner as “nowhere near the attachment disorder.”

A bivariate analysis was conducted between attachment and IF scores using the quantitative data, which yielded a nonsignificant result ( $r = .12, p > .05$ ). Therefore, no significant correlation was detected between attachment and children's IF behaviors. A direct interpretation of the quantitative result was that an adoptee's attachment with adoptive parents was not correlated with the level of the child's IF. Positive attachment and IF can coexist in a child, which was consistent with the case study findings.

## **Discussion**

This mixed methods study revealed qualitative themes and quantitative evidence in addressing the three research questions. Consistent with previous findings, this study reinforced that IF appears to be a prevalent issue in Chinese adoptees. Children's IF was demonstrated through quick bonding to new adoptive parents soon after adoption, initiating excessively friendly behaviors to strangers, and responding to strangers' affectionate behaviors without hesitation. A child's affectionate behaviors toward adoptive parents were deemed a sign of IF, as the child and adoptive parents did not have previous encounters with each other. Under attachment theory (Bowlby, 1969), a child selectively shows affection to and seeks proximity from the mother or the primary caregiver, and the attachment relationship is based on frequent behavioral exchanges between the child and the mother or primary caregiver (Sroufe & Waters, 1977). Naturally, children's excessive friendliness to strangers, without the selection process under the attachment theory, is considered atypical behavior.

IF behaviors were described as a manifestation of pathology and either classified as a subtype of attachment disorder under the *DSM-IV* (APA, 1994) or renamed as disinhibited social engagement

disorder in the most recent *DSM-5* (APA, 2013). The 5-item IF measure utilized in the study was consistent with the screening questions within the *DSM*, which concretized the IF through specific behaviors such as wandering off and going home with strangers. Although the items provided a simplified interpretation of IF, qualitative findings revealed multiple layers tied to IF that have not been adequately attended to by researchers and professional practitioners. The *DSM-IV* and *DSM-5* classifications were based on the presumption that IF was an outcome of pathogenic care or maltreatment that children had experienced earlier in life (APA, 1994, 2013).

There has been a lack of investigation into personal factors that may explain children's IF behaviors. Qualitative findings of this study illuminated the complex nature of IF and directed attention to other alternative criteria, in addition to pathogenic care, including children's personality types, developmental stage, and drive to meet personal needs. These findings were consistent with Bennett, Espie, Duncan, and Minnis' (2009) qualitative study that explored IF through children's lenses. Bennett and colleagues highlighted children's two internal drives underlying their IF behaviors: seeking love/attention and striving to meet personal needs. A comprehensive literature review by Love, Minnis, and O'Connor (2015) also challenged the pathogenic care criterion within the *DSM* by proposing several additional factors associated with IF, including genetic differences, inhibitory control, cognitive ability, and post-adoption caregiving.

Children's former institutionalization experiences were proposed to be a salient factor associated with children's behaviors (Bruce et al., 2009). The significant role of institutionalization in relation to IF was supported by numerous earlier studies conducted with internationally adopted children (Bruce et al., 2009; van den Dries et al., 2012). IF has been reported as a salient issue with previously institutionalized children in comparison with children raised in their birth families (Chisholm, 1998; Tizard & Hodges, 1978). Findings seem to be unanimously significant across the literature in regards to the association between children's institutionalized experiences and children's IF behaviors. The quantitative results of this study echoed previous findings, with institutionalization significantly associated with children's IF. Qualitative findings also highlighted the role of institutional care as a factor associated with children's IF behaviors. For example, children who received inadequate care from pre-adoption institutions may appear to be friendlier or seek food and/or attention from adults, as they had to compete with other children in the institution for a limited amount of available resources.

Another variable that revealed inconsistent findings between the qualitative and quantitative datasets was responsive parenting. Quantitative results of this study did not support the significance of caregiving by adoptive parents, which was supported by Zeanah and Smyke (2008), and IF was confirmed not to be associated with post-adoption caregiving quality. Qualitative findings of this study, on the other hand, demonstrated the importance of love and responsive parenting in working with children's behavioral adjustment. Similar findings can be retrieved from the study by van den Dries et al. (2012), which indicated that children receiving better maternal care after adoption presented less IF behaviors.

The relationship between IF and attachment has been repeatedly investigated in the literature, with two antithetical views: (a) IF is a form/subtype of attachment (APA, 1994; O'Connor et al., 2003); and (b) IF needs to be treated as a unique behavioral issue, separate from attachment (APA, 2013; Lyons-Ruth, Zeanah, & Gleason, 2015). A common theme between the two views is that IF behaviors are developmentally inappropriate. The quantitative results of this study were aligned with the latter view that IF is not significantly correlated with attachment. Qualitative responses from this study were congruent with the quantitative results, as participants indicated that positive attachment and IF behaviors indeed coexist in children. The qualitative findings furthermore challenged the pathological

stance that has been historically held about IF, with an alternative explanation that children's personalities, developmental stages, and internal drives to meet personal needs may be associated with their IF behaviors.

### Limitations

This study has three main limitations. The comparatively low Cronbach alpha value of the 5-item IF measure was the first concern, which brought about the question of whether or not the 5-item IF was adequate in measuring IF, although low level of internal consistency is noted to be common in short scales (Streiner, 2003). The second limitation was related to participants and self-report surveys, in which reporter bias and social desirability could confound the results; namely, participants might have chosen to respond to the items based on what they believed to be socially desirable responses. Further, using parents as the only participants is likely to arouse doubt on whether or not parental perceptions of children's IF behaviors were accurate. The third limitation was related to data saturation. Although sample size is not emphasized in qualitative research, data saturation has been consistently suggested, meaning that data collection should continue until the point that no new information arises. A practical concern is that qualitative results based on the four Chinese adoptees' experiences may not reach data saturation (Creswell, 2013; Teddlie & Yu, 2007), thus potentially affecting the analytical generalization of qualitative findings. Nevertheless, Teddlie and Yu (2007) offered further justification for the need of representativeness and saturation trade-off sampling in mixed methods research. This sampling technique entails unequal emphases of qualitative and quantitative sampling within a mixed methods study; namely, when quantitative representativeness is emphasized, less emphasis is directed to the qualitative saturation of the study.

### Research and Clinical Implications

Results of this study provide crucial implications for future research and practice by professional counselors who work with Chinese adoptees and adoptive parents (e.g., counselors working in school or family settings). Controversies on the categorization of IF (as attachment or other mental health disorders) in the *DSM*, along with the additional factors proposed by participants, indicate a compelling need to develop a more mature measure for IF, considering a wider range of behaviors beyond the five items. One goal of the new measure is to offer a justification on whether IF truly exists in a child and the severity of the IF tendency. Future research studies should be considered regarding the underlying causes of IF. Researchers should consider involving children in future investigations in order to acquire diverse perspectives on IF and to obtain more generalizable results from the first-person lens.

A clinical implication from this study is that professional counselors working with adoptees and adoptive families need to attend to the complexity of IF. IF behaviors certainly need to be monitored and screened because of the risks associated with the behaviors; however, no quick diagnosis should be reached without adequate evidence on the frequency and magnitude of the behaviors. Practitioners need to reassess the criteria defining pathology—whether or not children's friendly behaviors are truly indiscriminate and to what extent a friendly behavior should be classified as abnormal (Zeanah & Smyke, 2008). These clinical needs call for practitioners' familiarity with evidence-based research and more exposure to the target population, IF-related training programs, and a more comprehensive clinical questionnaire asking for further evidence to support children's IF occurrence and severity.

### Conclusion

This study enriched the knowledge of IF through a mixture of qualitative and quantitative findings. Results of this study unveiled Chinese adoptees' experiences of IF and shed light on factors

associated with IF, strengthening the significance of institutionalization as an important factor in children's IF behaviors. The authors also generated a significant regression model that accounted for 9% of the variance in IF (Liu & Hazler, in press). In alignment with recent research studies (Love et al., 2015; Lyons-Ruth et al., 2015) and the *DSM-5*, this study provided evidence to support the distinction of IF from attachment. It also introduced alternatives to the pathological perspective toward IF from previous research and diagnostic standards. The results of this study enabled a better understanding of IF and offered research recommendations and critical implications for professional counselors serving adoptive families.

#### **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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# An Exploratory Factor Analysis of the Sexual Orientation Counselor Competency Scale: Examining the Variable of Experience



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The Sexual Orientation Counselor Competency Scale (SOCCS), developed by Bidell in 2005, measures counselors' levels of skills, awareness, and knowledge in assisting lesbian, gay, or bisexual (LGB) clients. In an effort to gain an increased understanding of the construct validity of the SOCCS, researchers performed an exploratory factor analysis on the SOCCS with a sample of practicing counselors who were members of the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) and counselors-in-training ( $N = 155$ ) enrolled in four Council for Accreditation of Counseling & Related Educational Programs (CACREP)-accredited counseling programs. The data analyses resulted in a 4-factor model, 28-item assessment that explained 56% of the variance. In acknowledging the loading of the fourth factor, this result highlights the need to focus on involvement and engagement in clinical practice in order to maintain best practice standards. Furthermore, the fourth factor of experience adds a compelling perspective to consider when understanding, improving, and maintaining sexual orientation counselor competence.

**Keywords:** sexual orientation, counselor competence, exploratory factor analysis, best practice standards, SOCCS

In order for counselors to be ethical and effective professionals, they must be competent in providing services to sexual minority clients (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013). The American Counseling Association's (ACA) 2014 *ACA Code of Ethics* requires that counselors honor the uniqueness of clients in embracing their worth, potential, and dignity. Additionally, counselors should actively attempt to understand client identity, refrain from discrimination, and utilize caution when assessing diverse clients (ACA, 2014). Furthermore, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2009 *Standards for Accreditation* assert that counselors should understand identity development, develop self-awareness, promote social justice, and strive to eliminate prejudices, oppression, and discrimination. Therefore, it is both ethical and essential to empirically explore competence assessments in order to improve overall counseling competence.

Sexual minority clients are at risk for a myriad of concerns such as shame, depression, risky behaviors, self-harm, abuse, and suicide (Cooper, 2008; Degges-White & Myers, 2005; Human Rights Campaign, 2014; McDermott, Roen, & Scourfield, 2008). In order to align with the intended population of the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005), sexual minority clients are defined as individuals who identify as lesbian, gay, or bisexual (LGB). Since the 1970s, researchers have identified the importance of counseling for LGB individuals, as these clients have a higher propensity for suicide and substance abuse as compared to heterosexual populations (Cass, 1983; Cooper, 2008; Degges-White & Myers, 2005; McCarn & Fassinger, 1996; Troiden, 1979, 1989). Furthermore, at the turn of the 21st century, researchers began to note the importance of competence in providing effective counseling services to sexual minority clients (Bidell, 2005; Brooks & Inman, 2013; Graham, Carney, & Kluck, 2012; Grove, 2009; Israel & Selvidge, 2003).

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Bidell (2005) developed the SOCCS in an effort to measure counselors' awareness, skill, and knowledge competencies in assisting LGB clients. Initial research findings supported the criterion, concurrent, and divergent validity, and the internal consistency and test-retest reliability of the SOCCS with the norming population; however, the factor structure (construct validity) of the SOCCS with the norming population was questionable (i.e., 40% of the variance explained by the 29-item SOCCS). Therefore, additional research is warranted to examine the construct validity of the SOCCS with a different sample of counseling professionals, as construct validity provides a central understanding to whether or not the assessment: (a) measures the intended competencies, (b) is adequately explicated by a 3-factor structure, and (c) is best comprised of 29 items (Gall, Gall, & Borg, 2006). Consequently, the purpose of the present study was to examine the factor structure of the SOCCS with a sample of counseling practitioners and counselors-in-training to gain an increased understanding of the construct validity of the SOCCS. The findings of the present study add a new perspective, as the results display a potential 4-factor structure that warrants consideration in the literature.

## Sexual Orientation Counselor Competency Scale

The SOCCS (Bidell, 2005) is a 29-item instrument designed to measure counselors' level of competence in working with clients identifying as LGB. The SOCCS was developed based on the LGB-affirmative counseling and multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992) and included an item pool of 100 items that was reduced to 42 items with 12 items pertaining to skills, 12 items to awareness, and 18 items to knowledge. Bidell (2005) examined the factor structure of the SOCCS using exploratory factor analysis (EFA) with a principal axis factoring (PAF) and an oblique rotation, identifying a 3-factor structure: (a) Factor 1: Skills (11 items, 24.91% of the variance explained), which assesses counseling skills in working with LGB clients; (b) Factor 2: Awareness (10 items; 9.66% of the variance explained), which measures counselors' awareness of biases and attitudes about LGB individuals; and (c) Factor 3: Knowledge (8 items, 5.41% of the variance explained), which assesses counselors' understanding about the LGB population.

### Factor Analysis

Bidell (2005) also examined the criterion, convergent, and divergent validity of the SOCCS with his sample. Criterion validity of the SOCCS was examined using participants' education level and self-identified sexual orientation. A positive relationship was identified between the participants' SOCCS subscale scores and their level of education and sexual orientation. Convergent validity was examined by measuring the relationship between SOCCS subscale scores and participants' Attitudes Toward Lesbians and Gay Men Scale (Herek, 1998), the knowledge subscale of the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 1996), and the skills subscale of the Counselor Self-Efficacy Scale (Melchert, Hays, Wiljanen, & Kolocek, 1996). The results of the correlational analyses supported the convergent validity of the SOCCS. Discriminant validity was examined by comparing the mean social desirability scores with the SOCCS subscale scores, and results supported the divergent validity of the SOCCS within the norming sample.

### Norming Population of the SOCCS

The norming population for the SOCCS (Bidell, 2005) consisted of 312 mental health students, providers, and educators from across the United States. The majority of the sample was comprised of females ( $n = 235$ ) and the average age was 31.9 years old. Individuals were recruited from 13 public and three private universities. More than 80% of the population included students: (a) 47 were undergraduates from an undergraduate introduction to counseling course, (b) 154 were master's-level students in school or community counseling programs accredited by CACREP, (c) 32 were doctoral students from a CACREP-accredited counselor education program, and (d) 30 were from

university internship sites approved by the American Psychological Association. The non-student portion of the population was comprised of 49 doctoral-level counselor education supervisors. A majority of the population (85.5%) identified as heterosexual, 12.2% identified as LGB, and 2.5% chose to not identify. Bidell (2005) noted the limited gender variance in the development of the SOCCS, as it is possible that individuals within the 2.5% may identify on the gender continuum. More than half of the norm group ( $n = 191$ ) identified as European American or White, 41 as Latino, 32 as Asian American, 22 as African American or Black, seven as biracial or mixed, and four as Native American. Fourteen individuals identified as “other,” and this may have been because of rigid racial denominations provided in the demographics.

### Interpretation of the SOCCS

The SOCCS (Bidell, 2005) is a criterion-referenced measure consisting of rating scales. The SOCCS provides respondents with a range of seven choices to self-report on the three subscale domains (Skills, Awareness, and Knowledge): from (a) not at all true, to (b) moderately true, and to (c) totally true. Eleven of the 29 SOCCS items (2, 10, 11, 15, 17, 21, 22, 23, 27, 28, and 29) are reverse scored, and overall competence is interpreted by the sum of the items divided by the total number of items (29) to form a percentage score. Bidell (2005) does not provide information on criteria to determine low, moderate, or high competence; however, inferences can be made from interpreting the overall and subscale scores (Farmer, Welfare, & Burge, 2013).

The overall mean SOCCS (Bidell, 2005) score in the norm group was 4.64 ( $SD = 0.89$ ). Subscale mean SOCCS scores included 2.94 ( $SD = 1.53$ ) for Skills, 6.49 ( $SD = 0.79$ ) for Awareness, and 4.66 ( $SD = 1.05$ ) for Knowledge. Graham, Carney, and Kluck (2012) sampled 234 counseling students and found mean SOCCS averages for competence were 3.88 for Factor 1: Skills, 6.52 for Factor 2: Awareness, 4.67 for Factor 3: Knowledge, and 5.01 for overall SOCCS scores. Follow-up studies continue to support the original theme in which individuals believe they are more aware but less knowledgeable; furthermore, individuals believe they have less skills than knowledge pertaining to sexual minority counselor competencies (Bidell, 2012; Farmer et al., 2013; Grove, 2009; Rutter, Estrada, Ferguson, & Diggs, 2008).

In addition, Graham and colleagues (2012) also assessed for potential differences in SOCCS scores between individuals who have or have not attended a conference presentation, workshop, or training pertaining to LGB issues. No difference in SOCCS scores was identified between participants reporting that they attended a conference presentation with subject matter pertaining to LGB counseling or not; however, individuals who attended a workshop had higher competency scores in Skills,  $F(1, 225) = 61.03, p < .001$ ; Awareness,  $F(1, 225) = 4.42, p < .05$ ; and Knowledge,  $F(1, 225) = 4.34, p < .05$ . Additionally, individuals who attended a training session had higher scores in the domains of Skills,  $F(1, 225) = 32.07, p < .001$ ; Awareness,  $F(1, 225) = 33.62, p < .001$ ; and Knowledge,  $F(1, 225) = 33.62, p < .001$ ; and when compared to individuals who did not attend similar trainings. Furthermore, more experience with LGB clients yielded higher competency scores. A Tukey's post hoc analysis identified that individuals who had never provided counseling services to LGB clients had lower SOCCS scores ( $M = 4.43, SD = 0.72$ ) than individuals who had provided services to one to five LGB clients ( $M = 4.99, SD = 0.66$ ), six to 10 LGB clients ( $M = 5.57, SD = 0.55$ ), 11 to 15 LGB clients ( $M = 5.59, SD = 0.57$ ), or more than 15 LGB-identified clients ( $M = 5.78, SD = 0.50$ ). Therefore, the differences in SOCCS scores suggest that more exposure and experience with LGB clients could improve sexual minority counseling competence.

### Factor Analysis of the Original Instrument

The SOCCS (Bidell, 2005) coefficient alpha for internal consistency reliability was found to be

.90. The subscale scores for internal consistency were .91 for Skills, .88 for Awareness, and .71 for Knowledge. A subsection of the sample ( $n = 101$ ) including students and supervisors was used for test-retest reliability. One-week test-retest reliability was found to be .84 for the overall instrument, .83 for the Skills subscale, .85 for the Awareness subscale, and .84 for the Knowledge subscale (Bidell, 2005). In addition, Bidell (2013) investigated the potential for SOCCS scores to change after implementation of an LGB counseling course six weeks into the program, and identified that the participants' scores were significantly higher on the overall and subscale scores. Bidell's (2013) findings identified the ability for education to promote SOCCS scores in counseling students but challenged the test-retest reliability of the SOCCS. No published data was identified related to the inter-rater reliability or alternate forms of the SOCCS.

### **Additional Factor Analysis of the SOCCS**

Carlson, McGeorge, and Toomey (2013) examined the factor structure of the SOCCS with a sample of 248 master's and doctoral students in couple and family therapy and identified a 2-factor solution: (a) Factor 1: Awareness and (b) Factor 2: Knowledge and Skills. Further, three SOCCS items (i.e., 5, 24, 25) did *not* load into the combined Knowledge and Skills subscale and were removed. The second examination resulted in an acceptable model fit  $\chi^2(df = 8) = 20.65, p < .01$ ; however, it should be noted that five SOCCS item stems (i.e., 3, 4, 7, 8, 19) were altered and the 7-point scale was adapted to a 6-point scale. Therefore, based on the modifications made to the SOCCS, it is difficult to compare the factor structure results to other investigations using the unmodified SOCCS.

### **Counseling Competency With Sexual Minority Clients**

Researchers have utilized the SOCCS in an effort to further their understanding of counseling competencies related to working with sexual minority clients (Brooks & Inman, 2013; Graham et al., 2012; Grove, 2009). Grove (2009) provided counseling students ( $n = 56$ ) with the SOCCS, and an ANOVA identified that years in training provided a significant difference in scores for Skills ( $p = .002$ ), Awareness ( $p = .05$ ), and Knowledge ( $p = .001$ ). Although analyses were not conducted to determine the differences between subscales, Grove noted high scores in the Awareness subscale. Although individuals have strong, affirmative attitudes, they may lack the knowledge and subsequent skills necessary to effectively aid LGB clients. These SOCCS scores may be interpreted to show a variety of concerns such as inflated confidence, potential lack of training, and low competency. Graham and colleagues (2012) utilized the SOCCS with counselor education and counseling psychology graduate students ( $n = 234$ ) and yielded similar results to Grove. Participants scored highest on the Awareness subscale, followed by the Knowledge and Skills subscale scores. These research findings identify that counselor trainees may not be receiving the necessary knowledge and skills to become competent counselors in working with sexual minority clients.

Advances have been made in the counseling field regarding the understanding of competency in aiding sexual minority clients (Bidell, 2005; Graham et al., 2012; Grove, 2009); however, additional research is warranted. The commonly utilized SOCCS is a self-report measure; therefore, there is potential for participants to provide socially desirable answers. Further, because the SOCCS was created to measure counselors' level of confidence (self-efficacy) in providing counseling services to LGB clients, the literature has followed this narrow lead (Bidell, 2013; Carlson et al., 2013; Grove, 2009). The SOCCS was created prior to ALGBTIC's (2013) guidelines; therefore, the items may not align with the essential aspects of the guidelines. Considering this potential gap, it is essential to explore the psychometric properties of the SOCCS (Bidell, 2005). Nevertheless, the SOCCS is the most used assessment instrument for examining LGB counselor competence in training and research; hence, it is important to explore the reliability and validity of the instrument in order to support

continued exploration of LGB counselor competence. Therefore, we aimed to examine the factor structure of the SOCCS with a sample of counselor trainees and practitioners in order to gain an increased understanding of the psychometric properties of this assessment. The following research questions guided our investigation:

**Research Question 1.** What is the factor structure of the SOCCS with a sample of practicing counselors and counselors-in-training?

**Research Question 2.** What is the internal consistency reliability of the SOCCS with a sample of practicing counselors and counselors-in-training?

## Method

### Participants

We aimed to examine the factor structure of the SOCCS with a sample of practicing counselors and counselors-in-training. The data used for this investigation were part of a larger study regarding counselors' preparedness to assist clients in the coming-out process. Because online surveys tend to have a lower response rate (Shih & Fan, 2009), we decided to use additional intentional data collection methods in our sampling to achieve a sample of counselors-in-training and practicing professionals. The data collection assessments were distributed through ALGBTIC in order to acquire a national sample of counseling professionals and to include individuals who may perceive themselves as competent to work with sexual minority individuals. In addition, the data collection assessments were distributed to counselors-in-training enrolled in four CACREP-accredited counseling programs in four different southeastern states with the assumption that the student population would help to cover the domain of individuals who do not believe they are competent to assist sexual minority clients in counseling. We received a total of 200 responses, which gave us a response rate of 28.41%. However, because of missing data, 45 participants were eliminated, leaving 155 (22.02%) usable cases. Although the response rate was less than the weighted average Van Horn, Green, and Martinussen (2009) noted in their meta-analysis of counseling and clinical psychology journals (49.6%), we decided our response rate was adequate to continue because of the necessity of research on the factor structure of the SOCCS and the potential value of the implications on improving counseling services for sexual minority clients. Additionally, the demographics of the sample mirrored the overall population (i.e., a majority of the participants identified as white and female), which is presented in Table 1 (U.S. Census Bureau, 2016).

### Procedure

Our university's institutional review board approved this study prior to any data collection and recruitment. We implemented the Tailor Design Method (Dillman, Smyth, & Christian, 2009) in our recruitment and data collection (e.g., invitation, survey). We utilized Qualtrics, an electronic survey research tool, to assemble our informed consent, data collection instruments, and demographic questionnaire online. Qualtrics permitted us to collect anonymous data. After data collection, Statistical Package for the Social Sciences (Windows Version 20) was used for data cleaning and analysis.

### Data Screening

Before we analyzed our data, we screened our dataset. First, we needed to remove responses with at least one incomplete item from the overall data set to promote consistency (Warner, 2013). Listwise deletion resulted in the removal of 45 cases, resulting in 155 completed data collection packets for the investigation. SOCCS item scores were converted to standardized z-scores to determine if outliers

**Table 1**  
*Participants' Demographic Characteristics*

Characteristic	<i>n</i>	Total Percent
Gender		
Female	121	82.9
Male	24	16.4
Ethnic Background		
African American/African/Black	14	9.7
Asian/Asian American	6	3.9
Biracial/Multiracial	9	5.8
Caucasian (Non-Hispanic)	105	67.7
Hispanic/Latina/Latino	7	4.5
Other	2	1.3
Chose not to specify	2	1.3
Sexual Orientation		
Bisexual	8	5.2
Gay	5	3.2
Heterosexual	71	45.8
Lesbian	7	4.5
Other	3	1.9
Professional Status		
Student	102	61.5
Clinician	43	33.3
CACREP Status		
Accredited	73	46.8
Not Accredited	20	12.8
Age		
21–25	70	45.2
26–30	27	17.4
31–35	16	10.3
36–40	13	8.4
41–45	4	2.6
46–50	7	4.5
51–55	1	.6
56–60	6	3.9
61–65	1	.6
66–70	1	.6

*Note.* *N* = 155

existed in the data, and the results identified that no scores were greater than +4 or less than -4; therefore, no outliers were identified (Hair, Black, Babin, Anderson, & Tatham, 2010). Next, we examined the appropriateness of the sample size to conducting an EFA. Smaller sample sizes are suitable for EFA if several solutions have high loading variables (above .80; Tabachnick & Fidell, 2013). In addition, rather than sample size, the ratio of assessment items to participant may be used to determine appropriateness of data for EFA (Dimitrov, 2012; Nunnally, 1978; Tabachnick & Fidell, 2013), with a five participant cases-to-item ratio deemed acceptable. Because there were more than five cases per SOCCS item (5.34:1), we determined this sample size was appropriate for EFA. Our



next step was to examine the normality of the data and determine the most appropriate method of extraction. To assess for normality of our data, we checked the univariate normality of each SOCCS item, and if item univariate normality was satisfied, we checked multivariate normality using the Mardia test (Mvududu & Sink, 2013). We identified several SOCCS items that were not normally distributed; therefore, multivariate normality was not examined because univariate normality is a necessary condition of multivariate normality (Mvududu & Sink, 2013). In addition, our histograms, boxplots, and Q-Q Plots results identified that multiple SOCCS items were non-normally distributed; hence, we assumed the data was non-normally distributed, which can occur in social science research (Mvududu & Sink, 2013).

### Data Analysis

After screening the dataset for missing data and assessing for normality, we conducted an EFA to examine the factor structure of the SOCCS with our sample of counseling practitioners and counselors-in-training. Because of the non-normality of the data (Costello & Osborne, 2005), PAF was used for extraction with an oblimin rotation with Kaiser Normalization. A significant value ( $p < .001$ ) was identified for Bartlett's test of sphericity (Bartlett, 1954), and a value of .83 was obtained for Kaiser-Meyer-Olkin sampling adequacy for the SOCCS. Next, we examined internal consistency reliability of SOCCS using Cronbach's  $\alpha$ , thus assessing the degree of correlation between SOCCS items.

### Results

To examine the factor structure of SOCCS, we used EFA, employing PAF analysis. All SOCCS items displayed a factor loading of at least .3 and were initially retained (Floyd & Widaman, 1995; Hair et al., 2010). However, SOCCS items were reduced following classical test theory in order to reduce items with poor measurement properties and to increase internal consistency reliability (Crocker & Algina, 2006; DeVellis, 2003). As noted in Table 2, The PAF results identified the presence of six SOCCS factors with eigenvalues exceeding one, explaining 62% of the variance. However, the first three factors produced eigenvalues of greater than 2.8, whereas the remaining three were all less than 1.5. The three factors accounted for 49% of the variance. As noted in Figure 1, the scree plot, a preferred method for identifying factor solutions in EFA (Hair et al., 2010), identified a steep decline including three factors, a break near the fourth factor, and a significant plateau at the fifth factor, supporting a 3- or 4-factor model solution for the SOCCS with these data. The factor matrix showed loadings of more than .4 for the first three factors, and less than .4 for the fourth through sixth factors. The first three SOCCS factors paralleled Bidell's conceptually based factors of Skills, Awareness, and Knowledge. In the essence of EFA, we examined the potential construct being measured by the fourth factor and determined that all items (i.e., 4, 7, 8, 12 and 18) pertained to experience. Originally, these SOCCS items were included in the Skills subscale; however, we determined that the presence of these items together shows promise for a fourth SOCCS subscale of Experience. The model with four subscales accounted for 54% of the variance.

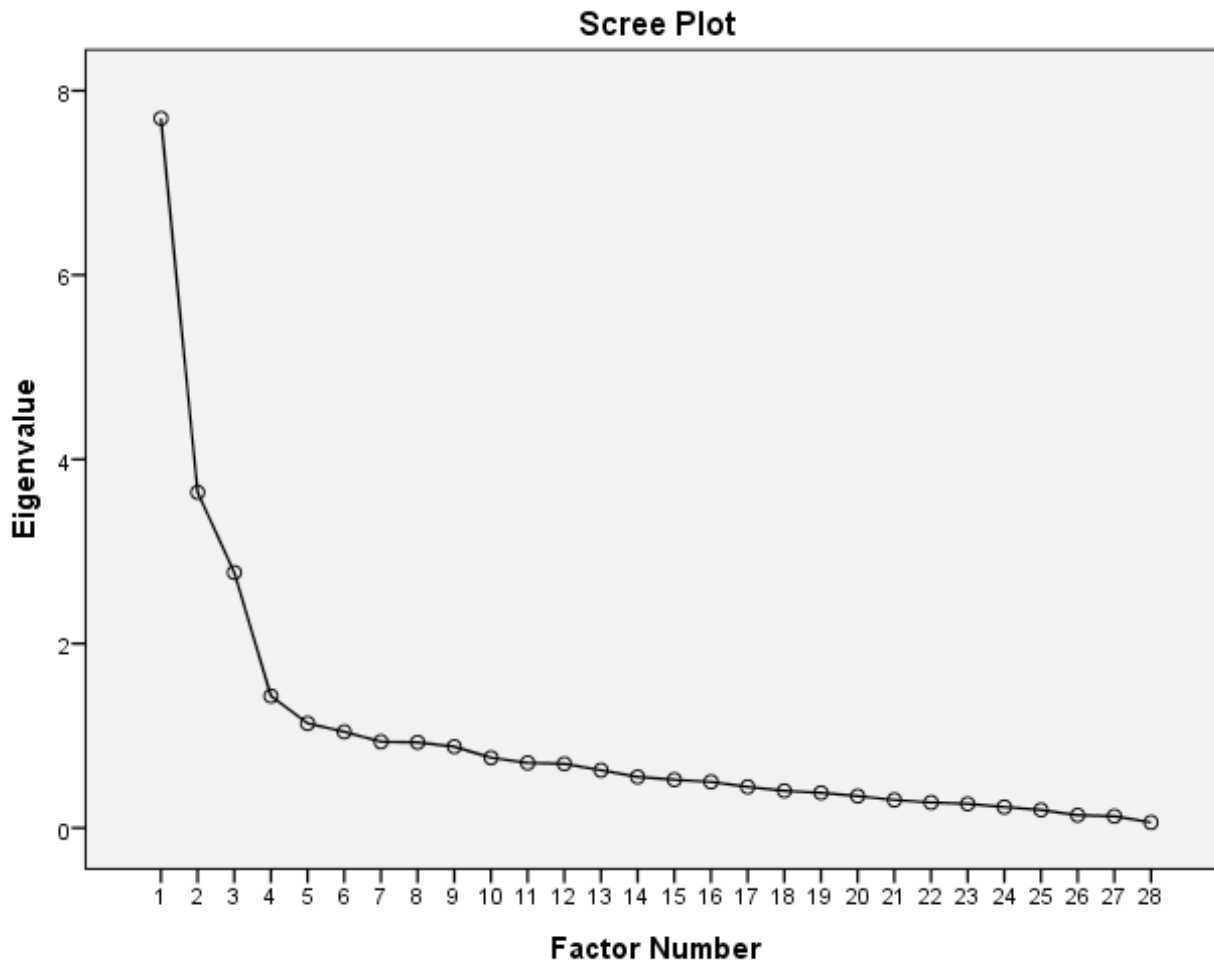
The Knowledge subscale was the only subscale that loaded as intended with eight items, accounting for 9.90% of variance as compared to 5.41% of variance in the original analysis (Bidell, 2005). Six SOCCS items loaded onto the Skills subscale, accounting for 27.5% of the variance as compared to 24.91% of variance in the original analysis. The remaining five SOCCS items that did not load onto the Skills subscale loaded together onto the fourth subscale, which is the Experience subscale. The Experience subscale accounted for 5.11% of the variance. Five SOCCS items loaded onto the Awareness subscale. Of the remaining items, three loaded onto both fifth and sixth factors (i.e., 11, 15, and 17). Unlike the Awareness subscale, which was theoretically justified, a fifth factor was not theoretically justified; therefore, we decided to keep these three items with the Awareness subscale.

**Table 2***Total Variance Explained*

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		Rotation Sums of Squared Loadings <sup>a</sup>	
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	7.705	26.568	26.568	7.344	25.311	25.311	5.422
2	3.722	12.834	39.402	3.263	11.250	36.561	3.520
3	2.828	9.750	49.152	2.365	8.155	44.717	3.982
4	1.442	4.972	54.124	1.005	3.464	48.181	5.050
5	1.195	4.121	58.245	.710	2.447	50.628	2.362
6	1.088	3.752	61.996	.601	2.072	52.699	1.440
7	.992	3.419	65.416				
8	.929	3.204	68.619				
9	.898	3.097	71.716				
10	.827	2.850	74.566				
11	.745	2.568	77.134				
12	.705	2.431	79.565				
13	.666	2.298	81.863				
14	.583	2.012	83.874				
15	.540	1.861	85.735				
16	.523	1.804	87.539				
17	.474	1.634	89.173				
18	.445	1.535	90.709				
19	.399	1.377	92.085				
20	.381	1.313	93.399				
21	.341	1.174	94.573				
22	.299	1.031	95.604				
23	.276	.953	96.557				
24	.257	.887	97.444				
25	.226	.781	98.224				
26	.194	.670	98.895				
27	.137	.472	99.366				
28	.126	.434	99.800				
29	.058	.200	100.000				

Note: Extraction Method: Principal Axis Factoring.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

**Figure 1.***Eigenvalues from 28-item SOCCS Factor Analysis*

Because SOCCS items 10 and 23 only loaded onto factors five and six and no other factor, we decided to remove these items for parsimony. Therefore, the Awareness subscale now has eight items, accounting for 13% of the variance. Further information on factor loadings can be seen in Table 3.

### Internal Consistency Reliability of the SOCCS

The second research question examined the internal consistency reliability of the SOCCS with a sample of counselors-in-training and practicing counselors. The original 29-item SOCCS displayed a strong reliability score with a Cronbach's  $\alpha$  of .90 (Leech, Onwuegbuzie, & O'Connor, 2011). As a 27-item assessment, the Cronbach's  $\alpha$  for the overall SOCCS was .894; although slightly lower than the original assessment, the reliability of the revised SOCCS displays strong internal consistency (Leech et al., 2011). Original SOCCS subscale reliability scores were .91 for Skills, .88 for Awareness, and .76 for Knowledge. Our item analysis of the SOCCS data identified strong internal consistency reliability with a Cronbach's  $\alpha$  of (a) Total SOCCS scores .893, (b) SOCCS Knowledge subscale scores .807, (c) SOCCS Skills subscale scores .877, (d) SOCCS Awareness subscale scores .814, and (e) SOCCS Experience subscale scores .872 (Ponterotto & Ruckdeschel, 2007).

**Table 3***Factor Loadings for a 4-Factor Solution*

SOCCS Item	1	2	3	4
I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.	.742	.255	.216	.356
I check up on my LGB counseling skills by monitoring my functioning/competency—via consultation, supervision, and continuing education.	.618	.214	.365	.418
I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.	.925	.224	.369	.588
I have done a counseling role-play as either the client or counselor involving an LGB issue.	.513	.138	.317	.470
Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.	.673	.326	.185	.533
The lifestyle of an LGB client is unnatural or immoral.	.173	.896	-.120	.133
I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work toward.	.132	.207	.083	-.088
I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.	.171	.426	.089	.127
It would be best if my clients viewed a heterosexual lifestyle as ideal.	.090	.393	-.020	.109
I think that my clients should accept some degree of conformity to traditional sexual values.	.102	.343	.004	.040
I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms.	.050	.200	.080	.163
Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.	.328	.618	.046	.096
I believe that all LGB clients must be discreet about their sexual orientation around children.	.115	.506	-.040	.010
When it comes to homosexuality, I agree with the statement: "You should love the sinner but hate or condemn the sin."	.289	.894	-.091	.180
LGB clients receive less preferred forms of counseling treatment than heterosexual clients.	.090	-.118	.584	.038
I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.	.468	.064	.581	.334
Heterosexist and prejudicial concepts have permeated the mental health professions.	.300	.129	.787	.202

There are different psychological/social issues impacting gay men versus lesbian women.	.098	-.093	.482	.202
I am aware of institutional barriers that may inhibit LGB people from using mental health services.	.524	.171	.684	.334
I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.	.394	-.023	.758	.195
Being born a heterosexual person in this society carries with it certain advantages.	.216	.040	.636	.112
I feel that sexual orientation differences between counselor and client may serve as an initial barrier to effective counseling of LGB individuals.	.038	-.220	.482	-.055
At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.	.904	.310	.301	.659
I have experience counseling lesbian or gay couples.	.440	.169	.147	.720
I have experience counseling lesbian clients.	.494	.178	.199	.847
I have been to in-services, conference sessions, or workshops which focused on LGB issues (in Counseling, Psychology, Mental Health).	.397	.261	.192	.540
I have experience counseling bisexual (male or female) clients.	.479	.181	.179	.891

## Discussion

The purpose of this research was to explore the factor structure and reliability of the SOCCS with a sample of counselor trainees and practitioners in the United States. Our results identified a 4-factor SOCCS model, including the subscales of Skills, Awareness, Knowledge, and Experience. The 4-factor SOCCS structure identified with these substantiate the three previous factors of Skills, Awareness, and Knowledge; however, an additional factor is noted. The fourth factor, Experience, echoes Graham and colleagues' (2012) findings, which note improved competence with practice. Hence, the results of this study should encourage researchers to explore beyond the 3-factor model and promote measurement versatility with counselor trainees and clinicians. Overall, our results identified a 4-factor SOCCS model with strong internal consistency, offering counselor educators and practitioners a sound method for assessing sexual orientation counselor competence.

### Implications for Counselors and Counselor Educators

Counselor competency with sexual minority clients is essential in counselor education (ACA, 2014; ALGBTIC, 2013; CACREP, 2009). Our findings support the use of the SOCCS as a valid and reliable measure of sexual orientation counselor competency. Therefore, we suggest that the SOCCS may be implemented in counselor training programs to assess trainees' levels of competency in providing services to sexual minority clients. Our results identified that in addition to the previously suggested areas of importance in sexual orientation counselor competence (i.e., Skills, Awareness, Knowledge), experience may be an important factor to consider. Counselor educators may consider methods of facilitating experiences within training in order to foster increases in competence. Further, the SOCCS may be used as a pedagogical intervention strategy in counselor education programs. For example, the SOCCS may be given to students to prompt reflection on overall and subscale competence levels regarding counseling sexual minority clients. The SOCCS may also be used beyond counselor education programs to assure that practicing counselors not only have, but also maintain necessary

components of competence in order to aid sexual minority clients. Additionally, the results of our study help to further sexual minority counselor competence literature. The SOCCS (Bidell, 2005) is an effective measure for researchers to employ to examine counselors' self-perceived levels of competence in working with LGB clients; however, the SOCCS also offers educators and practitioners a tool to support best practices in counseling and counselor education. Our SOCCS data yielded a potential fourth factor (i.e., Experience) that was not delineated as an essential component of counselors' competence in working with LGB clients in prior research. Therefore, this study prompts researchers, counselor educators, and counselors to consider the factor of counselors' experience in providing services to LGB clients as a necessary domain of counselor competence.

### **Recommendations for Future Research**

The SOCCS is an effective instrument in assessing sexual orientation counselor competence. At this time, there is no indication of cutoff scores that determine appropriate levels of counselor competence (e.g., counselor is competent or not competent to provide services to sexual minority clients). Hence, we recommend that future researchers investigate levels of competence that should be assessed as benchmarks for counselors-in-training prior to graduating from their graduate programs. To our knowledge, other than the SOCCS creator (Bidell, 2005), Carlson and colleagues (2013) are the only researchers to explore the factor structure of the SOCCS. However, Carlson and colleagues altered SOCCS item stems (i.e., 3, 4, 7, 8, and 19) in their investigation and transformed the 7-point scale to a 6-point scale. Their results displayed a 2-factor model that differs from the 3-factor model recommended by Bidell (2005); however, the amendments to the instrument make the SOCCS results difficult to compare to other studies. Further, to our knowledge, we are the only researchers to explore the factor structure of the SOCCS without altering the instrument prior to exploration. Moreover, our 4-factor SOCCS model results accounted for a larger percent of variance (56%) than the original 3-factor SOCCS model (40%; Bidell, 2005). We recommend that future researchers conduct confirmatory factor analyses with their data to determine if the four factors found in our results are consistent with other samples and populations.

### **Limitations**

We recognize that our study has limitations. The SOCCS is a self-report instrument, making the data vulnerable to social desirability bias (Gall et al., 2006). Our response rate may have contributed to our sampling and data collection methods (e.g., online survey), influencing the external validity of our findings. Because of recruitment from ALGBTIC, it is possible that there may have been bias, as members of this group may not have competence levels that are equivalent to the general counseling population. Additionally, because of an error in the original Qualtrics survey, complete SOCCS answers were not required, thus causing issues in missing data. Furthermore, our sample size was limited, affecting the interpretation of our findings. Nevertheless, our study examined an area warranting further investigation (counselors-in-training's and counselors' competency in providing service to sexual minority clients) and offered meaningful findings (e.g., a 4-factor SOCCS model).

### **Conclusion**

The social climate for sexual minorities is changing, and it is imperative for counselors to be competent to serve this population. Because of constant societal change, it is important for measures to be relevant in order to measure sexual minority counselor competence. The SOCCS (Bidell, 2005) is the most current and related instrument to measure sexual minority counselor competence. It fulfills an area of need in counselor training and development. This study provides helpful data to expand on the reliability and validity data of this useful assessment.

Moreover, the findings from the study present the case for a potential fourth subscale of Experience to be considered in addition to Skills, Awareness, and Knowledge. The existence of an additional factor pertaining to involvement and engagement in practice holds considerable implications for counselor training and effective practice with LGB clients.

### ***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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# Career Counseling in Middle Schools: A Study of School Counselor Self-Efficacy

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Students in K–12 schools benefit from career counseling as a means to improve their readiness for academic and career success. This quantitative study explored the career counseling self-efficacy of 143 practicing middle school counselors using the Career Counseling Self-Efficacy Scale-Modified and a subscale of the School Counselor Self-Efficacy Scale. Although school counselors were confident overall, evidence of specific areas of concern and limited time for career counseling was found. Results related to the importance of prior teaching experience in relation to career counseling self-efficacy also were highlighted. Implications for school counselors and policymakers include examining the amount of time school counselors spend on providing career counseling in comparison to time spent on non-counseling–related duties.

**Keywords:** career counseling, middle schools, school counselors, self-efficacy, time

All students in K–12 do not have the same exposure to career opportunities. Providing avenues for students to learn about and identify ways to access a variety of careers is the responsibility of counselors in the school setting. School counselors contribute to students' development in the domains of academic, career, and social and emotional development through comprehensive school counseling programs (American School Counselor Association [ASCA], 2014). ASCA published *ASCA Mindsets and Behaviors for Student Success: K–12 College and Career Readiness Standards for Every Student* (2014), which offers a framework of desired mindsets and behaviors for college and career readiness. This resource and others highlight the importance of a school counselor's work in the career domain. However, school counselors' knowledge and self-efficacy in the career counseling field may impact their ability to be effective in this aspect of their work (O'Brien, Heppner, Flores, & Bikos, 1997; Perrone, Perrone, Chan, & Thomas, 2000). This quantitative study explored the career counseling self-efficacy of practicing middle school counselors. As students move through elementary and secondary school, they continuously learn valuable knowledge and skills to explore postsecondary options and prepare to enter into the world of work. Middle school is an important time in this continuum for students as they consider their future academic and career plans and identify pathways to achieve their goals. The results of this study, as well as results related to the amount of time middle school counselors spend providing career counseling, yielded valuable implications for school counselors, K–12 stakeholders, and counselor educators.

## The Importance of Career Counseling

Students begin to develop career awareness in elementary school, explore careers during middle school, and move into career preparation and planning in high school. Career counseling connects the experiences students have in school to their future, which enhances academic motivation and provides meaning to and purpose for the work they are doing in school (Curry, Belser, & Binns, 2013; Scheel & Gonzalez, 2007). As children and adolescents learn about themselves and the world of work, they are more likely to make informed career decisions, value school, succeed academically, and engage in school offerings (Kenny, Blustein, Haase, Jackson, & Perry, 2006; Orthner, Jones-Sanpei, Akos, & Rose, 2013; Perry, Liu, & Pabian, 2010).

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Career counseling is needed in middle school in order to inspire young adolescents to make preliminary career decisions, to prepare them to take desired high school classes, and to equip them for future career pathways (Akos, 2004; Osborn & Reardon, 2006). Curriculum that integrates postsecondary college and career options in middle school has the potential to provide support and motivation for students (Curry et al., 2013). This type of curriculum connects directly to the comprehensive school counseling program. In schools with fully implemented comprehensive counseling programs that include career counseling, students self-reported higher grades, perceived they are better prepared for the future, recognized the relevance of school, and experienced a sense of belonging and safety, more so than in schools with less comprehensive school counseling programs (Lapan, Gysbers, & Petroski, 2001; Lapan, Gysbers, & Sun, 1997). In summary, establishing connections between a student's academic preparation and possible career options benefits students in various ways, and school counselors are essential guides in the career exploration process.

### **Career Counseling in Schools**

Despite this empirical evidence of its importance (Anctil, Smith, Schenck, & Dahir, 2012; Barker & Satcher, 2000; Osborn & Baggerly, 2004), school counselors can face barriers to implementing career counseling, including limited time because of competing demands, negative perceptions about career counseling, and low school counselor self-efficacy. For example, school counselors are often called upon to perform non-counseling tasks that take time away from providing a comprehensive school counseling program. School counselors desire to be engaged in promoting positive student outcomes and would prefer to spend less time on non-counseling-related activities (Orthner et al., 2013; Scarborough & Culbreth, 2008). There is some evidence that the desire to spend more time on counseling applies directly to career counseling, as found in a study of school counselors at all levels (Osborn & Baggerly, 2004). But, other studies have found that some school counselors are uncertain about the importance of career counseling (Perrone et al., 2000). These findings may indicate that although there is a desire to spend more time providing career counseling, there is uncertainty about its value.

Another potential barrier that is a focus of this study is individual school counselor self-efficacy. Self-efficacy, a core construct in this study, centers on the belief one has in his or her ability to perform a task (Bandura, 1986, 1997; Eccles & Wigfield, 2002). Self-efficacy of school counselors would be defined as beliefs about their abilities to provide effective counseling services (Larson & Daniels, 1998). High self-efficacy among school counselors would promote adaptive delivery of school counseling services to meet the needs of diverse student populations (Bodenhorn & Skaggs, 2005; Larson & Daniels, 1998). Social cognitive career theory (Lent & Brown, 2006; Lent, Brown, & Hackett, 2000) offers a framework for understanding self-efficacy in action—that is, how it impacts the interactions between individuals, their behaviors, and their environments. O'Brien and Heppner (1996) explored social cognitive career theory as it applies to interest, engagement, and performance of career counseling.

The interaction between people, their behavior, and their environment provides a highly dynamic relationship. Performance in educational activities is the result of ability, self-efficacy beliefs, outcome expectations, and established goals. School counselors have varied training experiences and personal self-efficacy beliefs that impact the delivery of a career counseling program. A school counselor's self-efficacy in career counseling can increase through four primary sources: personal performance, vicarious learning, social persuasion, and physiological and affective states (Bandura, 1997). School counselor self-efficacy may be influenced by many things such as graduate training, service learning, internships, professional development, and years of experience (Barbee, Scherer, & Combs, 2003; Lent, Hill, & Hoffman, 2003; O'Brien et al., 1997). Teaching is a related experience that may impact

career counseling self-efficacy. Some authors have highlighted prior teaching experience as helpful in the preparation of school counselors; others have not found such evidence (Baker, 1994; Peterson & Deuschle, 2006; Smith, Crutchfield, & Culbreth, 2001). Skills school counselors use to provide classroom guidance, which is one delivery method for career counseling services, are similar skills to those used by effective teachers (Akos, Cockman, & Strickland, 2007; Bringman & Lee, 2008; Peterson & Deuschle, 2006), so it is reasonable to expect that school counselors without teaching experience may be less comfortable managing a classroom of students than those with teaching experience (Geltner & Clark, 2005; Peterson & Deuschle, 2006).

There are two studies that have explored self-efficacy of school counselors with and without prior teaching experience. Scoles (2011) compared self-efficacy of 129 school counselors serving across all grade levels and did not find a statistically significant difference between those with and without teaching experience. In contrast, Bodenhorn and Skaggs (2005) found that respondents with teaching experience ( $n = 183$ ) reported significantly stronger self-efficacy than those without teaching experience ( $n = 42$ ). These conflicting findings about the importance of prior teaching experience suggest that further study is warranted.

### **Purpose for the Study**

Given the importance of beginning career exploration early and the essential role school counselors play in that process, this study focused on career counseling in the middle school setting. Understanding practicing school counselors' self-efficacy and their time spent providing career counseling will help administrators and policymakers better understand ways to increase career counseling in middle schools. As such, the following research questions were posed: (1) What are middle school counselors' levels of self-efficacy in career counseling? (2) How does middle school counselor self-efficacy in career counseling vary with previous K–12 teaching experience? and (3) What is the relationship between middle school counselor self-efficacy in career counseling and the amount of time spent providing career counseling?

### **Method**

A quantitative research design was used for this study. The researcher examined school counselor self-efficacy in the career counseling domain. A school counselor was invited to participate if he or she was a current middle school (sixth, seventh, or eighth grade) counselor in Virginia at the time of the study and his or her email information was provided on a district or school website. The electronic survey included three instruments: an information questionnaire that was used to collect data about personal experiences and training, the Career Counseling Self-Efficacy Scale-Modified (CCSES-Modified; O'Brien et al., 1997), and a subscale of the School Counselor Self-Efficacy Scale (SCSE-Subscale; Bodenhorn & Skaggs, 2005).

Descriptive statistics were compiled by computing means, standard deviations, and minimum and maximum scores for total career counseling self-efficacy, as identified by both the CCSES-Modified and the SCSE-Subscale independently. Means and standard deviations of the 25 items of the CCSES-Modified and the seven items of the SCSE-Subscale also were calculated.

Two analyses of variance (ANOVA) and a *t*-test were used to determine if there were statistically significant differences among means. Participants were given the opportunity to report their years of counseling experience both full- and part-time, and the researcher combined these to get a total number. This number was obtained by taking the total reported number of years as a full-time school counselor and adding that to .5 multiplied by the reported number of years as a part-time school counselor. Then, the researcher created discrete levels to represent groups of experience once the data had been collected in order to conduct the analysis. Identifying the range of experience of the sample and using a scale

appropriate for the sample determined the discrete levels. These three levels represented those who had the least experience, those in the middle, and those with the most experience as a school counselor. The researcher conducted an ANOVA with these groups and the SCSE-Subscale mean and a separate ANOVA with the identified groups and the CCSES-Modified mean.

The researcher obtained an answer of “yes” or “no” to indicate previous teaching experience. A separate value was given to answers of “yes” and “no” and the values were used to run a *t*-test with the mean for the SCSE-Subscale and the CCSES-Modified mean.

Participants indicated the total number of hours of conference presentations, workshops, or trainings that focused primarily on career counseling within the last 3 years. First, the researcher identified the range of the number of hours of training participants reported receiving in career counseling within the last 3 years. Then, the researcher created discrete levels to represent groups of recent training once the data was collected in order to conduct the analysis.

The third research question required a correlation to analyze the relationship between school counselor self-efficacy in career counseling and the amount of time (measured in percent) spent providing career counseling.

## Participants

The participants for this study were practicing middle school counselors, defined as counselors working in a school housing students in grades 6 through 8 at the time the survey was completed. The data cleaning procedures described below resulted in 143 participants out of 567 invitations, which is a 25% response rate. Of the 143 participants, 23 (16.1%) were male and 117 (81.8%) were female (three participants omitted this item). Regarding race, 110 participants (76.9%) identified as White/Caucasian, 20 (14.0%) as African American, four (2.8%) as Hispanic/Latino, and one (0.7%) as Multiracial, while five (3.5%) preferred not to answer and three participants omitted this item. Participants' ages ranged from 25 to over 65 years with an average age of 45 years ( $SD = 11$ ; respondents who reported being 65 and over were coded as 65).

Regarding training, the participants reported their highest level of education: 125 participants (87.4%) reported having a master's degree as their highest level of education, 11 (7.7%) had an education specialist degree, six (4.2%) reported having a doctoral degree, and one participant omitted this item. Participants reported a mean of 13.3 years ( $SD = 7.4$ ) of experience providing school counseling. Regarding full-time teaching experience in a K–12 school, 47 (32.9%) participants had experience, while 94 (65.7%) did not have this experience, and two people omitted this item.

## Instruments

The 49-item online survey included 17 items to gather demographic and professional information, the 25-item CCSES-Modified (O'Brien et al., 1997), and seven items from the Career and Academic Development subscale of the SCSE (Bodenhorn & Skaggs, 2005).

**Career Counseling Self-Efficacy Scale-Modified.** The CCSES-Modified (O'Brien et al., 1997) was used to assess overall career counseling self-efficacy. Participants were asked to indicate their level of confidence in their ability to provide career counseling. For this study, the terms “client” and “career client” were replaced with the term “student” to be more congruent with school counselor terminology. Permission was granted from the first author of the scale to the researcher to make these changes (K. O'Brien, personal communication, January 7, 2013). The CCSES-Modified contains 25 items that are rated on a 5-point Likert-type scale (0 = *Not Confident*, 4 = *Highly Confident*). Within

the CCSES-Modified, there are four subscales: Therapeutic Process and Alliance Skills, Vocational Assessment and Interpretation Skills, Multicultural Competency Skills, and Current Trends in the World of Work, Ethics, and Career Research. The full scale has a reported internal consistency reliability coefficient of .96 (O'Brien et al., 1997).

**School Counselor Self-Efficacy Scale-Subscale.** One subscale from the SCSE (Bodenhorn & Skaggs, 2005) was included in this study. The SCSE Career and Academic Development subscale was designed for school counselors to examine self-efficacy in the career domain. Using a 5-point Likert-type scale (1 = *Not Confident*, 5 = *Highly Confident*), participants indicated their level of confidence on each of the seven items. Bodenhorn and Skaggs (2005) reported a subscale internal consistency reliability coefficient of .85.

### Indices of Reliability in the Present Study

The internal consistency reliability in this sample for the CCSES-Modified was  $\alpha = 0.941$  and the SCSE-Subscale was  $\alpha = 0.871$ . The CCSES-Modified had four subscales: Therapeutic Process and Alliance Skills (10 items,  $\alpha = 0.820$ ), Vocational Assessment and Interpretation skills (6 items,  $\alpha = 0.855$ ), Multicultural Competency Skills (6 items,  $\alpha = 0.913$ ), and Current Trends in the World of Work, Ethics, and Career Research (3 items,  $\alpha = 0.747$ ). All of these exceed the common threshold for reliability for similar measures. The CCSES-Modified total score and the SCSE-Subscale score had a strong positive 2-tailed Pearson correlation (0.792), which was statistically significant at the 0.01 level. This strong positive relationship suggests these two measures captured related information from the participants.

### Procedure

The original sampling frame consisted of 576 middle school counselors with publicly available email addresses, which were collected from public school websites in all counties in Virginia. After Institutional Review Board approval was secured, participants were sent an email invitation with the informed consent and link to the web survey. One week later, participants were sent a reminder email. Upon completion of the survey, participants were given the opportunity to vote for one of five organizations to receive a \$100 donation as a token of appreciation for their time completing the survey. After the recruitment email was sent, there were nine people who indicated they were not eligible to participate. These included three individuals who sent a return email indicating that they were out of the office during the survey administration, three who were not currently middle school counselors, two who reported needing school division approval, and one person who had difficulty accessing the survey. This reduced the actual sampling frame to 567.

### Data Cleaning

One hundred and sixty-one respondents answered the survey items. There were 18 respondents who omitted 15% or more of the items from the CCSES-Modified or the SCSE-Subscale and were therefore removed from the study. This changed the total number of remaining respondents to 143. Of the 143 remaining, there were eight respondents who each omitted one item that was used to measure career counseling self-efficacy on the CCSES-Modified or the SCSE-Subscale. Each omitted item was replaced with the individual's scale mean (e.g., mean imputation; Montiel-Overall, 2006), and those respondents were included in the analyses. When the omitted item was part of an analysis for Research Question 2 or 3, the respondent was removed from the affected analysis. Omissions on the demographic questionnaire are noted above in the description of the participants.

## Results

### RQ1: What are school counselors' levels of self-efficacy in career counseling?

Overall, middle school counselors who participated in this study were moderately confident, confident, or highly confident in their ability to provide career counseling services. According to the CCSES-Modified, counselors felt least confident in the subscales of Multicultural Competency Skills and Current Trends in the World of Work, Ethics, and Career Research, while they reported the most confidence in their Therapeutic Process and Alliance Skills. Specific areas of school counselor self-efficacy deficits were related to special issues present for lesbian, gay, and bisexual students in the workplace and in career decision-making, as well as special issues related to gender and ethnicity in the workplace and in career decision-making. Table 1 provides descriptive statistics and reliability for each subscale and the total scale.

**Table 1**

*Career Counseling Self-Efficacy Scale-Modified Subscale Scores (N = 143)*

<i>Subscales</i>	<i>Min</i>	<i>Max</i>	<i>M</i>	<i>SD</i>	<i>α</i>	<i>Item M</i>	<i>Item SD</i>
Therapeutic Process and Alliance Skills (10 items)	21	40	35.24	4.05	0.82	3.52	0.40
Vocational Assessment and Interpretation Skills (6 items)	5	24	18.08	4.21	0.86	3.01	0.70
Multicultural Competency Skills (6 items)	0	24	16.52	4.79	0.91	2.75	0.80
Current Trends in the World of Work, Ethics, and Career Research (3 items)	3	12	8.09	2.44	0.75	2.69	0.81
<i>Total Scale</i> Total Instrument Score (25 items)	32	99	77.94	13.60	0.94	3.12	0.54

Note. 1 = Not Confident and 4 = Highly Confident.

The means and standard deviations for the SCSE-Subscale are listed in Table 2. On average, participants were confident or highly confident in their abilities to attend to student career and academic development.

**Table 2***School Counselor Self-Efficacy Scale-Subscale Individual Item Responses (N = 143)*

	% Response					<i>M</i>	<i>SD</i>
	1	2	3	4	5		
1. Implement a program which enables all students to make informed career decisions.	1	3	20	34	43	4.16	.89
2. Deliver age-appropriate programs through which students acquire the skills needed to investigate the world of work.	--	2	18	34	46	4.24	.81
3. Foster understanding of the relationship between learning and work.	--	0	9	40	51	4.42	.65
4. Teach students to apply problem-solving skills toward their academic, personal, and career success.	--	1	8	36	55	4.45	.69
5. Teach students how to apply time and task management skills.	--	2	6	35	57	4.46	.71
6. Offer appropriate explanations to students, parents, and teachers of how learning styles affect school performance.	--	2	15	39	44	4.24	.79
7. Use technology designed to support student successes and progress through the educational system.	--	6	22	44	29	3.96	.86
<b>Total Subscale Score</b>						<b>29.93</b>	<b>4.08</b>

*Note.* 1 = Not Confident, 3 = Moderately Confident, 5 = Highly Confident.

### **RQ2: How does school counselor self-efficacy in career counseling vary with previous K-12 teaching experience?**

Two *t*-tests were conducted to identify if there was a difference between career counseling self-efficacy among participants with and without previous experience as a teacher. Separate means and standard deviations were calculated for the two groups—those who had teaching experience ( $n = 47$ ) scored higher on the CCSES-Modified ( $M = 82.2$ ,  $SD = 9.7$ ) and the SCSE-Subscale ( $M = 30.9$ ,  $SD = 3.4$ ) than those without teaching experience ( $n = 94$ ), CCSES-Modified ( $M = 75.8$ ,  $SD = 14.7$ ) and SCSE-Subscale ( $M = 29.4$ ,  $SD = 4.3$ ).

Independent *t*-tests were performed to determine if the differences between the groups were statistically significant. For the CCSES-Modified, the assumption of homogeneous variances was not satisfied (Levene's test,  $F = 7.13$ ,  $p < .05$ ); therefore, the more conservative *t*-test was used to assess for a statistically significant difference ( $t = -3.06$ ,  $p = .003$ ). The mean score for the teaching experience group ( $M = 82.2$ ,  $SD = 9.7$ ) was statistically higher than the mean score for those without teaching experience ( $M = 75.8$ ,  $SD = 14.7$ ). For the SCSE-Subscale, the assumption of homogeneous variances was satisfied (Levene's test,  $F = 3.71$ ,  $p = .055$ ,  $d = .51$ ). The mean score of the group with teaching experience ( $M = 30.9$ ,  $SD = 3.4$ ,  $d = .39$ ) was statistically different from the mean score of the group without teaching experience ( $M = 29.4$ ,  $SD = 4.3$ ),  $t = -2.03$ ,  $p = .045$ . Cohen's *d* is a valuable index of effect size for statistically significant mean differences (Cohen, 1988). The Cohen's *d* of .51 for the CCSES-Modified and .39 for SCSE-Subscale both represent medium effect sizes.



### RQ3: What is the relationship between middle school counselor self-efficacy in career counseling and the amount of time spent providing career counseling?

The third research question required a correlation to analyze the relationship between school counselor self-efficacy in career counseling and the percent of work time spent providing career counseling. Participants reported the percentage of time they spend providing responsive services to students in the three school counseling domains, as well as testing coordination and other non-counseling-related activities, which is represented in Table 3. The averages and standard deviations of the percentage of time spent in each subscale were: *personal/social counseling* ( $M = 36.25, SD = 15.39$ ), *academic counseling* ( $M = 23.32, SD = 10.47$ ), *career counseling* ( $M = 12.15, SD = 6.98$ ), *Virginia State Standards of Learning (SOL) testing coordination* ( $M = 11.83, SD = 12.88$ ), and *other non-counseling-related activities* ( $M = 16.44, SD = 12.55$ ). One participant omitted this item; therefore,  $N = 142$  in Table 3. There was no statistically significant relationship between the CCSES-Modified and time providing career counseling ( $r = .160, p = .057$ ) and a statistically significant weak positive relationship ( $r = .286, p = .001$ ) between the SCSE-Subscale and time providing career counseling.

**Table 3**

#### *Self-Efficacy and Time Providing Career Counseling*

		% Career Counseling
<i>Career Counseling Self-Efficacy Scale-Modified</i>	Pearson Correlation	.160
	Sig. (2-tailed)	.057
	N	142
<i>School Counselor Self-Efficacy Scale-Subscale</i>	Pearson Correlation	.286*
	Sig. (2-tailed)	.001
	N	142

Note. \*Correlation is significant at the 0.01 level (2-tailed)

## Discussion

There were several key findings from this study of middle school counselors' self-efficacy with career counseling. First, it is important to note that there was a wide range in the total self-efficacy scores for middle school counselors. As a group, these counselors were the most confident in their Therapeutic Process and Alliance Skills, and least confident in Multicultural Competency Skills and Current Trends in the World of Work, Ethics, and Career Research. Specifically, special issues related to gender, ethnicity, and sexual orientation in career decision-making and in the workplace were areas of concern. School counselors who had previous K–12 teaching experience were significantly more confident providing career counseling than those without, as assessed by both measures. Finally, a Pearson correlation indicated there was a weak positive correlation between the SCSE-Subscale and the percentage of time school counselors indicated they spend providing career counseling. There was not a statistically significant relationship between the CCSES-Modified and time spent providing career counseling.

In this study, results indicate that middle school counselors spend more time doing non-counseling-related activities than providing career counseling, which is alarming. Career development is one of the three primary domains of a comprehensive school counseling program, and it is important for school counselors to create career development opportunities for students.

The majority of school counselors report the importance of career counseling; however, middle school counselors acknowledge they spend less time on career counseling than they prefer (Osborn & Baggerly, 2004). There is a need to reprioritize career counseling, which includes recognizing and acknowledging how career counseling intersects with academic and personal and social counseling in K–12 schools (Anctil et al., 2012).

Career counseling is valuable and evidence needs to be provided to indicate how non-counseling-related tasks take time away from school counselors' ability to offer adequate career counseling for students. Test coordination is time-consuming and an example of a non-counseling duty that some school counselors perform. Considering the amount of time this role requires, school counselors would find more time to provide career counseling services for students without this obligation. School counselors should gather evidence and provide accountability reports about how career counseling efforts contribute to student engagement and success.

### **Implications for School Counselors, K–12 Stakeholders, and Counselor Educators**

In general, the practicing school counselors in this study had ample self-efficacy with regard to providing career counseling. However, there were certain items on the CCSES-Modified and the SCSE-Subscale that reveal discrepancies in middle school counselors' levels of confidence. Counselors felt least confident in the subscales of Multicultural Competency Skills and Current Trends in the World of Work, Ethics, and Career Research. Specifically, they reported lower self-efficacy addressing special issues related to gender, ethnicity, and sexual orientation in relation to the world of work. In light of these findings, counselor preparation programs need to further investigate what is being taught in career counseling courses, how the content is being delivered, possible gaps in curriculum, and opportunities for outreach to current school counselors through continuing education. Given the powerful movement for advocacy related to these important social issues, it is in some ways confirming that the practicing counselors in this study felt less confident in these areas. Perhaps the national attention on issues of privilege and oppression related to gender, ethnicity, and sexual orientation has shed light on individual or systemic challenges these school counselors face as they try to serve diverse young adolescents in a dynamic phase of their development.

There are opportunities to increase career counseling self-efficacy related to gender, ethnicity, and sexual orientation in relation to the world of work. Bandura (1997) highlighted personal performance, vicarious learning, and social persuasion as particularly effective strategies for increasing self-efficacy. Continuing education, supervision, and professional organization engagement may be the best opportunities for continued development in these areas (Tang et al., 2004). In-service training and continuing education could be offered to provide school counselors relevant information to support their professional development and promote an increase in career counseling self-efficacy. Gaining up-to-date knowledge about the experiences of students with varied gender identities, ethnicities, and sexual orientations will best prepare school counselors to serve the entire student body. Observing advocacy approaches modeled by other leaders may inspire school counselors to use their voices in their own systems. Relatedly, this finding makes it apparent that K–12 school systems need clear and powerful policies and leadership around gender-, ethnicity-, and sexual orientation-related issues. School counselors are well positioned to partner with principals and superintendents in this important change process.

The second research question provided additional information about a somewhat contentious issue in previous research. School counselors who had teaching experience had higher career counseling self-efficacy than those who did not have teaching experience. This finding contradicts the

findings of a study conducted with school counselors in Ohio (Scoles, 2011) and supports the findings of the national study conducted by Bodenhorn and Skaggs (2005), as described above. Contradictory findings like these beg for more research. Perhaps the higher self-efficacy of those with previous teaching experience is related to the preparation in specific academic disciplines that teachers receive. It could be that because these school counselors were previously trained in a specific academic area, they are more confident in talking with students about careers in that particular career cluster (e.g., science teachers who become school counselors may be more prepared to discuss careers in science, technology, engineering, and mathematics with students). Conversely, this potentially narrow view of career opportunities may limit the career exploration of students if school counselors do not include a wide array of career options. An excellent area for further research would be to identify how previous teaching experience may specifically impact school counselor self-efficacy.

School counselors without teaching experience, although lower in self-efficacy than those school counselors with teaching experience, still had high career counseling self-efficacy. This suggests that school counselors without teaching experience have confidence in their ability to provide career counseling. If, as Peterson and Deuschle (2006) suspected, the advantage of those with prior teaching experience is because of the increased training and practice in classroom management and lesson preparation, one would expect that effect to diminish as years of school counseling experience are accumulated. A larger sample than the one in this study would be necessary to test that empirically. If, however, the impetus for the significant impact of teaching experience is more general, those newer school counselors without teaching experience may be adjusting to the setting and to new ways of managing their time, balancing multiple roles and responsibilities, incorporating community involvement, working with parents, fostering collaborative relationships, and becoming familiar with local resources. All of these tasks take time and effort and could impact a school counselor's self-efficacy to provide adequate services to students. It may be helpful for school counselors without teaching experience to ask for support and suggestions from seasoned school counselors in the district to learn from their experiences. In addition, professional development programming could be established for school counselors to become more familiar with the specific roles and responsibilities related to the career information, education, and counseling needs within a particular community.

Finally, the third focus of the study was on how school counselors use their time and if self-efficacy is related to that allocation. Most alarming about these findings was that school counselors are spending less time providing career counseling than they are doing non-counseling-related duties. A large percentage of middle school counselors' time was reported to be spent coordinating testing or doing other non-counseling-related tasks, which is not the most efficient use of school counselors' strengths. School counselors are uniquely trained to provide supplemental support for students in the academic, personal and social, and career domains in order to promote student success; therefore, it would be advantageous if they were able to utilize their time in a way that is consistent with the needs of students. One option to address the time constraint, particularly in this day of tighter budgets, is to utilize someone with an administrative background for the non-counseling duties in order for the school counselor to have time to incorporate adequate career counseling into their school counseling program. This is particularly important for middle school counselors providing career counseling because middle school students are preparing academic and career plans that will serve as a guide through high school and postsecondary educational endeavors (Trusty, Niles, & Carney, 2005; Wimberly & Noeth, 2005).

The world of work is continually changing, which makes it important to be aware of the current trends in this area. As these changes happen, marginalized populations face unique issues in the

area of career exploration and planning. Counselors need to be trained adequately to provide career counseling to clients. In addition to providing relevant information, promoting thoughtful reflection, and facilitating discussions for counselors-in-training, counselor educators could provide outreach and continuing education opportunities focused on career counseling.

Just as career counseling may be infused with academic and personal and social counseling for school counselors, counselor educators may consider infusing career counseling concepts throughout other courses and experiences during a training program. Counselor educators could model this authentic type of integration. Counselor educators could talk more about various career clusters and the value of career counseling throughout a training program rather than just in one specific course. Counselor educators may also facilitate discussions with counselors-in-training about their own career counseling experiences, allowing trainees time to reflect on their experience. In addition, trainees could talk about how they have worked with people in roles other than a counselor through the career exploration and planning process.

Counselors need to consider ways to utilize and increase the support of administration and teachers to identify what needs to change in order for them to reallocate their time so they are able to provide more career counseling. Providing evidence of the positive impact of their work may be an effective strategy. There are many approaches to this, such as utilizing current research studies to communicate support for the value of career counseling efforts. In addition, school counselors can gather data from current students, parents, and alumni regarding their perception of and desire for career counseling services through surveys or focus groups. Once specific programs are implemented, school counselors can evaluate the outcomes of the career counseling efforts through both formal and informal assessment procedures with students, teachers, and parents. Administrators should continue to express support for the career counseling efforts of school counselors and show support by advocating for more personnel in order for students to receive adequate career counseling and to meet the demand of the non-counseling tasks that counselors are assigned.

### **Limitations**

The findings should be considered in light of the limitations of the study. Because of the nature of instruments that involve self-report, the results are based on the current perception of the participants and not objective assessments of the effectiveness of their work. Also, it may be more socially and professionally desirable to have confidence in personal abilities and, therefore, some participants may have answered the way they thought they should. This study was limited to those middle school counselors who had publically available e-mail addresses and were working in Virginia. Non-respondents and middle school counselors outside of Virginia are not represented in these findings; therefore, generalizing the findings should be considered with caution. Furthermore, the 406 non-respondents and the 18 respondents who did not complete the entire survey may be systematically different from the 143 respondents who were included.

### **Conclusion**

This study has provided important new information about the self-efficacy of school counselors in the middle school setting as related to career counseling. Career counseling self-efficacy was high overall, with specific areas of deficit related to gender, ethnicity, and sexual orientation. Those school counselors who had previous teaching experience had even higher career counseling self-efficacy than those who did not. High self-efficacy in school counselors had little or no impact on the time spent providing career counseling services. Tailoring continuing education opportunities in career counseling and providing clear administrative leadership would further strengthen practicing school counselor self-efficacy. Utilizing support personnel for non-counseling-related duties may allow

school counselors to use their career counseling skills and training to help middle school students explore and connect with careers, thereby improving academic and life outcomes.

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# Mental Health Counseling and Specialty Courts

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Specialty courts, such as mental health courts, drug courts, and veterans treatment courts, were developed with the intention of reducing recidivism and obtaining better outcomes for participants selected from the particular populations served by each court. Efforts to improve the public good have produced a reimagining of the justice system with a focus on therapeutic jurisprudence and restorative justice. Counselors contract with the courts to provide therapeutic services that assist the courts in supplementing the more traditional court functions of punishment, corrections, and public safety. Mental health clinicians can fulfill pivotal roles in these courts as advocates, educators, and clinical technicians. This paper provides an introduction into specialty courts for counselors considering provision of clinical services in these still-developing areas.

**Keywords:** specialty courts, mental health courts, drug courts, veterans treatment courts, mental health counseling

In 1963, the passage of the Community Mental Health Centers Act (Feldman, 2003) led to the closing of most state psychiatric hospitals and the provision for providing services at the community level. However, the same act had the unintentional result of transferring patients with severe mental illness from psychiatric hospitals into jails and prisons (Farmer et al., 2017; Hnatow, 2015; Shenson, Dubler, & Michaels, 1990; Torrey et al., 2014). More recently, the war on drugs has exacerbated the problem of overcrowding in penal and justice systems ill-equipped to provide therapeutic services for these individuals (Hafemeister & George, 2012; Harvard Law Review, 1998; Torrey, 1997; Walsh & Holt, 1999). This predicament has led to the Cook County jail in Illinois being labeled as the country's largest mental health institution (Hill, 2016).

In order to facilitate greater efficiency and effectiveness in the justice system for the populations encountered, specialty courts act to counter a system that historically has depersonalized individuals (Kleinfeld, 2016). Specialty courts identify common issues faced by particular populations and address the underlying causes of criminogenic behavior by focusing on the individual to produce better outcomes. Although mental health professionals fulfill pivotal roles in these courts, many counselors are unfamiliar with specialty courts. The purpose of this paper is to describe the specialty court movement and the roles of counselors within it.

## The Justice System—Old and New

The justice system in America has traditionally been one of punitive action—to punish offenders and deter the tempted. Since the 1950s, America's policies targeting illicit drug use have resulted in a large population of low-level offenders serving long, mandatory-minimum sentences, often with inadequate support and resulting in repeated contact with the traditional criminal justice system (Haley, 2016; Kupers, 2015).

Between 1968 and 1978, the number of patients in state mental hospitals fell 64%, while the census in state prisons rose 65% (Steadman, Monahan, Duffee, & Hartstone, 1984). In 2012, the number of prisoners diagnosed with mental illness exceeded 352,000, more than 10 times the number in state

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psychiatric hospitals (Torrey et al., 2014). In the absence of evidence that incarceration without treatment is in their own best interest, or that of society (Isaac & Armat, 1990; Kondrat, Rowe, & Sosinski, 2012), such prisoners are a burden on the limited resources of prison systems in every state.

The specialty court movement arose to address the specific needs of the mentally ill, drug offenders, and other populations, and to effect a decrease in the underlying causes of criminal behavior and thereby reduce the number of people incarcerated in jails and prisons. Specialty courts take the traditionally adversarial roles of prosecution and defense and turn them into cooperative roles to foster a therapeutic environment for those individuals who would benefit (Kondo, 2001). Veterans treatment courts are a more recent addition to the specialty court movement, joining mental health courts, drug courts, gun courts, domestic violence courts, and other specialized courts (Baldwin, 2016). Veterans treatment courts treat underlying causes of crime and other challenges faced by veterans and service members.

The Center for Court Innovation developed three organizing principles for specialty courts (Boldt, 2014). The first principle is a problem-solving orientation that identifies and addresses underlying causes of criminality common to specific groups; the second principle is cooperation with community resources offering treatment and oversight; and the third principle is accountability (Boldt, 2014). These principles work within the context of the two major approaches of specialty courts: therapeutic jurisprudence and restorative justice.

## **Two Working Approaches in Specialty Courts**

The specialty court movement is based on two overarching approaches: therapeutic jurisprudence, which seeks improved outcomes for the individual facing charges; and restorative justice, which seeks restitution for all stakeholders.

Therapeutic jurisprudence promotes a wellness paradigm using the court as a therapeutic tool. Therapeutic jurisprudence takes the approach that it is in the best interest of society to work cooperatively with all stakeholders to provide better outcomes in criminal justice. The model is a new paradigm based on a cooperative and non-adversarial approach of judges, prosecutors, defense attorneys, and community and mental health professionals (Haley, 2016).

Restorative justice is the idea that justice is served by restoration, both to the individuals and to the community affected by crime. In traditional court settings, restoration includes financial restitution by the offender (to the victims) in addition to incarceration (for the public good). The Centre for Justice & Reconciliation has defined restorative justice as a process to heal harms and bring about transformation for all parties (Centre for Justice & Reconciliation, 2017). This is necessary because crime is more than simply breaking the law. Crime also causes people harm and hurts relationships and the community. Thus, a just response needs to address the harms as well as the wrongdoing (Centre for Justice & Reconciliation, 2017). Restorative justice in specialty courts focuses on treatment options for an individual's issues, which promotes the restoration of the offender. Working with specialty courts allows mental health counselors to combine individual therapy with vocational counseling, oversight of community service for program participants, aftercare supervision, and mediation and arbitration with victims to emphasize accountability for the individual (Haley, 2016), impacting the restorative process for all stakeholders. Integrating the counselor's toolbox with all of these challenges requires skill and patience.



## Clinical Integration With Specialty Courts

Specialty courts are challenging for all stakeholders. Judges must transition from performing as adjudicators of justice to facilitators of treatment, and the clinician serves both the court and the program participants by providing treatment services. Counselors educate and advocate for participants and are able to frame program objectives into long-term treatment outcomes and participant prognoses for judges and court officers (Kupers, 2015). The mental health counselor, as a therapeutic service provider, becomes a de facto expert who the court relies on to assist in the development and implementation of treatment goals (Hughes & Peak, 2012).

Specialty courts are full of legal terminology, and counselors working with the court can assist in conveying meaning clearly to program participants. A better-informed client will be more able to give informed consent and have more buy-in to the process. Facilitating education for participants increases the likelihood of successful completion of the program, which in turn translates to an improved quality of life and reduction in re-arrest rates (Haley, 2016).

Participants in specialty courts will bring many issues to treatment. Counselors may provide assessments for the presence of mental health disorders, substance use, and social service needs, and they may be called upon to facilitate other assessments on an as-needed basis.

Jurisdiction for participants is an area with a large amount of variety from program to program. For individuals that may be eligible for different programs, placing their case under the jurisdiction of one specialty court over another becomes a question of resources. For example, some mental health courts are able to address the substance use issues of participants, while others are not (Fisler, 2015).

Specialty courts operate under the model of managed care, in which the treatment modalities are brief and evidence-based, such as with cognitive behavioral therapy (Kupers, 2015). The Council of State Governments outlined best practices for the creation of mental health courts (Thompson, Osher, & Tomasini-Joshi, 2007), which included behavioral modification techniques and operant conditioning as a key educational element, and included instruction on proper use of negative and positive reinforcement techniques (Russell, 2015). Judges and court officers are able to use the Council of State Governments' model to structure their courts within the limitations of local resources and needs. Awareness of these needs and limitations allows the clinician to be more effective in influencing outcomes and program success for participants of specialty courts, of which three types are included in this discussion: drug courts, veterans treatment courts, and mental health courts.

## Drug Courts

In 1989, a judge in Miami, Florida, started ordering drug users that came before the court into treatment in lieu of jail. Out of this was born the drug court, which has now become the model for specialty courts. The Miami court started as a response to the criminogenic life-cycle experienced by low-level offenders appearing before the court: substance use → crime → jail → release, then repeat (Fulkerson, 2009). The effect of the new paradigm on the cycle became: substance use → crime → treatment → support and supervision, leading to reduced recidivism (Haley, 2016). Since that time, drug courts have quickly spread across the nation. By 2001, there were more than 700 drug courts in the United States (Harrison & Scarpitti, 2002) and 1,600 as of 2010 (Haley, 2016).

Drug courts use supervision and monitoring to ensure compliance to program requirements. Counselors serve as agents of the court, verifying adherence through substance abuse treatment services, drug testing, talk therapy, and encouraging abstinence as a condition to successful completion. Counselors working with drug court participants face a rather straightforward challenge,

in which compliance to program requirements and overall program success can be quantified through drug testing and analysis of available data, including re-arrest rates. More complicated are issues facing participants in other specialty courts, such as the veterans treatment courts.

### **Veterans Treatment Courts**

As of 2010, the United States had deployed approximately 1.9 million service members to serve in Afghanistan and Iraq (Rizzo et al., 2011). Conflicts from the Middle East have left the United States with over 40,000 wounded (Rizzo et al., 2011) and over 350,000 service members with traumatic brain injury (Baldwin, 2016). As the United States continues to conduct military operations around the world, the need exists to address the specific concerns of veterans returning to non-combat duties. Veterans treatment courts (VTCs) are now addressing, via the drug court model, various needs of this population (Slattery, Dugger, Lamb, & Williams, 2013). The first VTC was established in 2004 in Anchorage, Alaska, but the model from which most programs are built is the one established in Buffalo, New York, in 2007–2008 (Baldwin, 2016).

Issues the counselor may face with participants in VTCs include post-traumatic stress disorder, substance use, military sexual trauma, major depression, and neuropsychological problems (Eisen et al., 2012), as well as homelessness and unemployment issues (Baldwin, 2016). In addition to services available to participants in other specialty courts, VTCs are designed and built recognizing differing needs of supervision and support, including cooperation with the Veterans Administration (VA) and other service members (Russell, 2015). Connections the VTCs have through the VA make a difference for participants, who rely heavily on the VA for benefits. VA connections cannot easily be replaced or replicated and are scarce in many locales (Clark, McGuire, & Blue-Howells, 2014).

VTCs also differ from many other specialty courts in that they have a peer-mentoring component. Mentoring is the use of previous program participants and other service members in a peer-support role, similar to their use in 12-step programs as part of a successful drug treatment protocol. Mentoring is more important for this population because of the military's highly structured culture and the importance of respect for others with military experience (Clark et al., 2014; Russell, 2015).

Like other specialty courts, VTCs have some variance in those eligible for participation. VTCs often limit participation to those with certain mental health diagnoses or substance abuse issues and to those who are not charged with a felony or violent crime. Eligibility also may be restricted to only those deployed to a combat zone or only those who are eligible for VA benefits.

Funding for VTCs is different than that of other specialty courts, which rely on local sources of funding. VTCs get most of their funding through the VA (Russell, 2015), which operates through strict guidelines. In fact, VA guidelines currently limit the role of counselors, preferring instead services performed by psychiatrists and psychologists—a slightly different perspective than one seen in mental health courts.

### **Mental Health Courts**

The first mental health court was introduced in the late 1990s in Broward County, Florida (Linhorst et al., 2009), and by 2010 there were over 200 operating in the United States (Fisler, 2015; Hughes & Peak, 2012). Individuals enter the court system through arrest, usually for minor offenses (Hnatow, 2015; Walsh & Holt, 1999). Mental health courts differ from drug courts in the wider variety of conditions that must be addressed and the greater degree of treatment individualization available for participants. More robust measurement of program success is required as well. In drug court, success can be measured by length of time spent in sobriety. In mental health court, the variety of

illnesses and conditions specific to the individual requires more advanced assessment and occurs in the arena of a team approach, with counselor, case manager, psychologist, and court administration involved in the process.

Again, there is variance in the design and operation of mental health courts. The Council of State Governments' document begins with the assumption that mental health courts are designed with the cooperation of a variety of individual stakeholders, all of whom may bring a wide range of goals with them (Fisler, 2015). The focus on public safety and court jurisdiction means eligibility criteria is again an issue. Most programs exclude individuals facing charges for felonies and violent crimes (Linhorst et al., 2009).

Counselors working with mental health courts have great influence on participant eligibility, as well as treatment options. Counselors work to inform participants of the risks of participation, potential benefits, their rights and responsibilities, requirements of successful program completion, and any ramifications of program failure. Again, counselors who are able to communicate clearly with participants can develop the rapport needed for buy-in and informed consent. With specialty court familiarity, counselors can address concerns and considerations.

## **Clinical Concerns and Considerations**

### **Confidentiality and Privacy**

Kupers (2015) advocated for the need to keep interventions confidential and private. Specialty court participants' hearings before a judge should be segregated from regular court proceedings and entered in the specialty court docket (the list of cases to be tried). This may mean that all participants be placed on dockets in a separate courtroom and, if possible, in separate locations. Public mingling with individuals awaiting their turn on the docket represents an all-too-real possibility of the loss of confidentiality and privacy.

Up-front disclosure of the limits of confidentiality will lead to a participant more able to give informed consent, a deeper rapport with clients, and greater diligence on the part of the counselor (Kupers, 2015). In an era of multidisciplinary teams, confidentiality requirements must be rigorous. As with regular notes, counselors' and case managers' personal notes need segregation from formal notes used in treatment. Case managers should keep specific treatment information separate from court files, and if an individual fails the program or withdraws, transfer documents used by the court should be created using general treatment information to ensure confidentiality (Linhorst et al., 2009).

### **Consistency of Programs**

Consistency is an issue surrounding all areas of specialty court programs. One concern lies within law enforcement. The primary point of contact between an individual with mental illness and the justice system is often police or the county sheriff (Walsh & Holt, 1999). Having the ability to divert a person during daily operations, law enforcement benefits the most from training to identify and work with the mentally ill. In their survey of Virginia sheriffs, Walsh and Holt (1999) found that the majority of sheriffs received little or no instruction on working with individuals with mental illness.

More available training serves the public by providing more capable officers. Officers with experience and training in the diverse expression of mental illness and substance use are better able to recognize an individual in need or in crisis, with better outcomes (Ogloff et al., 2012). Overall, officers trained to deal more appropriately with detainees can reduce inappropriate incarceration, use of emergency services, recidivism, and cost to communities (Hnatow, 2015).

Consistency is necessary for fair and uniform needs assessments. Proper assessment is a cooperative process, requiring diligent coordination between counselors, case managers, and court officers. Regular meetings with stakeholders will promote assessment service needs, availability of services and costs, location and acquisition of funding, and specification of outcomes and outcome measurements (Walsh & Holt, 1999). With training and assessment addressed, counselors can direct more energy to advocacy needs.

### Advocacy

Counselors have a duty to educate and advocate for the communities with which they interact and the American Counseling Association (2003) is fully in support of this ideal. On the surface, this may appear to be in opposition to the demands of working in the arena of specialty courts, but counselors are in an ideal situation to promote better outcomes for clients through advocacy efforts (Grob, 1995; Kupers, 2015).

By providing services to participants and advocating for programs, counselors working with specialty courts not only actively serve client needs, but also provide ethical and pragmatic examples of conduct for those considering service to these populations. Linhorst et al. (2009) also noted that counselor participation contributes to the development of best practices for the courts.

### Conclusion

Specialty courts represent a new frontier for counselors. As mental health experts, counselors are the key to successful outcomes for participants (Linhorst et al., 2009). The need for cooperation and coordination by stakeholders with opposing goals and objectives and the increased scrutiny of treatment are challenges that await counselors with the courage to work with participant populations within specialty courts. The rewards of seeing change and improvement in participants' lives far outweigh the concerns of operating in these still-developing areas.

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# Counseling Preferences of Young Adults with Cancer

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This study examined preferences for counseling topics to discuss in individual, group, and family counseling among young adults with cancer, as well as their ranked preferences for attending individual, group, and family counseling. A sample of 320 young adults with cancer (18–39 years old) completed an online survey containing items relevant to young adults' psychosocial needs. Participants rated anxiety, finances, sad feelings, sexual and intimacy concerns, and stress management as most helpful for individual counseling; finding social support and getting information about one's medical situation as most helpful for group counseling; and no topics as most helpful for family counseling. Participants rated individual counseling as their primary choice of counseling modality, followed by group counseling, and lastly family counseling. Counselors may help young adult clients by familiarizing themselves with the unique experience of being diagnosed with cancer at an early age, as well as providing age-specific in-person support and counseling group opportunities.

**Keywords:** cancer, young adult, counseling preferences, counseling modality, psychosocial needs

The leading disease-related cause of death for adolescents and young adults is cancer, with almost 70,000 individuals newly diagnosed each year (Nass et al., 2015). Adolescents and young adults with cancer have specific psychosocial needs that are not the same as those of adults with cancer, yet we know comparatively little about those needs. In 2006, the National Cancer Institute called for research on the specific psychosocial needs of adolescents and young adults diagnosed with cancer. In 2013, an Institute of Medicine workshop reviewed the progress made since 2006 and reported that many challenges remained (Nass et al., 2015). Zebrack (2011) stated that developing age-appropriate support services would benefit adolescents' and young adults' psychosocial well-being. For young adults with cancer, having a counselor that is knowledgeable about their unique psychosocial needs is especially important (Katz, 2015). Psychosocial needs and concerns related to quality of life may include relationships with others, emotions, body image, and spirituality (Sodergren et al., 2017). Indeed, young adults with cancer experience psychosocial and supportive care needs that are "not only unique to their age group but also broader in scope and more intense than those at any other time in life" (Bleyer & Barr, 2009, p. 204). These individuals need to be a priority for counseling researchers, and we should be attuned to young adults' particular psychosocial needs and desires for counseling to help them as much as possible (Kumar & Schapira, 2013). Therefore, this study was designed to examine the perceived counseling needs of young adults with cancer.

We focused on individuals aged 18–39 because they have been shown to be developmentally different from adolescents (e.g., Arnett, 2000) and because they often have been lumped in with adolescents in research on their mental health needs (Haase & Phillips, 2004; National Cancer Institute, 2006). Although there are some similarities between adolescents and young adults with cancer in terms of psychosocial needs (Husson et al., 2017; Nass et al., 2015; Sender & Zabokrtsky, 2015; Sodergren et al., 2017), a growing discussion emphasizes the importance of exploring psychosocial needs across developmental age groups within the adolescent and young adult age

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range. This discussion especially focuses on the need for developing appropriate counseling and other psychosocial services (Fasciano, Souza, Braun, & Trevino, 2015; Iannarino, Scott, & Shaunfield, 2017; Katz, 2014, 2015; Salsman et al., 2014; Smith et al., 2013).

Generally, literature addressing the mental health needs and service usage of individuals with cancer is more abundant for older adults and for young adult survivors of *childhood* cancer, rather than for young adults diagnosed with cancer between the ages of 18 and 39 (Rabin, Simpson, Morrow, & Pinto, 2011). The research on the mental health needs of and service usage by adult cancer survivors older than 40 years of age suggests that they have a lower desire for, and utilization of, counseling services than do young adults with cancer (Gadalla, 2007; Hewitt & Rowland, 2002; Mosher et al., 2014). This need is largely unmet in the young adult population, in part because they may encounter difficulties affording counseling services (Hewitt & Rowland, 2002) or locating counseling services designed specifically for young adults with cancer (Marris, Morgan, & Stark, 2011; Zebrack, 2009).

Furthermore, there has been little research on the topics young adults with cancer would find beneficial to discuss in counseling or on the counseling modalities in which young adults with cancer would like to discuss specific topics. The current study's authors previously conducted the first-known study (Taylor & Kashubeck-West, 2013) to ask young adults with cancer to rate the helpfulness of specific topics of discussion across different counseling modalities (i.e., individual, group, and family counseling). A sample of 151 young adults with cancer rated 11 items as helpful to discuss in individual counseling: (a) stress management and/or anxiety; (b) putting your own needs before others' needs; (c) negative self-talk and sad feelings; (d) positive thinking; (e) living day to day; (f) trying to live a "normal" life; (g) finances; (h) partner concerns; (i) sexual and intimacy concerns; (j) finding social support; and (k) concerns with family. Participants identified the topic of trying to live a "normal" life as the most helpful individual counseling topic and alcohol or drug use as the least helpful topic of discussion. Within-group differences were found in that emerging adults (i.e., between the ages of 18–29 [Arnett, 2000]) rated the topic regarding thoughts about continuing or resuming education as significantly more helpful to discuss in individual counseling than did young adults (i.e., between the ages of 30–39 [Arnett, 2000]). Young adults rated the topic regarding partner concerns as significantly more helpful to discuss in individual counseling than did emerging adults. These findings seem to reflect age-related developmental tasks.

Taylor and Kashubeck-West (2013) also found that when asked to rate helpful topics for group counseling, young adults with cancer rated six topics on a group counseling needs assessment as helpful to discuss in group counseling with other young adults with cancer: (a) talking about feelings; (b) sharing medical information; (c) finding different ways to think about and cope with the experience; (d) finding meaning and purpose from the experience; (e) discussing concerns about intimate relationships; and (f) discussing concerns about casual relationships. These findings are consistent with Zebrack, Bleyer, Albritton, Medearis, and Tang (2006), who found that young adults with cancer ranked the opportunity to meet other young adults with cancer as being one of their top supportive care needs, regardless of whether young adults with cancer were currently receiving or had completed medical treatment.

Young adults with cancer may attempt to protect the feelings of family members and others by not wanting to discuss their diagnosis or negative feelings about it (Hilton, Emslie, Hunt, Chapple, & Ziebland, 2009; MacCormack et al., 2001), suggesting a hesitancy to fully utilize family counseling. When Taylor and Kashubeck-West (2013) asked participants to rate how helpful 19 different topics would be to discuss in family counseling, only two topics were rated as being helpful: stress



management and accepting the new "normal." Not only did young adults with cancer rate the fewest items as helpful to discuss in family counseling, dating concerns—a relational topic—was identified as the topic young adults with cancer least wanted to discuss in family counseling. Developmentally, as young adults with cancer work to gain independence from their family (Arnett, 2000), they may not see family counseling as an appealing option for supportive care.

The purpose of this study was to further examine the preferences of young adults with cancer for counseling topics and counseling modalities. This study builds on the 2013 study by Taylor and Kashubeck-West by using a larger sample of young adults with cancer, recruiting from a greater number of sources, and including more psychosocial concerns relevant to young adults with cancer using a counseling needs assessment tool. In extending previous exploratory work on this topic, this descriptive study had two primary goals: (a) to gain greater clarity of young adults' preferences for topics to discuss in individual, group, and family counseling; and (b) to understand young adults' preferences for these three counseling modalities. The results of this study provide counselors with helpful information as they attempt to meet the counseling needs of young adults with cancer.

## Method

### Participants

Participants were 320 young adults with cancer currently between the ages of 18 and 39, initially diagnosed with cancer at age 18 or older, and living in the United States. Descriptive analyses (see Table 1) showed that a majority of the sample identified as female (86%), Caucasian/White (87%), and heterosexual (94%). The mean age of the sample was 31.17 years old (range 18–39 years;  $SD = 5.14$ ). A majority of participants were partnered or in a committed relationship (68%), 71% had obtained at least an undergraduate degree, and 66% were currently employed, with approximately 17% unemployed and 17% on medical or disability leave. Participants in the sample reported living in 41 states and Washington, D.C.

Approximately half of the participants (51%) reported that they had received counseling from a mental health professional (e.g., counselor, social worker, psychologist, psychiatrist, pastor, or priest) since their initial cancer diagnosis. A majority of participants (66%) had tried to find a local in-person support group for young adults initially diagnosed with cancer during young adulthood, but less than half (48%) were successful in finding a local group.

On average, participants in the current sample were initially diagnosed with cancer at 27.76 years old (range 18–38 years;  $SD = 5.34$ ). Participants reported 26 different initial cancer diagnoses, with seven diagnoses being reported more frequently: (a) Breast (29%), (b) Brain (16%), (c) Hodgkin's Lymphoma (10%), (d) Thyroid (10%), (e) Leukemia (8%), (f) Non-Hodgkin's Lymphoma (7%), and (g) Testicular (5%). A majority of participants (70%) reported they had completed medical treatment; 29% were currently receiving medical treatment. Of participants who had completed medical treatment, the mean number of months since completing treatment was 32.68 (range 0–192;  $SD = 36.31$ ).

Most participants (78%) reported no recurrence of cancer. Of those who did have a recurrence ( $n = 69$ ), the mean age at recurrence was 30.00 years old (range 19–38 years;  $SD = 5.44$ ) and the mean duration of time between initial cancer diagnosis and recurrence was 2.06 years (range 0–10 years;  $SD = 1.88$ ).

### Procedure

All study procedures were approved by the university Institutional Review Board. Participants were recruited from cancer organizations based in the United States relevant to young adults with

**Table 1***Characteristics of Study Participants (N = 320)*

	Frequency (%) <sup>a</sup>
Gender	
Male	45 (14.1)
Female	275 (85.9)
Race/Ethnicity <sup>b</sup>	
Caucasian/White	279 (87.2)
African American/Black	10 (3.1)
Asian American	11 (3.4)
Hispanic/Latina(o)	28 (8.8)
Native American	3 (0.9)
Other	5 (1.6)
Current Socioeconomic Status	
Lower Class/Working Class	52 (16.3)
Lower Middle Class	73 (22.9)
Middle Class	148 (46.4)
Upper Middle Class	42 (13.2)
Upper Class	4 (1.3)
Sexual Orientation	
Heterosexual	297 (94.3)
Bisexual	12 (3.8)
Gay/Lesbian	6 (1.9)
Highest Level of Education	
Did Not Complete High School	1 (0.3)
Completed High School/GED	13 (4.1)
Some College	77 (24.1)
Obtained Undergraduate Degree	122 (38.2)
Some Graduate School	31 (9.7)
Obtained Master's Degree	63 (19.7)
Obtained a Doctorate	12 (3.8)
Stage/Grade of Initial Cancer Diagnosis	
0	23 (7.5)
1	75 (24.5)
2	108 (35.3)
3	70 (22.9)
4	30 (9.8)

*Note.* <sup>a</sup> Totals do not equal 320 because of missing data. <sup>b</sup> Percentages greater than 100% because of participants being able to select from more than one category.

cancer and with an online social media presence. Organizations were asked to post a recruitment solicitation for this study on the organization's Facebook and Twitter social media websites. In addition to a convenience sample, snowball sampling was used. The recruitment postings invited potential participants to send the study information to other young adults with cancer. Professional contacts with access to young adults with cancer (e.g., cancer support organization program directors, cancer-related non-profit executive directors, and academic professionals with expertise in psychosocial issues experienced by individuals with cancer) also were asked to invite young adults with cancer to participate. Upon completion, participants were invited to participate in a raffle

separate from the study survey for one of 20 randomly chosen \$10 gift certificates to Amazon.com. Counseling needs assessment items were presented in random order within counseling modality to prevent systematic order effects; similarly, counseling modality was presented randomly.

## Measures

**Counseling needs assessment.** Based on a review of the literature and feedback from two young adults with cancer, Taylor and Kashubeck-West (2013) developed three counseling needs assessment tools to explore topics that young adults with cancer might find helpful to discuss in individual, group, and family counseling. Their individual counseling needs assessment contained 31 items (Cronbach alpha = .91), their group counseling needs assessment contained 6 items (Cronbach alpha = .80), and their family counseling needs assessment contained 19 items (Cronbach alpha = .86). Comparisons of topic helpfulness between counseling modalities was limited because of the needs assessments containing different items.

The current study revised Taylor and Kashubeck-West's (2013) counseling needs assessments into one counseling needs assessment that was used to explore topic helpfulness for each counseling modality to better allow for topic comparisons. Reviewing the literature, soliciting feedback from psychosocial oncology mental health and nursing experts, and consulting with young adults with cancer led to the revised 38-item counseling needs assessment used in the current study. Participants were asked to rate their perception of how helpful each of 38 topics would be to discuss in individual counseling, group counseling, and family counseling. Individual counseling was defined as "attending counseling by yourself" (Cronbach alpha = .96); group counseling was defined as "attending counseling with people you have never met before who also have been diagnosed with cancer between the ages of 18–39 and are currently between the ages of 18–39" (Cronbach alpha = .97); and family counseling was defined as "attending counseling with someone you personally know" (Cronbach alpha = .98). Participants selected their responses on a Likert-based scale ranging from 1 (*very unhelpful*) to 3 (*neither helpful nor unhelpful*) to 5 (*very helpful*) for each of the three counseling modalities. Finally, participants were asked to rank their preferences for counseling modalities, with 1 being their most preferred counseling modality and 3 being their least preferred.

**Demographic items.** Participants were asked to report their age, gender, race/ethnicity, relationship status, sexual orientation, and current socioeconomic status. Additionally, they were asked about their medical treatment status—whether they were currently in medical treatment for their cancer diagnosis or if they had completed medical treatment—as well as how many months it had been since they completed medical treatment, if applicable. Participants were asked if they had received counseling since their initial cancer diagnosis and whether they had tried to find a local, in-person support group specifically for young adults with cancer. If they had tried to locate a local in-person young adults with cancer group, participants were asked if they had been successful in finding one.

## Results

The first goal of this study was to explore the perceived helpfulness of topics for young adults with cancer to discuss in individual counseling, group counseling, and family counseling. A mean helpfulness rating of 3.50 or greater on a 1 to 5 Likert-based scale—on which 3.0 was neither helpful nor unhelpful—was selected as indicating that a topic was rated as helpful to discuss in counseling. Individual counseling and group counseling both had 25 topics rated as helpful, and family counseling had 12 topics rated as helpful. Thus, participants found more than twice as many topics helpful for discussion in individual and group counseling compared to family counseling. See Table 2 for average helpfulness ratings by topic across the three counseling modalities.

**Table 2***Mean Differences Between Counseling Topics Across Counseling Modalities and ANOVA Results*

Variable	Individual M (SD)	Group M (SD)	Family M (SD)	N	F	$\eta^2$	Power
1. Accepting the new "normal" <sup>a</sup>	4.15 <sub>a</sub> (.99)	4.22 <sub>a</sub> (.96)	3.86 <sub>b</sub> (1.14)	286	21.76***	.07	1.00
2. Alcohol or drug use	2.65 <sub>a</sub> (1.34)	2.70 <sub>a</sub> (1.29)	2.49 <sub>b</sub> (1.21)	287	5.98**	.02	.88
3. Anxiety <sup>a</sup>	4.19 <sub>a</sub> (.99)	4.03 <sub>b</sub> (1.06)	3.77 <sub>c</sub> (1.18)	283	26.39***	.09	1.00
4. Being accepted by others	3.55 <sub>a</sub> (1.14)	3.63 <sub>a</sub> (1.17)	3.26 <sub>b</sub> (1.16)	282	17.30***	.06	1.00
5. Concerns with child(ren) <sup>a</sup>	3.30 <sub>a</sub> (1.33)	3.30 <sub>a</sub> (1.33)	3.22 <sub>a</sub> (1.41)	280	.92	<.01	.21
6. Concerns with family members other than partner, parent(s), sibling(s), or child(ren)	3.45 <sub>a</sub> (1.21)	3.37 <sub>a</sub> (1.22)	3.37 <sub>a</sub> (1.26)	283	.79	<.01	.19
7. Concerns with friend(s)	3.68 <sub>a</sub> (1.07)	3.69 <sub>a</sub> (1.07)	3.35 <sub>b</sub> (1.16)	283	17.50***	.06	1.00
8. Concerns with parent(s) <sup>a</sup>	3.57 <sub>a</sub> (1.18)	3.50 <sub>ab</sub> (1.22)	3.39 <sub>b</sub> (1.22)	285	3.83*	.01	.69
9. Concerns with partner	3.67 <sub>a</sub> (1.21)	3.53 <sub>ab</sub> (1.25)	3.43 <sub>b</sub> (1.28)	288	6.27**	.02	.90
10. Concerns with sibling(s)	3.33 <sub>a</sub> (1.22)	3.21 <sub>a</sub> (1.26)	3.24 <sub>a</sub> (1.22)	285	2.04	.01	.42
11. Creating a memorable document of your life for yourself <sup>a</sup>	3.28 <sub>a</sub> (1.23)	3.29 <sub>a</sub> (1.23)	3.18 <sub>a</sub> (1.27)	285	1.92	.01	.39
12. Creating a memorable document of your life to share with loved ones <sup>a</sup>	3.34 <sub>a</sub> (1.23)	3.32 <sub>a</sub> (1.21)	3.25 <sub>a</sub> (1.27)	286	1.00	<.01	.22
13. Dating concerns <sup>a</sup>	3.11 <sub>a</sub> (1.43)	3.15 <sub>a</sub> (1.44)	2.65 <sub>b</sub> (1.33)	284	28.97***	.09	1.00
14. Finances	3.82 <sub>a</sub> (1.13)	3.65 <sub>b</sub> (1.21)	3.60 <sub>b</sub> (1.25)	285	6.10**	.02	.89
15. Finding meaning in life <sup>a</sup>	3.61 <sub>a</sub> (1.18)	3.57 <sub>a</sub> (1.17)	3.35 <sub>b</sub> (1.19)	283	10.35***	.04	.99
16. Finding purpose in life	3.60 <sub>a</sub> (1.15)	3.59 <sub>a</sub> (1.17)	3.33 <sub>b</sub> (1.17)	284	12.36***	.04	1.00
17. Finding social support	3.84 <sub>a</sub> (1.08)	4.05 <sub>b</sub> (.99)	3.58 <sub>c</sub> (1.19)	282	24.59***	.08	1.00
18. Finding/making meaning from your diagnosis <sup>a</sup>	3.70 <sub>a</sub> (1.10)	3.73 <sub>a</sub> (1.13)	3.48 <sub>b</sub> (1.21)	281	8.91***	.03	.97
19. Getting information about your medical situation	3.52 <sub>a</sub> (1.17)	3.77 <sub>b</sub> (1.13)	3.51 <sub>a</sub> (1.23)	288	10.55***	.04	.99
20. How and what to tell your child(ren) about your situation	3.16 <sub>a</sub> (1.37)	3.27 <sub>a</sub> (1.31)	3.18 <sub>a</sub> (1.39)	282	2.18	.01	.45
21. Infertility issues	3.55 <sub>a</sub> (1.35)	3.50 <sub>a</sub> (1.35)	3.17 <sub>b</sub> (1.44)	286	19.01***	.06	1.00
22. Insurance issues	3.63 <sub>a</sub> (1.20)	3.56 <sub>ab</sub> (1.25)	3.40 <sub>b</sub> (1.29)	288	6.09**	.02	.89
23. Job situation	3.70 <sub>a</sub> (1.20)	3.55 <sub>ab</sub> (1.22)	3.29 <sub>b</sub> (1.24)	286	18.39***	.06	1.00
24. Living day to day	3.78 <sub>a</sub> (1.13)	3.85 <sub>a</sub> (1.13)	3.62 <sub>b</sub> (1.16)	285	6.50**	.02	.91
25. Making memories for your child(ren)/partner/family to have	3.37 <sub>a</sub> (1.20)	3.35 <sub>a</sub> (1.24)	3.33 <sub>a</sub> (1.34)	284	.17	<.01	.08
26. Negative self-talk	3.68 <sub>a</sub> (1.24)	3.68 <sub>a</sub> (1.15)	3.36 <sub>b</sub> (1.20)	283	15.46***	.05	1.00
27. Pacing yourself to prevent exhaustion <sup>a</sup>	3.74 <sub>a</sub> (1.14)	3.80 <sub>a</sub> (1.11)	3.52 <sub>b</sub> (1.20)	287	12.27***	.04	1.00
28. Pain and its effect on your life	3.66 <sub>a</sub> (1.11)	3.71 <sub>a</sub> (1.15)	3.47 <sub>b</sub> (1.23)	285	8.82***	.03	.97
29. Positive thinking <sup>a</sup>	3.99 <sub>a</sub> (1.03)	3.97 <sub>a</sub> (1.02)	3.72 <sub>b</sub> (1.10)	286	12.88***	.04	1.00
30. Putting your own needs before others' needs	3.86 <sub>a</sub> (.99)	3.79 <sub>a</sub> (1.02)	3.55 <sub>b</sub> (1.14)	287	15.38***	.05	1.00
31. Sad feelings <sup>a</sup>	4.08 <sub>a</sub> (1.01)	3.85 <sub>b</sub> (1.08)	3.62 <sub>c</sub> (1.19)	288	27.90***	.09	1.00
32. Sexual/intimacy concerns <sup>a</sup>	3.87 <sub>a</sub> (1.10)	3.44 <sub>b</sub> (1.31)	3.31 <sub>b</sub> (1.38)	286	26.93***	.09	1.00
33. Spirituality <sup>a</sup>	3.25 <sub>a</sub> (1.23)	3.25 <sub>a</sub> (1.27)	3.12 <sub>a</sub> (1.21)	284	2.92	.01	.56
34. Stress management <sup>a</sup>	4.22 <sub>a</sub> (.97)	4.09 <sub>b</sub> (1.00)	3.84 <sub>c</sub> (1.15)	288	22.78***	.07	1.00
35. Talking more effectively with health care professionals regarding your physical condition	3.74 <sub>a</sub> (1.16)	3.79 <sub>a</sub> (1.11)	3.51 <sub>b</sub> (1.24)	288	10.83***	.04	.99
36. Thoughts about continuing/resuming education	3.32 <sub>a</sub> (1.20)	3.32 <sub>a</sub> (1.23)	3.09 <sub>b</sub> (1.25)	288	10.36***	.04	.99
37. Trusting the doctor <sup>a</sup>	3.45 <sub>acd</sub> (1.17)	3.55 <sub>ac</sub> (1.15)	3.33 <sub>bcd</sub> (1.20)	286	7.31**	.03	.93
38. Will/advanced directive concerns <sup>a</sup>	3.39 <sub>a</sub> (1.18)	3.26 <sub>a</sub> (1.21)	3.33 <sub>a</sub> (1.19)	287	1.83	.01	.38

Note. Power = observed power at  $\alpha < .05$ . Means sharing a common subscript are not statistically different at  $p < .05$  according to Bonferroni pairwise comparison tests.

<sup>a</sup>Greenhouse-Geisser correction utilized for violation of Mauchly's Test of Sphericity at  $p < .05$

\*  $p < .05$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$

Next, we compared participants' ratings of counseling topic helpfulness among the three counseling modalities. A two-way within-subjects multivariate analysis of variance (MANOVA) was conducted to assess the interaction effect of counseling topic and counseling modality. There was a significant multivariate interaction effect: Pillai's  $V = .59$ ,  $F(74, 144) = 2.77$ ,  $p < .001$ ,  $\eta^2 = .59$ , observed power = 1.00. Given this significant multivariate interaction effect, a one-way within-subjects analysis of variance (ANOVA) was conducted for each of the 38 counseling topics included on the counseling needs assessment tool to better understand which topics were perceived as more helpful to discuss in certain counseling modalities (see Table 2 for ANOVA results).

Participants rated five topics as significantly more helpful to discuss in individual counseling than in the other two counseling modalities: (a) anxiety, (b) finances, (c) sad feelings, (d) sexual and intimacy concerns, and (e) stress management. The two topics (a) finding social support and (b) getting information about your medical situation were rated as being significantly more helpful to discuss in group counseling versus the other two counseling modalities. Finally, participants rated three topics as significantly more helpful to discuss in individual counseling than in family counseling: (a) concerns with parent(s), (b) concerns with partner, and (c) insurance issues. No topics were rated as significantly more helpful to discuss in family counseling than in individual or group counseling.

The second goal of this study was to examine whether there were differences in young adults' counseling modality preferences. Frequencies and percentages for counseling modality preferences can be found in Table 3. A majority of participants selected individual counseling as their first choice for counseling modality (73%), followed by group counseling (21%), and, finally, family counseling (7%). For second choice, the highest frequency of participants selected group counseling (45%), followed by family counseling (35%), and lastly, individual counseling (21%). For participants' third choice, family counseling was selected most frequently (59%), followed by group counseling (35%), and lastly, individual counseling (6%).

**Table 3**

*Counseling Modality Preferences (N = 296)*

	Frequency (%)
First Choice	
Individual Counseling	215 (72.6)
Group Counseling	61 (20.6)
Family Counseling	20 (6.8)
Second Choice	
Individual Counseling	62 (20.9)
Group Counseling	132 (44.6)
Family Counseling	102 (34.5)
Third Choice	
Individual Counseling	19 (6.4)
Group Counseling	103 (34.8)
Family Counseling	174 (58.8)

To explore whether significant differences existed among rankings of preferences for counseling modalities, a one-way within-subjects ANOVA was conducted. In conducting the analysis, Mauchly's

Test of Sphericity was statistically significant ( $W = .93, p < .001$ ), indicating heterogeneity of covariance matrices across levels of preference rankings for counseling modalities (Meyers, Gamst, & Guarino, 2006). Therefore, a Greenhouse-Geisser correction was utilized for interpreting results. The observed F value was statistically significant:  $F(1.87, 551.48) = 169.30, p < .001, \eta^2 = .37$ , observed power = 1.00. Bonferroni pairwise comparison tests ( $p < .05$ ) demonstrated that participants ranked individual counseling ( $M = 1.34, SD = .59$ ) significantly higher than group counseling ( $M = 2.14, SD = .73$ ), which in turn received a significantly higher ranking than family counseling ( $M = 2.52, SD = .62$ ). Thus, participants ranked attending individual counseling as their first preference for counseling modality, followed by group counseling ranked as their second preference, and finally family counseling ranked as their last preference.

## Discussion

The purpose of this study was to further examine the perceived counseling needs of young adults with cancer with regard to counseling. A paucity of research has studied counseling topic and modality preferences for young adult clients with cancer in depth. Both individual and group counseling had the same number of topics rated as helpful (25/38 topics), and 15 topics were rated as being equally helpful in group or individual counseling. Many of the 15 topics are discussed in the literature as relevant to young adults with cancer: infertility concerns (Eiser, Penn, Katz, & Barr, 2009; Gupta, Edelstein, Albert-Green, & D'Agostino, 2013; Katz, 2015; Kent et al., 2012), the "new normal" (Miedema, Hamilton, & Easley, 2007; Odo & Potter, 2009; Snöbohm, Friedrichsen, & Heiwe, 2010), employment (Katz, 2015; Odo & Potter, 2009; Zebrack, 2011), and pacing oneself to prevent exhaustion (Hauken, Larsen, & Holsen, 2013; Odo & Potter, 2009; Snöbohm et al., 2010), among other developmentally relevant topics. Participants indicated that discussing anxiety, finances, sad feelings, sexual and intimacy concerns, and stress management in individual counseling would be significantly more helpful than discussing these topics in group counseling or family counseling. Perhaps because these topics are fairly unique to one's specific life context, they may not be topics that would be as helpful to discuss with other family members or with other young adults with cancer. They may be topics that young adults with cancer prefer to gain insight about on their own, with a counselor providing feedback. Alternatively, they may be topics that are perceived as being too sensitive to discuss with others. Especially in regard to financial concerns or sad feelings, perhaps young adults with cancer do not want to worry or burden friends and family with their concerns (Brennan, 2004; MacCormack et al., 2001).

Participants rated the topics of finding social support and getting information about one's medical situation as significantly more helpful for discussion in group counseling than in individual or family counseling. Group counseling itself can be a way for young adults with cancer to find social support from others who understand their experiences (Kent et al., 2013). In addition, young adults with cancer may use group counseling to solicit advice and brainstorm ideas of how they can enhance their social support system. Even if someone is from a different background, such as a different social class, that person may be able to provide relevant information for increasing social support and interacting with one's support system. Similarly, getting information about one's medical situation is a topic that is not as context-specific as some of the topics rated as helpful to discuss in individual counseling (e.g., finances). Speaking with other young adults with cancer about one's medical experience and soliciting information about their medical experiences may be beneficial.

Consistent with Taylor and Kashubeck-West's (2013) findings, family counseling did not have any topics that were rated as more helpful to discuss in family counseling than in the other two counseling modalities. In addition, a few notable instances of family-relevant topics were rated significantly more helpful for discussion in individual counseling than in family counseling. These

topics included discussing concerns about one's parents, concerns about one's partner, and insurance issues. Although the topics discussing concerns with parents or with a partner may seem best suited for discussion in family or couples counseling, young adults with cancer were significantly more interested in discussing these concerns in individual counseling. Perhaps young adults with cancer do not want to appear ungrateful to others and would prefer to utilize individual counseling as a way to express frustration or as a way to consider alternative ways of interaction. This possibility would be consistent with MacCormack et al.'s (2001) finding that adult cancer survivors tend to prefer discussing concerns regarding family members in individual counseling rather than in family counseling.

This study also explored how young adults with cancer would rank preferences for counseling modality. Descriptive frequencies indicated that a strong majority of participants (73%) chose individual counseling as their first choice of counseling modality over group counseling or family counseling. Examining helpful counseling topics may be beneficial in understanding this result. Topics rated as more helpful to discuss in individual counseling than in other forms of counseling tended to be topics more specific to one's life context, such as financial concerns. Additionally, the topics involved feelings that may be perceived as negative feelings, such as anxiety, sadness, and stress. Topics chosen as most helpful to discuss in group counseling did not share the same underlying affective nature, but were related more to asking other young adults with cancer for their advice, experiences, and support. Counselors and other professionals should consider young adults' emotional state and purpose for attending counseling when recommending utilization of individual or group counseling. This study provides evidence that young adults with cancer do not particularly prefer family counseling or feel that discussing many topics in family counseling would be helpful. Developmental tasks during young adulthood, such as gaining independence from one's family of origin, may contribute to this.

### **Implications for Counselors**

Because participants in this study selected individual counseling as their first choice for counseling modality, counselors need to familiarize themselves with what young adults with cancer may want to discuss in individual counseling, as well as how a young adult may experience a cancer diagnosis during young adulthood. Katz's (2014, 2015) two books focusing on the psychosocial lived experience of young adults with cancer would be a beneficial starting point for counselors to familiarize themselves with relevant issues. When first exploring the concerns of clients who are young adults with cancer, counselors can begin by examining relevant developmental concerns related to the five counseling topics young adults with cancer in this study rated as being most helpful to discuss in individual counseling. Because the identified helpful topics relate primarily to emotions, an emotion-focused therapeutic approach (Greenberg, 2004) may be beneficial for young adult clients. Taylor, Hutchison, and Cottone (2013) reviewed three existentially based individual counseling models for adult cancer survivors that counselors may consider based on their young adult clients' needs: (a) dignity therapy, (b) meaning-making intervention, and (c) short-term life review.

An implication of this study for counselors relating to group counseling involves the limited availability of support groups for young adults initially diagnosed with cancer in young adulthood (Kumar & Schapira, 2013). Of the study participants who looked for a young adult cancer support group, less than half were successful in finding one. Young adults may then turn to the Internet to find support, but even then they may not be successful in locating the type of support they need (Cohen, 2011). More local support groups for young adults diagnosed with cancer during young adulthood are needed to provide them with a uniquely powerful experience in which they are heard and understood by others like them, rather than by others much younger or older. Additionally, local counseling groups for young adults with cancer diagnosed during young adulthood that

are led by counselors who understand their psychosocial concerns are needed. Taylor et al. (2013) reviewed four existentially based group counseling models for adult cancer survivors that counselors may consider based on their young adult clients' needs: (a) cognitive-existential group therapy, (b) self-transcendence group therapy (c) meaning-centered group psychotherapy, and (d) supportive-expressive group therapy.

Participants' lack of interest in the family counseling modality is an interesting result of this study. This result is supported by MacCormack et al.'s (2001) finding that many adults with cancer try to protect their friends and families by not sharing all of their emotional experiences with them. Rather than make general recommendations for clients who are young adults with cancer to participate in family counseling, counselors may want to make such recommendations on an individualized basis after thoroughly exploring clients' psychosocial needs and preferences. Young adults with cancer are in a developmental period in which they are striving to live as independent adults (Arnett, 2000). A counselor suggesting that a young adult client with cancer participate in family counseling may be perceived as a suggestion that the client is unsuccessfully navigating this developmental period. For young adults who are interested in family counseling, a biopsychosocial approach guided by a medical family therapy framework (McDaniel, Hepworth, & Doherty, 1992) may be worth considering. This study can aid counselors in formulating hypotheses for what young adults with cancer may perceive as beneficial in different counseling modalities, as well as what types of counseling these clients would find helpful.

### **Implications for Future Research**

Utilizing qualitative research methods may be especially helpful for future researchers (Kent et al., 2012) in continuing to explore young adults' preferences for counseling topics in different counseling modalities. Researchers could incorporate the counseling topics included in this study in their interview questions to further explore these psychosocial areas, as well as to discover additional helpful counseling topics. Inquiring about the results of the counseling modality preferences in a qualitative study also could lead to further understanding about the contexts behind selecting one modality over another.

Additionally, research exploring how counseling can increase quality of life for young adults with cancer would be a significant contribution to the literature. Quinn, Gonçalves, Sehovic, Bowman, and Reed's (2015) systematic review of the literature revealed a dearth of evidence-based approaches to enhance quality of life for adolescents and young adults with cancer. Because an experimental or quasi-experimental research design would be necessary to interpret whether counseling leads to an increase in quality of life, conducting such a research study would be complex and costly. But, a research study following up on these results to examine whether discussion of certain topics, participation in different counseling modalities, or particular counseling models can increase quality of life for young adults with cancer would greatly benefit the development of evidence-based psychosocial services for young adults with cancer.

### **Limitations**

Mono-method bias was an inherent limitation to this study because of the sole use of self-report for data collection. Additional limitations include the use of a convenience sample, as well as lack of diversity among the participant characteristics of gender and race. Furthermore, the possibility exists that there are other counseling topics that young adults with cancer would find helpful to discuss in counseling that were not included on this study's counseling needs assessment tool. Finally, if participants had never experienced one or more of the included counseling modalities, they may have been unsure about their perception of how helpful topics would be to discuss in those modalities or how they would rate their modality preferences.



## Conclusion

The purpose of this study was to examine the perceived counseling needs of young adults with cancer. This study resulted in clarifying topics young adults with cancer would find helpful to discuss in individual counseling, group counseling, and family counseling. Young adults rated anxiety, finances, sad feelings, sexual and intimacy concerns, and stress management as most helpful for individual counseling; finding social support and getting information about one's medical situation as most helpful for group counseling; and no topics as most helpful for family counseling. This study also found that young adults with cancer ranked individual counseling as their first choice for counseling modality, followed by group counseling and family counseling. Counselors and other mental health professionals can use these results as starting points for therapeutic conversations in various counseling modalities, creating treatment plans, establishing in-person groups, and developing evidence-based psychosocial programming and services for young adults with cancer in a variety of medical and supportive care settings.

### *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 SuperSkills Model: A Supervisory Microskill Competency Training Model

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Streamlined supervision frameworks are needed to enhance and progress the practice and training of supervisors. This author proposes the SuperSkills Model (SSM), grounded in the practice of microskills and supervision common factors, with a focus on the development and foundational learning of supervisors-in-training. The SSM worksheet prompts for competency-based supervisory behaviors from pre-session to post-session, highlighting a culturally aware supervisory relationship; goals and tasks; and feedback and reflection. The versatility of the SSM allows for utility in various settings, accommodates supervisor developmental level, and may be used to evaluate supervisor-in-training development.

**Keywords:** supervision, supervisors-in-training, SuperSkills Model, microskills, common factors

The profession of counseling has experienced an evolution regarding counseling training methods over the past decades (Capuzzi & Gross, 2009). Compared to literature on training counselors, literature on training supervisors has received less attention and the topic is less understood (Watkins, 2010). Thus, it is not surprising that systems of development for counselors-in-training (CITs) are more advanced than systems for supervisors-in-training (SITs; Watkins, 2010). For example, Ivey, Normington, Miller, Morrill, and Haase (1968) introduced microskills to the field of mental health care, and after four decades, the approach remains a training prototype (Ridley, Kelly, & Mollen, 2011); yet supervisors still lack a standard training model (Watkins, 2012b). Although much overlap exists in counseling and supervision tasks, the process of supervision adds more skill complexity than clinical tasks alone (Pearson, 2000). Further complicating the situation, many clinicians have assumed supervisory positions without training (Knapp & VandeCreek, 1997). Research has found that many supervisors feel incompetent and could be well-served by more supervisory training (Uellendahl & Tenenbaum, 2015).

A movement toward efficient methods of training supervisors should be informed by existing theory. Identifying with a theoretical model is paramount to facilitating growth in CITs (Lampropoulos, 2003). Various models of supervision have been proposed. Bernard and Goodyear (2014) broadly delineated first-wave supervision models into one of three categories: models grounded in psychotherapy theory, developmental models, and process models. Second-wave models are more eclectic, with the ability to combine or cycle between first-wave models as needed. The third-wave models reflect a common-factors approach, gleaning substantiated elements of supervision from the literature to amalgamate into a best-practices method (Bernard & Goodyear, 2014). Despite the combined breadth of models, there remains a lack of knowledge on what constitutes sound supervisory training, signifying the need for consolidation and movement toward supervisory competency models (Milne, Reiser, Cliffe, & Raine, 2011). Established theories of supervision may be enhanced when translated through microskills, which focus on specific behaviors to link theory and practice (Ivey, 1971; Ivey et al., 1968).

Any model that is chosen or created for effective supervisory training should be competency-based, and microskills may be a viable option. The microskills approach has been adapted for the training of supervisors with successful outcomes (James, Milne, & Morse, 2008; Richardson & Bradley, 1984; Russell-Chapin & Ivey, 2004), and there has been a call in the profession to move toward more competency-based forms of supervisor training (Milne et al., 2011). The SuperSkills

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Model (SSM) proposed in this article combines microskills training with supervision common factors to create a framework with which to enhance the development and training of supervisors. The SSM worksheet provides a consolidated and user-friendly tool to assist with the supervision of SITs (please contact the author for a copy of the worksheet).

### **A Brief Background of Microskills**

The use of microskills as a training instrument was born from the world of education. Succinctly, microtraining uses a systematic format to teach individual helping skills and may utilize recordings of practice, step-by-step training, and self-observation (Ivey et al., 1968). Fortune, Cooper, and Allen (1967) simplified and codified teaching skills into a model they called *micro-teaching*, aiming to provide students with an introduction to the experience and practice of teaching. The model provided experienced teachers with a vehicle for training novice teachers and gave the research team more control to track training effects.

When Ivey and colleagues (1968) introduced microskills within mental health care, they proposed the training of *microcounseling*, which focused on the specific behaviors of counseling skills, as useful in counselor education for the quick and effective teaching of counselor trainees. Ivey and colleagues' adaptation of microskills to the mental health field allowed counselor preparation programs to move from nebulous training techniques to a more systematic approach, providing supervisors with a more delineated method to track trainees' progress in actual skill behaviors. The structured method of tracking progress assists supervisors in the process of gatekeeping, making it easier to filter out candidates with difficulties or barriers to learning the core counseling skills (Lambie & Ascher, 2016).

The concept of utilizing microskills in the process of training supervisors has been broached by other researchers. Richardson and Bradley (1984) combined microskills and supervision training to create a *microsupervision model*, which breaks down the supervision skill acquisition process to assessment, modeling, and transfer. These three stages suggest how an SIT's supervisor identifies skill areas for growth, provides educative and corrective information to the SIT, and allows the SIT opportunities to integrate and display new skills. Russell-Chapin and Ivey (2004) utilized microskill design to develop the Microcounseling Supervision Model (MSM). The Counselling Interview Rater Form (CIRF) is a component of the MSM, which breaks down the counseling session into stages that are then comprised of specific skills to be assessed (Russell-Chapin & Ivey, 2004). The MSM is a useful tool to practice providing constructive feedback, because the CIRF "is mostly used as a method of providing positive, corrective, qualitative and quantitative feedback for supervisees" (Russell-Chapin & Ivey, 2004, p. 167). James, Milne, & Morse (2008) adapted microskills to the dialogue used by supervisors within a cognitive-behavioral supervisory approach. These models can be useful in the development of supervisors; however, there is a need for the creation of a supervision model that rises above current approaches, yet provides enough focus to be specific to clinical supervision (Morgan & Sprenkle, 2007). The proposed SSM acts to fill potential deficiencies by balancing focus between more detailed supervisory actions and a wider breadth of supervisory behaviors.

### **The Progression of Supervision Models**

Clinical supervision is recognized in the mental health professions as the signature pedagogy (Barnett, Erickson Cornish, Goodyear, & Lichtenberg, 2007; Goodyear, Bunch, & Claiborn, 2006). Introducing students to the foundational skills within mental health care has been a practice of supervisors for over 40 years (Ridley et al., 2011). Different professions within mental health care vary in job function and purpose, but the skills, processes, and objectives of supervision remain somewhat uniform across disciplines and cultures (Bernard & Goodyear, 2014). Supervision as an intervention

shares characteristics with other interventions—namely teaching, psychotherapy, and consultation—yet is distinct (Milne, 2006). The unique aspects of supervision include the propensity to be provided by and to individuals in the same profession, an evaluative and hierarchical nature, and an extension over time (Bernard & Goodyear, 2014).

The process of supervision is often referred to as *isomorphic*, meaning that the relationship between client and counselor is often similar in structure to the concurrent relationship between counselor and supervisor (Koltz, Odegard, Feit, Provost, & Smith, 2012). However, this triadic configuration does not take a fourth entity into account: the relationship between the supervisor and the supervisor's supervisor. This lapse is partially because of the underrepresentation of supervisory training knowledge in the counseling literature (Richardson & Bradley, 1984).

Another parallel between counseling and supervision is the utilization of theory to inform practice. Models of supervision may be classified in a number of ways. Bernard and Goodyear (2014) broadly delineated first-wave supervision models into one of three categories: models grounded in psychotherapy theory, developmental models, and process models. Psychotherapy-based models utilize psychotherapy's theoretical approaches as a framework for use in supervision. Choice of psychotherapy-based models is often informed by the supervisor's theoretical approach when in the counselor role. Familiarity with one's own theory may provide the supervisor a level of comfort and an added sense of competence. Developmental models focus on the developmental needs of the CIT based on the status, pace, or standard of professional development. Focus on individual development allows the supervisor to tailor interventions to the current needs of the supervisee. Also, under the developmental model umbrella, models of social roles take further consideration of CIT contextual needs, based on such factors as cultural or experiential background (Aten, Strain, & Gillespie, 2008). Process models focus on the process within each supervision session, spotlighting the relationship and interactions between supervisor and CIT. Bernard and Goodyear (2014) proposed that these broad categories are best utilized in conjunction with one another.

From the broad first-wave supervision models, Bernard and Goodyear (2014) identified second-wave models of the next generation: combined models and target-issue models. Combined supervision models may blend multiple approaches within one of the above three categories (e.g., two psychotherapy theories) or between the above three categories (e.g., one developmental model and one process model). This approach may allow supervisors to provide what is needed to themselves and their supervisees within the supervisory process. Target-issue models hone in on specific elements or needs within supervision. These may be helpful to supervisors who need a more direct, concentrated approach to address a specific issue that arises in supervision.

Third-wave models have emerged from continued research on specific supervision models, providing an index of evidence from which supervisors and researchers may benefit. A paucity of evidence for efficacy *between* supervision models has created a movement toward gleaning aspects found to be effective *within* supervision models (Sprenkle, 1999). Supervisory common factors refer to core components that remain consistent when cutting across models and perspectives (Watkins, Budge, & Callahan, 2015). Integrating different approaches to create common-factors models hinges on the assumption that supervision models are unique; by borrowing strengths from multiple models, new frameworks may be created to fill in weaknesses (Lampropoulos, 2003). For example, Lampropoulos (2003) used the notion of eclecticism by blending common supervisory pathways, stages, and processes to make a case for the incorporation of empirically validated practices both within and outside mental health care. Morgan and Sprenkle (2007) provided a similar process, utilizing broader supervision models and popular supervision conceptualizations to create a model

focused on relationship, development, and role continuums in the supervisory position. Aten et al. (2008) described an integrative model that they referred to as *transstheoretical*.

## The Case for Systematizing Supervisor Training

Aside from choosing a model of supervision, there are other elements that affect supervisory development. There are two environments supervisors practice within. Some assume the role in settings that primarily serve the public, acting as a supervisor to clinicians or interns working directly with clients. Others supervise in academic settings, primarily supervising the development of novice counseling students.

A large percentage of mental health professionals will ultimately act in a supervisory role (Norcross, Hedges, & Castle, 2002). This circumstance makes it especially perplexing that counseling professionals receive only minimal supervisory training (Pelling, 2008) and oftentimes no training at all (DeKruyf & Pehrsson, 2011). Supervisors are frequently placed into supervisory positions to learn on the job (Knapp & VandeCreek, 1997). Gonsalvez (2008) referred to this route of becoming a supervisor via the maxim *see one, do one, teach one*. When training does take place, it may come in the form of didactic (e.g., seminars, workshops, class instruction) or experiential (e.g., supervision of supervision) means (Watkins, 2012a). However, inconsistencies in training requirements for supervisors have been documented as recently as 2014 (Nate & Haddock, 2014). The Center for Credentialing & Education, an affiliate of the National Board for Certified Counselors, established the Approved Clinical Supervisor (ACS) credential, with 15 states having adopted the requirements as of 2016 (Center for Credentialing & Education, 2016). The compulsory conditions of becoming a supervisor still vary greatly.

Becoming a supervisor has developmental hurdles parallel to those of becoming a counselor (Milne, 2006). Processes and activities in both may look identical (Aten, Madson, & Kruse, 2008; Burns & Holloway, 1990). Encountering the shift in perspective from mental health practitioner to mental health supervisor can be troublesome (Watkins, 2013). SITs may experience feelings of anxiety and demoralization, trouble with forming a supervisory identity, and difficulty finding conviction about the meaningfulness of supervision (Watkins, 2013). Not unlike novice counselors, novice supervisors deal with the juggling of new skills and awareness, the discomfort of trying to find one's own style, and self-doubt (Gazzola, De Stefano, Thériault, & Audet, 2013). These challenges may account for supervision models that aim to utilize SITs' inherent therapeutic skills (Pearson, 2006).

The role of supervisor adds layers of responsibility that may not be present in the role of counselor alone. Counselors are responsible for advocating on behalf of clients (American Counseling Association [ACA], 2014); however, supervisors advocate for clients and CITs. The dual role of advocacy places the supervisor in the role of gatekeeper of the profession, charged with CIT development and the well-being of clients (Gaete & Ness, 2015). Balancing the duality of advocacy and evaluation may be taxing on new supervisors (Johnson, 2007).

The added responsibility of the supervisory role ushers in ethical issues beyond those incurred by clinicians alone (Rubin, 1997). Practitioners placed unwillingly into the supervisory role with little interest in the practice of supervision may pose a threat to the development of clinicians and future supervisors (Ladany, Mori, & Mehr, 2013). If trained in supervision by someone lacking passion for the practice, the meaningfulness of supervision is unlikely to be transmitted to the SIT (Watkins, 2013). It is more ideal to develop a supervisory identity while surrounded by others in a similar learning process (Watkins, 2013), a dynamic that may not be present for practitioners in the field learning new skills of supervision.

## Essential Supervisory Microskills: The SuperSkills Model (SSM)

The purpose of the SSM is to fill the need for a functional training model focused on supervisory behaviors gleaned from the supervision literature and deemed to be common across research. The focus is less on (but may be combined with) conceptualizations of supervisor theory and roles, and more on practical utility of supervisory behavior and process before, during, and after a given supervision session. The goal of the SSM worksheet and each of the foci is to help SITs integrate important aspects of supervision into each session. With this approach and tool, SITs are not left to remember all topics simultaneously; instead, the checklist included in the worksheet assists with staying on task and works toward laying the foundation for more adept integration of key supervisory factors as SITs gain more experience. The SSM worksheet may be utilized in a checklist or written fashion, incorporated into necessary supervision notes for documentation purposes, and completed to varying degrees of formality. Depending on supervisory style, the worksheet may be used during a supervision session or supervision-of-supervision meeting, or outside of these (prior to and/or after session). The SSM worksheet also can be used as a tool for supervisors to track individual progress and accordance with supervisory common factors. Generally speaking, the SSM and its worksheet can be adapted to meet the needs of the individual and environmental context.

Within the SSM, there is an assumption that appropriate preparation has taken place prior to or concurrently with supervision (e.g., supervisory training, development of a supervision contract, continued growth toward approach and identity/style, alignment with a model or structure, vetting of supervisees, ethical and legal considerations). These assumptions suggest that the SSM is not a stand-alone method for teaching and learning supervision, but rather a means to assist the foundational learning of SITs and provide supervisors at any stage in development with continued prompting of current supervisory focal points. As new potential supervisory common factors emerge from the literature, focal points may be altered or added. The first element of the current SSM is a pre-session contemplation that encourages intentionality and consideration of focus in an upcoming supervision session. The second component of the SSM emphasizes tangible supervisory behaviors that work toward creating and fostering a strong supervisory relationship hinging on cultural interest and awareness. The third facet of the SSM highlights supervisory goals and tasks and differentiates between practical and process goal and task foci. Feedback and reflection is the SSM's fourth dimension, which also gives consideration to SIT response to practical and process events, and includes attention to direct and indirect feedback and positive and constructive feedback. The final item of the SSM is post-session reflection, which allows for assessment of the supervision session. SITs may use this portion of the SSM to evaluate supervisory skill, consider future areas for focus, and document concerns or needs regarding the CIT.

### Pre-Session

The first component of the SSM is pre-session reflection. Prior to beginning a supervision session, it may be necessary for an SIT to refer to notes from previous sessions to recall past areas of focus or pressing issues. A CIT may be working on specific counseling skills chosen for review in the upcoming supervision session and SITs need to be mindful of the focus for the session. The focus also includes supervisory skills that the SIT plans to intentionally practice, which should be written in the initial pre-session consideration on the worksheet. However, flexibility is necessary; when CITs experience difficult client presentations, such as suicidal ideation, SITs may need to adjust focus to best serve the development of the CIT and the supervisory environment (Hoffman, Osborn, & West, 2013). As client welfare falls on the shoulders of both the CIT and the supervisor, there may be a need for SITs to inquire for updates in matters that have legal implications (Branson, Cardona, & Thomas, 2015).



Coming into session considering one's theoretical stance and supervisory style can be beneficial. Even though supervision is highly contextual with many areas to consider, supervision models act as a conceptual map to follow during sessions (Bernard & Goodyear, 2014). The "newness" of the supervisory role and the added layers of awareness may not equate to seamless use of a supervision model; however, using intention in supervision with regard to theory and style may aid continued understanding and improvement as a supervisor. The second pre-session consideration allows SITs to document intentions related to supervisory model, theory, or role.

### **Culturally Conscious Supervisory Relationships**

The SSM's second component is creating and maintaining a relationship with a focus on cultural factors. The supervisory relationship is a significant mediating factor for successful supervision outcomes (Ellis, 1991). Not only is supervisor focus on culture correlated with positive supervisory relationships (Schroeder, Andrews, & Hindes, 2009; Wong, Wong, & Ishiyama, 2013), but emphasizing culture fulfills the supervisor's responsibility to facilitate deeper awareness of cultural realities for supervisees (Fukuyama, 1994). Bordin (1983) conceptualized the supervisory relationship as the emotional bond between supervisor and supervisee and one of the triadic components in the supervisory working alliance (SWA). When SITs bring cultural considerations into supervision, stronger SWAs are created (Bhat & Davis, 2007; Crockett & Hays, 2015). Consequently, a lack of comfort in the supervisory relationship may create a less conducive atmosphere for broaching cultural dialogues (White-Davis, Stein, & Karasz, 2016). The SWA positively affects the therapeutic alliance (DePue, Lambie, Liu, & Gonzalez, 2016), CIT satisfaction with supervision (Crockett & Hays, 2015), CIT willingness to disclose information (Gunn & Pistole, 2012; Mehr, Ladany, & Caskie, 2010), and CIT work satisfaction (Stern, 2009).

The supervisory relationship is a large component of the SWA, and thus correlations of the SWA on other important supervisory factors may have bearing on building cultural relationships. SITs initiating productive conversations surrounding counseling self-efficacy (Ganske, Gnilka, Ashby, & Rice, 2015), CIT anxiety (Gnilka, Rice, Ashby, & Moate, 2016), and sources of stress and coping (Gnilka, Chang, & Dew, 2012; Stern, 2009) may ultimately strengthen the supervisory relationship. Focus on these factors has been shown to increase the prevalence of CITs bringing up cultural issues in supervision (Nilsson, 2007). Likewise, supervisors who bring cultural considerations into supervision engender higher levels of supervisee self-efficacy in skill and multicultural competence (Constantine, 2001; Crockett & Hays, 2015; Kissil, Davey, & Davey, 2013; Ladany, Brittan-Powell, & Pannu, 1997; Vereen, Hill, & McNeal, 2008).

A culturally conscious supervisory relationship is beneficial to both supervision and counseling environments; thus, documenting relationship-building actions on the worksheet gives appropriate and necessary focus to the actual relationship-building behaviors by the SIT. Providing time in supervision to focus on CIT relationships in both professional/academic and personal settings is important because both domains influence professional development (Rønnestad & Skovholt, 2003) and may ultimately relate to deepening the supervisory relationship (Mutchler & Anderson, 2010). Challenging dominant ideologies in supervision also has positive implications for broaching the concept of power within the supervisory and counseling environments (Hernández & McDowell, 2010). It may be useful for an SIT to inquire about a CIT's values, beliefs, and on what the counselor places importance, because highlighting culture and relationships in supervision works toward exemplifying the importance of focusing on culture to create therapeutic relationships with clients (Willis-O'Connor, Landine, & Domene, 2016). The SWA is compatible with a multicultural perspective in supervision (Bordin, 1983) and is considered transtheoretical, making the SWA adaptable to different counseling and supervisory theories (Bordin, 1983; Wood, 2005).

## Goals and Tasks

The SSM's third component, goals and tasks, is based on the two other components of Bordin's (1983) SWA. These are important to include because the SWA may be the most commonly cited factor in supervision literature (Watkins, 2014b). The goals refer to mutually agreed upon and understood objectives between the SIT and supervisee pertaining to the development of the CIT. The tasks refer to the action steps taken to achieve those objectives and the negotiation between SIT and supervisee to frame these steps in appropriate and achievable ways. Goals help to focus and direct supervision sessions while tasks act to pursue and attain the goals (Watkins, 2014b). The SSM worksheet includes space for the SIT to write goals and tasks for the supervision session, and the 11-point Likert scales provide the means to document the degree to which goals/tasks are agreed upon and achieved.

It is natural for novice supervisors to function from the perspective of a clinician, considering that this framework may be most comfortable or available (Watkins, 2014a). However, in doing so, the SIT may miss important components of CIT growth (Ponton & Sauerheber, 2014). Focus for goals and tasks should be directed at the process of counseling the client *and* the process of becoming (or being) a counselor; the SIT must attend to the space where the counselor's "professional" meets the "personal" (Ponton & Sauerheber, 2014). For example, if a supervisee is unsure how to proceed with a client's presenting issue, sole focus on goals and tasks aimed at client conceptualization and practical measures may foster dependence within the CIT to seek answers externally and work against a sense of self-efficacy and independence. Likewise, only attending to goals and tasks centralized to the counselor's personal process may miss the opportunity to locate practical skills. Balancing goals and tasks with emphasis on the CIT's process (e.g., potential feelings of inadequacy, confusion, difficulty with ambiguity) and practical abilities (e.g., specific skill use, conceptualization through a specific theoretical lens) may address individual needs and applicable skills to facilitate growth as a counselor. Differences will exist in CIT personality, ability, and developmental progress; therefore, SITs need to determine the appropriate equilibrium between process and practical focus for each supervisee (Reising & Daniels, 1983). The SSM worksheet contains space for the consideration of both practical and process goals and tasks, and the level of agreement and achievement.

## Feedback and Reflection

Feedback and reflection comprise the fourth component to the SSM. An integral component to the supervision process, feedback is considered to be a change mechanism consistent across supervisory theory (Goodyear, 2014). Developmental levels of CITs vary (Rønnestad & Skovholt, 2003) and may influence the style of feedback (e.g., direct, indirect). Using the example of CITs who self-criticize their demonstration of skill, it may be useful for SITs to provide direct positive feedback to communicate successful skill demonstration (e.g., "That is a good example of reflecting a feeling."). However, it is important to be mindful that feedback is a learning mechanism and to gradually remove oneself as support and transfer responsibility to the CIT (van de Pol, Volman, & Beishuizen, 2010). To that end, SITs may consider using indirect feedback to assist CITs to self-identify strengths (e.g., "If you had to identify a skill you did really well, what would it be?"). Instances exist throughout counselor development calling for various levels of direction in supervision (Goodyear, 2014), and SITs will develop a feel for when to provide direct and indirect feedback as they gain experience. To assist with this process, the worksheet includes a conceptual continuum for SITs to document feedback as direct or helping the CIT to self-identify.

Similar to goals and tasks, feedback for CITs should encompass both skill and process components (Liddle, 1986). Focus on learning counseling skills increases a CIT's professional competency and identity (Aladağ, Yaka, & Koç, 2014). The ability to make skills explicit helps CITs to know what to

look for and may assist the CIT and SIT in providing guidance and structure to the feedback process (Russell-Chapin & Sherman, 2000). Likewise, allowing CITs to use self-reflection to explore personal process components and arrive at meaningful conclusions may help facilitate learning, growth, and development (Guiffreda, 2015). For an example of skill versus process focus, consider a CIT learning to reflect feelings. By reviewing a recording of a counseling session, the SIT may witness the client expressing anger; or the SIT may choose to focus on skill, prompting the CIT to try identifying what feeling is being expressed or how to effectively reflect anger to the client. By focusing on process, the SIT may explore the CIT's relationship with anger (e.g., how others have displayed anger to the CIT or how the CIT expresses anger), as self-reflection could reveal a barrier toward accurately identifying and reflecting anger. The SSM worksheet contains both practical and process feedback and reflection sections for the SIT to consider.

It is an ethical imperative for supervisors to provide ongoing feedback and evaluation to CITs (ACA, 2014). Positive feedback to CITs has been found to increase counseling self-efficacy and lower anxiety, while negative feedback decreases counseling self-efficacy and elicits more anxiety (Daniels & Larson, 2001). Negative feedback may include such elements as vagueness, inconsiderate tone, hidden meaning, delay between an episode and reference to an episode, and subjectivity (Baron, 1988). Alternately, constructive feedback is relevant, shared immediately, factual, helpful, confidential, respectful, tailored, and encouraging (Ovando, 1994). Constructive feedback in supervision has been found to be the highest-ranked demand among CITs (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999), and when combined with microskills training, it has been found to contribute to learning effectiveness (Fyffe & Oei, 1979). CITs who do not receive constructive feedback may experience stagnation in skill progress (Russell-Chapin & Ivey, 2004). Constructive feedback can be challenging for SITs to provide (Motley, Reese, & Campos, 2014), especially because supervisors are trained as counselors and giving evaluative judgment may seem counterintuitive to the therapeutic skill set (Ladany et al., 1999). The struggles associated with constructive feedback may require supervisors to call upon the supervisory relationship, taking inventory of CIT self-efficacy and confidence levels, to inform how and when to provide constructive feedback (Daniels & Larson, 2001). Supervisor impediments to providing quality feedback are recognized by both CITs and SITs (Heckman-Stone, 2004); thus, the addition of positive and constructive feedback sections on the worksheet may prompt SITs to practice providing both forms of feedback to CITs. The explicit cue for feedback also acts as a practical measure to inform SITs' recording of supervision progress notes following the supervision session.

### **Post-Session**

The SSM's final component is post-session reflection. Utilizing the post-session for documentation benefits the CIT and the SIT. Maintaining supervision notes is an ethically sound practice and can assist supervisors in documenting practical, ethical, and legal issues (Luepker, 2012). Keeping records of supervision also proves beneficial to the development of SITs' style and theoretical stance (Bernard, 2014). Timely and accurate documentation may act as a future reminder for areas on which to focus for the CIT or SIT.

The supervision note may have an evaluative component to it. Where applicable, a supervisor may begin to evaluate a CIT based on criteria set by an associated institution (e.g., university, occupational setting) or on agreed-upon standards between the supervisor and CIT (e.g., a measure found in the literature based on specific need). Likewise, the SIT may utilize documentation to evaluate their progress as a supervisor. Each microskill suggestion may act as an area to consider for evaluation or self-evaluation. These areas may include progress on deepening the cultural relationship, assessment of supervisory actions in working toward agreed-upon goals, appraisal of goal achievement, appropriate

balance of direct feedback and assisting the CIT to formulate their own answers, appropriate balance of focus on counseling instruction and personal process, examples of interventions consistent with a theoretical model or supervisory role, and exploration of countertransference during the session.

## Discussion

The SSM's flexibility and focus on a behavioral framework may be efficacious in training supervisors from varying cultural identities and helping SITs learn how to supervise counselors of differing backgrounds. CITs gain multicultural knowledge in their development as counselors; this continual learning process is suitable to microskill techniques, as research has shown that newly acquired skills can be employed during continued multicultural awareness (Hall & Richardson, 2014).

The flexibility of the SSM gives SITs freedom in pace and style of development. Just as neophyte counselors are to focus on their own skills and process in early training, gradually increasing their abilities to work effectively with clients, SITs may follow a similar path of needing to focus on supervisory abilities before providing effective supervision (Lampropoulos, 2003).

The freedom to be flexible in supervisory development is corroborated by existing models. Morgan and Sprenkle (2007) suggested a model that conceptualizes supervisor behaviors and roles on continuums, assuming that supervisors will have knowledge of their own styles and strengths to adjust and flex where needed. Goodyear (2014) created a model that provides SITs the ability to choose how to provide feedback, landing anywhere between direct instruction and self-directed learning. The SSM's composition of common-factor components allows for adaptation to other models with both flexible and focused supervisory interventions. The SSM also utilizes updated research and literature to inform more specified behaviors associated with positive supervisory and therapeutic outcomes.

## Conclusions

Supervision continues to become more recognized, accepted, and vital to the mental health professions for the preparation of multiculturally competent counselors (Watkins & Milne, 2014). There remains a dearth of information on how to effectively train supervisors, and a movement toward competency-based models has been suggested (Milne et al., 2011). Just as Ivey and fellow researchers (1968) adapted microskills training to counseling in order to study and bridge theory and practice, consolidating supervisory common factors "could not only provide a template for supervision research, but also for teaching and providing supervision as well" (Morgan & Sprenkle, 2007, p. 2). The SSM and accompanying worksheet are a step toward a simplified conceptualization and user-friendly tool to continue progressing supervision training and practice.

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# Self-Care Through Self-Compassion: A Balm for Burnout

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Counselors are routinely exposed to painful situations and overwhelming emotions that can, over time, result in burnout. Although counselors routinely promote self-care, many struggle to practice such wellness regularly, putting themselves at increased risk for burning out. Compassion is essential to the helper's role, as it allows counselors to develop the therapeutic relationship vital for change; however, it is often difficult to direct this compassion inward. Developing an attitude of self-compassion and mindfulness in the context of a self-care plan can create space for an authentic, kind response to the challenges inherent in counseling. This article expands beyond the aspirational aspects of self-compassion and suggests a variety of practices for the mind, body, and spirit, with the intention of supporting the development of an individualized self-care plan for counselors.

**Keywords:** self-care, self-compassion, burnout, mindfulness, wellness

Wellness, prevention, and human development compose the core of a counselor's professional identity (Mellin, Hunt, & Nichols, 2011). This fundamental grounding is emphasized within the American Counseling Association's (ACA) *Code of Ethics* (ACA, 2014), as well as by the Council for Accreditation of Counseling & Related Education Programs (CACREP; 2016). To fulfill their role in the change process, counselors depend heavily upon compassion, a key component of the therapeutic relationship that—paradoxically—counselors may seldom apply to themselves (Patsiopoulos & Buchanan, 2011). Whereas compassion means being with others in their suffering (Pollack, Pedulla, & Siegel, 2014), self-compassion can be understood as “being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness” (Neff, 2003, p. 87). Higher levels of self-compassion can serve as a buffer against burnout (Barnard & Curry, 2011). Therefore, cultivating an attitude of self-compassion may assist counselors in employing self-care practices to refresh, rejuvenate, and recharge their bodies, minds, and souls. The purpose of this manuscript is to reimagine self-care as regular acts of self-compassion that benefit both clients and counselors.

## Self-Compassion

Self-compassion, a construct from Buddhist thought, consists of self-kindness, common humanity, and mindfulness, and is characterized by gentleness with oneself when faced with a perceived sense of inadequacy or failure (Neff, 2003). Self-compassion is not based on an evaluation of the self; self-compassion becomes the path to positively relating to oneself (Neff & Costigan, 2014). The concept of self-compassion is consistent with the idea of self-acceptance in the humanistic tradition (Neff, 2003). Carl Rogers (1961) described a successful outcome of psychotherapy as an increase in positive attitudes toward self: “The client not only accepts himself . . . he actually comes to *like* himself. This is not a bragging or self-assertive liking; it is a rather quiet pleasure in being one's self” (p. 87). The practice of self-compassion calls for a mindful awareness of emotions, and painful emotions are met with a sense of understanding, connection to our common humanity, and self-kindness (Neff, 2003). Neff and Costigan (2014) described self-compassion's relationship with pain thusly: “Self-compassion does not avoid pain, but rather embraces it with kindness and goodwill that is rooted in the experience of being fully human” (p. 114). Self-compassion practices have been found to improve psychological

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functioning in both clinical and non-clinical settings (Neff, Kirkpatrick, & Rude, 2007; Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011).

Mindfulness is one of the core components of self-compassion and is critical for the awareness of suffering that precedes compassion (Germer & Neff, 2015). Mindfulness is the focusing on the awareness of pain in the present moment, and self-compassion becomes the act of taking that awareness and encouraging kindness toward oneself. The common humanity component of self-compassion becomes one of acknowledgment that, as humans, we are imperfect and make mistakes; recognizing our flawed condition allows for a broader perspective toward our difficulties (Neff, 2003). Adopting such a view of pain reduces the chance of over-identification or getting so wrapped up in one's emotions that they become exaggerated (Neff & Costigan, 2014). When an individual can recognize pain as a universal occurrence, such a viewpoint then fosters a sense of connection with others who have felt suffering. Pain becomes an uncomfortable but acknowledged part of the human condition. When practicing self-compassion, the self-directed kindness is not done to change the circumstance of suffering, but done *because* there is suffering. The practitioner asks "What do I need now?" The individual then acts accordingly to provide comfort when experiencing the pain of inadequacy or failure (Germer & Neff, 2015). Learning self-compassion becomes a gift for both clients and the practitioner (Barnett, Baker, Elman, & Schoener, 2007). Making time for one's self is one way counselors can practice self-care (Patsiopoulos & Buchana, 2011). That self-acceptance can prove vital for counselors, whose work often puts them at a risk for burnout (Yager & Tovar-Blank, 2007).

## Counselor Burnout

Burnout is a multidimensional experience consisting of exhaustion, cynicism, and reduced professional efficacy that can result from dissatisfaction with the organizational context of the job position (Maslach, Schaufeli, & Leiter, 2001). Burnout can affect individuals in a variety of ways, with anxiety, irritability, fatigue, withdrawal, and demoralization as major examples (Schaufeli & Enzmann, 1998). Burnout can affect individuals at any point in their career and can hamper productivity and creativity, resulting in a reduction of compassion toward themselves and clients (Grosch & Olsen, 1994). "It is when counseling seems to have little effect that counselors reach despair because their *raison d'être* for choosing this work—to make a difference in human life—is threatened" (Skovholt, Grier, & Hanson, 2001, p. 171). Caring for others and caring for oneself becomes a difficult balance to achieve for both new and seasoned counselors alike. Carl Rogers (1980) wrote, "I have always been better at caring for and looking after others than I have in caring for myself. But in these later years, I made progress" (p. 80). Self-compassion can serve as a protective factor against such potentially debilitating effects of work-related burnout.

Historically, researchers examined the causes of burnout relating to demographic, personality, or attitudinal differences between individuals (Maslach et al., 2001). Today, burnout is viewed from an organizational standpoint and is concerned with the relationship, or *fit*, between the person and his or her environment, wherein mismatches can result in burnout over time (Maslach, Leiter, & Jackson, 2012). An individual's perceptions have a reciprocal relationship with the work environment; how counselors make meaning of their work impacts their satisfaction, commitment, and performance in the workplace (Lindholm, 2003). Counselors experiencing work-related stress and burnout will construct meaning differently and require a tailored self-care plan that reflects their individual assessment of their own fit within their work environment.

## Counselor Self-Care

Self-care can be defined as an activity to "refill and refuel oneself in healthy ways" (Gentry, 2002,

p. 48). Self-care is vital if we are to remain effective in our role and avoid burnout; however, many counselors do not regularly implement the techniques they recommend to clients in their own lives (O'Halloran & Linton, 2000; Skovholt et al., 2001). Although self-care is widely promoted within the counseling literature, this author contends that inherent in many self-care plans and workplace improvement efforts is the idea that overwhelming work-related stress reflects an inadequacy of the individual. The message in the literature often reflects the view that a counselor's distress hinges upon inadequate coping resources, poor health practices, or other kinds of personal failing, such as lacking assertiveness or not taking enough time off from work (Bradley, Whisenhunt, Adamson, & Kress, 2013; Killian, 2008; O'Halloran & Linton, 2000). As a result, self-care plans tend to take on the air of a New Year's resolution, a strategy to get better. This narrow focus reflects the historical view of burnout that focused primarily on its individual dimension, without taking into consideration the organizational, interpersonal, or societal perspectives (Schaufeli & Enzmann, 1998). When self-care plans are written like self-improvement plans, the opportunities for criticism and judgment abound, particularly for new counselors who struggle with anxiety and self-doubt (Skovholt, 2012). When counselors are suffering, experiencing symptoms of burnout, struggling to maintain healthy professional boundaries (i.e., under- or over-involvement), or feeling as though they are not caring for themselves effectively, shame may cause them to be less likely to seek assistance (Graff, 2008). Some counselors may fear negative repercussions as a result of disclosure, such as being perceived as impaired or having professional competency problems (Rust, Raskin, & Hill, 2013).

Self-care is an ethical imperative (ACA, 2014), because utilizing self-care strategies reduces the likelihood of impairment (ACA, 2010). Issues in a counselor's personal life, burnout in the workplace, mental or physical disability, or substance abuse can result in impairment (ACA, 2010). Sadly, in a survey completed in 2004, nearly two-thirds of participants knew a counselor that they would identify as impaired (ACA, 2010). Counselors who better manage their self-care needs are more likely to set appropriate boundaries with clients and less likely to use clients to meet their own personal or professional needs (Nielsen, 1988). Self-care education has been integrated into the accreditation standards for counselor training (CACREP, 2016), and there are multiple articles discussing how to incorporate the value of wellness and self-care into counselor education programs (Witmer & Young, 1996; Yager & Tovar-Blank, 2007). For counselor educators and supervisors, monitoring counselors-in-training for possible impairment is an important part of the responsibility of gatekeeping (Frame & Stevens-Smith, 1995). However, despite this attention, both students and practicing professional counselors still struggle to implement self-care (Skovholt et al., 2001; E. Thompson, Frick, & Trice-Black, 2011).

Bradley and colleagues (2013) suggested that many of the self-care suggestions in the literature are too general, focusing mainly on general health practices, such as eating healthily and getting enough sleep, or professional recommendations regarding seeking support from colleagues. A case can be made that a counselor would be better served by employing an overall approach to efforts that are based in a self-compassionate mindset. Therefore, actively seeking awareness of one's own signs and symptoms that indicate suffering can not only help counselors recognize burnout, it also can provide clues toward the first step in soothing.

Mindfulness represents one possible means of increasing such awareness. Mindfulness allows the practitioner to be present in the moment non-judgmentally (Kabat-Zinn, 1994). To practice self-compassion, a counselor needs to be willing to attend to feelings of discomfort, pain, or suffering and acknowledge the experience without self-recrimination (Germer & Neff, 2015). Consider the experience of having a regular client stop attending sessions and returning calls or abruptly discontinuing services. Although common, the ambiguous loss of a connection with a client can be a source of stress and pain

(Skovholt et al., 2001). It also can provide an opportunity. Covey (2010) shared the following quote that is often misattributed to Viktor Frankl: "Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom" (p. VI). The space Covey describes is our opportunity to be mindful of the stimulus and choose to offer ourselves compassion in response. Choosing to deny, suppress, or distract to avoid these feelings may cause the counselor to miss the trigger to practice self-care. When such feelings are recognized, the counselor may act compassionately toward himself or herself by normalizing or validating the experience. Within self-compassion, the concept of common humanity becomes crucial to precluding the often-automatic tendency to become self-critical for experiencing discomfort (Neff, 2003). Thoughts such as, "I shouldn't feel this way," "Just snap out of it; it's not so bad," or "What's wrong with me?" invalidate the sufferer and may cause the counselor to feel as though self-care is an act of indulgence rather than an essential, self-directed gift of kindness. Expressing kindness through self-care acknowledges that counseling can be both difficult and rewarding, a duality representative of the human condition.

When counselors choose to practice self-care, they enhance themselves and their practice. One participant in a narrative inquiry on self-compassion in counseling stated: "What's so important about self-compassion? Three words: Avoidance of burnout" (Patsiopoulos & Buchanan, 2011, p. 305). Another participant noted, "When we come from a self-compassionate place, self-care is no longer about these sporadic one-time events that you do when you feel burned out and exhausted. Self-care is something you can do all the time" (Patsiopoulos & Buchanan, 2011, p. 305). The consequence of our job as counselors is working compassionately with suffering, and in doing so we suffer (Figley, 2002).

For someone to develop genuine compassion toward others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one's own feelings and to care for one's own welfare. . . . Caring for others requires caring for oneself. (Germer & Neff, 2015, p. 48)

Self-care, then, is a vital part of a counselor's responsibilities to clients and to one's self.

It is important to remember that counseling can be emotionally demanding for counselors in different ways (O'Halloran & Linton, 2000). Self-compassion encourages remembering the shared human experience (Neff, 2003), as the experience of being a professional counselor can be quite isolating, especially for those working in more independent environments (e.g., school counselors, private practitioners; Freadling & Foss-Kelly, 2014; Matthes, 1992). Using mindfulness, counselors can maintain an objective stance that can allow the counselor to view one's work circumstances with a non-judgmental lens (Newsome, Waldo, & Gruszka, 2012), then act kindly to intervene with a self-care practice that is revitalizing to mind, body, and spirit. Using self-compassion tenets as a guide, self-care plans can be created that are authentic and kind, connect us to the human experience, and reflect a balanced state of self-awareness.

### **Creating a Self-Compassion-Infused Self-Care Plan**

In wellness counseling, optimal functioning of the mind, body, and spirit is the goal for holistic wellness (Myers, Sweeney, & Witmer, 2001). The physical dimension is the most common focus for wellness intervention (Carney, 2007); however, this is quite limiting in a profession that is often sedentary, with long hours and pressure to meet productivity demands (Franco, 2016; Freadling & Foss-Kelly, 2014; Ohrt, Prosek, Ener, & Lindo, 2015). Maintaining one's health is important but may not be enough to assuage the emotional demands of a high-touch profession in which a strong professional relationship is combined with the often-conflicting pressures of reimbursement; short-

term, diagnosis-focused treatment; and behaviorally based outcomes associated with managed care (Cushman & Gilford, 2000; Freadling & Foss-Kelly, 2014). Developing a collaborative treatment plan is a common practice in counseling; it allows the counselor and the client to determine the possible direction and outcomes for their work together (Kress & Paylo, 2015). In the best case, this plan is individualized, specific, and open to revision when necessary. A good self-care plan can follow the same formula.

What follows are specific suggestions regarding self-care practices that stretch beyond the “should,” the “ought to,” and the New Year’s resolution language. When reading the interventions, consider the question Linder, Miller, and Johnson (2000) suggested for clients when encouraging self-care: “How do you reassure yourself?” (p. 4). The suggestions are organized into mind, body, and spirit; however, these are artificial divisions and some interventions may satisfy in multiple ways.

### **Interventions for the Mind**

Mindfulness is a component of self-compassion, but it can also be used intentionally as a regular practice for self-care. Mindfulness can be described as a dispositional trait, a state of being and a practice (Brown, Ryan, & Creswell, 2007). The use of mindfulness has been integrated into many facets of counseling practice (I. Thompson, Amatea, & Thompson, 2014). For those attracted to the practice of mindfulness for self-care, non-judgmental awareness can be integrated as a practice (e.g., a set time for engagement in a particular mindfulness exercise) or as a way of being during particular activities within the day. Exercises such as mindful eating, maintaining sensory awareness while washing dishes, or mindful walking can be helpful for those who are looking for brief, everyday opportunities for self-care. Researchers I. Thompson and colleagues (2014) found that higher levels of mindfulness corresponded with lower levels of burnout. Mindfulness has been suggested as a beneficial way to teach self-care in counselor training (Christopher, Christopher, Dunnagan, & Schure, 2006), and also as a way to reduce stress and increase self-compassion in students training to be in helping professions (Newsome et al., 2012). For any number of reasons, not all counselors may find benefit in mindfulness practices; therefore, some may choose methods of self-care that are more mentally invigorating.

Intellectual stimulation in any endeavor is important to maintain engagement, interest, and enjoyment, but such motivation can be particularly helpful when a work position contains routine, mundane, or downright boring tasks. To create a stimulating work life, seasoned professionals find active ways to continue their professional development, which can decrease the boredom that can lead to burnout (Skovholt et al., 2001). Activities for growth and development can include learning something new within counseling or outside the profession, such as learning a new language, or how to make sushi, write code, or play a strategy game such as the ancient board game, *Go*.

The role of a counselor involves exposure to circumstances of human suffering, painful emotions, and heartbreaking situations, which increases the risk of burnout due to absorption of the clients’ pain (Ruysschaert, 2009). Finding a way to keep and maintain positive memories, cards and notes, compliments or successes—what this author terms *warm and fuzzies*—either personally or professionally, in a box, folder, jar, or bulletin board, can be a helpful response. Bradley and colleagues (2013) suggested tracking small changes made by clients when discouraged and sharing the progress with co-workers.

Writing can be a powerful intervention in a counseling setting and can benefit both mental and physical health (Pennebaker & Seagal, 1999; Riordan, 1996). Counselors can use the medium of writing in a multitude of ways. Whether through journaling, narrative, poetry, musical lyrics, or letters, the act of writing can reduce emotional inhibition (Connolly Baker & Mazza, 2004). Creative

writing can be used to access the healing benefits of writing without worry about form or audience (Warren, Morgan, Morris, & Morris, 2010).

Warren et al.'s (2010) *The Writing Workout* is a way to express, validate, and externalize painful emotions. This wellness approach illustrates how creative writing for self-care can cultivate compassion. Narrative writing strategies can allow the writer to change the outcome of a lived experience or reframe a life experience (Connelly Baker & Mazza, 2004). Creating a narrative of an event can help the storyteller organize details and events, reflect and process thoughts and feelings, and derive meaning from experiences (Pennebaker & Seagal, 1999). A creative, mindful writing intervention could be used to examine a clinical situation that may not have gone as the counselor had hoped, or to creatively explore life lessons derived from a clinical encounter. For some clinicians, writing gives voice to emotions too raw to easily speak aloud (Wright, 2003).

Traditional journaling can allow for self-reflection, increased self-awareness, and growth (Lent, 2009; Utley & Garza, 2011). Journal writing can be inherently self-compassionate. Linder et al. (2000) discussed the use of a non-judgmental journaling practice in which there are no wrong words and writers are encouraged to use random sentences and words that do not make sense. Through almost nonsensical form, journaling offers a sense of safety and freedom, while creating a trusting relationship with the journal. Linder et al. (2000) stated, "Journaling finds the meaning in meaninglessness and negates the emptiness through creating writing from the heart. It is an outlet to tell the truth without being judged" (p. 7).

Beyond the traditional journal, counselors may find alternative ways to use journaling for emotional expression, such as use of bullet journaling or a personal blog online. Bullet journaling uses a rapid-logging approach, or a visual code, to represent tasks, events, and notes in a physical notebook (Bullet Journal, 2017). Keeping a bullet journal is a clever way of managing multiple arenas of one's life in a single place, and the events and notes categories can be particularly helpful in the practice of journaling for self-care. Events are to be written down briefly and objectively despite the degree of emotional content they carry (Bullet Journal, 2017), offering an opportunity to practice the non-reactive skill of mindfulness (Kabat-Zinn, 1994). Once an event has been entered, the counselor can respond mindfully to it by writing at length on the following page. The notes category for bullet journaling consists of ideas, thoughts, or observations (Bullet Journal, 2017), which could include inspirational quotes, eureka moments, or other insights worth reviewing at a later date. The author can use signifiers (i.e., symbols) to create a legend to provide additional context for an event, note, or task. The bullet journal approach for self-expression exemplifies a creative twist on an old concept to better fit the preferences of the writer. Similarly, scrapbook journaling can be used to accommodate the types of expressive media that resonate with the counselor's personal style or interests (Bradley et al., 2013). Counselors can use photos, poems, song lyrics, and quotes to reflect their emotional state, and then reflect on the emotional patterns or themes that arise. For counselors who prefer to share their thoughts on the Internet, an online blog can be a cost-effective, accessible medium to express oneself emotionally and share thoughts, feelings, and experiences with others (Lent, 2009). Counselors should consider the risks associated with the use of the Internet and maintenance of confidentiality in an online medium in accordance with the *ACA Code of Ethics* (2014).

Finally, a simple self-care intervention can involve writing oneself a permission slip or prescription for something. This could be the permission to be imperfect, to take a mental health day, or to run through a sprinkler on a hot day. A writing assignment of this sort expresses kindness in providing the very thing that is needed for an emotional recharge. In some cases, this may involve taking a quiet moment to allow one's mind to wander. This can occur during a warm bath or shower at the end of

the day or while savoring a warm cup of coffee or tea in the afternoon. Although mind-wandering can be a threat to effectiveness and productivity when it occurs at inopportune times, taking time for mind-wandering can relieve boredom, stimulate creative thoughts, and facilitate future planning (Smallwood & Schooler, 2015).

### Interventions for the Body

Many self-care plans begin and end with a strong concentration on physical self-care, typically involving making nutritional changes and increasing physical activity (Bradley et al., 2013; E. Thompson et al., 2011). These therapeutic lifestyle changes (TLCs) can have a huge impact on health and well-being (Walsh, 2011). Although the mental health benefits of these types of changes are well documented (Walsh, 2011), a myopic focus on physiological wellness may be limiting, and self-care should include a broader range of ways to cope (E. Thompson et al., 2011). For individuals wishing to focus specifically on such changes, using the imagery of caring for oneself as one does a plant may increase self-awareness of bodily self-care needs (Bradley et al., 2013). Considering one's needs in this metaphorical way may help counselors increase their own self-compassion by considering their unique needs and the changes they are ready and willing to make. A counselor may indicate they require shade from the sun, which could represent reducing over-stimulating environments; good spacing from other plants, indicating healthy boundaries or alone time; and water and nutrients, which may remind the counselor to keep a pitcher of water on the desk and a bag of almonds in a drawer. Externalizing in this way can be particularly helpful when learning self-compassion because often counselors find it easier to care for others than themselves (Patsiopoulou & Buchanan, 2011).

Although exercise has clear mental health benefits (Callaghan, 2004), for some the concept of exercise may lack appeal or may prove difficult to prioritize within a daily work schedule. The use of stretching, walking, or yoga for a short amount of time may be more easily integrated into a hectic schedule. Yoga has been found to be equivalent to exercise in many mental and physical health domains, but not all types of yoga have been found to improve overall physical fitness as compared to more rigorous exercise (Ross & Thomas, 2010). The practice of yoga has been found to increase acceptance of self and others and reduce self-criticism (Valente & Marotta, 2005). Further, the regular practice of yoga can “provide therapists with a discipline capable of fostering a greater sense of self-awareness and helping to develop a lifestyle that is conducive to their own personal growth and the goals of their profession” (Valente & Marotta, 2005, p. 79).

The benefits of movement go beyond improvements in cardiac and musculoskeletal health, while serving to benefit the mind and the spirit. Dance has been used for centuries as a healing practice (Koch, Kunz, Lykou, & Cruz, 2014) and reduces stress, increases stress tolerance, and improves well-being (Bräuninger, 2012). Marich and Howell (2015) developed the practice of *dancing mindfulness*, which utilizes dance as the medium for practicing meditation. Dancing mindfulness participants report improvement in emotional and spiritual domains, greater acceptance of self, and an increased ability to use mindfulness in everyday life (Marich & Howell, 2015). However, caring for oneself requires more than just nutrition and movement; self-care plans should metaphorically consider the environment.

Skovholt et al. (2001; Skovholt, 2012) uses the concept of a greenhouse to describe the characteristics for a healthy work environment. Plants flourish within a nurturing greenhouse environment. Likewise, counselors thrive within a work environment that is characterized by a sense of autonomy and fairness; growth-promoting and meaningful work; reasonable expectations and remuneration; and trust, support, and respect among colleagues (Skovholt, 2012). The metaphorical work “greenhouse” contains individualized supports and resources that allow for growth and

rejuvenation, but can protect the counselor from the harshness that could characterize their work. Examining and adjusting factors that may be under the counselor's control, such as breaks between clients; scheduling of clients engaged in trauma work; number of assessments, intakes, or group sessions in one day; or other malleable elements can help create a work day that best meets the needs of the counselor. Strategic planning and focused intentionality allows the counselor to engage fully in each client encounter.

### **Interventions for the Spirit**

Religion and spirituality are important factors within the lives of many clients (Cashwell, Bentley, & Bigbee, 2007). Within the United States, 77% of adults identify with some religious faith (Masci & Lipka, 2016). However, the United States is growing in those who identify as *spiritual*, with 59% of adults reporting a regular "deep sense of 'spiritual peace and well-being'" (Masci & Lipka, 2016, para. 2). To attend appropriately and fully to clients' religious and spiritual needs, counselors also need to care for their own spiritual selves.

Humanistic counselors engage fully with clients to create a genuine connection and are most effective as helpers in areas in which they themselves are stronger and more grounded (Baldwin, 2013). Therefore, when addressing the spiritual concerns of a client, counselors need to be aware of where they are on their own spiritual path. Otherwise, there is no assurance their own religious or spiritual concerns will not create an obstacle for their client's growth (Sori, Biank, & Helmeke, 2006). A counselor's spiritual concerns can influence the therapeutic alliance in many ways. Influences can include increased reactivity to the spiritual concerns of the client, decreased recognition of how the client values personal spirituality, or inattention to how the client's spirituality may be a therapeutic resource or contributing factor to distress (Sori et al., 2006). Sori and colleagues (2006) concluded that failure to be aware of spirituality as an aspect of the human condition can create potential boundary issues, limit a counselor's understanding of the client due to unexamined beliefs rooted in one's own spiritual background, and result in difficulty managing the emotional uncertainty and pain of clients due to the counselor's own struggles with faith. Therefore, engaging in reflection, exploration, or a regular spiritual practice can benefit both the counselor and the client.

Spirituality in counseling has been defined as "the capacity and tendency present in all human beings to find and construct meaning about life and existence and to move toward personal growth, responsibility, and relationship with others" (Myers & Williard, 2003, p. 149). This definition conceptualizes spirituality as a central component of wellness that shapes one's functioning physically, psychologically, and emotionally, not as separate parts of the whole being (Myers & Williard, 2003). Valente and Marotta (2005) asserted that a healthy spiritual life can be emotionally nourishing and keep burnout at bay. Further, greater self-awareness of one's spirituality may allow practitioners to be more present with their own suffering and that of their clients. Chandler, Miner Holden, and Kolander (1992) stated that attending to spiritual health when making personal change toward wellness will increase the likelihood of self-transformation and greater balance in life. Because there are many expressions of spirituality, individuals wishing to incorporate spirituality into their self-care plan should consider choosing activities that align with personal goals and are consistent with their values (Cashwell et al., 2007).

A spiritual self-care practice can create an inner refuge (Linder et al., 2000) that can offer sanctuary for a counselor when overwhelmed by personal or professional suffering (Sori et al., 2006). Particularly for those in the exploration phase of their own spirituality, but beneficial for all, conducting a moral inventory can assess how individuals are living in accordance with personal beliefs and values (Sori, et al., 2006). Following the moral inventory, a counselor may create a short



list of principles to live by (i.e., a distilled list of values consistent with religious and spiritual ideas that are particularly personally valuable; V. Pope, personal communication, August, 2016). Individual research or joining a spiritual community can be helpful for education, support, and guidance in learning more about a particular religious or spiritual tradition (Cashwell et al., 2007). Some religious traditions, such as Seventh-Day Adventists, offer guidelines for physical and mental exercises, as well as nutritional advice that can be translated into intentional counselor self-care practices. Seventh-Day Adventists have a strong focus on wellness and advocate a vegetarian diet and avoidance of tobacco, alcohol, and mind-altering substances (General Conference of Seventh-Day Adventist World Church, 2016). Further, self-reflection may be regularly incorporated into rituals associated with an important time of year such as Lent or the Days of Awe.

For many, prayer can be a powerful practice for connecting with a higher power. Prayer is an integral part of a variety of spiritual traditions and has been associated with a variety of improvements in health and well-being (Granello, 2013). Spending time in communion with a higher power can be integrated into a regular routine for the purpose of self-care. Meditation also can be a spiritual practice and has a long history of applications and associations with health improvement (Granello, 2013). Broadly speaking, there are two types of meditation: concentration, which involves focusing attention (e.g., repeating a mantra, counting, or attending to one's breath), and mindfulness, which non-judgmentally expands attention to thoughts, sensations, or emotions present at the time (Ivanovski & Malhi, 2007). These quiet practices can allow the participant moments of silence to achieve various ends, such as relaxation, acceptance, or centering.

Connecting with the earth or nature also can be a practice of spiritual self-care. Grounding exercises such as massage, Tai Chi, or gardening can be helpful to encourage a reconnection with the body and the earth (Chandler, et al., 1992). Furthermore, spending time in nature has been found to be rejuvenating both mentally and spiritually (Reese & Myers, 2012).

Engaging in a creative, expressive art activity for the purposes of spiritual practice and healing can be incredibly powerful to heal mind, body, and soul (Lane, 2005). Novelist John Updike has said, "What art offers is space—a certain breathing room for the spirit" (Demakis, 2012, p. 23). Art can come in many forms. Expressive arts can be a powerful tool of self-expression (Snyder, 1997; Wikström, 2005) and provide many options that can easily be used as self-care interventions. Sometimes the inner critic, need for approval, fear of failure, or a fear of the unknown can create barriers to exploring one's creative energy (N. Rogers, 1993). Maintaining a self-compassionate attitude can allow counselors to create a safe environment to practice self-care free of judgment.

Use of dance, music, art, photography, and other media can be used intentionally for holistic healing. Through the use of clay, paint, charcoal, or other media, the creator can become in touch with feelings, gain insight, release energy, and discover alternative spiritual dimensions of the self, as well as experience another level of consciousness (N. Rogers, 1993). Music has been found to be both therapeutic and transcendental (Knight & Rickard, 2001; Lipe, 2002; Yob, 2010). There are various ways to incorporate music into a self-care plan depending on interest, access, and preference. In many cultures, music and spirituality are integrally linked (Frame & Williams, 1996). Listening to a favorite hymn, gospel music, or other type of liturgical music can be one way to revitalize the spirit during the workday. Relaxing music has been found to prevent physiological responses to stress and subjective experience of anxiety in one study of undergraduates (Knight & Rickard, 2001). Singing is another way of expressing thoughts and feelings, and for some it can provide a vehicle for self-actualization, connection to a higher power, and self-expression (Chong, 2010). After a long day, singing in the office, in the car, or while cooking dinner can be particularly cathartic.

## Conclusion

Counselors are routinely exposed to painful situations, traumatic circumstances, and overwhelming emotions. Consequently, they could benefit from creating a safe place for vulnerability, especially when emotionally overwrought after a long day or a particularly difficult counseling session. To thrive as a counselor, self-care is essential, yet many struggle to care for themselves as they care for their clients. To best achieve holistic wellness, counselors must incorporate interventions for the body, mind, and spirit. Counselors can apply self-compassion principles to the creation of an individualized self-care plan, one that functions to rejuvenate flagging professional commitment and soothe potentially debilitating stress. By cultivating an attitude of self-compassion, counselors may be more attentive to their own needs, reducing the risk of developing burnout and benefitting both clients and themselves. These counselors also may be more effective in assisting clients with overcoming their own barriers to self-care. Similarly, counselors who serve as educators or supervisors can model such principles and routinely ask students and supervisees, “What do you need now?” to increase awareness and the practice of tuning in. Consequently, the self-compassionate counselor learns to create a self-care plan that becomes a balm for burnout.

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